

Coping with Pregnancy

Experiences of Adolescents
in Ga Mashi Accra



Coping with Pregnancy

Experiences of Adolescents in Ga Mashi, Accra

Rebecca Henry
Clara Fayorsey

ORC Macro
Calverton, Maryland USA

November 2002



This report presents findings from a qualitative research study conducted in Accra, Ghana in 2002 as part of the MEASURE *DHS+* project. ORC Macro coordinated this activity and provided technical assistance. Funding was provided by the U.S. Agency for International Development (USAID) through its mission in Ghana.

Additional information about the MEASURE *DHS+* project can be obtained from MEASURE *DHS+*, ORC Macro, 11785 Beltsville Drive, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999; email: reports@macroint.com; internet: www.measuredhs.com).

This publication was made possible through support provided by the U.S. Agency for International Development under the terms of Contract No. HRN-C-00-97-00019-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

Suggested citation:

Henry, Rebecca and Clara Fayorsey. 2002. *Coping with Pregnancy: Experiences of Adolescents in Ga Mashi, Accra*. Calverton, Maryland, USA: ORC Macro.

Contents

	Page
Acknowledgments.....	vii
Summary.....	ix
Map of the Ga Mashi Community of Central Accra.....	xiv
1 Introduction.....	1
1.1 Purpose of the Study and Study Questions.....	3
1.2 Background.....	3
2 Methods and Research Process.....	7
2.1 Study Methods.....	7
2.2 Case Studies.....	7
2.3 Teachers and School Personnel.....	8
2.4 Health Care Providers.....	8
2.5 Informed Consent.....	8
2.6 Staff Recruitment.....	9
2.7 Research Schedule.....	9
2.7.1 Phase One.....	9
2.7.2 Phase Two.....	9
2.7.3 Phase Three.....	10
2.8 Demographic Characteristics of Case Study Participants.....	10
3 Growing Up: Work, Aspirations, Dating, and Sex.....	13
3.1 School, Work, and Aspirations.....	13
3.2 Boyfriends, Dating, and Sex.....	15
3.3 Common Sense in Dating and Girls' Reports of Parental Supervision.....	16
3.4 First Sex.....	19
4 Knowledge About the Body, Menstruation, Sex and Contraception, and Pregnancy Intentions and Strategies for Preventing Pregnancy.....	23
4.1 First Menstruation.....	23
4.2 Learning about Sex and Related Topics from Teachers.....	24
4.3 Fertile Period.....	25
4.4 Pregnancy Intended or Unintended?.....	26
4.5 Using Periodic Abstinence.....	26
4.6 Using Modern Contraception: Understanding and Practice.....	27

4.6.1	Condoms and Withdrawal.....	28
4.6.2	The Pill, Injectables, and IUDs.....	29
4.6.3	Rumors.....	30
5	Finding Out About the Pregnancy and Deciding Whether to Terminate or to Continue the Pregnancy	33
5.1	I'm Pregnant.....	33
5.2	Girl and Boyfriend Agree on Birth or Abortion	34
5.2.1	Deciding to Give Birth to a First Child or to Terminate the Pregnancy.....	35
5.2.2	Agreeing to Terminate a pregnancy.....	37
5.2.3	Boyfriends and Husbands	39
5.2.4	Giving Birth or Spacing Second Children	40
5.3	Girl and Boyfriend Do Not Agree	41
5.3.1	Boyfriend Does Not Accept Responsibility.....	41
5.3.2	Girl Wants Abortion, Boyfriend or Husband Wants Birth	43
5.3.3	Girl Wants Birth, Boyfriend or Husband Wants Abortion	45
5.4	Parents or Guardians Decided.....	45
6	Information, Resources, and Techniques for Managing Abortion and Birth in Ga Mashu Town	49
6.1	Knowledge About Abortion.....	49
6.1.1	Early Abortions are Better than Later Abortions: Effects on Fertility	50
6.1.2	Sin or Necessity?.....	51
6.1.3	Keeping Abortion a Secret.....	52
6.2	Experiences of Surgical Abortions	52
6.2.1	Hospital Abortions	53
6.2.2	Abortions in Hospital Staff Quarters	54
6.2.3	Private Clinic Abortions	55
6.2.4	Postabortion Complications from Clinic Abortions	55
6.2.5	Cost of Clinic Abortions	56
6.2.6	Postabortion Counseling After Clinic Abortions.....	57
6.2.7	Incomplete Plans and Failed Attempts to Obtain Clinic Abortions.....	58

6.3	Herbal Medicine and Home Remedies: Using Multiple Methods.....	59
6.3.1	Auntie Mercy or Aatsoo.....	60
6.3.2	Multiple Methods.....	61
7	Conclusions.....	63
8	Recommendations.....	67
	References.....	69

Acknowledgments

The authors would like to thank the USAID mission in Ghana and especially Lawrence Darko and Peter Wondergem for their financial support for this project and facilitating the dissemination workshop in Accra.

We also thank the staff at ORC Macro, especially Stanley Yoder for reviewing the proposal and Glen Heller for support with the Atlas IT data processing during the coding and data processing stages.

We wish to thank the Research and Marketing Systems organization for their support in carrying out a census of health service providers and schools in the Ga Mashi area.

We are grateful to the headmasters, staff and administration of the Wesley Junior Secondary School, the Bishop Boy School, The Sempe Junior Secondary School, and the St. Mary's Secondary for their support of this project during the data collection stages.

Thank you to those participating in the dissemination workshop during which the recommendations for the report were developed. Representatives from each of the following organizations attended the workshop: Ghana AIDS Commission, University of Ghana, Sociology Dept., University of Ghana, School of Public Health, Ministry of Manpower Development, National Population Council, Ministry of Health, Reproductive Health Services, Ministry of Women and Children's Affairs, YMCA, JHPIEGO Corp. Accra, Ministry of Health, Health Research Unit, ISSER, Ministry of Health, Health Education Unit, Graphic Commission Group, University of Ghana, Dept. of Geography, WAJU, PPAG, NCWD, PIP, GBC Radio Production, GSMF Intemation, UNFPA, Ghana Education Service/CRDD, Save the Children, NNS Gender Programme, Ghana Health service, AYA, UNICEF, Engender Health, GSMF, Parliamentary Caucus on Population and Development, ACTION AID, DFID.

Finally special thanks go to all the participants in the project, for their endurance and support. We especially appreciate the patience and enthusiasm of the 29 girls who participated in the study and who shared their experiences of coping with pregnancy.

Summary

This study explores the strategies used by adolescent girls living in urban Accra, Ghana to cope with unintended pregnancies. It examines the processes leading to pregnancy and compares the strategy of terminating a pregnancy with that of carrying the pregnancy to term. The study was initiated in response to findings from the 1998 Ghana Demographic and Health Survey (GDHS) indicating that early pregnancy loss among girls age 15 to 19 was twice as high as that of other age groups, and pregnancy loss among urban teens was twice that of rural areas.

Methods

The study was conducted in Ga Mashi Town in Central Accra, an urban setting. Several field methods were used to elicit information from three groups in the Ga Mashi community: adolescents, school personnel, and health care providers.

The primary method was the collection of case studies for 29 girls who had experienced at least one unintended pregnancy between the ages of 13 and 19. Case studies consisted of three interviews with the girls, each lasting from one to two hours. In addition to gathering detailed pregnancy, birth, and abortion histories, the case studies focused on specific areas of the girls' daily lives related to getting pregnant and coping with the pregnancy once it occurred. For example, besides gathering a family history, we also asked the girls about their experiences of the onset of menstruation, puberty instruction received in the home and elsewhere, their knowledge of contraception, their boyfriends' ages and occupations, and the nature and length of their involvement with these boys, including first sexual experiences.

The other methods included community observations, focus group discussions with in-school and out-of-school adolescent girls and peer promoters, and interviews with teachers and health care providers.

Findings

Growing up: work, aspirations, dating and sex: The participants generally began working during their mid-teens after they had dropped out of school, and their early money-making activities usually involved selling small items. Family financial limitations, rather than getting pregnant, were the main reason the girls cited for not continuing schooling past junior secondary school. They expected to support themselves as adults and to provide some of their children's support. They aspired to move from selling small items to selling bigger items in the market, developing capital to trade, or going on to vocational jobs such as hair braiding or sewing. Along with developing their means of making a living, girls developed ongoing relationships with boyfriends during this stage of their lives.

The majority of participants became sexually active at about age 16, after dropping out of school. Their first sexual partners were boyfriends either close to their own ages or between 5 and 12 years older. Those were boys or men with whom they had an ongoing relationship in which both "love" and "chop money" contributions were essential for a relationship to develop. About a third of the girls described their first sexual experience as involving force and/or deception by a boyfriend, or, as a rape by a nonboyfriend. Such actions caused a substantial number of girls to

begin having sex before they wanted to. A third of the girls reported having relatively few partners (one or two) and long-term relationships of between 4 and 10 years. Not infrequently, these early relationships led to long-term child-rearing unions over time.

According to girls' reports, parents discouraged sexual activity most often when girls were still in school. However, while girls said their parents did not want them to become pregnant too young, according to girls' reports, about half of the parents accepted girls' sexual activities once the girls were past their mid-teens. In addition, the parents advised or supervised the practice of serial monogamy, or "sticking to one guy at a time."

Knowledge about the Body, Menstruation, and Contraceptive Practice: Participants displayed awareness of their own monthly menstrual cycle. They learned this partly through routine puberty instruction given by female caretakers as well as through friends and teachers. Girls described the majority of their pregnancies as accidental or not planned. This included first pregnancies and often, subsequent ones. Although some said they had a vague idea that they wanted one or two children, they were not actively trying to get pregnant at this point in their lives.

The most common strategy the girls used to prevent pregnancy was periodic abstinence. Some parents and teachers encourage girls to practice periodic abstinence with boyfriends, but there was widespread belief that the fertile period occurs during and immediately before and after menstruation, and girls practiced periodic abstinence accordingly. The problem with this widespread belief and practice is that it is incompatible with the biological understanding of ovulation and would logically cause women to use periodic abstinence in ways that would promote pregnancy rather than prevent it. The second most common strategy was use of condoms, although only five girls reported ever using them consistently. Some used them during the nonbiological "fertile period." The participants were hesitant to use other modern methods, including the hormonal methods, especially before they had at least one or two children.

Finding out and negotiating whether to keep or terminate the pregnancy: The habitual monitoring of the menstrual cycle by girls led them to know or suspect, generally within one to two months, that they were pregnant. This advance knowledge gave girls enough time to negotiate within their social network a plan for coping with the pregnancy and still have time for a first trimester abortion. The decision whether to terminate or to continue the pregnancy depended on the social circumstances and people involved.

Most commonly, girls and their boyfriends made the decision to keep or terminate the pregnancy together. If the couple decided to keep the child, a public acknowledgement of paternity was made. If they decided to terminate the pregnancy, the boyfriend often supplied the girl with money to have an abortion although this did not necessarily cause the relationship to end. In situations where the adolescent was dependent on parents or guardians or when the couple did not agree on a plan of action, parents and guardians made the decision. About a third of the time they opted for an abortion and two-thirds of the time for a birth. They generally supplied some financial support for the birth of the child and/or the abortion procedure. There was also a substantial minority of girls whose boyfriends denied responsibility for the pregnancy when it occurred. In such cases, responsibility for terminating the pregnancy fell to the girl or her family. These girls used their own resources entirely or borrowed money for the abortion on a pretext, rather than obtaining all of it or part of it from the boyfriend.

Information, Resources, and Techniques for Managing Abortion and Birth: Information about abortion and the methods used to terminate a pregnancy was readily available to participants from networks of friends. There is some controversy about whether clinic or herbal abortions are preferable, although the majority of girls used clinics for their abortion. In general, it is understood that too many abortions could be dangerous and could affect a girl's future fertility. Although most girls, whether or not they had had an abortion, said that abortion was morally wrong, they all cited practical reasons why it is acceptable for a girl to have an abortion. Their reasons included if the girl did not have the means to care for the child, or parents to help, or if there was no father, or if the girl was in school. The word for abortion in the various languages spoken by the girls connotes murder or spilling blood, while the word for miscarriage connotes a natural process.

Participants used clinics and hospitals most often for their abortion. Of the successful abortions, 23 were clinic abortions and 5 were herbal. The girls were usually accompanied to the procedure by a friend, and less often by a female relative or a boyfriend. Their boyfriends usually paid the clinic abortion costs, which ranged from 30,000 cedis to 300,000 cedis with an average cost of 90,000 to 100,000 cedis. Girls whose boyfriend/husband did not acknowledge the pregnancy and girls who obtained abortions against their boyfriend wishes paid for the procedure themselves using their own money, money they got from parents, money they borrowed from friends, or combinations of these. A clinic abortion was sometimes preceded by a failed attempt to terminate the pregnancy using home remedies, pharmaceuticals, or herbs bought in the market. In the experience of these participants, the vaginally inserted form of Aatsoo seemed to be an effective abortifacient with few side effects when used early in pregnancy. Usually, the cost was less than 10,000 cedis. The participants in this study experienced few complications from their clinic or herbal abortions. There was little postabortion counseling following clinic abortions.

Conclusions

These findings run counter to the assumption that most unmarried adolescent girls who get pregnant generally have multiple sexual partners, are casual about sex, or exchange sex for money out of necessity. In this study, force and deception by boyfriends and other males play a major role in girls initiating sex before they want to. These relationships often continued and thus it seems that date rape may be accepted in this community. Although the "deprivation leading to exchange of sex for gifts and money" dynamic does not fit well with the experiences described by these girls, it may apply to other groups, such as street youth. In addition, it suggests that the "sugar daddy" phenomenon, as described by Dinan (1983) and others, may be more common in Accra among girls with middle socioeconomic backgrounds than those with lower socioeconomic backgrounds or among girls living in other locales, such as Kumasi (1983).

Although girls did make efforts to practice birth control, the methods they used were ineffective and led them to have repeated unintended pregnancies during their teens and beyond. Girls' awareness of their menstrual cycle, however, generally led to early knowledge of the pregnancy once it occurred. This allowed them time to negotiate with their boyfriend, parents, and others about how to handle the pregnancy, and to seek information about abortion services from friends and others if necessary, and still have time for a first trimester abortion.

The study findings contradict to some extent the assertion that the boyfriends or sexual partners of adolescent girls routinely do not take responsibility for mistimed pregnancies or insist on abortions. Rather, it seems that in this community, getting pregnant and having a child together as a couple can be the first step in forming a long-term union. In cases where the couple decided not to continue the pregnancy, the boyfriend usually took responsibility for the abortion costs, as much as he could afford. While it does happen that boyfriends refuse responsibility for a pregnancy, this did not happen in the majority of cases, and care should be taken not to assume this is the rule.

Girls' early awareness of pregnancy, the availability of abortion information and services, and the ability to raise the money, all contributed to obtaining apparently safe abortions. This is not to dismiss the possibility that a minority of girls who are alienated from family and the community may have tragic experiences with other abortive measures. However, this does not appear to be the common experience in this community. Adolescent girls appear to use abortion both to delay childbearing and to space children.

These girls' experiences of adolescent pregnancy challenge some of the basic assumptions on which health surveys of teenage pregnancy and abortion are based and can be used to refine survey strategies. For example, one assumption is that "married" as opposed to "unmarried" is an unambiguous distinction that can easily be measured by asking one question.

The differences in findings between this study of adolescent abortion and those conducted among other groups, such as street youth, or middle class youth, suggest that looking at the data at the aggregate level masks differences that are important for program planning and implementation. Standardizing approaches rather than adapting them to specific groups, can lead to programs that do not address the health behavior of the adolescent group the program is designed to change.

Recommendations

Pregnancy and Sexual Violence Prevention

Since girls who become pregnant often begin having sexual relationships after they leave school, pregnancy-prevention efforts should focus on both male and female out-of-school as well as in-school adolescents and youth. The following strategies might be used to reach these groups.

- Build on existing puberty practices of parents and other caretakers. Parents and other caretakers might be educated to include information on the biological fertile period, modern methods of contraception, and the dynamics of date rape, to their existing practices of puberty instruction. An example of a message aimed at boys through their parents and caretakers is, "When a girl says no to sex it means no." For girls, "It is important to say no both verbally and non-verbally through body language."
- Many girls who have recently migrated to Accra from other areas of Ghana might be reached with pregnancy-prevention and sexual violence education through the "madam" for whom they sell food items and with whom they live. Others might be contacted through local "susu collectors" or mobile bankers, since many save their money this way.

- Train teachers about the biological fertile period during pre-service training and in-service training on holidays and encourage routine teaching of pregnancy prevention, including modern contraception in the classroom. Encourage teacher-parent dialogue about the curriculum related to reproductive health in the schools at PTA meetings in the schools, so parents are aware and can reinforce learning.
- Encourage family planning, postnatal care, and abortion providers to promote biological understandings of the fertile period and modern methods of birth control. Postnatal care and abortion clinic visits are opportunities to reach adolescents and youth with information about modern contraception.

Abortion Education

Conduct dissemination meetings for health care providers, e.g., hospital, family planning, maternal health, abortion, and postabortion providers, regarding the findings of this study of adolescent pregnancy and abortion to generate further strategies to reduce the incidence of unwanted pregnancy and abortion among adolescents and youth in their communities.

Since some pregnant girls are more vulnerable than others—those without supportive boyfriends or those involved in a family conflict over whether or not to have an abortion—social service and abortion service providers should be informed of these differences and instructed how to assess girls’ vulnerability and provide support accordingly.

Development of Public Awareness and Social Support Programs

Expose the public to the variations in the social dynamics of teenage sexual practices and use of abortion in the community. For example, include information on how and where forced sex generally occurs so parents, caretakers, and adolescents can be alert to preventing opportunities for sexual violence.

Develop adolescent centers that provide adolescent-friendly reproductive health services. Keep the scope of the centers broad, beyond reproductive health.

Strengthen already existing UN and MOH programs to support girls’ education.

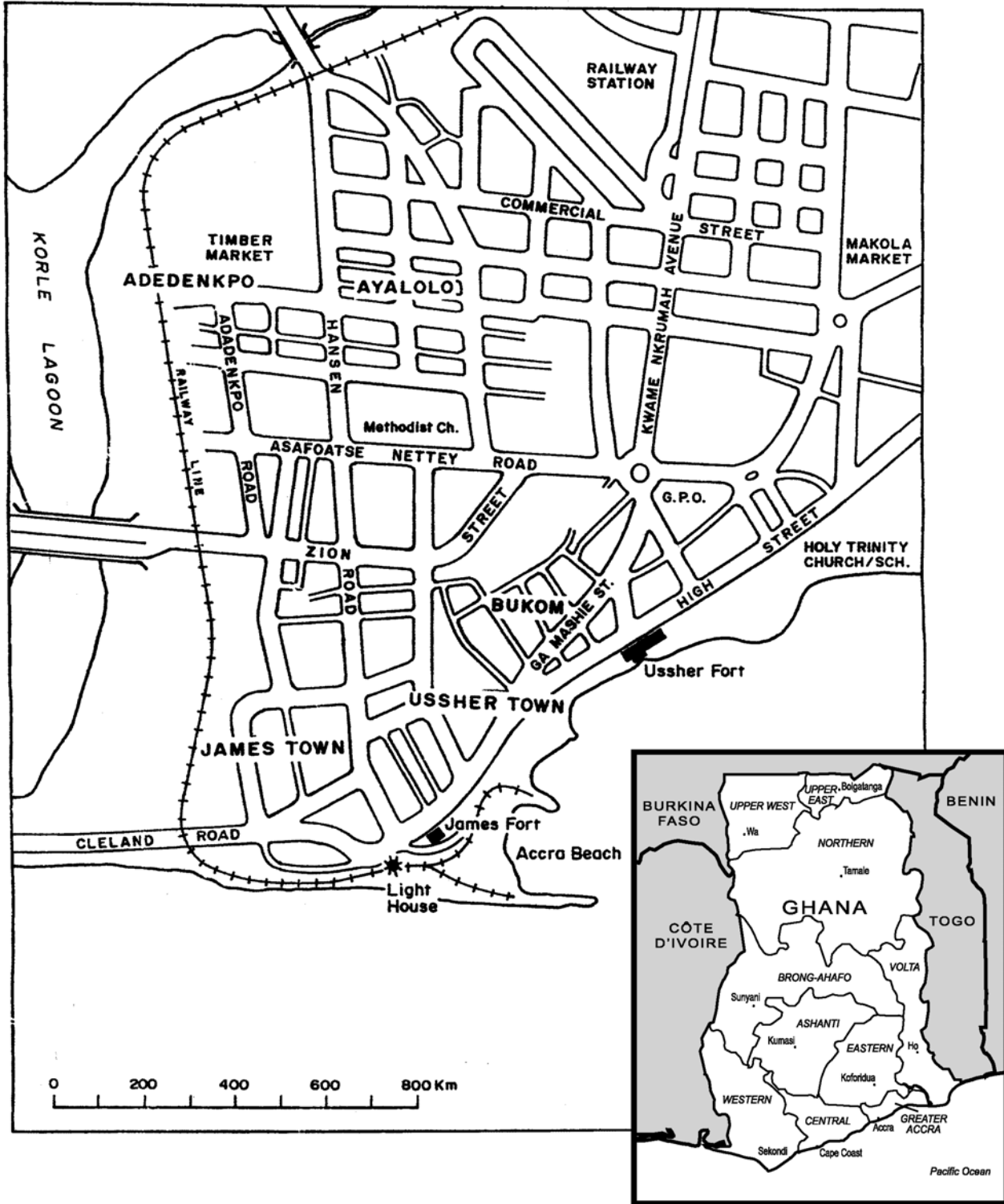
Data Collection and Research

Since there is variability in the process of becoming married and living arrangements during the process, characteristics such as “married” versus “unmarried,” “broken home,” or “single-parent family” must be defined and measured carefully according to local practices; they cannot easily be measured by asking one question on a survey questionnaire.

The differences between the findings of this study of adolescent abortion and those of studies conducted among other groups, such as street youth or middle-class youth, suggest that local studies should be implemented to guide program planning and implementation according to local practices.

STUDY AREA

THE GA MASHI COMMUNITY OF CENTRAL ACCRA



1 Introduction

This study explores the strategies used by adolescent girls living in urban Accra, Ghana to cope with unintended pregnancies. It examines the processes leading to pregnancy and compares the strategy of terminating the pregnancy to that of carrying the child to term. The study is initiated in response to the findings of the 1998 Ghana Demographic and Health Survey (GDHS), which found early pregnancy loss among girls age 15 to 19 to be approximately twice as high as in other age groups. In urban areas, pregnancy loss among teens was more than twice as high as in rural areas. Most of these losses seem to be induced abortions. A high incidence of abortion among teenage girls poses numerous social and health concerns for public health professionals. For example, one may ask whether or not adolescent pregnancies are intended. If they are not, what practices are leading to unintended pregnancies? Are girls using unsafe methods to terminate unwanted or mistimed pregnancies? Are their futures adversely affected by becoming pregnant and/or by having an abortion? The health survey-based studies from Ghana provide some insight into these questions.

The 1998 Demographic and Health Survey found that sexual activity generally begins before marriage in Ghana; the average age at first sex being 18 while the average age at first marriage was 20. Other smaller, targeted surveys of adolescent sexual activity in Ghana found that the sexual initiation of many adolescents starts much earlier and varies according to their residence and education (Agyei and Hill, 1997; Nabila and Fayorsey, 1996; Adomako, 1991; Ankomah and Ford, 1994; Anarfi, 1997). Researchers have identified a whole gamut of reasons for initiation to sex before marriage. For example, some look to adolescents as the cause, citing peer pressure, deception by partners, experimentation, and desire (Adomako, 1991). Some cite the loss of puberty initiation practices, once quite extensive and consistently practiced in Ghana, and the resulting lack of knowledge and guidance (Tagoe-Darko, 1997). Yet, others blame early sexual initiation or poverty and the resulting “sugar daddy” phenomenon (exchange of gifts for sex), the lack of supervision or support from parents, or the moral degeneration of the younger generation (Nabila and Fayorsey, 1996). Regardless of the dynamics of sexual initiation, most surveys find that adolescents in Ghana do not tend to use modern contraception regularly to prevent pregnancy.

The recent demographic and health survey found that among sexually active adolescents age 15 to 19 who reported having had intercourse during the preceding month, 79 percent said that they were not using any contraceptive method (GSS and MI, 1999). The GDHS, like other studies of contraceptive use among teens, found that although knowledge and approval of the use of modern contraceptives was high, contraceptive use was low (Agyei and Hill, 1997). Periodic abstinence appeared to be the most used method among teens (PIP, 1995) and condoms were the most used modern method of contraception (Adomako, 1991; Ankomah, 1998). A countrywide analysis of family planning points found that most providers will not provide short-term contraceptive methods to women with fewer than 2 children or long-term methods to women with fewer than 3 to 4 children, which also affects contraceptive use by teens (GSS, 1997; Stanback and Twum-Baah, 2001). Not surprisingly, about half of the girls who got pregnant during their teens, whether married or not, said that the pregnancy was mistimed (GSS and

MI, 1999; Nabila et al., 2000). What makes a pregnancy “mistimed” is unclear. Abortion, however, appears to be a fairly common strategy for controlling births in Ghana.

Although exact figures on the incidence of abortion are difficult to obtain (GSS and MI, 1999; Agyei and Hill, 1997), a recent study estimated the rate to be as high as 19 abortions per 100 pregnancies (Ahiadeke, 2001). The Ghanaian government relaxed its abortion law in 1985, allowing registered physicians to perform abortions if “pregnancy results from rape or incest, if the physical or mental health of the mother is at risk or in cases of fetal disease or abnormality” (Rahman et al., 1998). In practice, however, it is an open question whether medically performed abortions are available to the general public including adolescent girls.

Some studies based primarily on focus group survey methods have found that adolescent girls experience more complications from abortion. The reasons are complex, and include the tendency to delay getting an abortion and having less access to surgical abortions because of excessive fees and other medical barriers. As a result, adolescent girls seem to often resort to unlicensed providers and unsafe methods to obtain an abortion (Ampofo, 1989; Garshong et al., 1999). In addition, because of assumptions about why and with whom girls become sexually involved, (“sugar daddies” or casual partners), they are not likely to be supported by their partners when they become pregnant and do not have the financial resources to obtain safe abortions. Another likely reason why girls get abortions is lack of awareness or information about their bodies. A study by Lassey (1995), however, contradicts the idea that adolescent girls delay getting abortions. His study found that of the 212 admissions for complications of induced abortion (40 percent among girls age 15 to 20), most abortions had been conducted in the first seven to ten weeks of pregnancy. Health complications were not analyzed according to age, although significant complications occurred at registered and unregistered health facility sites and among those using self-induced methods. Pregnancies among adolescent girls also seem to have negative consequences on their well-being and their future.

One of the factors that seems to underlie the pattern of early sexual initiation is an educational gender bias in Ghana, whereby parents generally prefer to educate their sons and not their daughters (Lloyd and Gage-Brandon, 1994). Girls without financial resources who want to remain in school are thought to trade sexual favors with boys and men who supply them with the material and financial resources they need to stay in school. Girls who practice unprotected sex with multiple partners are at greater risk for acquiring HIV infection, and may have little say in the use of protection during these sexual encounters (Akuffo, 1987; Anarfi, 1997). In addition, early pregnancy seems to be a reason for girls leaving school, thus decreasing their chances of getting an education and all of the resulting opportunities that education confers (Akuffo, 1987; Adomako-Ampofo, 1991; Anarfi and Awusabo-Asare, 1993).

Although demographic and health studies of adolescent health in Ghana contain useful information about the dynamics of adolescent sexual behavior, contraceptive practices, pregnancy, and abortion, they say relatively little about girls’ perspectives and experiences on these matters. For example, there is little understanding about how teenage girls try to prevent pregnancy other than by using modern methods or how a pregnancy (accidental or otherwise) affects their aspirations and their social situation. It is not known how the decision to terminate a

pregnancy is made—that is, why one course of action is preferred, what alternatives are available, how pregnant unmarried girls seek support, advice, and treatment, or how the male who fathered the child influences these processes. By examining a range of adolescent experiences and drawing on the ethnographic literature, this study seeks to identify how girls become pregnant and then cope with the pregnancy and when they and their significant others might benefit from interventions. Insight into the specific dynamics of the process from the girls' perspectives offers new information for developing a coordinated and targeted effort between family planning, abortion and health education service providers, and schools to address issues related to teenage pregnancy and abortion in the community.

1.1 Purpose of the Study and Study Questions

The study plan recognizes unmarried adolescent girls as active agents in the social processes of becoming pregnant and coping with an unintended pregnancy, and thus the study questions focus on their actions and the events surrounding unintended pregnancy.

The study is organized around the following questions:

1. What are the backgrounds and defining life events of unmarried adolescent girls living in Ga Mashi Town? What are their experiences with sexual relationships?
2. What strategies are used to prevent pregnancy? How and what do girls learn at home, from friends, and in school about sex, pregnancy, and contraception?
3. What strategies are used by unmarried adolescent girls to cope with unwanted pregnancy? How do peers, sexual partners, parents, siblings, teachers, and others figure into the decisionmaking process, and how are information and material resources obtained and used? How do girls' estimation of their life chances and their future plans affect their actions and their decision to keep or terminate a pregnancy? What are the processes involved in carrying the child to term or terminating the pregnancy (including postabortion care and family planning counseling) in Ga Mashi Town?

1.2 Background

The study was conducted in Ga Mashi Town in Central Accra (see map). This Accra neighborhood was chosen as the study site for two reasons: 1) because it is an urban setting and the incidence of “pregnancy loss” in urban settings was found to be about twice as high as in rural settings (GSS and MI, 1999) and 2) the principal investigator from the University of Ghana hired to conduct the research had previously conducted research in this community and thus had connections on which to draw.

According to oral traditions and historical research, the current site of Accra was first settled by several Ga clans who had migrated from what is now Nigeria in the beginning of the 14th century. Ga oral tradition says that people came by land and by sea from Benin and further east over time (Buah 1980). Central Accra, where Ga Mashi is located, is one of six Ga towns¹

¹ There are six principal Ga towns, namely, central Accra, Osu, La, Teshie, Nungua, and Tema.

and covers a wide area including government administrative blocks, markets, residences, and various commercial centers. Central Accra is composed of both the nucleuses of Ga people—no longer considered the majority (Dakubu, 1997)—around the beach and extends inland, covering areas like James Town, Ussher Town, Bukom, and a highly heterogeneous migrant settlement adjoining this traditional enclave. The main languages spoken in the city are Ga, Twi, Hausa, and English.

Central Accra is populated largely by traders and fishermen, and most of the inhabitants of Ga Mashi Town are in the lower socioeconomic class. The area is very densely populated, with compounds including from 6 to 20 people. Most houses do not have kitchens, bathrooms, or toilets. Ga Mashi does have shared public facilities, such as public toilets and public baths. There are at least four junior secondary schools (JSS) and one senior secondary school (SSS) in Ga Mashi, and these are a mix of private and public schools. There are also two public health facilities—the Ussher Polyclinic and the James Town Clinic—as well as a number of private health facilities, such as pharmacies and midwife homes. Korle-Bu Hospital, associated with the University of Ghana and the main teaching hospital in the country, is located within 20 kilometers of Ga Mashi Town and provides abortion services to a large population of adolescent girls in the area.

The population of Ghana includes several dozen ethnic groups that speak approximately 44 languages. The Akan family of languages such as Twi and Fante dialects are spoken most commonly (Lentz, 2000). Twi is almost the lingua franca of Ghana.

The participants in the study came from seven ethnic groups and included 13 girls from different Akan groups, 13 from non-Akan groups (mostly Ga), and 3 of mixed ethnic origin. Such diversity makes it difficult to generalize about the residence and marriage patterns that would be historically familiar to the families of these girls. The DHS data from several West African countries have shown that ethnic contrasts remain strong in rural areas but tend to dissipate in urban areas. There are, however, several contrasts between the Akan and Ga people that are relevant to puberty rites, marriage, and residence patterns.

The matrilineal Akans were once primarily farmers, and the maternal uncle played a major role in household decisions. Marriage was exogamous and, after marriage, the woman went to live with her husband. Marriage was a process that began with a public declaration of intention to marry, whereby the groom's family offered drinks to the bride's family, and then moved to an "engagement" period when the bride price was negotiated. Once satisfactory payment was made, the bride could move in with her husband.

Among the Ga people, the pattern of negotiating marriage was similar in that it progressed in stages and culminated with the payment of the bride price. However, once the bride price was paid, the bride often continued to live with her mother. Duolocal residence was the norm for married couples. The men and women of the Ga people once lived in separate spaces, with men living with their brothers in groups of 3 to 10. Thus, there was no expectation that newlyweds would establish their own household separate from the extended family. Ga extended-family households were women-headed economic units based on trade, and all the

members were expected to contribute. Young girls became part of this trading system early on, often dividing their time between attending school and working for the household. Living in extended family units is the norm, but the distinct separateness of the sexes has somewhat diminished in Central Accra. From a survey of Ga Mashi Town, Fayorsey found that about 70 percent of married women were not living with their husbands (Fayorsey, 1993). They sent them food and spent nights with them, but their primary residence remained a compound largely made up of female relatives.

2 Methods and Research Process

2.1 Study Methods

Several field methods were used in this study to elicit information from three groups in the Ga Mashi community: adolescents, school personnel, and health care providers. The primary method was the collection of case studies for girls who had experienced at least one unintended pregnancy between the ages of 13 and 19. The other methods included community observations, focus group discussions with in-school and out-of-school adolescent girls and peer promoters, and interviews with teachers and health care providers.

2.2 Case Studies

Case study information was gathered from 29 girls. The girls were recruited in two ways to participate in this study. First, interviewers went house to house in Ga Mashi Town to ask whether there were adolescent girls of reproductive age in the house and whether they would like to participate in focus group discussions about girls' health. During the focus groups, questions were asked about the body, pregnancy, and abortion. After the focus group discussions, some girls who had children or who had expressed more knowledge of abortion were asked individually whether they had had an abortion and whether they would like to participate in the in-depth interview phase of the study. Second, during the house-to-house recruitment, some girls—when the opportunity to speak with them alone arose—were asked whether they knew anyone who had experienced a pregnancy as an adolescent. Those who said that they had had an abortion were invited to participate in the study. Eventually, through word of mouth among girls in the neighborhood, 29 girls were recruited and interviewed. The interview took place at a school in the neighborhood to preserve the girls' anonymity.

Each case study consisted of three interviews with the girls, each lasting from one to two hours. In addition to gathering detailed pregnancy, birth, and abortion histories, the case studies focused on specific areas of the girls' daily lives related to getting pregnant and coping with the pregnancy once it occurred. For example, besides gathering a family history, we also asked the girls about their experiences of the onset of menstruation, puberty instruction received at home and elsewhere, their knowledge of contraception, their boyfriends' ages and occupations, and the nature and length of their involvement with these boyfriends, including their first sexual experience. We also asked about their schooling and their aspirations, including how they made money and planned for the future.

The case study was intended to make this type of research as holistic as possible, including the interviews with those most intimately involved in helping the girls cope with the unintended pregnancy. According to the interview staff, however, the girls did not give permission to interview their parents, sexual partners, and close kin. Therefore, the analysis is based mainly on the participants' reports of their experiences.

Field observations included observations of the daily lives of adolescents living in Ga Mashi Town, which were recorded by fieldworkers throughout the project. This included the places where the teens hung out, what they did after school, how they formed groups, what they

did for fun, what media they watched or read, and how they earned money. An assessment was also conducted to locate the schools and private and government health care facilities in the neighborhood.

Focus group discussions were conducted with in-school and out-of-school adolescents as well as with peer educators at the schools that the case study participants attended. These groups served several purposes: they assisted in the recruitment of additional schoolgirls who had experienced unintended pregnancy to participate in the study, they gathered additional information on adolescents' knowledge of reproductive health, and they learned more about what adolescents do for fun.

Information on the schools the girls attended and the facilities where they obtained their health care, including abortions, was gleaned from the interviews conducted with the girls.

2.3 Teachers and School Personnel

Twelve teachers, administrators, and school health personnel who served the girls participating in the study were interviewed. These interviews were held during the second and third phases of the study in five neighborhood junior and senior secondary schools. The school employees were also interviewed on school policy regarding premarital sex and student pregnancy, and on what students are taught in the school's curriculum about reproductive health. Members of the research team attended sex education classes, which included information about abortion, for each grade level in which this subject is taught.

Health care providers, school personnel, and others who communicated with the girls participating in the study were prioritized for interview. Other providers, school personnel, and community members were added to fill out the sample as needed.

2.4 Health Care Providers

Eleven health care providers who serve the Ga Mashi Town community were interviewed. These included both biomedical providers (government and private clinicians and hospital staff) and nonbiomedical providers (pharmacists, peer promoters, abortionists, herbalists, and others) from four facilities in the area and the market. They were interviewed about their experiences serving unmarried adolescent girls and their policies and/or practices regarding abortion and postabortion care.

All the interviews were tape recorded and translated into English. The interview guides were generated according to the objectives outlined above.

2.5 Informed Consent

All the participants in the study consented to be interviewed, either orally with the investigators' signatures, or in writing. Oral consent for participation was obtained once the groups had convened and before the discussion. Girls considering joining the study were read a consent form and then asked if they would like to join the study, and oral consent was obtained.

The biomedical practitioners (public health nurses, midwives, and doctors) and school personnel (teachers and administrators) were required to sign a consent form before being interviewed.

2.6 Staff Recruitment

A Ghanaian anthropologist on the faculty of the University of Ghana was hired as a principal investigator to direct the fieldwork. The investigator then hired two masters' students and one research assistant to recruit and interview the participants.

2.7 Research Schedule

2.7.1 Phase 1

Phase 1 involved four focus group discussions and in-depth interviews of the 29 girls who had been chosen as the primary participants from whom the case study information was to be gathered.

For the first week, 24 girls were recruited from the Ga Mashi communities to participate in the first two group discussions. The recruitment was done on the basis of age and residence in the community. During the first two focus group discussions, which were held with both in-school and out-of-school girls, participants were asked to assist in identifying young girls who had been pregnant before and had either carried the pregnancy to term or had an abortion. Some of the focus group participants later became respondents for the actual case studies. Two other group discussions were held with peer promoters and adolescent boys.

The first phase of the study also included initial interviews with the case study participants. An average of four girls were interviewed each day by the principal investigator and the two research assistants. All the interviews were tape recorded and transcribed.

In addition, information on where the girls went for health services and attended school was noted and, during the second phase of data gathering, was used to identify the health care providers and teachers to be interviewed. During this phase of the study, some in-depth interviews with school personnel and health care personnel were also conducted.

2.7.2 Phase 2

The major aims of the second phase were to conduct in-depth interviews with teachers and school administrators on adolescent reproductive health issues—and specifically on school policy about reproductive health—and to conduct a second round of interviews with the girls and the members of their social networks. The girls were not very enthusiastic about our request to interview the members of their social networks, especially their boyfriends, mothers, and aunts. The reason given was that although teenage pregnancy is common, there is still a stigma attached to the termination of pregnancy, especially through abortion. Abortions are therefore performed secretly, with the knowledge of few friends or relatives.

Twelve teachers from schools the girls attended were also interviewed during this phase. Classroom observation during life skill classes was also carried out during this second phase in all of the five schools visited. These classroom observations were performed to enable the investigators to assess the content of the schools' curricula on sexual and reproductive health.

Phase 2 also involved a second set of interviews with the 29 girls.

2.7.3 Phase 3

The major aims of the third phase of the study were to conduct in-depth interviews with some modern and alternative health service providers and to complete the third set of interviews with the 29 participants.

The third phase was beset by major setbacks. The research team spent a week trying to locate and interview providers of abortions in the Ga Mashi area. Although some members of the community identified them, when we approached these providers, they were not willing to be interviewed. All of the abortion providers we contacted denied having performed abortions. This may be because, during the third phase of the study, the community seemed to become highly sensitized to the issue of unwanted teenage pregnancies because of our frequent visits to certain members of the community. Most of those performing abortions were not ready to talk to us; they were either afraid or thought we were from the police. The one person who performed abortions who agreed to be interviewed evaded our questions.

The third phase also required numerous callbacks on the 29 girls we had interviewed during the first two phases of the study.

2.8 Demographic Characteristics of Case Study Participants

Twenty-nine adolescent girls and youth age 15 to 24 who had been pregnant in the last year and a half and who had experienced an unintended pregnancy between the ages of 13 and 19 were recruited as participants. The sample may be divided into two groups: the 15- to 19-year-olds, who are strictly adolescent girls, and the 20- to 24-year-olds, who may be described more appropriately as "youths" but who had experienced pregnancy and abortion as adolescent girls. Thirteen of the girls were between the ages of 15 and 19, and 16 were between the ages of 20 and 24 at the time of the interviews.

The collective pregnancy experience of the girls was substantial. All of the participants had had at least one pregnancy, 18 participants had experienced two or more pregnancies between the ages of 13 and 19, and 9 participants had experienced three to seven pregnancies.

Age	Unintended pregnancies	Number of abortions	Number of births	Number of miscarriages
14-19	49	21	26	2
20-22	14	9	5	
Total	63	30	31	2

About a third of the participants can be considered migrants to the area; they had lived in cities outside of Accra through puberty and early adolescence. Some had experienced their unwanted pregnancies in other locales. These were mainly Kwahu, one or more of their parents being from or around Bimbong. Most of these girls lived together in a compound with a “madam,” a term the participants used to refer to a woman for whom they worked and with whom they also usually lived.

3 Growing Up: Work, Aspirations, Dating, and Sex

Interviewers asked participants open-ended questions about their school and work experiences and their aspirations. They also inquired about the girls' sexual and relationship history—for example, the nature of their relationships, with whom they had been involved, what their first sexual experience had been like, and why they remained with a boyfriend. The process by which these participants formed child-rearing unions in this community emerged through this interview and helped clarify the factors leading to early pregnancy and how and why the girls chose to continue their pregnancy or ended up terminating it. Parents' and guardians' participation in the process of girls' schooling, work, and dating activities, as described by the girls, is also considered in this chapter since this adult oversight affected the girls' activities.

3.1 School, Work, and Aspirations

It was clear from the responses of all the participants that they fully expected to make their own living and provide a good amount of their children's support. This is common practice among women in many parts of Ghana (Clark, 2000; Birmingham et al., 1966; Lloyd and Gage-Brandon, 1993). When asked about their aspirations, most girls said they either wanted to develop their trading activities by acquiring capital to buy goods or that they wanted to complete vocational training in hair braiding or sewing. During these conversations, the girls rarely referred to finishing secondary school and getting a white-collar job as an aspiration or as a missed opportunity.

The average grade completed among the participants was JSS 1 or the first level of junior high (UNESCO, 1992). Nearly all the participants reported that their parent(s) had wanted them to continue school for as long as possible and had urged them to avoid getting pregnant while in school. Most of their parents, they said, were not able to provide the financial support—including fees, supplies, uniforms, desks, and chairs—necessary for them to continue school beyond the primary or JSS levels.

According to the girls' reports, the main reason for dropping out of school was because their parents or guardians could no longer afford to pay for their schooling. As they further described their situations, it was apparent that multiple reasons, including family finances, the girls' interest and aptitude, and other school-related factors, often contributed to their dropping out. The latter reasons included things such as exams thrown out due to irregularities or lack of furniture at the school. The reasons the girls gave for their parents' inability to pay for school included a decrease in income due to divorce, illness, a downturn in business, or job loss. A change in the status of the parents' relationship, such as divorce, led to a decrease in child support, usually (but not always) from the father. Sometimes, the parents being involved in some trading activity that required them to move from city to city was cited as a contributing factor. The following account was given by one girl, Diana, who had wanted to stay in school but could not convince her father to help her financially.²

I attended school near the Timber market, and all along it was only my mother who cared for me. I didn't know who my father was until I got to JSS 1, when we were told to bring our own tables and chairs to school. My mother couldn't afford them, so I insisted I

² Pseudonyms are used for all study participants and interviewers.

wanted to see and get to know who my father was. So, at age 11, I got to know my father. I thought that getting to know and meet my father was going to lessen my mother's financial burdens, but I was wrong. My father continued to be irresponsible towards us, his children. [Diana]

Most of the participants started to work during their teen years, usually after they had already dropped out of school. The girls' first jobs were mainly to sell small items in the market or "in the traffic." For example, Karen said,

Everything, sometimes handkerchiefs, sometimes polish. I used to sell in the traffic or sometimes at Katmanto market. . . If I sold one packet in a day I made a profit of 10,000 cedis. [Karen]

Participants said that they sold items such as corn, maize, water, shoe polish, kenkey, oranges, fried fish, ice water, and ground nuts. They reported making about 5,000 to 15,000 cedis profit per day selling small items (7,000 cedis = \$1 US, approximately). Over time, the girls described moving into better moneymaking situations, such as selling at a stall in the market. A fair number of participants managed to save money from these earnings to improve their earning situations—by getting vocational training, for example.

Those who attended some vocational training used their savings and/or the contributions of boyfriends or parents to pay the training fee.

I always kept 5,000 cedis and used the other 5,000 cedis. I had already gone to ask the charge for learning hairdressing; they said they would charge 400,000 cedis and a crate of minerals and one bottle of liquor. So when I saved up to the necessary amount I gave the money to my mother and she bought the drinks and sent me to the hairdresser. [Karen]

Karen reported that it took more than a year to save 50,000 cedis to begin vocational training. Vocational training was sometimes interrupted by a pregnancy and/or the inability to continue paying the fee. One participant who reported making more money than was typical said that it was her boyfriend who had set her up with enough capital to trade larger goods.

Some girls who started working while they were still attending school said that their interest in school eroded because of work. For example, Lily said,

She [mother] was a fishmonger and that was her main source of income. . . back when there was a lot of fish in our waters my mother was quite rich and we had no problems financially. I used also to sell, so whenever I needed something I bought for myself. In some cases, I even paid my own school fees. . . Well, I did [enjoy school] at a time when my mother was a bit wealthy, but when I had to sell in order to help educate myself I lost interest in school, so my performance was poor. [Lily]

Another participant, Rachel, said that her boyfriend convinced her that school was a dead end.

My mate discouraged me [from continuing school] by saying that, in fact, lately it is more difficult to get jobs even if you get the highest of all qualifications. So why worry oneself to continue and waste time schooling when one is only going to be jobless? So I quit school and started trading.

She went on to explain how her stepfather reacted to her dropping out of school.

In fact, my stepfather in particular was very disappointed and did all he could to send me back to school, but I refused. My mother also tried to talk to me of my school, but I refused to listen to both of them and did whatever I wanted. But now I wish I had continued. [Rachel]

According to the girls' reports, only 5 of the 29 participants were in school when they had their first sexual experience and only 4 were in school when they got pregnant for the first time. The teachers interviewed in the study tended to confirm that the girls did not become pregnant before leaving school. For example, even the teachers with the longest tenure (42 years) could recall only two cases of a student who left school because of pregnancy. Most of the teachers could not describe any such firsthand experiences with students.

3.2 Boyfriends, Dating, and Sex

When we asked the participants why they got involved with their boyfriends, they all cited both love and financial support. For example, when asked whether she had gotten involved with her boyfriends for financial support, Yolanda said,

Well, much as I did love them, the first and second ones were also money motivated. I was then in school and needed some financial support. And since they were in a position to help, I gave in. [Yolanda]

Pellow described the presence of this social dynamic in Ghana as far back as the 1970s: "Today premarital sexual life is woven round the notion of material recompense for sex, and no self-respecting woman would enter into a premarital sexual relationship without the potential for material recompense" (Pellow, 1977), as have others more recently (Ankomah and Ford, 1994; Mikell, 1988).

Dinan distinguishes this type of "sexual exchange," which is considered acceptable to both men and women in Ghanaian society, from "formal prostitution," which is not (Dinan, 1983).

In general, the participants objected to any suggestion in the interviewers' questions that they got involved with men because of money alone. Ruth clarified this by saying,

Okay, not financial support, but he saw me and he liked me; so I was seeing him. It's not just because of money that a woman sees a man. [Ruth]

A minority of the girls said that they had gotten sexually involved with a boy or man because of money or because they were not looked after by their parents. Although some cited the previous reasons, further questioning exposed multiple other motivations. For example, Karen said,

I got involved with him because they [my parents] were not looking after me. He was giving me money to eat with, then I would also work and add some to it. That's how I got involved with him. [Karen]

But Karen, whose boyfriend denied responsibility when she got pregnant, also said,

Yes, I did love him, but the way he behaved when I got pregnant! [Karen]

Although the reasons for becoming involved were not wholly financial, in Ga Mashi—as in other places in Ghana—financial contributions to support daily life were an expected part of developing a relationship with a boyfriend. The financial contributions of the boyfriend to the daily needs of the girl were referred to as “chop money.” Abu made the following observation about chop money, which suggests the degree to which the practice is embedded in love relationships: “Chop money,” the Ghanaian-English phrase for “money for food,” is the subject of much marital strife. The Akan verb stem *di* (to consume, enjoy) refers both to eating and to sexual relations. Moreover, the Ghanaian-English verb “to chop” refers to both food and sex...Chop money is both a practical economic arrangement and a symbol of love. A man’s interest in a woman is indicated by how much effort he makes to satisfy her needs” (Abu, 1983). Abu suggests that the regular contribution of chop money is a feature of not only premarital but also of married life in Ghana, and that it is one of the conditions of an ongoing relationship.

The girls participating in the study used chop money for their daily needs. Besides food, it was used for medical expenses, school fees, clothes, or for miscellaneous items needed on a day-to-day basis. If the boyfriend was unable to provide any support, the girl did not stay with him long-term, regardless of whether or not she loved him.

I loved him, but he could not buy me the things I wanted. He was not working, he could not help me, and I was not grown; I was not doing anything. [Arial]

The daily needs of the girls from poorer families may make them more likely to use chop money for basic rather than luxury items. However, the participants said that they did not get involved solely for this reason.

3.3 Common Sense in Dating and the Girls’ Reports about Parental Supervision

The girls’ reports of their parents’ and guardians’ responses to their early sexual activities suggest that sex with boyfriends was more strongly discouraged while the girls were still in school. Parents used a variety of means to discourage their daughters from having sex. Joy, for example, explained how her mother convinced her to wait to have sex with her current husband, who is six years older than her.

When I got to form 1 at the age of 13, at the time my husband was expressing interest in me, my mother called me and told me I was not old enough to go into relationship, so I

should forget about that. She told me men would trick me, but if I gave myself to any man, he would leave you. She said she wanted me to complete my schooling and not stop midway, so I should not get involved with any man and get pregnant; if I would be friends with him I should not have sex with him. So I also took good care of myself and did not allow him to sleep with me. I had my ways of keeping him away. He took care of me when I was in school, he bought pamphlets for me, exam fees. He used to help me out. [Joy]

According to the girls' combined reports, the most common method of supervision by parents or guardians was to routinely keep the girls near home and occupied after school until bedtime with household chores, eating, and schoolwork. For example, Charity noted,

Especially when I was in school, I was warned to stay away from boys. We were mostly indoors anyway after school. I'll clean the house and eat, then my father's wife would teach me at home. After that we'll all sleep. [Charity]

Some parents monitored their daughters to prevent them from having extended contact with boys after school and would separate them when they observed friendships developing. For example, Iris said that, since her first menstruation, her mother's reaction was the following:

[She] discouraged me from having male friends around my area where I lived. She always complained whenever she saw me talking with men she didn't really know. Sometimes she even sends me away from the men. [Iris]

One girl said she was sent to a foster parent because her mother did not like a girl she had befriended. A minority of the girls reported occasional physical abuse by family members as a method to keep them away from boyfriends or other men, including relatives. Opal said she was beaten by her brother when she was 14 or 15 years old for staying overnight at the home of her boyfriend, a man she eventually had two children with and now considers her husband.

I had this boy who used to give me lots of gifts during the difficult conditions in my life, so I used to go to his house. Sometimes I would stay for about three days [at boyfriend's house] before coming home. But my big brother did not like the idea and beat me whenever I went to see the boy. Anyway, all the beatings did not deter me from sneaking to the boy at night and coming home the following dawn. [Opal]

Although some girls reported that their parents or other relatives attempted to keep them from having sex, most of the girls said that their parents advised them, but did not restrict their movements with boys and men during their teens. Advice from parents and friends included telling them how to keep from getting pregnant or getting involved too young. In the following excerpt, one girl explains her mother's approach:

Girl: Yes, she told me that when my period is due I should not have sex. If I do and he puts his sperm in me, I will conceive.

Interviewer: That means they are not against you being sexually active, but they want you to be careful so as not to get pregnant?

Girl: Yes. . . They ask me to stick to one man, so if they see me with someone else they warn him to stay away from me. [Karen]

Charity said that her parents offered the following piece of practical advice about sex with boyfriends:

They also said although they did not want me to get involved with men, if I should start seeing men I should stick to one man so that if I get pregnant he will accept responsibility and look after me. I listened to them, so the man I gave birth with was my only boyfriend. But when I was coming here, I told him that I was coming to learn a vocation so that I could no longer be with him, but he looks after my child. [Charity]

One participant said that her family enforced the one-boyfriend policy as follows:

They ask me to stick to one man, so if they see me with someone else they warn him to stay away from me. [Karen]

In many cases, the girls' stories about their sexual experiences indicated that their parents seemed to accept their early sexual activities. For example, Diana was 14 when she had her first sexual experience. She described it and her mother's response as follows:

He asked me to go to his house with him. When we got there he forced me and slept with me. On my return home, I told my mother, but she didn't say much. All she said was that since he's my boyfriend, it's okay to sleep with him. [Diana]

Finally, about a third of the participants interviewed were currently living without the supervision of a parent or relative, but were being supervised by an unrelated guardian, usually a "madam." Typically, these girls came from outside the area and had come to Accra to make money for themselves and to send home to their families. They reported getting more freedom in Accra to interact with boys than they did in their hometowns and that they were not monitored as closely as those currently living with relatives. For some, this was welcome.

My mother was very strict on me having male friends [in my hometown]. But since I came to Accra, no one restricts me when it comes to men. I do what I please. [Eve]

They knew, however, that if they had a child they could not stay at the house and work for the madam after the child was born. Thus, although these girls had more sexual freedom, they had less choice about terminating or continuing a pregnancy if they became pregnant (see below).

3.4 First Sex

On average, the participants in this study had sex for the first time just before they turned 16, a younger age than the national norm (GSS and MI, 1999). Girls tended to have their first boyfriends near or within 10 years of their own age. “Boyfriend” here refers to males with whom the girls had sexual relations. Most of the participants met their boyfriends at school, during social activities, at the market, or through friends. About a third of the participants’ first boyfriends were within three years of their own age. The rest were 5 to 12 years older, with three notable exceptions: one girl was forced to marry a middle-aged family friend, another got involved with a taxi driver, and a third girl was raped in her hometown. (The man was arrested and tried, and the girl later developed a relationship with a boyfriend her age.)

The most common first-sex scenario reported by participants was that the girl’s boyfriend had convinced her to come to his house, where the two had either consensual or forced sex. For example, Naomi who had run away from home, got involved sexually for the first time at age 14.

He was a regular customer at the bar where I cooked. Then one day, he proposed love to me and I agreed. We were in a relationship for a long time and one day he asked me to accompany him to his house. I agreed and we went. Then he talked to me to sleep with him. I did understand and slept with him. I understood his proposal and gave in. . . I enjoyed it. [Naomi]

Unlike this girl, a third of the participants described their first sexual experience as traumatic, either because their boyfriends deceived them about what was going to happen, because it was a struggle, because it was painful, or because they were raped by a nonboyfriend. For example, when Lily was 17, she had her first sexual experience with her boyfriend, who eventually became her husband.

I had this boyfriend who asked me to accompany him somewhere. Initially, I didn’t want to go, but upon pressuring me I followed him. Apparently, it was his house he meant. So when we got to the house, he drugged me with alcohol and I slept. Then he had sex with me. When I woke up I got angry and went home and told my mother. But my mother didn’t say anything. Later, the boy came to apologize for doing that to me. . . [Lily]

Surprisingly, many girls who said they were forced into having sex the first time were still with the same boys and even had children with them.

The one who broke my virginity is the one I stay with. I have never had any other boyfriends, and I know he is the one I will marry since he is the father of my children. . . I love him and he loves me. The only reason we are not married is because he has no money. [Lily]

Evidently this phenomenon of boys luring girls to their homes to have sex is so widespread that some girls said that they had been warned about it by their parents and guardians. Sarah, for instance, said her grandmother told her that “some of the men did rape girls, so I should never follow a man to his house.”

In two cases, the participants described their first sexual experiences as rapes. One was raped by a neighbor and the other by a trusted member of her church.

We were attending the same church. . . so that day he said I should not leave, but that I should wait for him and that he wanted to discuss something with me. And I asked him what he wanted to discuss with me and he said he wanted to ask me for a long time, and since he was my leader I could not say I was leaving and going home. There were three of us. He made the others leave so I was the only one left behind. . . When he came, he sat beside me and started holding me. I asked him what he was doing and that, please, I did not like that, and he said he loved me and that was what he wanted to ask me. And I said he should talk and that he should stop holding me, and at that point he struggled with me and had sex with me [Faith].

Most of the participants interviewed said that, so far, they had had sexual relationships with only one or two partners, and that their relationships lasted a long time. A third of the girls reported having relationships lasting from 4 to 10 years with their first boyfriends.

In summary, the girls in this community started to develop their adult lives—including making a living and developing serious relationships—during their mid-teenage years. They fully expected to support themselves and to provide some of their children’s support as well, as their activities indicate. The girls generally began working during their mid-teens after they had dropped out of school, and their early moneymaking activities usually involved selling small items. Their family’s limited resources, not pregnancy, was the main reason the girls cited for not continuing past junior secondary school. The participants generally aspired to move from selling small items to selling larger items in the market, developing capital to trade, or obtaining vocational jobs such as hair braiding or sewing. Some girls reportedly saved money from selling small items to attain these goals. Along with developing their means of subsistence, the girls developed ongoing relationships with boyfriends during this stage of their lives.

The majority of the participants became sexually active at age 16 on average, after dropping out of school. Their first sexual partners were boyfriends either close to their age or between 5 to 12 years older, and were boys or men with whom they had an ongoing relationship. Both love and chop money contributions were as essential for a relationship to develop as they were in the broader Ghanaian society (Dinan, 1983). According to the girls’ reports, parents discouraged sexual activity most often when girls were still in school. However, while the girls said that their parents did not want them to become pregnant too young, about half of the parents accepted the girls’ sexual activities once the girls passed their mid-teens. In addition, the parents advised or supervised the practice of serial monogamy or “sticking to one guy at a time.” Sexual violence by boyfriends against girls played a major role in the participants’ early sexual initiation.

About a third of the girls described their first sexual experience as date rape or rape by a nonboyfriend. The sugar-daddy phenomenon—where a girl has an older male who gives her money for sex and then a younger real boyfriend—was not prominent among this group of participants. Pressure and force from boyfriends, however, caused many girls to begin having sex before they wanted to. Those who were raped by a nonboyfriend were all living with parents at the time. However, the rapes did not appear to be the result of parental neglect, but occurred when the girls were doing their chores or participating in extracurricular activities.

Although promiscuity was suspected to be a major cause of unwanted pregnancy and subsequent abortion, this hypothesis was not validated by the accounts of these participants. A third of the girls reported having relatively few partners (one or two) and long-term relationships lasting between 4 and 10 years. First boyfriends were usually close to the girls' age or were 5 to 12 years older. Sometimes, these early relationships led to long-term child-rearing unions.

4 Knowledge About the Body, Menstruation, Sex and Contraception, and Pregnancy Intentions and Strategies for Preventing Pregnancy

This chapter examines what girls know about menstruation, sex, and pregnancy, as well as their intentions regarding pregnancy and the actions they took to avoid getting pregnant by their boyfriends. In general, the participants had much to say to interviewers about menstruation, the fertile period, contraception, and other related topics. This knowledge, they said, was gained at home when they first began to menstruate, at school, and among friends.

4.1 First Menstruation

When asked to talk about their first menstruation, about a third of the participants reflected on how their mothers or other female caretakers prepared mashed yams and a boiled egg for them to eat as soon as they told the older women of the event. Female caretakers also used this occasion to discuss sexual practices with the girls. Opal described her experience, which is typical, as follows:

I was really afraid. When I saw the blood, I took a piece of paper to clean it off. But a neighbor was passing by and noticed what I was doing. She asked me to go and tell my mother about it. I obeyed and my mother explained to me what menstruation was and how to take care of myself. She also gave me an egg to eat. She also told me I was matured as a woman, and that if I go sleeping with men, I will get pregnant. [Opal]

Nearly all of the participants, whether or not they were provided with special food at their first menstruation, reported that they had been instructed by their mother or female caretaker on how to care for themselves during menstruation and were told that they could now get pregnant if they had sex.³ Many participants said that in addition to being told by their mothers or female caretakers, other female relatives who became aware of their maturation (aunts, sisters, foster parents, and grandmothers) also warned them that they could now get pregnant and cautioned them about boys and sex.

While most female caretakers were fairly explicit in telling the girls that menstruation meant that they were now women and could get pregnant if they had sex with boys, a few parents were less direct. For example, Lily was told not to “‘play’ with men” or she would get pregnant, and Victoria was told not to “go following men around.”

Several of the participants said they had been too shy to tell their mothers or aunts when they began menstruating, or reported that they had run away from home before discussing menstruation with their mothers or female caretakers. These girls, however, seem to have eventually learned the same information either from girlfriends or boyfriends. Friends, most girls said, were the best source of such information. For example, Naomi who had run away from home at the age of 13 said,

³ The majority of girls said that their mother or another female in the household (i.e., aunt, grandmother, or sister) had instructed them when they had their first menstruation. The rest were instructed by a female step-parent (on the father’s side) or peers, including, in two cases, a boyfriend.

You can ask from your friends, your peers, or older friends. For instance, I learned about menstruation from many elder friends. I also learned about abortions from friends. [Naomi]

Two girls reported that it was their boyfriends and not a mother or female caretaker who told them about menstruation. A girl's boyfriend told her:

If you have not started menstruating and you are sexually active you won't get pregnant, but once you start menstruating you could get pregnant. [Ariel]

4.2 Learning about Sex and Related Topics from Teachers

About a third of the participants said that they learned something about sex and related topics in school as well. The others either did not recall whether they had been taught about sex, said they had been taught nothing about sex, or had dropped out of school before they were old enough to have that class.

Both the girls and the teachers interviewed for the study described a variety of reproductive health topics that were discussed in school, including physical and emotional development process, reproductive organs, menstruation, sex, fertility, contraception, and teenage pregnancy; however, not all the topics were taught at all schools. The teachers reported that representatives from various organizations came to lecture periodically on reproductive health in the schools. Classes on reproductive health were said to be taught generally at JSS and SSS levels. However, some teachers reported that sexual development was taught at the primary level as well. Life-skills teachers reported that the curriculum included topics related to the physical and emotional development of the children. One of them said,

At the JSS level we teach them the physical development that they see when they enter into adolescent age, where the girl begins to develop breasts, have her menstruation, the formation of the hips and other things both boys and girls having pubic hairs, at the armpit and around the sexual parts. We also encourage them to keep themselves neat, at this stage they are developing. So they have to know personal hygiene, how to keep themselves very neat to prevent other infections and other diseases. [Life-skills teacher JSS]

For example, Joy, who had finished JSS 3, discussed what the life-skills teachers said they always taught about sex in school:

We were taught in school that from age 12 onwards [that] the female body starts to develop into that of a teenager; your breasts would develop and you will get pubic hair. When it gets to your first menstruation you may either get stomach cramps or feel cold. You have to ask an elderly person to show you what to do. . . we were taught that if you had sex you would get pregnant, but we were not taught anything about abortion. But I know about it. [Joy]

Several life-skills teachers from different schools explained that they always taught pupils that they should marry before engaging in sexual activity. However, they added,

But teaching the child that and if he or she takes your advice [is another matter].

Interestingly, one girl reported being taught nonbiological information about sex and pregnancy in her school.

When I was in form 1 at [school], they taught us how to call a man when you want to have sex and how a man can call a woman if he wants to have sex. They also taught us how the womb opens during menstruation. . . They said you use body language and you caress the man. . . [Karen]

Several teachers mentioned that representatives from sexual organizations visited the schools regularly to teach about reproductive health, but they didn't know the details. From the girls' perspective, their education did sometimes include information on contraception and abortion. One girl described what she learned as follows:

Yes, [I was taught about abortion]. They said when you go for an abortion they would raise your feet and light a torch into your womb, and they would open your womb and take out the baby. The teacher said when a woman is pregnant she does not know immediately, and that it takes some time for her to know she's pregnant. We were also told to insist on condoms. The teacher said sometimes the men would lie to us that they would not come in us, but by the time you realize he's come in you and it may give you problems. [Karen]

4.3 Fertile Period

The majority of the participants expressed the same understanding of the female fertile period. Bernadette stated it as follows:

What I learned is that one has to wait five days after menstruation before going to a man if she does not want to be pregnant. But if one has sex soon after menstruation, then the person is likely to get pregnant. You can also get pregnant when you are menstruating and have sex. [Bernadette]

The idea that one could get pregnant immediately before, during, and for several days after menstruation was widespread and was even taught in some schools, according to the girls' and two teachers' reports. One of the girls quoted above alluded to the womb being open during menstruation, and the following teacher from another school explained exactly what she tells girls about the fertile period:

You, the girl, if you menstruate and you allow anybody to just have sex with you, it is likely you will get pregnant. You also tell them the menstrual cycle is the fertile time, and it is not as if you are encouraging them to engage in those things, but just to tell them so

that they will know some of those things; also how to keep themselves well and all that.
[Life-Skills Teacher]

This explanation seems to correspond to the following theory of the womb, which was expressed by several participants:

When you are going to menstruate, the womb opens up so when you have sex and the man puts his sperm in you and the womb closes, you will conceive. [Karen]

Several participants said that the fertile period occurred a week or ten days after menstruation. But most participants, including two teachers, said that it occurred during menstruation.

4.4 Pregnancy Intended or Unintended?

All of the study participants said that their first pregnancy and most of their subsequent pregnancies had been “accidental” or unplanned. Some had a vague idea that they wanted at least one child or perhaps two, but none said that they were trying to get pregnant at that stage in their lives. Their strategies for preventing pregnancy tended to support their stated intention of not wanting to become pregnant. The majority of the participants said that they had used periodic abstinence or a modern contraceptive method at some point during their reproductive years, although none of them reported using anything other than periodic abstinence before their first pregnancy. The participants had been pregnant more than once during their teen years and after were more likely to have tried modern methods of contraception to prevent other pregnancies, especially if they had one or two children. They said that friends or health care providers had suggested that they use contraceptives after they had given birth.

4.5 Using Periodic Abstinence

Many of the participants held nonbiological ideas about the fertile period and acted accordingly to prevent pregnancy. About a third of the girls we interviewed went into details about how they monitored their menstrual cycle each month. They counted by using a calendar. For example, Karen said,

Sometimes it [my menstruation] comes on the 14th or 16th. It changes...I check the date, when it is getting past the date and it has not come, I get scared and go to the lab to check if I'm pregnant. [Karen]

Some of the participants said that they had learned this with the help of their mother or of another caretaker. For example, Zoe said,

When I started menstruating, my grandmother used to check the dates for me. I informed her when I start and when my period stopped, but then, when I matured, I stopped telling her about it. . . . When we were around 14, 15 years old she told us she would not keep checking it for us so we should note down the dates when we start and when we finish. If

in March or January I start my period on the 15th. I know that by the 15th of the next month, February 15th. I will have my period; so I know how to take care of myself. [Zoe]

The girls used their awareness of the cycle, sometimes with the help of their mothers, to practice periodic abstinence. Wanda, for example, said,

When it gets to my time of the month and I menstruate, [mother] cautions me to take care of myself. [Wanda]

However, the girls were not always able to follow through with the practice. For example, Opal said that she generally would not go to her boyfriend's house until 1 week after menstruation, but she also tells the following story:

On one of my visits to the boy's house, I had just ended my period earlier in the day, and he wanted to have sex that night. I refused, but he forced me. A month later, I didn't menstruate and that was when I realized I was pregnant. [Opal]

Periodic abstinence, even practiced according to nonbiological theories of the body is not possible without the cooperation of the boyfriend. One participant who admitted that she did not know when the fertile period was, explained that she prevents pregnancy as follows:

But what I do know is that if I sleep with my boyfriend every day, I never get pregnant. But if I sleep with him periodically, like once or twice a week, then I'm most likely to get pregnant. So I sleep with my boyfriend every day in order to prevent pregnancy.

The problem with this widespread understanding of the fertile period and practice of periodic abstinence is that it is incompatible with the biological understanding of ovulation, which often caused women to use periodic abstinence in ways that promoted pregnancy rather than prevented it.

4.6 Using Modern Contraception: Understanding and Practice

Besides using periodic abstinence (according to nonbiological ideas of the fertile period), slightly more than half of the participants said that they had at least tried some form of modern contraception. The Ghana Social Marketing Foundation supplies the local pharmacies in Ga Mashi with different types of condoms (both male and female), the "Secure" brand of oral contraceptives, and foam tablet vaginal inserts; according to their local pharmacists, they are sold at a subsidized price to local residents. One of the three pharmacists interviewed said that rather than selling contraceptives to unmarried clients, he refers them to the family planning clinic nearby. The others said that they would sell to unmarried clients. Condoms, the pharmacists said, were the most popular contraceptives and that it is usually the male who buys them. Participants said that condoms and Secure were usually purchased at a pharmacy rather than at the clinic.

The majority of the participants in the study named and discussed several methods of contraception during their interviews. Some had heard about them in school, others at the clinic,

and others from friends or the television. For example, Diane summarized the common understanding of the methods as follows:

Yes, I know that the men use condoms to protect them from impregnating girls. I also know of Secure, which is used by girls who don't want to get pregnant. I also know that injectables are used by mothers who have had children before and don't want anymore children. [Diane]

Although most of the participants knew about several contraceptive methods, few of them used a method regularly, and none reported using contraception before their first pregnancy. When the participants used modern methods, the descriptions of how they used them suggested that they had not used them correctly, which led to further pregnancies. Of those who used modern methods, 14 tried condoms, 7 tried pills, and 3 tried DMPA, an injectable hormone administered once every three months. The girls' experiences with the methods, including side effects and thoughts about the consequences of using them, are discussed below.

4.6.1 Condoms and Withdrawal

Condoms were the most-often tried and used method of contraception. About half of the participants said that they had tried a condom at least once. Condoms, however, were usually spoken of as a method used by the man rather than the woman. Five of the participants said that their boyfriends used condoms with them regularly.

My boyfriend uses the condoms any time we have sex. . . I think it is okay. I feel comfortable with it. [Diana]

Another nine participants said that they had tried condoms and, for one reason or another, did not use them regularly. For example, Ariel and one other girl said that she used them during the fertile period, which she understood as falling immediately before, during, and just after menstruation:

When it was getting to my period, or just after my period, I would use condoms. I would feel what my friend told me [about the fertile period] was true, so I would ask my boyfriend to use them. But I still got pregnant a second time. [Ariel]

The most common reason for not using condoms regularly, however, was that the participants did not like them. For example, Phoebe said,

It was my boyfriend who used condoms. He said if we used them I would not get pregnant, but then I did not enjoy it when he used condoms, so I asked him to stop using them. [Phoebe]

There were several rumors about condoms that the girls reported, the most common being that they can come off and get stuck inside the woman's body. One participant described how this happened to her friend.

A friend ever used it with her boyfriend but, unfortunately, the condom slipped into the girl's womb. It took an operation to remove the condom from the girl's womb. Since then, I advised myself against the use of condom. [Yolanda]

Others said that they did not use condoms because they carried diseases, or because they burst. Some were told by their mothers or a teacher to use withdrawal as a method of contraception. None of the participants, however, mentioned using withdrawal as a method of contraception.

4.6.2 The Pill, Injectables, and IUDs

Seven participants said they had tried using birth control pills; some had children and others did not. Three of the participants said they had tried DMPA injections. All three of these participants had had at least two pregnancies and two had given birth once each. The third participant had three children. None of the participants had tried the intrauterine device (IUD), and only two participants mentioned the IUD as a method of contraception. (Both said that it could cause damage to the womb.)

Although three of these participants reported taking the pill regularly, the others did not. The variations included, for example, not taking the pill when the boyfriend was traveling, or taking it sporadically. For example, Eve, who began taking the pill a few months before the interview, said,

I take it once every three days. Sometimes too I take two tablets a day. . . no one taught me. I just bought it from the pharmacy shop and started taking them the way I thought best. [Eve]

Not surprisingly, one of these girls reported that the pill had failed to keep her from getting pregnant. Two others said that they had stopped taking the pill because of the side effects that they experienced when they used Secure.

I have ever tried using the Secure once, but I started experiencing irregular menstruation up to now. For instance, sometimes for two whole months I wouldn't see my period, so I stopped using it. But I still experience the irregular menstruation. [Sarah]

There also seemed to be some confusion among the three girls who had recently started taking DMPA about how long it lasted. Two girls thought it lasted two or three years, the other two or three months.

Wanda, who had had one birth and one abortion, explained why she didn't return for a second DMPA shot; she said,

But since I had the injection, in the mornings when I wake up and I'm washing, I shiver and my heart beats fast and I pant and I also feel dizzy. And it also made me bleed for a long time. When I went to tell them, they gave me some medicine, including vitamin B complex and multivites, but it did not improve. . . I'm not able to do much around the

house, and when it did not improve after taking the medicine they gave me, I went to the hospital, did a card, and saw the doctor and I was given some medicine. Since three months expired I have not been there again. [Wanda]

4.6.3 Rumors

Diana who had had two abortions (one at 14 and one at 16) said the following when she was asked why she did not use contraceptives:

Because I don't have any children yet. [Diana]

This idea was expressed by others as well, including those who had never tried a modern contraceptive method. The underlying rationale seemed to be that family planning methods could affect fertility. For example, the following girl, whose brother worked for a family planning organization, said,

I know about Secure as another family planning method, but I have never used it. . . I want to be able to have children in the future, but I hear if you take Secure you can't have any more children. [Alexandra]

Rumors reported by those who had used Secure and those who had not included the following: "It gives a vaginal discharge;" "it is not good for your health;" "it gives heart disease;" "it makes you sick;" "it can kill;" "it causes you not to be able to have children in the future;" and "it is generally not good."

In summary, the girls displayed a good awareness of their monthly menstrual cycle. They learned this partly through routine puberty instruction by female caretakers as well as through friends and teachers. The girls described most of their pregnancies as accidental or unplanned. This included the first pregnancies and often the subsequent ones. Although some girls said that they had a vague idea that they wanted one or two children, they were not actively trying to get pregnant at this point in their lives. Their strategies for preventing pregnancy tended to support their stated intentions of not wanting to become pregnant, but their practices were highly ineffective, and the girls tended to have repeat unintended pregnancies.

The most common strategy the girls used to prevent pregnancy was periodic abstinence. Some parents and teachers encourage girls to practice periodic abstinence with boyfriends, but there was a widespread understanding that the fertile period occurred during and immediately before and after menstruation, and girls practiced periodic abstinence accordingly. The problem with this widespread understanding and practice is that it is incompatible with the biological understanding of ovulation and would logically cause women to use periodic abstinence in ways that would promote pregnancy rather than prevent it. This contraceptive strategy, rather than modern contraceptive methods, was especially used to prevent first pregnancies. The second most common strategy, besides periodic abstinence, was the use of condoms.

Condoms were usually described as a method used by the boyfriend rather than by the girl. Five participants said that they had used condoms consistently for some time; nine others did not. Some girls who had experience with them said that they did not like how they felt and others said that they used them only during the “fertile period.” The participants were hesitant to use other modern methods, including the hormonal methods, especially before they had at least one or two children. Most of those who had tried those methods either rejected them because of side effects or had used them incorrectly. Not surprisingly, these practices resulted in repeated unintended pregnancies for the participants.

5 Finding Out About the Pregnancy and Deciding Whether to Terminate or to Continue the Pregnancy

Interviewers asked participants open-ended questions about each of their pregnancies—for example, how they became pregnant, how they learned that they were pregnant, who was told, what reactions or recommendations the girls received, and why and how they decided to have an abortion or to carry the pregnancy to term? (As noted in chapter 2, collectively, the 29 participants experienced a total of 49 pregnancies during their teen years.) The girls' descriptions of the process of deciding to keep or terminate a pregnancy indicate that their decisions cannot be separated from the process of forming stable child-rearing unions in the community, or from the need for women to establish stable, independent means of financial support. Thus, some of the elements involved in forming stable unions are analyzed in the context of the decisionmaking process. The persons involved in deciding how to handle a pregnancy were most often the girl and her boyfriend; however, parents, guardians, and other adults were often involved in the process in various ways. Although the cases do not always fit neatly into one category, they are divided into the following sections to illustrate the points related to the decisionmaking process and the strategies the girls used to achieve their goals:

- 1) Cases where both the girl and her boyfriend agree on either an abortion or birth
- 2) Cases where the girl and her boyfriend do not agree on abortion or birth
- 3) Cases where the parents or guardians are involved in the decisionmaking process

The first step in deciding whether to terminate or to continue an unintended pregnancy was to establish that one was indeed pregnant.

5.1 I'm Pregnant

When asked how and when they knew they were pregnant for the first time, most of the girls said that they suspected or knew they were pregnant shortly after their first missed period. For example, Wanda said she thought she was pregnant four days after her period didn't come, and she took immediate action, getting a pregnancy test at the Ussher Clinic. While some girls suspected that they were pregnant after the first missed period, others said they waited for a second month before confirming the pregnancy. For example, Faith, who occasionally misses periods, said the following:

The first time I was pregnant, I did not feel that anything had happened to me. I missed my period for one month. This used to happen to me, so I did not think it was a pregnancy. But then, when I missed my period for a second month and I noticed a change in my body—my navel protruded and my breasts became fuller—a friend of mine told me where I could get a pregnancy test. [Faith]

About half of the participants said that they knew for sure they were pregnant when the missed period occurred in combination with other symptoms, such as nausea and vomiting,

breast tenderness or fullness, dizziness, the development of white palms and soles,⁴ or just “feeling sick.” Some participants said that they consulted friends, sisters, or boyfriends to confirm their suspicions or to ask their opinions on the signs and symptoms to try to establish whether they were pregnant. Only about a quarter of the girls said that they used pregnancy tests to confirm the pregnancy, as Wanda did, above.

Three girls said that someone else told them they were pregnant based on observations of changes in their bodies. For example, one of the girls said,

Well, I missed my period for several months and started feeling very sick. Then one day, when my mother visited, she noticed I was pregnant and told me. I also noticed my palms had gone pale. [Joy]

The three participants who were not aware that they were pregnant, but had to be told by someone else, were younger ones, between 14 and 16 years old. Most girls figured out on their own that they were pregnant sometime during the first or second month of pregnancy, early enough to obtain an abortion in the first trimester if they chose to do so.⁵

Age at which pregnancy experienced	Aware of pregnancy (first pregnancy)			Not aware or someone else told them	Total
	1-2 months	2-3 months	3+ months		
14	2			1	3
15	1			1	2
16	2	4	1	1	8
17	4	3			7
18	1	3			4
19	1	2			3
Total	11	12	1	3	27
N = 29 (2 missing answers)					

5.2 Girl and Boyfriend Agree on Birth or Abortion

In 14 of the 49 cases of pregnancy discussed in this section, the girl and/or her boyfriend wanted to give birth and/or convinced the other to want to give birth too. Ten of these were first births for the participants, and five were second births—usually with the same boyfriend or “husband.” In general, the decision to carry the child to term was the impetus to further solidify the relationship with the boyfriend and to advance the marriage process.

⁴ Pale soles and palms usually suggest anemia, thus this finding may indicate a compromised nutritional status of the girls before or during early pregnancy.

⁵ These findings support and reflect the findings of a 1997 study conducted at Korle-Bu Hospital. Of the 212 admissions for postabortion care in a one-year period, the author reports that 90 percent of abortions had been performed before the tenth week, and half before the seventh week of pregnancy (Lasey, 1995). These girls must have been aware of their pregnancies within the first or second month in order to arrange a first-trimester abortion.

In 13 cases, the couples eventually agreed that they would obtain an abortion. Seven of these were first pregnancies and six were second, third, or fourth pregnancies. If family building is the main reason to give birth, the reasons for having an abortion suggest the factors that hinder the family building process. Multiple reasons to delay family building, some of which overlap with the reasons to space children, will be discussed later in the chapter. Regardless of whether the couple decided to have an abortion or to give birth, it was generally the boyfriend's responsibility to pay for the medical costs incurred.

5.2.1 Deciding to Give Birth to a First Child or to Terminate the Pregnancy

Once the participants knew they were pregnant, the next step involved telling their significant others about their condition. One 15-year-old participant said that her mother urged her to tell her boyfriend about the pregnancy "immediately" or, she said, "he might deny it was his." Another participant explained why a girl often goes to the boyfriend immediately with the news.

There are some men that deny responsibility or take you for a ride when the pregnancy is advanced. I wanted him to be straight with me and asked him whether we should abort it or not. [Zoe]

According to the girls' reports, a little less than half the time, the boyfriend asked the girl what she wanted to do and other times the boy decided and the girl went along. Sometimes, agreement was reached after extended discussions during which one eventually convinced the other. In these discussions, the main issue was earning power. One girl described the negotiation with her boyfriend as follows:

He said I should not have an abortion. I had wanted to have an abortion and then, after I finished the work, have a baby, but he said I should leave it. . . He brought drinks and claimed responsibility. [Grace]

One of the participants who had a religious orientation described more of a struggle in deciding to terminate a pregnancy.

So, when he came and I told him, he said he had heard and that it was two months, but he would not let it get to three months, that we would have an abortion. I told him Ei, I can't abort it and that I've never had an abortion before, and my mother says since she became mature she has also never had an abortion, so I should never do that. So I'll give birth and that God will show that way, and that if I give birth we'll be able to feed the child. Then he was patient and he gave me money and he coerced me for a long time before I went. [Joy]

Sometimes the decision to keep the child derived from other factors related to the history of the relationship. For example, in one case the girl had terminated her first pregnancy by the boy; however, when she got pregnant the second time, they decided to give birth. The participant explained the decision as follows:

After the abortion she [mother] saw I was different, disorganized, so she asked me and I told her [about the abortion]. In fact, she was troubled, so she went to see the man and she told him that if he knows that he will marry me, then if I get pregnant we should give birth. And she would not see me get pregnant a second time for him to tell me to get an abortion. If that is the case, then we should stop seeing each other. So, when I got pregnant again, he agreed that I should give birth... When I told him he wanted it... it was when I got four months pregnant he came to do the knocking. [Joy]

Knocking

As illustrated in the quote above, when the couple decided to give birth to a first child, the boyfriend made a public acknowledgment of the relationship and of his responsibility for the pregnancy by doing the “knocking.” For example, Eden said,

I told my boyfriend and he asked me what I wanted to do with the pregnancy. I told him I wanted to carry it full-term. He agreed and we decided he should go and see my parents to perform the knocking ceremony so that at least they would know he has put me in the family way. [Eden]

The knocking ceremony usually involved a trip by the boy’s parents to the girl’s house to meet her family and discuss the couple’s relationship. One girl gave the following account of the occasion of her knocking and how her boyfriend contributed to her welfare afterwards:

I told my mother, and when I was four months pregnant they came to do the knocking and performed the rites. They gave me three pieces of cloth so that I could sew and wear when I’m going to the clinic. When I was going to the clinic, I used to collect money from him, and when I’m given prescriptions I bring it to him. . . . When I gave birth he was able to provide for me, but after he lost his job, things were not so good. [Zoe]

The knocking rite (which may go by other names in other locales) is a key step in forming stable unions in Ghana. According to some, this can be thought of as either an engagement or a traditional marriage, and the participants seemed to attribute variable significance to the practice. One participant’s boyfriend performed a knocking before the participant got pregnant, which connotes more of an engagement or marriage. The other girls said that their boyfriends had performed the knocking after they had gotten pregnant and decided to keep the child. These girls said that the rite was performed, at least in part, to acknowledge paternity, as in the case of Eden above.

Regardless of the possible multiple significances of the rite, the general understanding about the boyfriend’s responsibilities when a couple decides to give birth appeared to be that he will at least continue to contribute chop money; pay for all of the medical costs incurred for antenatal care, prescriptions, delivery, and other medical bills; and provide what the girl needs to attend the clinic. The amount of the boyfriends’ contributions varied, sometimes from week to week, depending on how much they were able to earn.

Parents, however, were not always happy about the news of pregnancy and the decision to give birth. Ariel explained the reaction of her parents and that of her boyfriend as follows:

When he told his parents, they complained. They said I was not grown and he was also not grown and we were going to give birth. I told my parents and they also agreed, so I kept the pregnancy. [Ariel]

According to the participants' reports, their parents did not want to see them begin families during their teens. Sometimes this was expressed as the girl or a boyfriend "not being grown enough." Most of the time, this seemed to refer to the girl's maturity as an income generator rather than her physical development. For example, when Eve was asked to clarify what she meant by "not grown," she said, "I have no job or any skills." In most cases, however, where parents objected to their children giving birth "too young," according to the girls' reports, they eventually accepted the situation if the couple decided to give birth. All the participants said that they gave birth either at a hospital or a government-run clinic. No one reported giving birth at home.

Planning to carry a child to term did not always result in a baby. Three of the participants who had prepared to give birth and performed the knocking ceremony had miscarriages; one miscarriage was at seven months. The participants who had miscarriages reported going to the hospital when they started to miscarry.

5.2.2 Agreeing to Terminate a Pregnancy

Abortion was used by participants both to delay childbearing and to space children. The reasons for deciding to have an abortion were usually multiple, including financial problems, the couple's lack of interest in staying together, and/or the girl being in school. Getting an abortion for financial reasons did not necessarily cause the couple to break up. Some of the couples who had had an abortion went on to have a child or two together later.

The most common reason given by participants for having an abortion to delay childbearing was to maintain or improve their sources of financial support and to improve their moneymaking or vocational potential. Sometimes this reasoning was applied to the boyfriend and sometimes to the girl. For example, an 18-year-old girl with an unemployed boyfriend described making the decision as follows:

When my friend confirmed I was pregnant I told my boyfriend and he said I should abort since he was unemployed. He's under apprenticeship as a carpenter, and if his master gets to know he has impregnated a girl, he will be dismissed. So I agreed to the abortion. [Diana]

Participants used abortion sometimes repeatedly to delay childbearing or to space children. A 16-year-old girl who got pregnant for a second time for the same boy (after having one abortion at age 14 at the behest of her mother) decided that a second abortion would be best because she was not yet able to help support the child.

For the second pregnancy, I decided to abort immediately. In fact, I realized that my mother was right. Bringing up a baby was no small task. I needed to be employed or have money to care and take the child for antenatal, but since I'm not in a position to do that I had to abort it. He [boyfriend] said that if that was my decision, then so be it. I could go and have the abortion. [Pauline]

One participant who had had six pregnancies while in her teens described using abortion twice in a row to space her first and second children. After one abortion at age 13, she had a child at 14, then terminated a pregnancy when she was 15 and again at 16. At age 18, she had a second child with the father of the first.

Being in school was also cited as a reason for getting an abortion. The discussion around the reason why to have an abortion when the girl was in school, however, was not that it would ruin the girl's future if she had to drop out of school, but to avoid shame. For example, a 16-year-old girl impregnated by an older schoolmate described her partner's reaction as follows:

He said I was going to school so he made me have an abortion because he didn't want it to get out. [Pauline]

This participant said that a relative offered to pay for her to attend another school after the abortion, but that she met another boy and got pregnant again before she could go back to school. Another participant said that she and her boyfriend obtained an abortion because the couple did not want to stay together. The health of the teenager was never cited as a reason for terminating a pregnancy, although it was cited as a reason for not having an abortion.

In these situations the boyfriend usually paid for the abortion, sometimes with the help of the girl; parents were generally not included in the decisionmaking process. In fact, participants said that they generally kept the abortion a secret.

When parents and guardians found out about a planned abortion, they either agreed to it or imposed another plan. For example, one participant said that when she became pregnant at 16 and her boyfriend gave her the money to get an abortion, her aunt told her to go ahead.

I told my auntie that he gave me the money to have an abortion. She said if he has said that and given me the money then I should go and do it.

One participant who agreed with her boyfriend that she wanted to have an abortion described what happened when both their families became involved in deciding whether to terminate the pregnancy.

I wanted to abort them all. . . He [boyfriend] also wanted me to abort all of them. He gave me the money to go and have the abortions. . . in fact, the reason was that he could not afford to take care of a family. . . My mother noticed I was pregnant. . . she was very disappointed and talked me into aborting the pregnancy. But my boyfriend's father is a lawyer. He was against the abortion. His reason was that, supposing something went wrong, he could be held responsible. So I should not abort. But then the reaction of my

grandmother and mother made me to try aborting the pregnancy by taking in the sugar and muscatel solution, and it landed me in a disaster. In fact, when my father got to know about the pregnancy, he was so upset with me. [Bernadette]

After two failed abortion attempts, she gave birth to her first child. This is perhaps partly why couples keep the information about pregnancy to themselves and obtain abortions secretly as often as possible.

5.2.3 Boyfriends and Husbands

Ten of the study participants, ranging in age from 16 to 22, said that they were either planning to get married or hoped to get married to their current boyfriends. They were speaking in each case of a boy or man with whom they had created a pregnancy that resulted in either an abortion or a birth. The following participant, who was 18 years old when she first became involved with her boyfriend, had two children with him and is still with him at the age of 21.

I worked with my mother and met this young man who expressed interest in me. We moved together for a while and I got pregnant. . . No [we are not married], but we intend to get married as soon as he gets a better job. . . He comes to the house often and gives us our chop money. [Lily]

Even more significant, however, was that seven participants, ranging in age from 18 to 24, referred to themselves in casual conversation as already being married by sometimes calling their partners their “husbands,” and two others said they had already been married but no longer were. When asked directly, however, all of these participants said that a legal marriage ceremony had never been performed. When Candace was asked directly why she called herself married when there had been no legal ceremony, she said,

Okay, since some time ago I can say that you are married. When you have a child with a man and you are living together, they say you are married. [Candace]

Many of the participants said they lived with their husbands or boyfriends, as did Candace, but only two participants lived with their partner exclusively, like Rachel, who said,

When I met him, not long after, I got pregnant. As soon as I realized I was pregnant, I moved out of my parents’ house to live with him in his house. So I have been living with him for the past nine years. [Rachel]

It turned out that most study participants who said they were living with either their husbands or boyfriends actually lived in at least two locations. Usually, one location was the home of a maternal relative and the other was either the home of the boyfriend’s family or a single-family dwelling.

I have two homes. The one in this community is the [family name] family house. In that house we are a lot. My aunties, uncles, and their children all live there. My second home is my husband’s house. We are only three living together, myself and husband and our

child. I only come to the family house during the day to sell my goods, and at night my boyfriend comes to take me and the child home. [Eden]

Unlike the two participants quoted above, “living” with a husband or a boyfriend did not necessarily mean that the girl kept her belongings at the boyfriend’s house, that she ate with him daily, or that his house was the only place she slept. As described earlier, duolocality is the normal residential pattern for people living in Ga Mashi. For example, another participant who had two children (and two abortions) with her boyfriend said she lived with her boyfriend. Later, however, she also said,

I live with my grandmother and my two children. We sit together and eat. But my boyfriend gives me chop money. [Bernadette]

The consistent features of the relationships where participants referred to their partners as “husbands” are that they had between one and three children with their partners, the partners contributed some financial support on an ongoing basis, and they had maintained the relationship for at least four years (one as long as ten years). However, the same conditions applied to the lives of about half of the participants who said that they were “planning” or “hoping” to get married. The ones who said that they were planning to get married said this would happen when their boyfriends were earning more money.

The description above indicates that there are multiple arrangements for stable unions;, thus, the meaning of the knocking ceremony must be interpreted in this context. The point is that none of the participants gave birth without first performing a knocking or similar rite and, therefore, they had an acknowledged father for the child or children.

5.2.4 Giving Birth or Spacing Second Children

The common logic girls applied to giving birth to second children was that if a girl had one child with her boyfriend, she might as well have two. According to participants, either they or their boyfriends applied this logic as a rationale for giving birth to a second child. For example, Naomi explained why she gave birth again at 18.

I got pregnant again when my son was two years old. I wanted to abort it, but my boyfriend encouraged me to keep it since I already have a son with him. So I kept it for full-term and gave birth to another boy. [Naomi]

Sometimes a girl used the dangers of abortions to bolster her argument with her boyfriend if the couple had a history of giving birth together but the boyfriend did not want the girl to give birth in a particular instance. For example, Lily had one child with her “husband” and wanted a second one; she said,

But I promised that after this second one I will abort any other pregnancies that come since I don’t want to have more than two children...I refused for the simple reason that I already had one child with him so there is nothing wrong with having a second one. Secondly, because my parents said I could die in the process of an abortion. [Lily]

This participant went on to carry her second pregnancy to term then terminated her third pregnancy with an abortion.

Participants, like the one quoted above, generally said that having too many abortions (usually more than one or two) was not good for the woman. They reported that this opinion had been expressed by their parents, health care providers, and others. For example, another participant described this as part of her reason for having a second child with her boyfriend.

After the second abortion, I didn't want to do any more abortions because I learned from adults that too many abortions weakens the womb and one might not be able to have a child in the future. [Opal]

Five participants said that even after having one child with a boyfriend or husband they terminated a subsequent pregnancy because their first child was too young. Most of the time, the girl's children were still under one or two years old when she decided to get an abortion. For example, Ariel said the following about when she got pregnant for the second time by the same boyfriend:

The second time, when our child was one and a half years, when I told him he said no, that our child was not yet grown, and if I would give birth again it would disturb him and I also understood it. [Ariel]

In two of these cases, the girls had abortions to space children without the consent of the husband.

5.3 Girl and Boyfriend Do Not Agree

Couples disagreed about giving birth or having an abortion in two ways: 1) when the boyfriend did not accept responsibility for the pregnancy, and 2) when the couple had strong but opposing desires regarding giving birth or having an abortion. Girls used various strategies to resolve these situations, mainly by bringing her parents or guardians into the decisionmaking process. Whether parents were brought into the process often seemed to depend on whether the girl wanted to give birth or to have an abortion. The general assumption seemed to be that the parents would enable the girl to give birth if she wanted to do so.

5.3.1 Boyfriend Does Not Accept Responsibility

Among the 49 accounts of teen pregnancy, six participants reported that their boyfriends, at least initially, denied paternity or refused to provide support. According to participants, their boyfriends used various strategies to avoid taking responsibility for the pregnancies. For example, Faith, who was 18 at the time she got pregnant, said her boyfriend accused her of having another lover because she refused sex once.

Once, when I went there, he wanted to have sex with me and I did not permit him, and he said it was because I had found myself another lover. [Faith]

This was his reason, she said, for denying paternity.

Another participant, who was 17 and still in school at the time of her pregnancy, said her boyfriend had already drifted away by the time she became aware of her pregnancy. She sought the advice of a sister and girlfriend, who recommended that she abort the child before her mother and aunt found out.

In fact, when I realized I was pregnant I went to tell my boyfriend, but he didn't even mind me. And for a long time he wasn't giving me money to feed myself, so I decided not to say anything about the pregnancy. I decided to abort it since keeping the pregnancy will mean no support from the boy. [Iris]

Iris went back to school after having an abortion, but she dropped out shortly thereafter because her mother could no longer pay the school fees.

Another participant, who was 16 and learning hairdressing when she became pregnant, said she had gotten agreement from her boyfriend when they first began dating that he would marry her. However, when she became pregnant, rather than denying the pregnancy privately to her, he moved to another city without performing the knocking rite.

He goes to Kumasi and comes. He's also an Ashanti, so I knew he was my tribesman. So I introduced him to my mother and father and he said he would perform the marriage rites. But when I got pregnant and I told him, when he went to Kumasi he did not return again. . . He got frightened that I was pregnant, so he ran away. He told me he was going to Kumasi to bring money and that I should give birth and I've not heard of him since. [Karen]

In cases where the boyfriend denied responsibility for the pregnancy, the cost of the abortion fell to the girl. All three girls terminated these pregnancies by either borrowing money on a pretext from their parents or another adult, by using their savings, or both. One used traditional medicine, and two others had clinic abortions—one at a hospital and another at a private clinic. They all said that their boyfriends' refusal had led them to have an abortion and to have to pay for the procedure themselves.

That is why I terminated the pregnancy. . . He denied responsibility, so I was so hurt and I told him I do not want to give birth where there is no one to father my child.

The strategies used by other participants, however, demonstrate that abortion was not the only option when a girl was faced with a boyfriend who denied responsibility for a pregnancy. For example, a strategy used by Yolanda, who was 16 and in school in her hometown, during her pregnancy was to tell her parents about the boy's refusal to acknowledge paternity. They in turn intervened and forced the boy to claim responsibility for the pregnancy. Yolanda gave the following account of these events:

I told my parents about it and we marched to the boy's house to announce the pregnancy to his parents. Initially the boy denied it, but after reporting him to the Chief, he finally

agreed and was made to pay a fine of 300,000 cedis and a sewing machine for making a schoolgirl pregnant. [Yolanda]

After giving birth, Yolanda said she dropped out of school because she felt too ashamed to continue:

I got pregnant and had to stop going to school.... No one did [asked me to stop school]. I advised myself against going to school when I realized I was pregnant...usually when girls get pregnant in school others start teasing her when they get to know about the pregnancy. I didn't want to go through the humiliation from school, so I stopped. [Yolanda]

Another participant, who had been pregnant twice, each time by a different man, had problems getting her second boyfriend to take responsibility for the pregnancy.

When I got pregnant and he did not mind me. [Pauline]

She found a third boyfriend who agreed to take responsibility for the pregnancy.

It was the man I'm seeing now, that I had two children with. He looked after me until I gave birth. [Pauline]

In all of the cases where the participants said that their boyfriends refused to acknowledge the pregnancy, the girls either opted for an abortion or they involved others (parents or another boyfriend) to establish a father for the child. In the cases where they had abortions, the girls had to pay for the medicine and procedure themselves.

5.3.2 Girl Wants Abortion, Boyfriend or Husband Wants Birth

The main reasons that participants cited for wanting to have an abortion, even when their boyfriends/husbands wanted them to give birth, was to maintain or improve their sources of financial support and improve their earning or employment potential—the same reasons given in situations where both the girl and her boyfriend wanted to terminate the pregnancy. This happened even when a couple already had one child together. Another less frequently cited reason for having an abortion was that the girl did not love the boyfriend and wanted to avoid further involvement with him. In most of the situations where the girl wanted an abortion, neither the girl's nor the boy's parents were brought into the process of deciding how to handle the pregnancy. The general understanding was that a girl should get the consent of the boyfriend/husband either to terminate or continue a pregnancy. This did not always happen, however, according to the girls' reports.

The consensus seemed to be that a girl should get the consent of her boyfriend or husband to have an abortion. In the three cases where the couple disagreed, one girl eventually obtained the consent and help of her boyfriend, and two girls obtained abortions on their own. In two other cases where there was disagreement, the girls used home remedies to induce abortion, but were unsuccessful.

5.3.2.1 Delaying the First Birth

One participant was living in a house with a madam when she became pregnant, and she feared that if her madam found out she would have to move back with her mother, whom she described as abusive. She explained this to her boyfriend, who was not able to provide her with shelter, and convinced him to pay for an abortion.

I told the boy that I wanted to have an abortion because if the woman [madam] gets to know, she would not allow it. She did not even allow me to go out. . . she could have said she would not let me live with her again and she would send me to my mother, and I did not want that. . . Yes, I loved him, but he was not working and he had no money. . . he was not in a position to look after me. [Ruth]

Opal who did not get agreement from her boyfriend to terminate her first pregnancy described her experience as follows:

I cried and told the boy about it and he said I should continue the pregnancy, but I refused and aborted it at Mr. [X's] clinic. He decided to end the relationship with me, but not long after he came back to me and I got pregnant again and had my first child. [Opal]

She stated her reasons for having the abortion as follows:

I just wasn't ready to have too many children. I wanted to travel abroad to join my sister, so I didn't want to get pregnant. [Opal]

Another girl was raped by a church member. She wanted an abortion, but she was afraid after a poor experience with a first abortion.

I made up my mind to have an abortion, but then I was afraid because I had had an unpleasant experience before, so I decided against it, and I told him. ...he will do that [perform the ceremony] in February... If I say I don't want him, my child will have no father, so I'm going to marry him. [Faith]

She could not afford the hospital abortion at the time and attempted an inexpensive home remedy that did not work.

5.3.2.2 Spacing

Candace, who is currently pregnant by the same boy with whom she has a child, said that she tried to have an abortion, but was unsuccessful.

When I told him, he asked me if I would give birth and I said yes, but later, after pondering over it, I told him that our first child was not yet grown so we should terminate

the pregnancy. But then he said I should leave it. He is not aware that I have used these medicines at his back. . . My child is not yet grown [so I want to terminate it]. [Candace]

As mentioned earlier, even after having one child with a boyfriend or husband, some women aborted a second without the consent of the boyfriend or husband to space their births.

5.3.3 Girl Wants Birth, Boyfriend or Husband Wants Abortion

In situations involving a second birth with the same boyfriend or husband, it was easier for the girl to give birth without the boyfriend's or husband's consent, because public recognition of paternity had already been established. However, if the girl wanted to give birth and the boyfriend or husband wanted an abortion, the girl might again bring her parents into the process by telling them about the situation. The latter cases are discussed in the next section.

In two cases of second pregnancy, the participants said that because they already had one child with a man, they went ahead and had a second child even though the boyfriend or husband objected. For example, Lily said,

When I realized I was one month pregnant, I told my boyfriend. He was annoyed with me for getting pregnant and again said I should abort, but I refused. . . [I] promised that after this second one I will abort any other pregnancies that come, since I don't want to have more than two children. . . I refused for the simple reason that I already had one child with him, so there is nothing wrong with having a second one. [Lily]

In the instance of a girl who was forced to marry a man more than two decades her senior, she was able to argue her way into giving birth when he wanted her to have an abortion.

My boyfriend advised me to abort it, but I refused because I was afraid. . . He said I was too small to have a child, but I also told him that if he knew I was too small, why did he force me to go to bed with him? We quarreled for a while and then later he gave me money to go back to my hometown for the baby to be born. [Hope]

5.4 Parents or Guardians Decided

Parents, guardians, and other adults play various roles in helping teens cope with pregnancy. Sometimes they instructed the girl on what they considered to be the proper course of action, provided money, helped the girl obtain an abortion, or advised a couple who could not decide what to do. Parents or female caretakers made the decision to have an abortion or to give birth in 10 of the 49 cases analyzed. They usually had multiple reasons for making their decision, including that they were strongly opposed to abortion, that the girl was completely dependent on them, or that the couple disagreed on the decision.

Most of the participants reported that they began to earn their own income in their mid-teens or earlier. In two cases, however, the participants reported that they were completely dependent on their female caretakers for financial support at the time they became pregnant.

Naomi, for example, who had run away from her mother at the age of 13 and was living with a woman who employed her to work in a chop bar, gave the following account of how the decision to have an abortion was made:

I was still 13 years then [when I got pregnant]. The owner of the chop bar told me I was pregnant. I told her I hadn't had my period that month and she said then that I was pregnant. She took me for a laboratory test and I tested positive for pregnancy. Then she asked a doctor to abort it. [Naomi]

When asked whether she or her boyfriend had wanted the abortion, she said,

No [I didn't say I wanted it aborted]...I went to tell my boyfriend about it and he said I shouldn't abort it. He said I should carry it full-term, but the chop bar owner insisted I abort it since she was caring for me at that time. I agreed with her decision because I was then living in her house and she was guidance, sort of. The boy too was unemployed... [Naomi]

Another participant, who was not working yet at age 17, said the following about the decision regarding her pregnancy:

I did not have the power to decide at that time. Even if I wanted to do something, I did not have the money...I was not working [at the time of my first pregnancy]. [Ariel]

Her parents and boyfriend advised her to carry the pregnancy to term, and they supported her and her child.

According to two participants' reports, their parents were very opposed to abortion, either because it was not practiced at all in the family or because they believed that it endangered female fertility.

After I told him, I told my mother and my mother said they would not allow me to have an abortion, so I should give birth, because if I had an abortion I may not be able to have children in the future... The boy also said I should give birth. His father is from a royal family, so they don't do abortions in their family, and my mother was also against it. [Charity]

In four cases, the girls brought in family members to help mediate the dispute. In two cases, the family members sided with the girls' plan to keep the baby and in the other two cases they agreed with the boyfriends' plans to have an abortion. One girl described the reasoning of her parents, who prevailed and supplied more support so that the girl could give birth to her first child.

We moved in together for a while and I got pregnant. . . When I got pregnant for the first time and told them [parents] they didn't say anything. However, when my boyfriend [with whom I'd moved out] said I should go and terminate the pregnancy, my parents strongly objected to it and said it was not the best. They explained that, in case I die in the process

of aborting, the man will still go ahead and get another woman, but they would lose a daughter forever. So I listened to my parents and carried the pregnancy full-term. . . my boyfriend too occasionally sent me money for my medical bills and food. But I stayed with my parents. . . he comes often to the house to give us our chop money. [Lily]

In two cases, the parents sided with the boyfriend and agreed with the decision to terminate the pregnancy. Diana described what happened to her, as follows:

I told my boyfriend about it and he said I couldn't be pregnant. He then suggested an abortion...I wanted to have a baby. So I went and told my mother about the pregnancy and she also insisted I go for an abortion since I'm still too young to mother a child...she didn't suggest it, but commanded that the pregnancy be aborted. So I had no choice...because she cares for me. If I go ahead with the pregnancy she might send me away from her house. [Diana]

In summary, the process of negotiating whether to terminate a pregnancy cannot be separated from the process of forming stable child-rearing unions in the community, nor can it be separated from the need of women to keep or establish a stable means of income. The habitual monitoring of the menstrual cycle by girls led them to know or suspect, generally within one to two months, that they were pregnant. This advance knowledge gave girls enough time to negotiate a plan to cope with the pregnancy within their social network and still have a first trimester abortion. The persons most often involved in deciding whether to terminate an unintended teenage pregnancy were the girls and their boyfriends. Parents were also important to the process in some but not most cases; they played various roles, including instructing the girls on the proper course of action with the boyfriends, providing advice and money, accompanying them for the abortion procedure, and sometimes by deciding about abortion or birth.

The participants made it clear, through both what they said and did, that acknowledgement of paternity by the boyfriend to the girl's family was a fundamental factor in deciding whether to terminate the pregnancy or carry the child to term, regardless of the amount of his financial contribution. In all the cases where the father did not acknowledge paternity, the girls opted for a secret abortion. The knocking rite, which has various meanings—from simple acknowledgement of paternity to engagement or marriage—was performed in all the cases where the couple decided to have the child. Some girls referred to their partners as husbands if they already had children with them and if the partner had performed a knocking rite. Others with the same history did not. The couple usually did not live together after the rite, but the boyfriend or husband was responsible for contributing chop money and paying for all the medical needs. Besides an acknowledging father, other conditions for beginning a family with a boyfriend were that the girl be out of school and that she not be completely financially dependent on her parents but have some form of income, if only by hawking food items in the market.

When both the girl and her boyfriend wanted an abortion, it was for the following reasons: to delay child rearing until one or the other (or both) established a better means of support, to avoid shame if the girl was in school, or because they did not want to be together. Abortion was also used by couples to space their children by about two to three years.

The situations where a parent or guardian intervened in the decisionmaking process were when the boy did not acknowledge the pregnancy, or when the couple disagreed on whether to terminate the pregnancy. In the latter case, the parents or guardians were brought in when the girl wanted to give birth and the boyfriend or husband wanted to terminate the pregnancy. Parents or guardians also entered into the decisionmaking process when the girl completely depended on them and the boyfriend was unable to provide enough support. Bringing the parents in did not always result in the girl's wishes being followed.

Sometimes the parents insisted that the girl have an abortion if that was what the boyfriend wanted. When the parents were significantly involved in the decisionmaking process, two-thirds of the time they insisted on giving birth, and a third of the time they opted for abortion. Usually, after a girl had one child, the parents were less involved with decisions about subsequent pregnancies. However, the girls usually hid the pregnancies they planned to terminate from their parents, even after they were married. The girls who lived with madams seemed to have less choice about terminating or continuing a pregnancy, unless their boyfriends were able to support them.

6 Information, Resources, and Techniques for Managing Abortion and Birth in Ga Mashi Town

“Friends in my area usually go to [the hospital] for the abortions, and in my community it is no secret talking about abortions.”

The girls’ knowledge about experiences with abortion are analyzed below, using the participants’ retrospective reports. All of the 28 cases of abortion for which data were collected⁶ (19 among girls between the ages of 14 and 19, and 9 among women age 20 to 24), and several abortion attempts are analyzed below. Of the successful abortions, 23 were clinic abortions and 5 were herbal. The analysis of these abortions will indicate who assisted the girls in obtaining the procedure, how much the procedure cost and who paid for it, and how the girls perceived the experience. We will also inquire about postabortion complications and postabortion care and counseling.

6.1 Knowledge About Abortion

Nearly all the participants, whether or not they had ever had an abortion, discussed at least two or three methods of abortion with the interviewers. For example, although Diana said she had never had an abortion, she described both herbal and home remedy methods of abortion.

I know of a drug sold at the timber market called Aatsoo. It is sold by the herbalists. It is round and you insert it in the vagina. After a couple of days, the pregnancy will be aborted. There is another way. This time you mix milk with a lot of sugar and drink and the pregnancy will come. Others too mix some coffee with a lot of sugar and milk. This is supposed to be drunk. Others too go to the hospitals, and the doctors insert and push some metal instruments in the vagina and terminate the pregnancy. [Diana]

Information on herbal medicines and home remedies such as those described by Diana, as well as where to obtain clinical abortions and when to have an abortion, was easily obtained by the participants. They said that they learned the information most often from friends and peers, who were described as the best source of information on abortion. Some participants also described what they had learned about abortion in school, on television, or from older family members.

One participant, for example, said that she had learned about an herbal remedy called “Auntie Mercy” from her mother and aunts by listening to them discuss it, and eventually by running errands to buy it for them.

When those who are older than me—my aunts and mother—are chatting, I go and sit and listen. When they ask me to leave, I don’t go. I pretend I’m not listening, but I hear everything. . . They used to talk about it, so I knew the purpose for which they used it when they sent me to buy it, so I also bought some. [Pauline]

⁶ Participants experienced 30 abortions collectively. Data were collected for 28 of these.

Several other participants said that although girls might learn about methods of abortion by listening, they would not actually ask older women about such methods.

You do not necessarily go to them [older women] asking. They usually discuss such things among themselves and some of us listen. [Eve]

Nor, as another participant pointed out, would a girl ask an herbalist or a pharmacist directly about methods of abortion unless she actually wanted to buy something, as Diana explained.

In fact, we hear about these things from friends rather than going to ask from an herbalist or drug sellers. You only go to the herbalists or drug sellers if you want to cause an abortion. But you don't go there to know about them for knowing's sake. [Yolanda]

6.1.1 Early Abortions are Better than Later Abortions: Effects on Fertility

In examining the decisionmaking processes in the previous chapter, specifically the urgency that was sometimes expressed about going ahead with an abortion, it appears that most girls and their boyfriends were aware that an early abortion was generally safer than a late one. One participant put it like this:

An abortion is okay when the pregnancy is just a month old. But after three months it can be dangerous to the mother's health. Also, if it is done in the afternoon it is more painful. It is better to abort in the morning. [Bernadette]

Some girls had a preferred method of abortion. Other girls said that traditional methods were dangerous or not effective. One participant who finished JSS 3 said that she learned the following in her hometown school:

We were told that you could die if you had an abortion. We were told you could have it done at the hospital. We also learned that some people used traditional medicine, which was not safe. [Charity]

At least seven girls used herbal remedies, five successfully, to cause an abortion. Some explained their preference for the herbal methods as follows:

I think I prefer them [herbs] to going to hospital where you will be made to open your legs for equipment to be pushed into your womb. [Theresa]

The decisionmaking process illustrates the widespread belief that too many abortions can cause infertility. Girls also believe that abortions can cause sickness or death. One participant reported the following:

My father's wife told me that if I ever got pregnant I should not have an abortion and that I should come and tell her. . . because if I have an abortion I may not be able to have children in future. [Charity]

One participant explained why too many abortions cause infertility; she said,

If you overdo it your womb—the opening—will become wide.

Like contraception, abortion's effect on fertility was not viewed as a problem once women had enough children.

Abortion can cause you not to have more children. It's okay if you already have a lot. [Candace]

6.1.2 Sin or Necessity?

Nearly all the participants said they believed that abortion was not a good thing. According to their statements, they thought that abortions are “not the best,” “not good,” “sinful,” “dangerous,” “can kill,” or can “make one sick” or “barren.”⁷ Yet, when asked in which situations abortion was acceptable, all but one participant used logic based on the pragmatism of raising a child to describe situations where abortion was acceptable and even necessary. These reports came from all the participants, not just those who had had an abortion. For example, Yolanda expressed the following strong antiabortion opinion.

I think abortion is bad in every sense of it. The Bible even says that we should fill the earth. If you abort, then you may never be able to have any more children in the future. Secondly, you may lose respect from the man who made you pregnant and also you may die through the process if you are not lucky. . . So abortion is not part of God's commandments. It is bad. There is nothing good about it. If your parents were to be causing abortions, then some of us would not have been born. [Yolanda]

When asked in what situations abortion was okay, she provided the following explanation:

Abortions may be okay if the man refuses responsibility for the child. Also if there is no way one can look after the child. Then one can consider an abortion. [Yolanda]

Referring to herself, another participant explained her reasons for having an abortion as follows:

I think that if someone is in my position—no job, no parents to help her—then the person can consider abortion and, to me, that is okay. [Iris]

⁷ See Bleek (1981) for a description of the differences between public and private perceptions of abortion in Ghana, and Bleek and Asante-Darko (1986).

Another participant said that getting pregnant while in school was particularly problematic and that this was a good reason to have an abortion.

But then if a schoolgirl is pregnant, it is better to have the abortion or else the child will suffer, since the schoolgirl cannot care for herself and the child. In fact, her friends will laugh at her in school and she cannot go to school.

Overall, the reasons that the girls found acceptable for having an abortion were: 1) there was no father for the child; 2) there was no one to help the girl look after the child; 3) there were no financial resources to care for and feed the child; and 4) the girl was still in school. These reasons outweighed the moral arguments against abortion in the girls' decisions to keep or abort since they were rarely mentioned in that context. None of the girls mentioned rape or not liking the boyfriend enough as legitimate reasons to have an abortion.

6.1.3 Keeping Abortion a Secret

Society's attitudes regarding abortion and miscarriage are embedded in the words used to describe the two events. Miscarriage is commonly said to mean "spoilt" pregnancy, while abortion connoted "spilling of blood" or "killing your child," according to the participants. When the two words were contrasted, most participants said something like the following:

Abortion is usually associated with a murder or sinful act, while a miscarriage is seen as a natural process that God did not want the pregnancy to be. [Eve]

The participants understood that it was best to keep an abortion a secret and those who had had abortions said they did so.

As for abortion, it is hidden. . . the way spilling of blood is not good and you've been able to spill blood; you have to hide it. If you hide it and only God knows about it, then you keep praying maybe God will forgive you. But if you don't hide it and talk about it openly, even when you're walking, people will be insulting you. [Ruth]

6.2 Experiences of Surgical Abortion

The surgical abortions are divided into three basic groups for discussion: hospital abortions, abortions initiated by hospital staff (Korle-Bu Hospital staff quarters), and private clinic abortions. The following accounts are not based on direct observation by a third party, but on the girl's account of the experience, and must be understood in this light.

The elements that could be gleaned from many participants' accounts of clinic abortions included the following:

- Who accompanied the girl
- Whether the girl filled out a card
- Whether the girl was put to sleep
- The general type of instrument used

- Whether the girl had any complications
- Whether the girl was counseled on birth control
- The cost of the procedure.

Some of this information—especially whether the girl had postabortion complications and whether she was counseled on contraception—was obtained through interviewers’ probes if the girls did not include this information in their spontaneous accounts.

The girl often had someone accompany her when she was getting a surgical abortion, regardless of where it was performed, usually a friend. Other times her mother or an aunt would accompany her, or, even less frequently, her boyfriend. One girl explained her boyfriend’s reaction to her request that he accompany her.

When I asked my boyfriend to accompany me for an abortion he said he had never accompanied anyone to have an abortion before and that he was scared. [Wanda]

This participant’s mother and aunt accompanied her to the hospital for the abortion procedure. Many girls said that they did speak with their boyfriends afterward about how the procedure went and asked them to buy any medications prescribed, which the boyfriends usually did.

6.2.1 Hospital Abortions

Only 4 of the 23 surgical abortions were performed at a hospital. Six other girls negotiated with the hospital staff for abortions that took place at the residence of a hospital staff member. The first step in a hospital abortion involved filling out a card, for which the girl was usually charged a fee. For example, one participant said,

So, when we got to [the facility], she made me to go for a card, which cost 5,000 [cedis]. Then I waited until it was my turn. There were other girls there to have abortions. When it was my turn, the nurse called me and I went into the doctor’s room without my friend.

Presumably, filling out a card involves providing identification information and a medical or pregnancy history for the record kept at the clinic or hospital.

Some participants also described the procedure as follows:

When I got there, I was made to undress and to lay down on a bed with my legs apart. Then he inserted a suction device in my vagina and sucked out the blood. In less than 10 minutes it was over and he said I could go home. I saw everything he did. . . Yes, it was [painful].

Based on the participants’ reports, most of the abortions involved the use of an instrument that was described as looking or sounding like a suction device. One participant, however, said that the abortion she had at the hospital was a “D and C.” Following most procedures, the girl was given a prescription and some cotton wool to use as padding.

Another account of a hospital abortion that took about an hour and a half involved a procedure where the girl was put to sleep.

Before the abortion, I was made to go for a card. After the card, a nurse called me to her office and asked if my mother knew about the abortion. I said no and she took me to a room where I was given an injection. I fell asleep and when I woke up the act was completed. I was then told to go home. . . I was feeling very sick and weak. So my friend hired a taxi and we came home. I slept for hours and when I woke up I was fine.

One girl spoke of the doctor pressing on her stomach during the procedure, after she had received an injection.

Brother took me to [hospital]. I was made to lay down with my two legs apart. Then the doctor inserted some metal-like tools in my womb and kept pressing my stomach. A few minutes later it was all over. . . When I was getting up, my abdomen hurt a lot. I could not stretch and stand upright, so I lay there for some time. When I felt better, then I left.

6.2.2 Abortions in Hospital Staff Quarters

The girls who did not have their abortions in the appropriate unit of the hospital, but in the staff residences, or “nurses’ quarters,” as they were sometimes referred to, said that they went to the “big hospital” first and were then directed to the staff quarters, where the abortion procedure was performed. One participant explained it as follows:

My mother arranged everything. We went to the big hospital and someone called the doctor for my mother. After talking with my mother for a while, we went to his house and he did it for me there. . . It was a doctor because he was called doctor. . . the operation was performed in his bedroom. [Diana]

Another participant gave an account of the price negotiation for the cost before the procedure at the staff quarters.

We went to [hospital], the place where they admit pregnant women, and those who do the family planning over there, and they took us to the quarters and we saw the doctor. . . He said the pregnancy was two months advanced, and that I would pay 70,000 [cedis] and I told him the money I had was not up to that, so we bargained for some time ‘til it came to 60,000 [cedis], and he did it for me. [Wanda]

There does not seem to be any obvious reason why some girls had their abortions in the quarters instead of the hospital except that perhaps the doctors negotiated a fee that would go directly to them and the other personnel who supported the procedure. None of the participants who went to the staff quarters mentioned making up a card before the procedure.

Two participants said they were put to sleep and four said they were not. Again, a suction device was usually described as the tool used.

6.2.3 Private Clinic Abortions

Participants reported that 13 surgical abortions had been performed at private clinics. The clinics (six in all) were described by location, usually a market-designated location. Two study participants said that the staff wore uniforms at the private clinics where they had their abortions.

It looked like a clinic. The people were in light blue uniforms. It's a story building at [market location]. Upstairs.

According to one participant, at least one of these clinics advertised its services on a sign outside the clinic door. Apparently, the clinic provided other services besides abortions.

When we went, the nurses asked what we were there for and my friend told them I was pregnant and I wanted an abortion. They sent me into a room and they pressed my stomach and the man said I was really pregnant and I went to urinate. When I came back they sent me to another room. [Bernadette]

Several of the participants said that they filled out a card at the clinic before the procedure.

They made a card for 3,000 [cedis] before they did it. [Grace]

Among the 13 accounts of abortions performed at the private clinics, five girls said that they were awake during the abortion and two said that they were put to sleep. The others didn't include this information in their stories. One said she had received an injection to decrease the pain, but that she did not lose consciousness. Again, a suction device was used to perform the abortions.

Since we were not able to interview the providers at these clinics, the credentials of those performing the abortions are unclear; nor is it known whether the clinic was legally recognized. What is clear is that these clinics were fairly well known. The basic procedure followed at the hospital and the nurses' quarters seemed to have been followed at the clinics, according to the girls' reports.

6.2.4 Postabortion Complications from Clinic Abortions

According to Hatcher, postabortion warning signs include fever, chills, abdominal pain, cramping or backache, tenderness in the abdomen, prolonged or heavy bleeding, foul vaginal discharge, and a six-week delay in resuming menstrual periods.⁸ (Hatcher, 1998:694)

Few participants reported any health problems after their hospital, staff quarters, or private clinic abortions. Some described feeling somewhat shaky or weak immediately after the

⁸ "Teenagers tend to have abortions later in gestation than do adult women, and therefore, as a group, experience more complications. Adjust for length of gestation, however, and teenagers have fewer complications than do older women." (Hatcher, 1998)

procedure, and a few reported two to four days of bleeding and/or abdominal pain. For example, a typical response was,

The pains didn't last for two days and ceased.

Two girls mentioned drinking a blood tonic, which they said, helped them feel better. Several of the participants just said that the procedure was “problem-free.” Only three participants described notable problems after their abortion procedures. One described a complication two days after the hospital procedure.

Well, two days later, I started experiencing some abdominal pains. I told the boy and we went to the hospital together. I explained to the nurse my condition and she gave me some drugs to take for a week. After the drugs, I was Okay. I never fell sick and I never went back there. [Eve]

Two girls who had abortions at private clinics reported some problems immediately after the procedure. The first described her experience as follows:

But then, I was in severe pains. I was also feeling dizzy and weak on my way home. So I went to sit under a tree for a while. When the dizziness was better, I went to buy the drugs that he prescribed for me...went to a drug store and told them I have had an abortion but I'm still bleeding so profusely. So they gave me some drugs to take and after a few days the bleeding stopped. [Opal]

This participant went to another private clinic provider for her next abortion because, she said she “bled too much” after the abortion at the first private clinic. Another participant said that she experienced a complication after her abortion, but she blamed it on herself for not following the provider’s instructions.

After the abortion, he gave me a prescription to go and get some drugs. I forgot about the prescription and went to work. But later on I started bleeding and experiencing severe pains. I was sent back to the man and he gave me some injections for the next five days. After that I got well and the bleeding and pains stopped. Since then, I decided I wasn't going to have an abortion anymore. [Rachel]

Both participants recovered by the second week after their abortions.

6.2.5 Cost of Clinic Abortions

The cost of a clinic abortion, whether performed at the hospital, the Korle-Bu Hospital nurses’ quarters, or in a private clinic, ranged from 30,000 cedis to 300,000 cedis, according to the girls’ reports. It was interesting that the participant who had obtained her abortion at a hospital in another area of Ghana was charged the lowest fee, 30,000 cedis. The average cost of an abortion obtained in or near Ga Mashi Town was closer to 90,000 or 100,000 cedis. The participants said that the fees charged by the person providing the abortion were sometimes based on the number of months the pregnancy had progressed. In one instance, a girl said she

had paid 150,000 cedis for a two-month-old pregnancy and 300,000 cedis to the same provider for a three-month-old pregnancy one year later.

At the time, I was three months pregnant and the man said it was now expensive so he would charge 300,000 [cedis], and I pleaded with him to reduce it. I had lied to my father that I wanted something so he should give me 100,000 [cedis] and he used to tell me that he'll give it to me the following day. So the day he finally gave it to me, I had borrowed 200,000 [cedis] from a friend already, so I added to it. I did not tell my auntie this time because she will say, "Again?" So I just told my friend and I went alone. [Karen]

Another participant, however, said she had paid the same price for two abortions from the same provider at another clinic—150,000 cedis each for both a two-month- and three-month-old pregnancy. At least three participants said that they were refused abortions because the clinic or hospital providers said the pregnancy was too far advanced to do a safe abortion. More than two-thirds of the abortions were paid for by the boyfriends or husbands. Of the remaining third, half of the procedures were paid for by the girls and half by parents or guardians.

6.2.6 Postabortion Counseling After Clinic Abortions

When the participants were asked whether they were given any counseling after their clinic abortions, most could not recall or said that they had received none. Only four participants could recall specifics about postabortion counseling. Two participants who had their procedures at the hospital or in the staff quarters said that the doctor told them the following after the procedure:

Yes [the doctor counseled], he said I should never get myself pregnant again. According to him, he did the abortion for me because I'm too young. However, if it were to be an older person, he wouldn't have done it. So I should be careful. [Iris]

Upon probing, this participant could not recall being told about any specific ways to “be careful,” such as contraceptive methods. Another girl said that she was told the following after the same doctor had performed her second abortion:

He did the abortion for me in the same way the first one was done, but this time he advised me to use some contraceptives since I'm too young to be aborting all the time. [Diana]

Two participants said that they received some postabortion counseling after their private clinic abortions. A participant said that she was told the following after her first abortion at the age of 16:

When I had the abortion, the doctor told me that if I go to my husband again it won't be long and I will get pregnant, so I did not go there for about four months. . . No, he didn't [counsel me on how to avoid pregnancy]. All he said was [that] I should be patient and wait a while before going to my husband; so I waited for about five months. [Joy]

The provider seemed to be recommending abstinence. Another participant, however, said that she was given extensive counseling at a private clinic after her second abortion with the same provider at age 17.

He told me not to come for an abortion again and that if I was pregnant I should give birth. . . He told me to take care of myself and that there was a lot of contraceptives available over the counter. He also told me about condoms and that I should insist on condoms, and if the boy would not allow it then I should leave him and go home. He also told me that if I ever got pregnant again, I should not use traditional medicine to abort it because it could be fatal. So I thanked him for his advice. [Karen]

If the girls' reports are any indication, postabortion counseling does not appear to be practiced by either the hospital or the clinic staff, although some medical personnel provided advice to the girls who came for repeat abortions.

6.2.7 Incomplete Plans and Failed Attempts to Obtain Clinic Abortions

Four participants described incomplete plans or failed attempts to have a clinic abortion. In one case, a schoolgirl reported being too afraid to go through with the abortion.

When we got to the gate I told him I was afraid that I was going to die. . . I told him [the doctor] that I was afraid and that I would not go through with it.

Two participants who had each had at least two abortions mentioned that they would not go to the hospital for an abortion because the hospital staff would not do the abortions. Rachel said that on her fifth pregnancy, at the age of 22, she went to the hospital for a second abortion.

They told me at [hospital] they no longer do abortions, so I should protect myself with condoms. Let me tell you a story. You see, my last child, I wanted to abort it. But when I went to [hospital], the nurses advised against it and told me that I had had too many abortions and this last one could kill me. That did not deter me. I insisted I wanted it, then the doctor mentioned the charge for doing the abortion. I didn't have that much money. When I came home, the little money I had got lost. I didn't want to tell my husband I wanted to have an abortion, so I could not ask for money. So after a while, I went back to [the hospital] and the midwives. . . encouraged me to have the baby. I listened and had the last child and it happened to be a girl. My other two children were boys. So I thank God for her life. [Rachel]

For her sixth pregnancy, this same participant found an alternative location to obtain an abortion: a private clinic.

Another participant said that she didn't have an abortion because,

The doctor, he said if I aborted the child I would die. It frightened me.

Regarding her second pregnancy with her second boyfriend, Naomi said the following about trying to get an abortion:

My boyfriend took me to [hospital] to get an abortion, but when the doctor examined it he said it was four months old and that it could not be aborted. So I carried it full-term. [Naomi]

6.3 Herbal Medicine and Home Remedies: Using Multiple Methods

The home remedies and herbal medicines described by the participants were sometimes spoken of as day-after methods to prevent abortion or as menstrual regulators used as soon as one noticed a delayed period. Several participants explained how to use these methods.

Drank brandy after missing period for three days and it would come....[Candace]

If you have sex with a man and he puts his sperm in you and you know you are late, you will buy some of the medicines they sell at the toilet and use it in an enema, like the akumadada. And also the mixture of ginger and pepper that they sell at the toilet. When you buy it and use it in an enema, it will come. But then, if you are careless and you don't do it early enough, you will get pregnant. [Candace]

One girl said that she was taught in a class at school what to do to bring on menstruation:

They taught us all; we were taught that when your period is late you will eat coffee and sugar, then it will come...two sachets [of coffee] and half packet of sugar.

Others spoke of the same methods as ways to terminate a pregnancy more than a few weeks old. Home remedies consisted mainly of some liquid—such as Guinness, brandy, milk, muscatella, tea, or Nescafe—mixed with nearly equal amounts of sugar. One participant said that she just drank brandy to cause the abortion.

Another participant said that financial constraints caused her to try a home remedy at three months rather than have a clinic abortion.

I tried the tea, I mean Nescafe, at three months. I wanted to have an abortion, but my boyfriend would not give me the money. I tried the coffee, but I could not get it right. I could not get enough sugar, so it did not work and I forgot about it. [Mary]

Since it is costs more to get a surgical abortion than to use a home remedy or buy an herbal medicine, it is possible that girls who are not financially independent and do not have the consent of their boyfriends are more likely to use these methods.

Another method was mentioned by three participants but was actually used by only one in a failed abortion attempt. This was called Ergot.

It [is] called Ergot, tiny pills, even if you are six months pregnant you can use it to abort. You take three in the morning, three in the afternoon, and three in the evening and you don't eat the whole day, but by the following morning it will come. . . It would hurt like you're in labor, you will push it out. . . A friend of mine used it. . .If you do not have a prescription, you have to beg for a long time before they sell it to you. [Karen]

She is likely referring to Ergotamine, a uterine-contracting agent designed to minimize bleeding after a pregnancy termination.

6.3.1 Auntie Mercy or Aatsoo

I know of a drug sold at the timber market called Aatsoo. It is sold by the herbalists. It is round and you insert it in the vagina. After a couple of days, the pregnancy will be aborted.⁹ [Diana]

The five participants who used herbal remedies to successfully terminate their pregnancy all used Auntie Mercy in the vaginal suppository form. Of the two who said they had used Auntie Mercy unsuccessfully, one drank it as a solution and the other douched with it. Four of the five girls who successfully used Auntie Mercy to terminate their pregnancies said that they just had a normal period after taking the medicine. One participant, however, described her first abortion experience at age 16 as follows:

The medicine was sold to me at 35,000 cedis. I was asked to insert it into my vagina for three days. . . Two days after I removed it my stomach started hurting. I had body pains all over. I could not even hold anything. My hands were also hurting. I was in pain. So at that point my mother got to know that I was pregnant and was trying to terminate the pregnancy. . . So later. . . I felt like urinating, and when I went to the bathroom some liquid started coming out and blood started coming out. . . It was coming out a lot, it was heavy, and when I strained myself the thing fell in. . . so I called my mother to come and see and she said it was left with something more to come. . . Then my stomach was hurting a lot and the rest would not come out, so my mother got a bottle for me and told me to blow into the bottle and strain myself and that it would come out. So I did it for some time and I could no longer do it, and then I felt a sharp pain in my abdomen and the thing came out and I bled for some time. . . She gave me some medicine and I took it, some antibiotics. . . I did not go to the hospital so, as I took the medicine, I bled for four to five days, then the bleeding stopped. [Faith]

One participant said that an herbalist in the market advised her to go to the hospital for an abortion when she approached her for abortifacient during her second month of pregnancy. The

⁹ Haatso was described by Ottoo (1972) as “efficient haemostatics, such as haatso, a postnatal tonic drank by the calabash full, two to three times a day.”

participant said that she was afraid to go to the hospital for an abortion, so the herbalist apparently worked with her. She described the procedure as follows:

She gave me some medicine, some tiny medicines, and she made me pound it in a mortar. . . It was from a paw paw tree and she made me boil it; she said I should mix it with the other one, boil it, sieve it, and use it in an enema. But when I did it, it did not come. She gave me another one. I don't remember the name of the drink, but then I threw up anytime I drank it. I drank it twice and decided not to drink it again. When I told her, she gave me another one, but I haven't used it...it was from a tree, it's long. She said I should grind it and use it in an enema, but when I came home I decided not to do it. [Candace]

One participant said she decided to use Auntie Mercy when her boyfriend did not produce the money fast enough for a surgical abortion.

I told him and he said he was going to find money for me to go to the hospital for an abortion. But it was delaying. . . I got to know all the ways that people did abortions. . . I went straight to the Timber market and got the herb. It is called "Aatsoo." [Rachel]

Most participants said that this medicine can be obtained at the market, but one participant knew how to harvest and prepare it and did so on at least one occasion.

I didn't want the pregnancy. That was why I told my friend and she also helped by going with me to harvest the herbs for the abortion. [Theresa]

6.3.2 Multiple Methods

At least four participants described using multiple methods before they successfully terminated their pregnancies.

A friend told me I could boil some Guinness and add some sugar to it and drink. I did that, but it couldn't abort. Then she advised me to go to the pharmacy, a shop, and buy a drug. It has a white packaging, and there are two tablets in it. I took both orally, but again the pregnancy did not come. Then I went to see an herbalist who gave me some herbs to insert in my vagina. I did that and a week later, the pregnancy was aborted. . . It was painful and made me very weak, until the abortion took place. . . [afterwards] I was normal. I only bled heavily for one week and was okay. . . I did not have money to go to the hospital. [Naomi]

The participant below described a failed abortion attempt consisting of consuming sugar and muscatella.

I have ever tried that, but it failed me. I became very ill after taking the concoction. I was rushed to [the hospital]. I was given an injection and I felt better. But I couldn't abort. I carried the pregnancy full-term and gave birth to my first child. [Bernadette]

In summary, there was some controversy about whether clinic or herbal abortions were preferable, but the majority of girls obtained their abortions at clinics. It was understood that too many abortions can be dangerous and can affect a girl's fertility. Most girls, whether they had had an abortion or not, said that abortion was morally wrong; however, they all cited practical reasons why it is acceptable for a girl to have an abortion. These reasons included the girl not having the means to care for the child and not having parents to help, the father being absent, or the girl being in school. The word for abortion in the languages spoken by girls connotes "murder" or "spilling blood" while the word "miscarriage" connotes a natural process.

The participants used clinics and hospitals to terminate their pregnancies more than any other method. They were usually accompanied by a friend and sometimes by a female relative or a boyfriend. The boyfriends usually paid the clinic abortion fees, which ranged from 30,000 cedis to 300,000 cedis, with an average cost of 90,000 to 100,000 cedis. Girls whose boyfriends or husbands did not acknowledge the pregnancy and those who obtained abortions against their boyfriends' wishes paid for the procedure with their own money, money they got from parents or borrowed from friends, or some combination of these. A clinic abortion was sometimes preceded by failed attempts to terminate the pregnancy using home remedies, pharmaceuticals, or herbs bought in the market. In the experience of these girls, the vaginally inserted form of Aatsoo had been found to be an effective abortifacient with few side effects when used early in pregnancy; it usually costs less than 10,000 cedis. The participants experienced few complications from their clinic or herbal abortions and received little postabortion counseling after clinic abortions.

7 Conclusions

These girls' experiences leading up to becoming pregnant and the strategies they used to cope with pregnancy both contradict and explain some of the findings in the health and survey literature on adolescent health and sexual behavior in Ghana. Although the findings are limited to girls in Ga Mashi, Accra, they point out the need for smaller, more in-depth studies both to counter general assumptions about the experience of teenage pregnancy and abortion and to adapt programs to specific circumstances in communities where the social dynamics vary.

First, these girls' stories illustrate that they are struggling to establish themselves as money earners and partners in stable relationships with males, beginning in their mid- to late-teens. Their long-term financial strategies typically involve trade and employment rather than formal education. Formal education did not appear to be an option for most of these girls, not because they had to drop out of school due to pregnancy, but rather because their parents and guardians were unable, or perhaps unwilling, to support them beyond junior secondary schooling. It was at that point, after leaving school, that most girls transitioned into adult pursuits, which included developing a stable sexual relationship.

Most of these girls were in long-term relationships with a first or second boyfriend or had one or two sexual partners before developing a long-term relationship. Many of these relationships endured whether the couple considered themselves married or not. Those who did not have long-term relationships generally practiced serial monogamy. Girls tended to get sexually involved with boys their own age or within 10 years of their age with a few exceptions. Girls maintained that they became sexually involved with their boyfriends because of both love and money, as is common in various socioeconomic groups in Ghana (Pellow, 1977).

These findings contradict the assumption that most unmarried adolescent girls who get pregnant have multiple sexual partners, are casual about sex, or exchange sex for money out of necessity. About the latter point, girls from lower socioeconomic groups are thought to be especially vulnerable to exchanging sex for gifts either because their parents cannot support them or because they cannot earn enough money to survive or stay in school. Most of these girls however, were surprisingly resourceful in making money. None of the girls in the study said their parents or guardians deprived them of food or a place to sleep, nor did they say financial support was the sole or major reason for getting sexually involved with a man. Only one girl in the study (a migrant from Kumasi) described getting into this type of sexual relationship in her hometown. This suggests that the "sugar daddy" phenomenon described by Dinan (1983) and others may be more common among middle-class girls than among lower-class girls living in Accra or in other locales, such as Kumasi. Although the "deprivation leading to exchange sex for gifts and money" dynamic does not fit closely with the experiences described by these girls, it may fit other groups to some extent, such as street youth.

Violence, on the other hand, did seem to play a role in early sexual initiation. The few girls who may be considered the less "supported" of the group indicated they ran away or started living with a boyfriend to escape from emotional and physical abuse at home. In addition, violence and deception by boyfriends and other males played a large role in these girls' early initiation to sex. Many said they were raped by their boyfriend or by someone else as their first

sexual experience and, thus, may have started having sex earlier than they would have otherwise. Surprisingly, these relationships often continued, and thus it seems date rape may be accepted in the community.

All of the participants said that their first pregnancies and most of the subsequent ones were accidental or mistimed, whether they were married or not. There is no indication that the girls got pregnant because they wanted to hold on to their boyfriends, force their boyfriends to marry them, or to gain economic or social status in the community. The main reason they got pregnant was that they either did not use a contraceptive method or they used one ineffectively.

The most common contraceptive method used was periodic abstinence. Besides parents or guardians, and friends, teachers influenced or reinforced the girls' understanding of the menstrual cycle and of pregnancy-prevention methods. (None of the girls mentioned learning about the fertile period from health care providers.) The problem with the information on periodic abstinence coming from parents and teachers was that it was based on nonbiological understandings of the fertile period. Therefore, although the girls practiced periodic abstinence, they did it in ways that promoted pregnancy rather than prevented it. About half of the participants said that they had tried condoms, but only about a third said that they ever used them regularly. The girls were hesitant to use any other modern method before they had children. A few of the girls tried hormonal methods, usually after attending a clinic for postnatal care.

Overall, these girls tended to have repeated unintended pregnancies during their teens and beyond. The girls' awareness of their menstrual cycle, however, was remarkable and generally led to early knowledge of the pregnancy once it occurred. This allowed them time to negotiate with boyfriends, parents, and others about how to handle the pregnancy and to seek information about abortion services from friends and others if necessary. The girls' descriptions of the process of deciding whether to terminate a pregnancy indicate that their decisions cannot be separated from the process of forming stable child-rearing unions in the community nor from the need for women to keep or establish stable, independent means of financial support.

The decision whether to terminate a pregnancy or to continue it to term was made in several ways, depending on the social circumstances and the people involved. Most commonly, the girls and their boyfriends jointly decided whether to terminate the pregnancy. In many cases, they decided to continue the pregnancy and the boy then acknowledged paternity by performing a public rite called "knocking" or a similar rite. This was the first step toward a long-term union and implied that the male involved would provide chop money and other support. If the decision to have an abortion was made jointly, the boyfriend often supplied the girl with money to have the abortion, although this did not necessarily cause the relationship to end.

Second, in situations where the adolescent depended on parents or guardians, or when the couple did not agree on a plan of action, the parents and guardians decided. About a third of the time parents and guardians opted for abortion. Depending on their decision, parents and guardians usually supplied some financial support for the child and/or the procedure.

Third, for a minority of girls whose boyfriends denied responsibility for the pregnancy, the responsibility for terminating the pregnancy fell to the girl or her family. In such cases, these

girls used all their resources or borrowed money on a pretext for the abortions, rather than getting all of it or part of it from the boyfriend. Practicing serial monogamy, or having only one sexual partner at a time was a strategy used by girls and supported by some parents to avoid situations in which the boyfriend could deny responsibility for the pregnancy.

Again, these findings somewhat contradict the assertion that the boyfriends or sexual partners of adolescent girls do not take responsibility for mistimed pregnancies or insist on abortions. Rather, it seems that in this community, getting pregnant and having a child together can be the first step in forming a long-term union. In cases where the couple decided not to continue the pregnancy, the boyfriend usually took responsibility for the abortion fees, as much as he could afford. While it happened that some boyfriends refused responsibility for a pregnancy, this did not happen in the majority of cases and it should not be assumed that this is the rule.

The general understanding among participants was that early abortions were safer. In addition, it seems that various abortion options and effective services were readily available in this community (although some are expensive), and that girls had no problems obtaining information about such options from networks of friends. Clinical abortions and one herbal option were both effective and available, according to the girls' reports, few complications were reported. Most girls had surgical abortions. It is not known whether the private clinics the girls attended were licensed facilities; however, most of the girls used this option and they reported few if any complications after the abortion. In the cases where the boyfriends refused to acknowledge paternity and the parents were not informed, the girls did not resort to "back-street abortions," but used the same means to obtain an abortion as the girls whose boyfriends paid for the abortions—private clinics and/or vaginally inserted Auntie Mercy herbal medicine.

The girls in this study reported having first trimester abortions, which supports the findings of Lassey's study (1995) of the complications of induced abortions conducted at Korle-Bu Hospital, Accra. This also contradicts some general assumptions that adolescent girls tend to delay getting abortions and therefore suffer more complications. The girls' early awareness of their pregnancy, the availability of abortion information and services and their ability to raise the money contributed to obtaining safe abortions. This is not to dismiss the possibility that a minority of girls who are alienated in other ways from their family and the community may have tragic experiences with other abortive measures, but this does not appear to be the common experience in this community. Adolescent girls appeared to use abortion both to delay childbearing and to space children.

These girls' experiences of adolescent pregnancy challenge some of the basic assumptions upon which health surveys of teenage pregnancy and abortion are built, and they can be used to refine survey strategies. One assumption is that "married" as opposed to "unmarried" is an unambiguous distinction that can be easily measured by asking one question. Another assumption is that those who are married are much less likely to get an abortion than those who are not. Although marriage practices were not the focus of this study, the lives described by girls suggest that getting pregnant is the first step in a longer process of union formation, and that there is variability in the process of becoming married and in the meaning of practices such as "knocking." In some cases, it may take years for couples to get married,

depending on the circumstances. It seems possible that a girl may refer to herself as married during a long-term relationship, as was the case in some of these interviews. In addition, once one is married, either legally or by common law, it cannot be assumed that the nuclear, single-family dwelling, or the pooling of resources is the arrangement into which families settle either currently or historically in Ghana. Thus the definition of who is and who is not married and what a “broken home” or a single-parent family is, must be measured carefully according to local practices, and these may vary from region to region.

Furthermore, the differences between the findings of this study of adolescent abortion and of the studies conducted among other groups, such as street youth or middle-class youth, suggest that examining the data at the aggregate level masks differences that are important for program planning and implementation. Standardizing approaches instead of adapting them to specific groups can lead to programs that do not address the health behavior of the adolescent group the program is designed to change. For example, the assumption that girls are promiscuous or that boyfriends lack interest or responsibility in deciding whether to terminate a pregnancy can lead to alienation of the target group. Girls may reject health messages about sexual behavior that do not seem to apply to them. Or, important players in the decisionmaking process about how to handle an unintended pregnancy, such as boyfriends, may be ignored by programs.

Based on these findings, the following recommendations were developed by an interdisciplinary group organized by NPC and the USAID mission in Ghana.

8 Recommendations

Pregnancy and Sexual Violence Prevention

Since girls who become pregnant often begin having sexual relationships after they leave school, pregnancy-prevention efforts should focus on both male and female out-of-school as well as in-school adolescents and youth. The following strategies might be used to reach these groups.

- Build on existing puberty practices of parents and other caretakers. Parents and other caretakers might be educated to include information on the biological fertile period, modern methods of contraception, and the dynamics of date rape, to their existing practices of puberty instruction. An example of a message aimed at boys through their parents and caretakers is, “When a girl says no to sex it means no.” For girls, “It is important to say no both verbally and non-verbally through body language.”¹⁰
- Many girls who have recently migrated to Accra from other areas of Ghana might be reached with pregnancy-prevention and sexual violence education through the “madam” for whom they sell food items and with whom they live. Others might be contacted through local “susu collectors” or mobile bankers, since many save their money this way.
- Train teachers about the biological fertile period during pre-service training and in-service training on holidays and encourage routine teaching of pregnancy prevention, including modern contraception in the classroom. Encourage teacher-parent dialogue about the curriculum related to reproductive health in the schools at PTA meetings in the schools, so parents are aware and can reinforce learning.
- Encourage family planning, postnatal care, and abortion providers to promote biological understandings of the fertile period and modern methods of birth control. Postnatal care and abortion clinic visits are opportunities to reach adolescents and youth with information about modern contraception.

Abortion Education

Conduct dissemination meetings for health care providers, e.g., hospital, family planning, maternal health, abortion, and postabortion providers, regarding the findings of this study of adolescent pregnancy and abortion to generate further strategies to reduce the incidence of unwanted pregnancy and abortion among adolescents and youth in their communities.

Since some pregnant girls are more vulnerable than others—those without supportive boyfriends or those involved in a family conflict over whether or not to have an abortion—social service and abortion service providers should be informed of these differences and instructed how to assess girls’ vulnerability and provide support accordingly.

¹⁰ See Tagoe-Darko (1997) for further discussion of this approach.

Development of Public Awareness and Social Support Programs

Expose the public to the variations in the social dynamics of teenage sexual practices and use of abortion in the community. For example, include information on how and where forced sex generally occurs so parents, caretakers, and adolescents can be alert to preventing opportunities for sexual violence.

Develop adolescent centers that provide adolescent-friendly reproductive health services. Keep the scope of the centers broad, beyond reproductive health.

Strengthen already existing UN and MOH programs to support girls' education.

Data Collection and Research

Since there is variability in the process of becoming married and living arrangements during the process, characteristics such as “married” versus “unmarried,” “broken home,” or “single-parent family” must be defined and measured carefully according to local practices; they cannot easily be measured by asking one question on a survey questionnaire.

The differences between the findings of this study of adolescent abortion and those of studies conducted among other groups, such as street youth or middle-class youth, suggest that local studies should be implemented to guide program planning and implementation according to local practices.

References

- Abu, Katharine. 1983. The separateness of spouses conjugal resources in an Ashanti town. In *Female and male in West Africa*, ed. Christine Oppong. London: George Allen and Unwin.
- Adomako-Ampfo, A. 1991. *Attitudes and practices regarding premarital sex among adolescents in Ghana*. A study funded by UNFPA. Legon, Ghana: Institute of African Studies.
- Agyei, W.K.A. and R.B. Hill. 1997. Sexual behaviour, reproductive health and contraceptive use among adolescents and young adults in Ghana. A paper presented at the Research Seminar to Disseminate Some of the Findings of the Ghana Adolescent Fertility Survey undertaken by the Department of Community Health, Ghana Medical School, and the Institute for Urban Research, Morgan State University.
- Ahiadeke, Clement. 2001. Incidence of induced abortion in southern Ghana. *International Family Planning Perspectives* 27(2):96-101.
- Akuffo, Felix Odei. 1987. Teenage pregnancies and school drop-outs: the relevance of family life, education and vocational training to girls' employment opportunities. *Sex roles, population and development in West Africa*, ed. Christine Oppong. Portsmouth: Heineman, pp.154-164.
- Ampofo, D.A. 1989. Extent of the problem of adolescent pregnancy in Korle-Bu teaching hospital. *Ghana Medical Journal* 23(3):155-160.
- Anarfi, John. 1997. Vulnerability to sexually transmitted disease: Street children in Accra. *Health Transition Review*, Supplement to Volume 7, 281-306.
- Anarfi, John K., and Kofi Awusabo-Asare. 1993. Experimental research on sexual networking in some selected areas of Ghana. *Health Transition Review*, Supplement to Volume 3, 29-43.
- Ankomah, Augustine. 1998. Condom use in sexual exchange relationships among young single adults in Ghana. *AIDS Education and Prevention* 10(4):303-316.
- Ankomah, Augustine, and Nicholas Ford. 1994. Sexual exchange: Understanding premarital heterosexual relationships in urban Ghana. In *AIDS: Foundations for the future*, ed. P. Aggleton, P. Davies, and G. Hart. London: Taylor and Francis. pp.123-135.
- Birmingham, Walter, I. Neustadt, and E.N. Omaboe. 1966. *Marriage, family and household. A study of contemporary Ghana*. London: George Allen and Unwin; University of Ghana, University College of Ghana.
- Bleek, Wolf. 1981. Avoiding shame: The ethical context of abortion in Ghana. *Anthropological Quarterly* 54(4):203-209.

- Bleek, Wolf, and Nimrod K. Asante-Darko. 1986. Illegal abortion in southern Ghana: methods, motives and consequences. *Human Organization* 45(4):333-344.
- Buah, F.K. 1980. *A history of Ghana*. MacMillan.
- Clark, Gracia. 2000. Mothering, work, and gender in urban Asante ideology and practice. *American Anthropologist* 101(4):717-729.
- Dakubu, Kropp M.E. 1997. *Korle meets the sea: A sociolinguistic history of Accra*. Oxford: Oxford University Press.
- Dinan, Carmel. 1983. *Sugar daddies and gold-diggers: The white collar single woman in Accra*. In *Female and male in West Africa*, ed. Christine Oppong. London: George Allen and Unwin. pp. 344-366.
- Fayorsey, Clare Korkor. 1992/1993. Commoditization of childbirth: Female strategies towards autonomy among the Ga of southern Ghana. *Cambridge Anthropology* 16(3):19-45.
- Fayorsey, Clare Korkor. 1993. Economy, kinship and fertility among the Ga of southern Ghana. Doctoral Dissertation. New Hall, Cambridge. University of Cambridge, Department of Social Anthropology.
- Garshong, Bertha, Mercy Abbey, Ini Huijts, and Sam Adjie. 1999. *Adolescent reproductive health study – 2nd draft report*. Accra, Ghana: Health Research Unit, Ministry of Health.
- Ghana Statistical Service (GSS). 1997. *Second round situation analysis study of family planning service delivery points in Ghana*. Accra, Ghana: GSS.
- Ghana Statistical Service (GSS) and Macro International Inc. (MI). 1999. *Ghana Demographic and Health Survey 1998*. Calverton, Maryland, USA: GSS and MI.
- Hatcher, Robert A. 1998. *Contraceptive technology*. 17th ed.: New York. Ardent Media, Inc. pp. 694.
- Lassey, A.T. 1995. Complications of induced abortions and their preventions in Ghana. *East African Medical Journal* 72(12).
- Lentz, Carola. 2000. *Ethnicity in Ghana: The limits of invention*. London: Palgrave.
- Lloyd, Cynthia B., and Anastasia J. Gage-Brandon. 1993. Women's role in maintaining households: Family welfare and sexual inequality in Ghana. *Population Studies* 47:115-131.
- Lloyd, Cynthia B., and Anastasia J. Gage-Brandon. 1994. High fertility and children's schooling in Ghana: Sex differences in parental contributions and educational outcomes. *Population Studies* 48:293-306.

Mikell, Gwendolyn. 1988. Sexual complementarity in traditional Ghanaian society. *Canadian Journal of African Studies* 22(3):656-661.

Nabila, J.S. and Fayorsey, C. 1996. *Adolescent fertility and reproductive behaviour in Ghana: The case of Accra and Kumasi*. Family and Development Programme Technical Series No. 7, Dept. of Geography and Resource Development, University of Ghana, Legon, Ghana: University of Ghana.

Nabila, John, Clara Fayorsey, and Matilda Pappoe. 2000. *Youth and reproductive health in Africa: Assessment of adolescent reproductive health needs in Ghana*. Accra, Ghana: UNFPA.

Otoo, S.N. 1972. The traditional management of puberty and childbirth among the Ga people, Ghana. *Tropical and Geographic Medicine* 25:88-94.

Pellow, D. 1977. *Women in Ghana: Options for autonomy*. Algonac, Michigan: Reference Publications.

Population Impact Project (PIP). 1995. *Adolescent fertility and reproductive health in Ghana*. A publication of PIP, Dept. of Geography and Resource Development, University of Ghana, Legon.

Rahman, Anika, Laura Katzive, and Stanley K. Henshaw. 1998. *A global review of laws on induced abortion, 1985-1997*. New York: CRLP Publications.

Stanback, John, and K.A. Twum-Baah. 2001. Why do family planning providers restrict access to services? An examination in Ghana. *International Family Planning Perspectives* 27(1):37-41.

Tagoe-Darko, E. 1997. Adolescent reproductive health: The neglected role of traditional teachings and practices in Ghana. A paper presented at the Annual Meeting of the Population Association of America. March 26-30. Washington, D.C.

UNESCO. 1992. *Statistical yearbook*. Paris, France: UNESCO.