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ABORTION: CONTEMPORARY VIEWS OF SENIOR HIGH SCHOOL STUDENTS IN ACCRA, GHANA

Cynthia Gadegbeku* & Jennifer Akoto - Bamfo
Department of Family and Consumer Sciences, College of Agric. & Consumer Sciences,
University of Ghana, P. O. Box LG 91, Legon, Accra – Ghana
*Corresponding Author

Abstract

The main objective of the study was to assess Senior High School students' views on abortion. Data was collected from 300 students, using purposive sampling. The data collection tool employed was a questionnaire. The study assessed students' knowledge and use of abortion methods, investigated their source of information, evaluated their knowledge of complications of abortion and identified barriers associated with the youth accessing reproductive health services. It was realized that all respondents (100%) had knowledge about abortion; felt it was illegal and were unaware that the act was legal to an extent in Ghana. Most respondents indicated abortion should not be legalized in Ghana mainly because it would increase promiscuity. Ninety percent (90%) of respondents were aware of a variety of abortion methods with the main ones being traditional methods. Respondents received abortion information mainly from their friends or peers (53%). The majority (90%) felt abortion should not be legalized but then they would opt for it if the need arose mainly because of their desire to continue schooling, to avoid shame, dishonor and stigmatization. Most respondents indicated the key complication of abortion was death. The main barriers associated with the youth accessing reproductive health services were lack of knowledge (59%). It was recommended that intensive reproductive health education be organized for the youth on abortion and other reproductive health issues by the Ghana Health Service and other relevant stakeholders; sex education be instituted at an early grade in the school system. Peers counselors should be trained in each Senior High School to extend reproductive health information. The mass media should also increase its coverage of reproductive health issues. Reproductive health centers, programs and services should also be designed to be youth friendly.

Key words: *Abortion, Contemporary Views, Students, Youth*

1. Introduction

The universality of abortion and its existence throughout history is well documented. In recent times, abortion has been an issue of interest to individuals and families. Just as efforts have been made to find technologies and socially acceptable ways to overcome childlessness, efforts have been made to prevent unwanted pregnancies through abortion and contraceptive use (World Health Organization, 1998; 2003; 2012). Abortion is 'expulsion of an embryo or fetus from the uterus before it is sufficiently developed to survive ' (Insel & Roth, 2004) or 'the loss of pregnancy before the foetus is viable'(GHS, 2003). It is also the loss, expulsion or termination of a pregnancy before 28 weeks of gestation (Deganus et. al., 2002). Abortions are classified as spontaneous or induced based on how it occurs or the rationale for the act. This article focuses on induced abortion. Induced abortion is the termination of pregnancy by artificial or mechanical means or with the use of drugs (Insel & Roth, 2004). Such abortions are typically characterized as either therapeutic or voluntary.

Medically, a therapeutic or safe abortion is performed to save the life of a pregnant woman; prevent harm to the woman's physical or mental health; terminate a pregnancy where indications are that the child will have a significantly increased chance of premature morbidity or mortality or be otherwise disabled; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy. This kind of abortion is performed by trained medical personnel under hygienic conditions, using hygienic techniques in a hospital, medical or clinical setting (Deganus et al., 2002: Biney, 2011). Voluntary or unsafe abortions on the other hand, are performed at the request of a pregnant woman or partner for non-medical reasons, social or financial purposes (Roche, 2004; Criminal Code of Ghana, 1960; Morhee and Morhee, 2006; UNESA, 2007; Schorge et al., 2008). The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills or in an environment that does not conform to minimal medical standards or both (WHO, 2012).

Unplanned sex among the youth is on the increase and this mostly results in unwanted pregnancies which, in most cases, are eventually aborted (Ahiadeke, 2001; Agyei - Mensah et al., 2002; Henry & Fayorsey, 2002). Induced abortions have therefore become a worldwide occurrence and something common among the youth (www.worldometer.info/abortions, 2014). This is approximately 125,000 abortions daily. Abortions account for 14% of maternal deaths in the African Region (Atlas of African Health Statistics, 2012). In Ghana, 22% − 30% of all maternal deaths are due to abortion complications (GHS, 2003). Abortions were found to be highest among adolescents and lowest among women aged 30 to 39 years (Pazol et al., 2013). The youth get pregnant mainly because although they are sexually active and aware of the benefits of contraceptives, they are ineffective users of contraceptives. Studies in Ghana have also shown that among women who experienced induced abortions, between 2002 and 2007, approximately 70% failed to use a contraceptive prior to the terminated pregnancy (GSS, 2007). Another reason for the low level of use of contraceptives according to Anarfi (2005) is the perception that it is easier and safer to obtain an abortion than to practice contraception on a regular basis. Such youth have difficulty obtaining contraceptives either from health providers or pharmacy shops (Gadegbeku, 2010), and have fears about contraceptive side effects and its failure (Klofkorn, 1998; Allan Guttmacher

Institute, 2002; Aziken, Okanta & Ande, 2003). In their desire to continue schooling or for fear of being stigmatized and for other socio- cultural reasons, the youth who get pregnant decide to abort as a way out of their predicament (Bleek, 1981; Bleek, 1990; Klofkorn, 1998; Maforah *et al.*, 1997; Suffla, 1997; Gadegbeku, 2010).

The Ghana Health Service has instituted policies and guidelines for providing reproductive health services (Stanback & Twum – Baah, 2001; GHS, 2003) but then health provider's cultural values, beliefs and attitudes have been realized to serve as barriers to the provision of these services especially to the youth (Gadegbeku, 2010). Some health providers feel the youth are too young thus if given access to family planning services, it would promote promiscuity so they deny them access to family planning services (Gadegbeku, 2010). As result of this and other reasons, contraceptives use among the youth and adolescents to prevent unwanted pregnancies and eventually, unsafe abortion is reportedly low (Nnko & Pool, 1997; GDHS, 2003; GSS, 2003; GSS, 2009). Sexually Transmitted Infections (STIs) continue to rise with peak ages below 29 and 34 years for males and females respectively. This presupposes that the youth are indulging in unprotected sex, which could result in unwanted pregnancies and unsafe abortions. According to WHO (2012), an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47,000 women and disabilities for an additional 5 million women. These deaths and disabilities could be prevented through sex education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion (WHO, 2012).

There are laws governing the use of abortions. In Ghana abortion is illegal unless it is performed by medical personnel in a medical facility for reasons including rape or defilement of a female idiot, incest, and fetal impairment or when physical or mental risk could occur to harm the mother/woman (Criminal Code of Ghana, 1960; Morhee and Morhee, 2006; UNESA, 2007). The Criminal Code Subsection (1) of Ghana's Constitution (1993) indicates that "any woman who with the intent to cause abortion or miscarriage, administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever, is guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years." The prevalence of this law coupled with cultural inhibitions and improper professional attitudes of health providers prevent people especially the youth from seeking safe induced abortions. Rather females continue to have unsafe abortions in spite of the unhygienic and life threatening methods used in some cases (Gadegbeku, 2010).

Different methods, whether legal or not (even if it means risking their lives), orthodox or non-orthodox have been used to induce abortion (Insel & Roth, 2004; Kelly, 2004). Anecdotal evidence and studies in Guinea, Ghana and Cote d'Ivoire have shown women resort to the use of methods like using walls or blows to the lower abdomen to induce abortion; insertion of sticks, roots amongst others into the uterus through the vagina, placement of chemical and herbal solutions into the vagina or uterus, ingestions of herbs, concoctions and other poisons (MOH, 2002). Others use ergot, herbs (like parsley), chemicals or poisons (including arsenic, lead and phosphorous), infliction of voluntary trauma (punches, falls), oral or vaginal administration of natural products (teas, infusions, vegetable seeds), manufactured products (beer, wine, soapy substances, bleach) or pharmaceutical products (quinine, laxatives, estrogen, digoxin, misoprostol) and insert physical objects (catheter, sharp objects, dilation and curettage, suction aspirators) into the uterus (Lowenstein, 1996; Allan Guttmacher Institute, 2002; Insel & Roth, 2004; Kelly, 2004).

Both safe and unsafe abortions have risks involved and these risks are well documented with the most serious one being mortality (Aziken et. al., 2003). According to the WHO (2012), about 3 million women in developing countries engage in unsafe abortions that result in complications leading mainly to maternal deaths and infertility. In 2009, it was realized that more than one in ten maternal deaths in Ghana were the result of unsafe induced abortion (Ghana Statistical Service, 2009 as cited in Guttmacher Institute Series, 2010). Abortions also place a financial burden on both the public health care system and poor families. The youth are predisposed to complications of abortions because they delay in seeking help as a result of fear of social sanctions, ignorance and the high cost of medical services.

Whether therapeutic or voluntary, abortion is yet to be embraced fully by the Ghanaian society. In Ghana, induced abortion is culturally perceived as an issue that goes against traditional ethics and values. Several churches, religions, ethnic groups, families, individuals and interest groups frown on this act. Abortion is perceived as immoral and definitely not the solution to unwanted pregnancies (except in situations where it poses a health problem to the woman but the phenomenon is prevalent. Anecdotal evidence suggests students in Senior High Schools are aborting, with majority of these cases never being reported. It is important that the views of students or the youth on this issue are understood, so as to develop strategies and intervention programmes to improve their reproductive health and reduce the incidence of unsafe abortions. The specific objectives of the study were to assess students' knowledge and use of abortion methods, investigate their sources of information on abortion methods, evaluate their knowledge about complications of abortion, and identify any barriers associated with the youth accessing reproductive health services.

2. Methodology

A total of 300 students selected from five Senior High Schools in Accra comprised the study sample. The Educational Institutions and respondents were selected purposively. The Heads of selected institutions granted permission for the study to be conducted in their schools. When researchers entered a class, they informed students about the purpose of the study and asked for volunteers. Informed consent was obtained from respondents to demonstrate their voluntary participation. The first sixty students in each school who volunteered to be part of the study were selected.

2.1. Instrumentation

Relevant data was collected using a questionnaire. The questionnaire was used since the population was assumed to be sufficiently educated. Due to the sensitive nature of the questions, the instrument also allowed for anonymity of respondents. On the average, respondents used about thirty minutes to complete a questionnaire. A review and analysis of secondary data and information on abortion was also done.

2.2. Data analysis and presentation

Researchers edited responses for consistency, accuracy and appropriateness. Data analysis was done using the Statistical Package for Social Sciences (SPSS) software (Version 16.0). It was presented descriptively using frequency and percentage distribution tables and graphs where appropriate.

2.3. Ethical consideration

Due to the sensitive nature of the study, the researcher sought permission from respondents and assured them of confidentiality before administering the questionnaire. Respondents also gave verbal consent to be part of the study. They were assigned codes to ensure anonymity.

3. Results and Discussions

3.1. Demographic information

Table 1 presents the demographic characteristics of respondents. The majority of respondents were females. Respondents ranged in age from 14 – 25 years with their average age being 17 years. Ninety-nine per cent (99%) of the respondents were single. Literature reveals that single women are more likely to use induced abortion. The highest reported abortion incidence realized among younger women less than 25 years of age, thus making the target population the most vulnerable and the ones most exposed to the abortion risk (Ahiadeke, 2001). Respondents were mostly Christians (86%) and predominantly Akans. The study sample studied a variety of courses including Visual Arts, Business and General Arts.

Table 1: Demographic characteristics of respondents

Characteristics		No. (n = 300)	Percentage
Gender	Males	120	40
	Females	180	60
Marital status	Single	297	99
	Married	3	1
Age	Below 17 years	87	29
	17 years	93	31
	Above 17 years	120	40
Religion	Christian	261	86
	Muslim	39	14
Ethnic background	Akans	141	47
	Ewe	78	26
	Northerners	45	15
	Ga/Krobo	33	11
	Guans	3	1
Course of study	Visual Arts	129	43
	Business	126	42
	General Arts	30	10
	Science	15	5

3.2. Knowledge about abortion

The study revealed that all respondents (100%) had an idea about abortion. The majority (88%) indicated abortion was the termination of a pregnancy before full term. They further indicated it was morally wrong and illegal to perform abortions. Their responses were similar to those of informants in a research conducted in Malawi where respondents assumed all abortion was illegal (Jackson et al., 2011). These findings suggest knowledge about abortion was limited and inadequate among the youth. They seemed ignorant about the fact that abortion was legal to an extent in Ghana. In Ghana, although abortion is illegal on demand and for economic or social reasons (Ahiadeke, 2001), it is legal under a variety of circumstances including: rape, defilement, or incest; when the pregnancy poses a risk to the life of the pregnant woman or causes harm to her physical or mental health; or if there is a chance that if the pregnancy is retained till full term, it may devlop abnormalities or disease (Ahiadeke, 2001;Criminal Code of Ghana, 1960; Lithur, 2004 ; Marley et al., 2005; Morhee and Morhee, 2006; GSS, 2007; UNESA, 2007; Sedgh, 2010). Marley et al., (2005) also realized that knowledge and accurate information on the abortion law was limited and inadequate even among health personnel who had to educate or advise people (including the youth) on abortion.

When asked whether or not induced abortion should be legalized, 90% of respondents stated that even though various circumstances may drive young women or the youth (with their partners) to opt for an abortion when pregnant, it was not the ideal remedy therefore it should not be legalized. Reasons given by respondents for suggesting abortion should not be legalized are presented in Table 2. The majority of the study sample explained it would increase sex and promiscuity among the youth while 29% said it would result in barrenness. Some of these reasons were shared by friends of the Pro-Life group in the United States of America who argued that the availability of legal abortion is not essential especially to the well-being of a woman, but viewed it instead as having an overall destructive effect especially on traditional morals and values (Insel & Roth, 2004).

Table 2: Reasons why abortion should not be legalized

Reasons	No. (n = 270)	Percentage
It would increase sex and promiscuity among the youth	222	74
It results in death	207	69
It is an immoral act	171	57
It is sin against God	138	46
It increases prostitution	102	34
It could result in barrenness	87	29

3.3. Involvement in sexual activity

Respondents were asked to indicate whether they had ever been involved in a sexual activity. Majority (75%) stated they had never engaged in sex, while a minority (25%) indicated they had. It must be noted that socio–culturally, premarital sex is frowned upon in the Ghanaian society thus it is likely certain respondents might not have given honest responses in this instance. Sixty – one percent (61%) of respondents who had sexual encounters had it between ages 10 – 17 years while 39 % engaged in sex when they were 18 years and above. It showed these respondents engaged in sex at a tender age or as minors thus confirming the assertion by Agyei-Mensah *et al.*, (2005) that Ghanaian youth aged 10 to 24 years were sexually active at a tender age. By law, anyone below 18 years could not give consent for sexual intercourse thus their sexual encounter could be perceived as either rape or defilement by Ghanaian law.

3.4. Awareness & Use of Contraceptive to prevent pregnancy

The most direct way to reduce abortion is to prevent unintended pregnancies by increasing the practice of effective contraception (Ahiadeke, 2001). Respondents' knowledge and use of contraceptives is presented in Fig 1. The findings suggest respondents were mainly aware of a variety of short-term methods of contraceptives to prevent pregnancy, with the condom being the most known and withdrawal method being the least known method. This finding is similar to findings of Gadegbeku (2010), where the condom was realized as the most commonly known and used contraceptive.

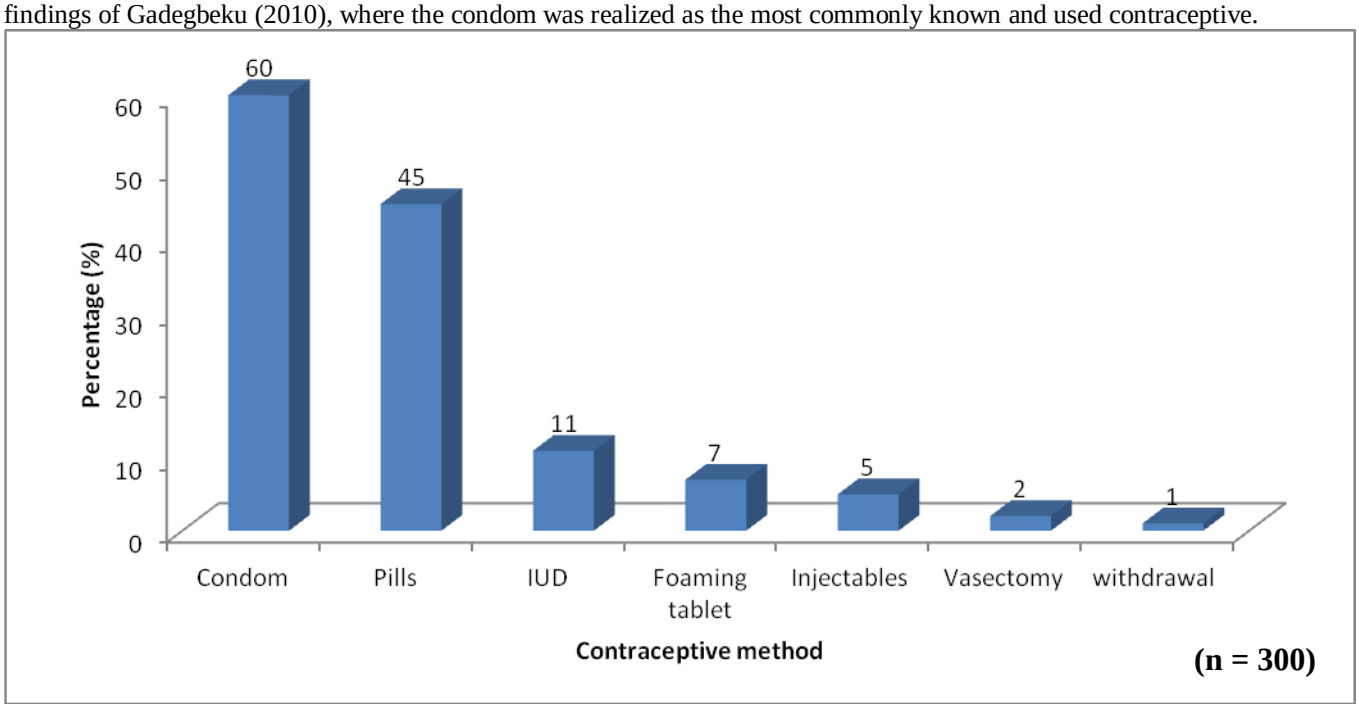

Fig 1: Respondents' knowledge about contraceptives

Of the 25% respondents who had ever had sex, 66% explained they did not use a contraceptive while 34% used contraceptives (mainly condoms). Bongaarts and Westoff (2000) explained that as contraceptive use increases, the reliance on abortion decreases. With minority of respondents not using contraceptives, it presupposes there was the likelihood for reliance on abortion if unintended pregnancy occurred. Respondents gave diverse reasons for non-use of contraceptives and these are presented in Table 3. The main reason was lack of knowledge (54%) while the least reason indicated was its use being a waste of time (6%). Lack of knowledge and the fear of the side effects were identified in studies by Gadegbeku (2010) and Biney (2011) as reasons for non-use of contraceptives. Klofkom (1998) also explained that most people become sexually active before becoming fully aware of the need for contraception. Such people are commonly ineffective users of contraceptives, indulge in unprotected intercourse, become pregnant, and because of their desire to continue schooling or to prevent public or societal disgrace, they resort to abortions (Klofkorn, 1998). There was also a clear indication that certain respondents were aware of the need to obtain and use contraceptives but might not have prepared towards their sexual encounter. Preparedness towards sexual encounter is therefore very relevant to prevent unwanted pregnancies. Reasons given by respondents for non-use of contraceptives suggest that despite mass health education by the Ghana Health Service and relevant stakeholders, the youth still have inadequate sexual health education.

Table 3: Reasons for non-use of contraceptives during sexual encounter

Reasons for non-use	No (n = 50)	Percentage
Lack of knowledge	27	54
Not prepared for the sexual encounter	23	46
Afraid of side effects	17	34
Dislike contraceptives	14	28
Unavailability of contraceptives	8	16
Unnecessary to use it	5	10
Waste of time	3	6

3.5. Knowledge about abortion methods

Fig. 2 presents information about respondents' knowledge about abortion methods. The majority (90%) of respondents had knowledge about a variety of abortion methods with the main one being the use of herbs concoctions and solutions (traditional methods) and the least being the use of abortion services in a recognized health facility (22%). Respondents explained that herbs, concoctions or solutions like: gasoline, detergents or excessive drinking of alcohol were easy and accessible means of inducing abortions. This result confirms findings of Marley *et al.*, (2005) and Agyei-Mensah *et al.*, (2005) that more people are aware of traditional methods of abortion. It also confirms the assertion by Taylor & Kannae, (2005) that most youth would opt to have abortions at unrecognized health facilities and using other methods of abortion. Knowledge about the use of emergency contraceptives (used to prevent pregnancy in the first few days following unprotected intercourse, contraceptive failure or misuse, rape or coerced sex) among the youth was also high. It must be noted here that emergency contraceptives are not appropriate for regular use or as a primary contraceptive method but just as a "back-up" contraceptive method because of the higher possibility of failure compared with other non-emergency contraceptives. In addition, frequent use of emergency contraception could result in side-effects such as menstrual irregularities and headaches (ACOG, 2005; ARHP, 2006: WHO, 2005).

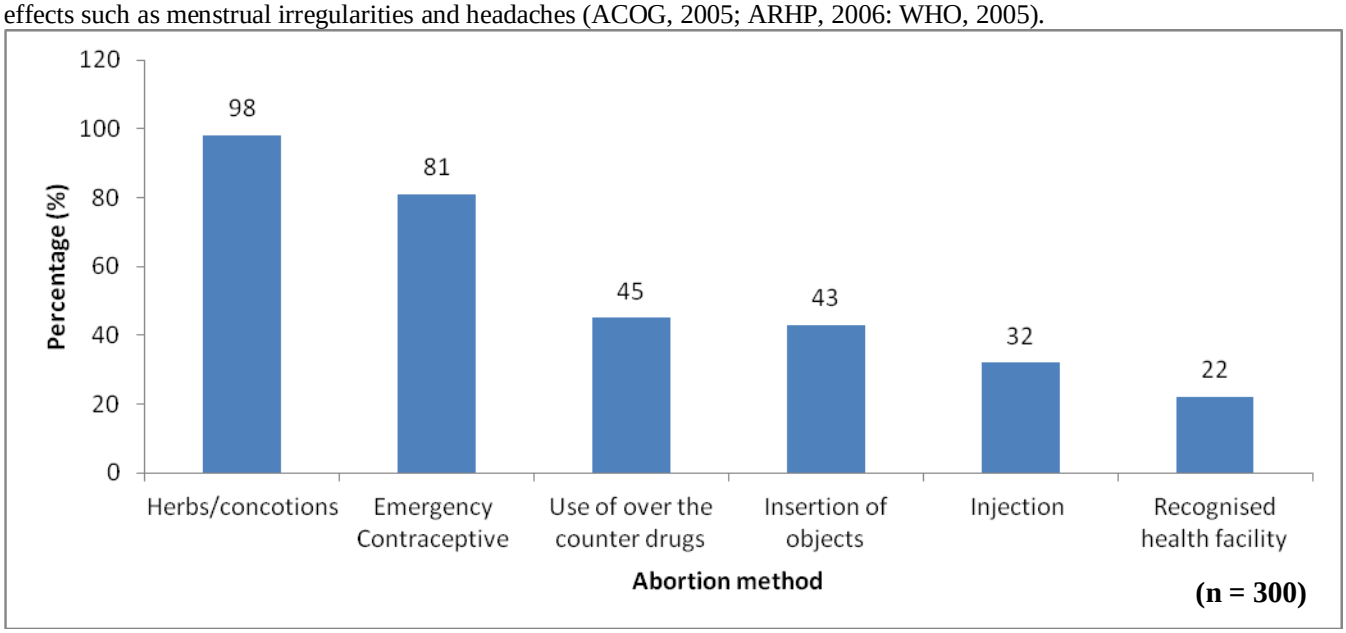

Fig 2. Knowledge about abortion methods

3.6. Sources of information on abortion methods

Findings in Table 4 showed the youth derived information about abortion from a variety of sources with the main source being friends and the least source being older and experienced family members. The findings generally conform to findings of Henry & Fayorsey, (2002) indicating that the youth obtain abortion information from their friends and peers. The mass media which is used to create awareness (about health issues including abortion) was also realized as a source of information for 44% of the study sample. Few respondents indicated they sought information from older and experienced family members because they were perceived by the youth as outdated and old fashioned and more likely to discourage abortion based on their experiences. The extended family played a major role in education in the past but with modernization, the trend has changed. Currently, parents feel embarrassed to discuss sex issues with their children and perceive such discussions as something that could make their children promiscuous (Biney, 2011). This lack of parent-child communication in sexual issues is however influencing risky sexual behavior among adolescents (Baumeister et al., 1995; Wetherill et al., 2010). The youth rather resort to their peers for information which may be inaccurate. For instance, they may encourage them to opt for abortion at unrecognized health facilities instead of recognized health facilities or advise them to use traditional methods of abortion. When information is diffused through social networks, it becomes acceptable thus speed up or increase adoption and vice versa (Upadhyay, 2001; Rogers 2003). The use of friends or peers as a source of reproductive health information is therefore a very important means through which health providers and relevant stakeholders can send or diffuse accurate health information to ensure the youth practice healthy sexual behaviour.

Table 4: Source of abortion information

Source	No (n =300)	Percentage
Friends or peers	159	53
Youth Educational Programs	141	47
Mass Media (Television, Radio, Newspaper)	132	44
Course(s) taught in school	90	30
Books / literature	75	25
Health facilities/ clinics	57	19
Older/experienced family member	39	13

3.7. Reasons why students would opt for an abortion

The decision to abort may be difficult yet, certain factors pressurize people, especially the youth, to engage in the act (Allan Guttmacher Institute, 2002). Reasons why respondents would opt for an abortion if there was an unintended pregnancy are presented in Table 5. Their main reason would be their desire to continue schooling. This result is similar to findings of certain researchers who found out that most youth would abort because of their desire to continue schooling or to avoid the humiliation and the stigma of carrying an unwanted pregnancy (Klofkorn (1998; Allan Guttmacher Institute, 2002; Henry & Fayorsey, 2002; Marley et al., 2005). It can be deduced from data in Table 5 that the response rate was quite high (Average = 63.2%), implying mainly for socio-cultural reasons, most respondents would opt for an abortion should they find themselves or their partners pregnant although they initially indicated abortion should not be legalized. This shows there is an urgent need to intensify reproductive health education (especially in relation to abortions and abstinence from sex) among the youth to prevent unintended pregnancies and performance of unsafe abortions.

Table 5: Reasons why respondents would opt for an abortion

Reason for use of abortion	No (n = 300)	Percentage
Desire to continue schooling	294	98
To avoid shame, stigmatization and dishonour to family	291	97
Partner would abandon me	255	85
Fear of society's reaction	246	82
Result of rape/defilement/ incest	216	72
Coerced/Forced by partner/parents	192	64
Male partner not being financially sound	144	48

3.8. Views about complications of abortion

The decision to terminate a pregnancy may be a difficult one because both safe and unsafe abortions have risks involved which are well documented (Aziken, Okanta & Ande, 2003). Respondents knowledge of complications involved in abortions are presented in Fig. 3. It was realized from the study that general awareness of complications of abortion among respondents was high. The major complication of abortion indicated by all respondents was death. This is in congruence with findings of the World Health Organization (2012) that induced abortions contribute significantly to maternal death. Complications of unsafe abortions also remain a significant cause of high maternal mortality and source of concern in Ghana (Ahaideke, 2001; Marley et al., 2005). The least stated complication was nausea (26%). Sixty – eight percent (68%) also indicated there could be damage to organs like vagina tear and uterine perforation. Other known complications indicated by respondents such as anaemia, abdominal pains, infection and excessive bleeding among others were also realized in literature (Insel & Roth, 2004; Irving, 2005). Respondents however did not have knowledge about psychological difficulties that result from abortions (Hahn & Payne, 2003; Insel & Roth, 2004). It must be noted that awareness of all these complications should ideally serve as a deterrent but then majority of the study sample indicated they would still opt for an abortion if the need arose. There is therefore the need to intensify reproductive health education to reduce the incidence of risky sexual behavior among the youth.

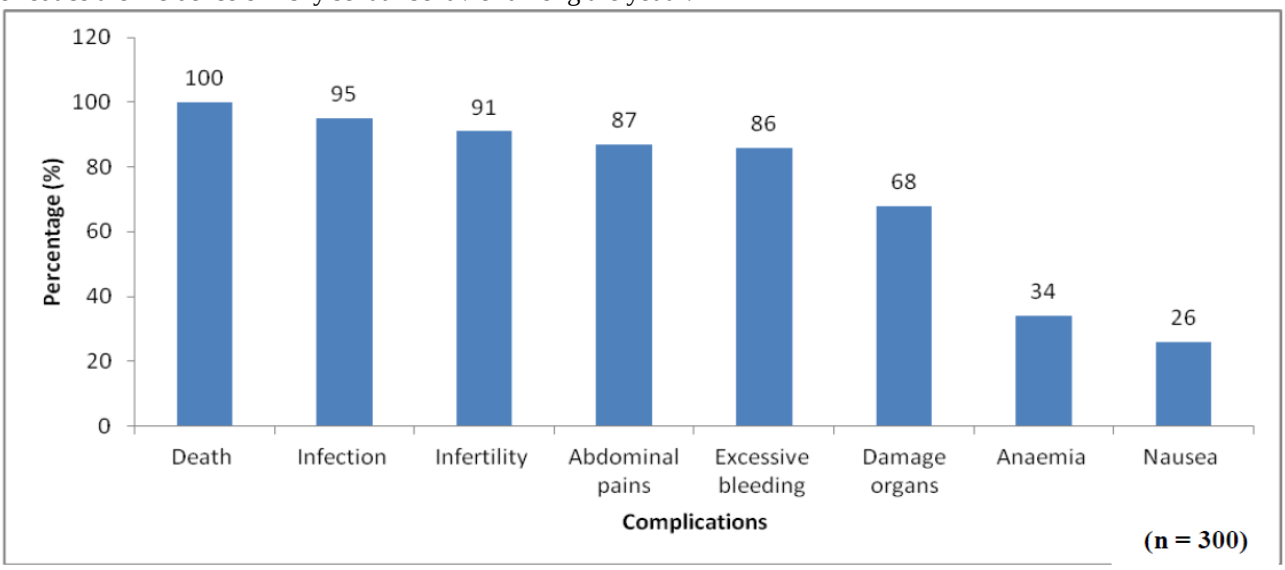

Fig 3: Knowledge about complications of abortion

3.9. Barriers associated with accessing reproductive health services

Barriers to the youth accessing reproductive health services are presented in Table 6. Lack of knowledge about reproductive health services was the main barrier indicated by respondents. This implies that the Ghana Health Service and relevant stakeholders need to step up their reproductive health education especially to the youth. Thirty-six percent (36%) indicated difficulty accessing reproductive health services was a barrier. The Ghana Health Service has instituted policies and guidelines for providing reproductive health services (Stanback & Twum – Baah, 2001; GHS, 2003) but then health provider's religious and cultural inhibitions, together with improper professional attitudes (they not being client friendly) have been realized to influence their provision of these services especially to the youth (Gadegbeku, 2010). Some health providers feel the youth are too young to access family planning services since it would promote promiscuity so they deny them access to these services (Gadegbeku, 2010). This pre-supposes these students may not access reproductive health facilities should they get pregnant. Religious and cultural beliefs, realised by Marley et al., (2005), as barriers deterring the youth from accessing abortion and other reproductive health services in health centers were also mentioned by a minority of respondents.

Table 6: Barriers to accessing reproductive health services

Barriers	No (n =300)	Percentage
Lack of knowledge about RH service	177	59
Fear of discrimination and stigmatization	129	43
Difficulty accessing RH facility/ services	108	36
Privacy confidentiality invasion	105	35
Fear of arrest and prosecution	72	24
Religious and cultural beliefs	42	14

4. Conclusion and Recommendation

In conclusion, respondents had knowledge about abortion methods, its complications and barriers to accessing reproductive health services. Their main source of information was from friends or peers. The majority felt abortion should not be legalized but then they would opt for it if the need arose mainly because of their desire to continue schooling, to avoid shame, dishonor and stigmatization. In view of the findings, it is recommended that education of the youth by the Ghana Health Service and all relevant stakeholders in school, church and at home be stepped up to ensure the youth abstain or practice safe sex (i.e. use contraceptives). Reproductive health education could also be introduced into the school system by the Ghana Education Service at an early grade. The mass media should still be used to create or increase awareness of reproductive health issues. Since the main source of information was from: friends and peers, some youth could be trained as peer counselors in all Senior High Schools to educate their peers' specifically on abortions and generally on reproductive health issues. The youth should also be educated on the extent of legality of abortions so that if the need arose, they would rather access safe health facilities instead of using unsafe abortion methods. It is worth mentioning that although knowledge about the legal laws tends to increase access to safe abortion services and ultimately reduce the mortality rate, it could act as a catalyst to increase the incidence of abortion or risky sexual behavior among the youth. Intensive education therefore needs to be done to encourage the youth to abstain from pre-marital sex or use contraceptives. With the youth mentioning barriers to accessing reproductive health services (especially abortion services at recognized health facilities), it pre – supposes they may not access the facility should they get pregnant. The identified barriers therefore need to be properly addressed and reproductive health educational programs redesigned for the youth taking into consideration these identified barriers. Reproductive health facilities should also be made youth friendly to encourage their patronage.

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