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# “I know that it’s a sin, but I do not have the means”: Abortion decision making in Lomé, Togo

By

Emily R. Adams

Master of Public Health

Hubert Department of Global Health

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Monique Hennink, PhD.
Committee Chair

_____

Roger Rochat, MD
Committee Member

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By

Emily R. Adams

Bachelor of Science

St. Lawrence University

2016

Thesis Committee Chair: Monique Hennink, PhD
Committee Member: Roger Rochat

An abstract of

a thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

in Hubert Department of Global Health

2018

**ABSTRACT**

"I know that it's a sin, but I do not have the means":
Abortion decision making in Lomé, Togo
By Emily R. Adams

Unsafe induced abortion is a problem in the small West African country of Togo, though the literature lacks reliable and consistent estimates of the magnitude of the problem. Currently, Togolese law allows abortion in only a few limited circumstances including rape, incest, fetal malformation, or if the mother's health is in danger. Despite its limited legality, evidence suggests that unsafe induced abortion lowers the rate of fertility by as much as 10.8% in Togo. There has been no research on why and how women in Togo choose to have abortions, which is crucial to implementing interventions aimed at reducing the burden of unsafe abortion. Our study aimed to provide an explanatory model of the influences on abortion decision-making among women in Lomé, the urban capital of Togo. We used qualitative research methods comprising 20 in-depth interviews with women and reproductive healthcare providers at four healthcare facilities in Lomé to explore abortion decision-making. Data analyses followed the grounded theory approach. Results showed that there are three spheres of influence on women's decisions to seek an abortion: *access to abortion services*, *financial resources*, and *social acceptability*. Influences within each of these spheres collectively determine a woman's decision on abortion. By conceptualizing the main spheres of influence on the decision process, we identify potential points of implementations for interventions aimed at reducing the rate of unsafe induced abortion among women in Lomé, Togo.

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**ACKNOWLEDGEMENTS**

I am very grateful to Togo's Ministère de la Santé for facilitating this research and to healthcare providers at each of our four study sites for welcoming us with open arms and allowing us to use their facilities and records. This research greatly benefited from the mentorship of Dr. Koffi Siliadin, our in-country advisor (and 2016-2017 Humphrey Fellow at Emory University) who supported us with his knowledge and boundless enthusiasm for women's health in his country. A huge thank you to my colleagues on the Emory University EGHI field study team for their help with instrument development, data collection, and overall moral support in Togo: Haley McLeod, Rishi Varan, Kate Anderson, and Daniel Bergman. I'd also like to thank our Togolese friends and guides, who fed us well, showed us their beautiful country, and discussed their perceptions of abortion with us. Thank you to Emory University's GFE Fund and GEMMA Fund for funding this research and sending me to the field.

A huge thank you to my mentors at Emory University, Dr. Monique Hennink and Dr. Roger Rochat, for their time, advice, and their support throughout the entire process. Both are veritable experts in their fields and I am humbled to have been able to work with them. Additionally, I'd like to thank my friends and family for their endless support and encouragement of my goals.

Above all, I'd like to thank the Togolese women and providers who confided in me their deeply personal experiences and feelings. Some of them had never before spoken of their abortions and it was a deep honor to hear their stories. Without them, this research would not have been possible.

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CHAPTER 1: INTRODUCTION

*Background*

One of the United Nations' Millennium Development Goals identified the target of decreasing maternal mortality by three quarters globally by the year 2015—a goal that remains largely unmet. One of the most significant barriers to reducing maternal mortality is the continued incidence of unsafe abortions, defined by the WHO as a pregnancy-ending procedure performed by an individual lacking the necessary skills, carried out in an environment that does not meet minimal medical standards, or both (WHO, 2006). Unsafe abortions, 98% of which occur in developing countries, account for 13% of maternal deaths globally and make up 49% of abortions worldwide (Ahman & Shah 2011).


*Figure 1: Map of Togo within West Africa (source: operationworld.org).*

In the West African country of Togo (see Figure 1), unsafe abortion is a problem that remains difficult to quantify, meaning that the literature lacks consistent estimates of the extent of the issue. Existing research indicates that unsafe abortion results in a reduction of

at least 10.8% in potential fertility in the small country (Awifa et al. 2012). Compounding the issue is the complicated legal status of abortion in Togo—currently, abortion is legal only in cases of rape or incest, fetal impairment, or if the pregnancy poses a health hazard to the mother (Vinod & Ferre 2014). Women who wish to undergo an abortion for other reasons then must resort to illegal and often unsafe methods.

Further lacking in the literature are perspectives from women and reproductive healthcare providers on family planning and abortion decision-making in Togo. Understanding why women choose to regulate their fertility or terminate pregnancies—and how such decisions are made—is crucial to providing useful healthcare resources and to improving policy with the aim of decreasing the incidence of post-abortion mortality.

*Problem Statement*

Women in Togo choose to have abortions for a variety of complex and nuanced reasons. After making the initial decision to have an abortion, women must decide on the method they will use to terminate a pregnancy. With this in mind, this study focuses on the following question:

- What influences the abortion and method decision-making processes among women in Lomé, Togo?

To answer this question, the investigator explored the process of abortion decision-making and women's perspectives on abortion using the following sub-questions:

- What is the process of deciding to have an abortion?
- How do women choose which method of abortion they will use to terminate their pregnancies?

*Purpose Statement*

There is a clear need to assess the contextual influences of abortion in Togo to inform both policy and potential interventions. Abortion literature often also fails to fully conceptualize abortion decision making from a qualitative perspective, focusing instead on quantitative data on demographic factors or on qualitative results that examine one or two influences rather than constructing a framework to describe the process. Even when this type of conceptualization is present in the literature, Togo is often overlooked in favor of more populous countries like Ghana (Aniteye & Mayhew, 2013; Schwandt et al., 2013). This paper aims to fill that gap by proposing a conceptual model for abortion decision-making in Lomé.

*Significance Statement*

This research will explain how and why women in Lomé, Togo decide to have abortions and which methods they choose to use. Understanding the major factors that push women to terminate their pregnancies is key to developing effective interventions aimed at reducing the incidence of unsafe abortion—only by understanding why women choose to have unsafe abortions can we hope to eliminate them. Maternal mortality due to abortion procedures is completely avoidable, so we must understand the context in which unsafe provoked abortions continue to occur. The findings from this study will inform interventions and policies to address the socio-cultural contextual factors that lead to choosing an unsafe abortion procedure.

CHAPTER 2: COMPREHENSIVE LITERATURE REVIEW

## *Introduction*

This review details the background and context of abortion decision-making in Togo to inform qualitative research on the influences on this decision-making process. Key topics of investigation include unwanted pregnancy and fertility intentions, demographic determinants of abortion, the context of legality and access to abortion, and social influences on abortion decision making. Because there is very limited work on abortion in Togo, the context of legally-restricted abortion in sub-Saharan Africa in general was used to inform this qualitative study. Lacking from the literature is a conceptual framework to describe the many influences on abortion decision making and their nuanced interplay, especially in the Togolese context.

### *Unwanted Pregnancy: A Global Issue*

Unintended pregnancy is a serious issue worldwide, with an estimated 41% of total pregnancies worldwide falling under this designation (Singh, Sedgh, and Hussain 2010). Unintended pregnancies are often unwanted, with parents either unequipped for or unwilling to have children (Tsui et al., 2010). An estimated 42 million (22%) of pregnancies worldwide are electively terminated yearly (Ahman & Shah, 2014). While termination can be a safe option for unwanted pregnancies, 20 million abortions per year are carried out under unsafe conditions, and 47,000 maternal deaths were due to unsafe abortion in 2008—most of these occurring in Africa or Asia (Tsui et al. 2010; Ahman & Shah 2014). In sub-Saharan Africa, 98% of abortions are unsafe, leading to complications including infertility and death (Ganatra et al., 2017).

Maternal mortality due to unsafe abortion is a completely preventable problem. Most mortality associated with unwanted pregnancy is due to unsafe abortion, but contraception use significantly reduces the possibility of this by preventing the pregnancy (Ganatra et al., 2017; Ahman & Shah, 2014). Additionally, unsafe abortion poses a risk to women's health, with common complications including infection, loss of fertility, and death (Ganatra et al., 2017). Understanding the process by which women set their fertility intentions and then decide to follow through on these intentions is critical in identifying opportunities for public health interventions aimed at reducing the burden of maternal mortality due to unsafe abortion.

*Fertility Theories*

There are several frameworks proposed in the literature to explain reproductive decision-making in general. A 1974 decision-making model describes reproductive decisions as "a set of perceived advantages and disadvantages to childbearing," and incorporates the concept of dynamic decision-making in response to varying inputs (Hass, 1974). In conjunction with this model, the Theory of Planned Behavior (TPB)—originally formulated to describe health decision-making in general—can be applied in this context to describe how fertility intentions are formed (Ajzen, 1991; Azjen & Klobas, 2013). TPB explains the fertility decision-making process using three types of beliefs: behavioral beliefs, which lead to attitudes towards having a child; normative beliefs, which are a result of perceived social norms surrounding motherhood; and control beliefs, which combine to produce a level of perceived control over the decision to have a child (Ajzen, 1991; Ajzen & Klobas, 2013). Decisions are then ultimately an aggregate of these three beliefs—higher

levels of behavioral and normative beliefs, combined with a feeling of control over the decision-making process, leads to a higher likelihood of setting an intentional fertility plan (Ajzen & Klobas, 2013).

Also important consideration is a woman's ability to follow through on previously established fertility intentions, termed *reproductive autonomy*. Uphadyay et al. (2014) developed a reproductive autonomy scale, which also acts as a measure of empowerment. Their scale is based on Connell's Theory of Gender and Power, a framework that explains gender roles that men and women assume through the examination of sexual divisions of labor and power, and social norms and relationships (Connell, 1987). Recent scholarship builds on this conceptual framework through the identification of several factors crucial to reproductive autonomy: a woman's self-efficacy, decision-making power within the household, communication ability, equitable gender role attitudes, and her ability to manage coercion (Uphadyay, 2014). A woman's level of reproductive autonomy then combines with her ability to control the timing, spacing, and number of pregnancies—which are often influenced by outside community and social factors—to determine if she can achieve her reproductive intentions (Uphadyay, 2014; Balk, 1994).

Worldwide, a woman's reproductive autonomy varies, and is dependent on the relationship she has with her partner and the culture and context in which she lives (Balk, 1994; Uphadyay et al., 2014). A woman with reproductive autonomy present in her decision-making can improve and maintain her health and to seek health resources when necessary (Fikree & Pasha, 2004). Overall, autonomy in reproductive health decision-making, including in the context of fertility, is associated with improved health (Fikree & Pasha, 2004, Balk, 1994).

*Achieving Fertility Intentions*

Once a woman has decided upon her ideal family size, and has the autonomy to act to achieve her fertility intentions, she has multiple tools at her disposal for planning her pregnancies. In sub-Saharan Africa, women use both contraception and abortion as methods of limiting their family size, despite varying availability and legality of both methods (Guillame, 2000; Guillame & Desgrées de Loû, 2002; Lauro, 2011; Bankole et al., 2006). In many developing contexts, knowledge of contraception methods is high, with most women reporting familiarity with at least one method, but rates of contraceptive use remain low (Guillaume, 2002; Lauro, 2011).

Interestingly, fertility rates in some sub-Saharan contexts cannot be explained by contraceptive use alone, indicating another factor at play (Guillaume & Desgrées de Loû, 2002). Abortion is used in sub-Saharan Africa as a substitute or alternative to modern forms of contraception, which could account for gaps between expected and actual fertility rates (Lauro, 2011). Throughout the African continent, access to contraception is low and access to (illegal, unsafe) abortion is high, which explains the important role of abortion as a method of family planning (Lauro, 2011). If a woman is unable to adhere to her fertility intentions using contraception, she can retroactively plan her family by using abortion to end an unwanted pregnancy.

In Togo, data from the 2013 Demographic and Health Survey indicate a discrepancy between fertility intentions and actual fertility. Women reported wanting a total of 4.1 children, but had an average of 4.8 children (*Enquête Demographique*, 2013). This discrepancy between actual and intended fertility indicates that women's fertility desires

do not match up with outcomes, pointing to a potential risk of abortion as a tool to avoid unwanted pregnancy outcomes in Togo.

### *Influences on Abortion Decision Making*

A wide variety of influences on abortion decision-making are detailed in the literature, though the situation in Togo specifically remains understudied. In describing this decision process, scholars tend to focus on a few influences at a time rather than building a functional model of decision making based on many inputs. The influences can be broken into several categories: demographic, institutional (including accessibility and legality), and social.

#### *Demographic influences*

Demographic influences on abortion decision-making are well understood in the literature on abortion, and many studies have been done in Togo's neighboring countries.

Abortion is common in sub-Saharan populations overall, with middle-aged women likely to have sought at least one abortion within their lifetimes (Rominski et al., 2014; Mote et al., 2010). These lifetime abortions seem to be occurring at a young age because younger women reported having had abortions more recently than their older counterparts (Rominski et al, 2014; Sundaram et al., 2012; Mote et al., 2010). Younger women cited reasons such as still attending school, fear of bringing shame upon the family, and judgement by their friends as reasons to choose to abort (Schuster, 2005; Koster-Oyekan, 1998; Svanemyr & Sundby, 2007). Age is also linked to abortion safety, with younger women more likely to seek unsafe abortions (Sundaram et al., 2012). Additionally,

several studies in Ghana agree that women who seek abortions are more likely to be educated, wealthy, and urban than their non-abortion seeking counterparts (Rominksi et al., 2014; Sundaram et al, 2012; Mote et al., 2010).

Marital status and wealth are also important influencers in abortion decision-making, with women who have never been married more likely to have had abortions than married women (Sundaram et al., 2012; Rominksi et al, 2014; Mote et al., 2010). The increased incidence of abortion among unmarried women alludes to potential societal unacceptability of male-female sexual intercourse among unmarried females.

The literature on abortion indicates that socioeconomic status is a nuanced indicator of abortion-seeking behavior. Women of higher socioeconomic status were more likely to have had abortions than their less wealthy counterparts because material wealth facilitated access to abortion services (Rominksi et al., 2014; Mote et al., 2010). However, insufficient financial means was also cited as a reason to have an abortion due to the inherent need for resources in raising a child (Schuster, 2005; Chae et al., 2017). Therefore, in cases where lack of means is a reason to terminate the pregnancy, women are more likely to use one of the unsafe but more affordable methods of abortion. In Togo, one study concluded that wealth was associated with increased abortion seeking behavior (Gage, 1994). However, this paper is over 20 years old and is therefore no longer representative of the current situation in Togo.

The literature remains mixed on if a woman's employment status or number of children impacts her decision-making autonomy within the household, with some authors reporting an association and others unable to find a link (Osamor & Grady, 2018; Acharya et al., 2010; Mote et al., 2010). In one study, women who were formally employed were

twice as likely to seek abortions than those who were not formally employed (Mote et al., 2010). This corroborates the data on socioeconomic status that implicates increased wealth as a facilitator for abortion (Gage, 1994; Rominski et al., 2014; Mote et al., 2010). In cases where employment status and/or number of children were confirmed factors in an abortion decision, women cited desires to space births, care for current children, and have time to devote to economic productivity as reasons for terminating pregnancies (Mote et al., 2010; Osamor & Grady, 2018; Chae et al., 2017).

*Institutional influences & access*

Togo is a patriarchal society, meaning that cultural context is structured around the systemic domination of women by men; therefore, by definition, women's health is not a priority (Gage, 1994). In patriarchal societies in sub-Saharan Africa, policymakers have ignored the urgent need to prioritize abortion due to potential inability to fully comprehend the magnitude of the problem (Braam & Hessini, 2004). This patriarchy, combined with persistent structural gender inequality, means that institutions in countries like Togo are designed to put women at a disadvantage. This systemic silencing of women means that choice, especially in matters as morally contentious as abortion, is inaccessible to women seeking to control their fertility (Braam & Hessini, 2004).

This patriarchy extends to all facets of institutions in their societies, including the legal systems, which outlaw abortion in most sub-Saharan African countries. In general, legal frameworks have significant power in underscoring values and giving legitimacy to culturally-constructed morality within societies (Braam & Hessini, 2004). Therefore, the restricted legality of abortion in many sub-Saharan countries like Togo supports society's

tendencies to view it as immoral and shameful. Interestingly, in Ghana, knowledge of the procedure's illegality was associated with increased abortion-seeking behavior, indicating that restricted legality has limited efficacy in directly deterring women from having abortions (Sundaram et al, 2012). Abortion in countries with restricted legality is more likely to be unsafe than in countries with more liberal abortion laws—therefore, restricting access through the legal system serves only to prevent women from having access to *safe* abortion decisions, but may have no effect on decreasing abortion-seeking behavior in general (Hord & Wolf, 2004; Chae et al., 2017).

In countries with restricted abortion legality, access to safe abortion services is limited. However, limiting access does not limit desire for abortion services, and so women often instead seek unsafe abortions (Svanemyr & Sundby, 2007). In countries like Togo, women often resort to unsafe methods such as drinking traditional herbs mixed into tea, taking anti-malarial medications, drinking bleach, or curettage performed by an unqualified individual (Haddad & Nour, 2009).

*Social influences*

Social structures and the other people contained within them play a key role a woman's abortion decision-making process. Key players in the process include male partners, family/friends, and social networks within communities.

The male partner plays an important role in the family planning decision-making process. In many developing contexts, a woman's reproductive healthcare is completely controlled by her husband/partner, without her involvement (Chae et al., 2017; Osamor & Grady 2018; Senarath & Gunawardena, 2009). In Nigeria, several factors were associated

with decision-making autonomy, including region of the country, urban vs. rural residence, age, education, socioeconomic status, and husband's occupation (Osamor & Grady, 2018), which is consistent with conclusions from a variety of reviews across Asia and Africa (Gage, 1995; Meekers & Oladosu, 1996; Becker et al., 2006; Acharya et al., 2010). This leaves a large proportion of women whose reproductive decisions are likely to be made by their male partners.

This influence over reproductive decisions extends to abortion, with women scoring higher on an autonomy scale significantly more likely to seek an abortion than those who scored lower (Mote et al, 2010). Additionally, women who involve their partners in the process, and whose partners are supportive of their abortion decision, are more likely to have safe abortions than women with unsupportive partners (Sundaram et al., 2012).

Most studies agree that abortion is highly immoral within sub-Saharan African communities. Therefore, there are severe consequences for choosing to have an abortion, including stigma, judgment, and shame (Svanemyr & Sundby, 2007; Haddad & Nour, 2009). There are also significant consequences for mistimed pregnancies; a young, unmarried girl faces stigma, judgment, and shame for being pregnant (Atuyambe et al., 2005). In many cases, abortion is a preferable outcome due to the ease of hiding the procedure as compared to the difficulty of hiding a pregnancy and resulting child (Atuyambe et al., 2005).

The highly moralistic nature of societies such as Togo confers stigma to abortion, making women more likely to hide their current or past experiences with the procedure (Kumar et al., 2009). These types of societies are also likely to equate abortion to murder (Orner et al., 2011;). Though most sub-Saharan African women in the literature believed

that abortion was morally reprehensible, many had still sought the procedure themselves. In most of these cases, sociocultural influences—including stigma, lack of resources, and pressure from outside forces—simply outweighed personal moral values (Svanemyr & Sundby, 2007; Koster-Oyekan, 1998). Despite a strong certainty that abortion was morally wrong, women often felt they had no choice but to end their pregnancies.

Importantly, the literature has extensively documented the unwillingness of women's reproductive healthcare providers to perform abortions due to the perceived immortality of terminating a pregnancy (Hord & Wolf, 2004; Aniteye & Mayhew, 2013; Schwandt et al., 2013). Even in contexts where abortion is legal in limited circumstances, like Togo, providers are generally not willing to perform the procedure, citing a dissonance between abortion and their perceived role as facilitators of life (Schwandt et al., 2013).

*Abortion in Togo*

The exact incidence of unsafe induced abortion remains unclear in Togo, but estimates in surrounding countries indicate it is likely high, with the West African region experiencing an induced abortion rate of 34 per 1,000 women aged 15-44 (Singh et al., 2018). Existing research indicates that unsafe abortion results in a reduction of at least 10.8% in potential fertility in the small country (N'Bouke et al., 2012). Compounding the issue is the complicated legal status of abortion in Togo—currently, abortion is legal only in cases of rape or incest, fetal impairment, or if the pregnancy poses a health hazard to the mother (Mishra & Ferre, 2014). Women who wish to undergo an abortion for other reasons, then, often resort to illegal and unsafe methods.

Contraceptives, which could be an important tool for decreasing the incidence of unsafe abortion, have been historically under-utilized and the dominant methods—detailed in the most recent, but woefully out of date literature—were condoms and fertility cycle calculations (Rahmane et al., 2002). Availability of contraceptives is a heavy influencer on their low use; less than half of clinics in Lomé had modern contraceptive methods stocked (Turner, Senderowicz & Marlow, 2016**).** Currently, Togo has an estimated 35% unmet need for modern contraceptive methods, which contributes to the burden of unwanted pregnancy—and, consequently, to the burden of unsafe abortion (Cahill et al., 2018).

Further lacking in the literature are perspectives from women and reproductive healthcare providers on family planning and abortion decision-making in Togo. Understanding why women choose to regulate their fertility or terminate pregnancies—and how such decisions are made—is crucial to providing useful healthcare resources and to improving policy with the aim of decreasing the incidence of post-abortion mortality. There is a clear need assess the contextual influences of abortion in Togo to inform both policy and potential interventions. Abortion literature often also fails to fully conceptualize abortion decision-making from a qualitative perspective, focusing instead on quantitative data on demographic factors or qualitative studies that fail to construct frameworks to describe the process. Even when this type of conceptualization is present in the literature, Togo is often overlooked in favor of more populous West African countries like Ghana (Schwandt et al, 2013; Aniteye & Mayew, 2013). This paper aims to fill that gap by proposing a conceptual model for abortion decision-making in Lomé.

# CHAPTER 3: MANUSCRIPT

## Contribution of Student

For the following manuscript, I conceptualized the project with help from my mentor Dr. Roger Rochat, collected the interview data along with two members of my research team, coded and analyzed the transcripts, and developed an explanatory model with the help of my thesis advisor, Dr. Monique Hennink. I served as principal author. This manuscript will be submitted to International Perspectives on Sexual and Reproductive Health for publication consideration.

**ABSTRACT**

Unsafe induced abortion is a problem in the small West African country of Togo, though the literature lacks reliable and consistent estimates of the magnitude of the problem. Currently, Togolese law allows abortion in only a few limited circumstances including rape, incest, fetal malformation, or if the mother's health is in danger. Despite its limited legality, evidence suggests that unsafe induced abortion lowers the rate of fertility by as much as 10.8% in Togo. There has been no research on why and how women in Togo choose to have abortions, which is crucial to implementing interventions aimed at reducing the burden of unsafe abortion. Our study aimed to provide an explanatory model of the influences on abortion decision-making among women in Lomé, the urban capital of Togo. We used qualitative research methods comprising 20 in-depth interviews with women and reproductive healthcare providers at four healthcare facilities in Lomé to explore abortion decision-making. Data analyses followed the grounded theory approach. Results showed that there are three spheres of influence on women's decisions to seek an abortion: *access to abortion services*, *financial resources*, and *social acceptability*. Influences within each of these spheres collectively determine a woman's decision on abortion. By conceptualizing the main spheres of influence on the decision process, we identify potential points of implementations for interventions aimed at reducing the rate of unsafe induced abortion among women in Lomé, Togo.

## INTRODUCTION

### *Background*

One of the United Nations' Millennium Development Goals identifies the target of decreasing maternal mortality by three quarters globally by the year 2015—a goal that remains largely unmet. One of the most significant barriers to reducing maternal mortality is the continued incidence of unsafe abortions, defined by the WHO as a pregnancy-ending procedure performed by an individual lacking the necessary skills, carried out in an environment that does not meet minimal medical standards, or both (WHO, 2011). Unsafe abortions, 98% of which occur in developing countries, account for 13% of maternal deaths globally and make up 49% of abortions worldwide (Ahman & Shah 2011).

In the West African country of Togo, unsafe abortion is a problem that remains difficult to quantify, meaning that the literature lacks consistent estimates of the extent of the issue. Existing research indicates that unsafe abortion results in a reduction of at least 10.8% in potential fertility in the small country (N'Bouke et al. 2012). Compounding the issue is the complicated legal status of abortion in Togo—currently, abortion is legal only in cases of rape or incest, fetal impairment, or if the pregnancy poses a health hazard to the mother (Vinod & Ferre 2014). Women who wish to undergo an abortion for other reasons, then, must resort to illegal and often unsafe methods.

### *Abortion decision-making*

Women in sub-Saharan Africa use multiple methods for planning their families, including abortion (Lauro, 2011; Guillame, 2002). A wide variety of influences on abortion decision-making are detailed in the literature, though the situation in Togo remains

woefully understudied. Influences can be broken into several categories: demographic, institutional (including accessibility and legality), and social.

*Demographic influences*

Demographic influences on abortion decision-making are well understood in contexts similar to Togo. Abortions are common among the population and happen during young adult years (Rominski et al, 2014; Sundaram et al., 2012; Mote et al., 2010). Young women's reasons for having an abortion include still attending school, fear of bringing shame upon the family, and judgment by their friends and community (Schuster, 2005; Koster-Oyekan, 1998; Svanemyr & Sundby, 2007). Younger women are also more likely to seek unsafe abortions (Sundaram et al., 2012). Women who seek abortions are more likely to be educated, wealthy, urban-dwelling, and unmarried (Rominksi et al., 2014; Sundaram et al., 2012; Mote et al., 2010). Women of higher socioeconomic status are more likely to have abortions than their less wealthy counterparts, but insufficient financial means is also a common reason to have an abortion due to the inherent need for resources in raising a child (Schuster, 2005; Rominski et al., 2014; Mote et al., 2010).

The literature remains mixed on if a woman's employment status or number of children impacts her decision-making autonomy within the household, with some authors reporting an association and others unable to find a link (Osamor & Grady, 2018; Acharya et al., 2010; Mote et al., 2010). In cases where employment status and/or number of children were confirmed factors in an abortion decision, women cited desires to space births, care for current children, and have time to devote to economic productivity as

reasons for terminating pregnancies (Chae et al., 2017; Mote et al., 2010; Osamor & Grady, 2018).

*Institutional influences & access*

In patriarchal societies in sub-Saharan Africa, policymakers have ignored the urgent need to prioritize abortion due to potential inability to fully comprehend the magnitude of the problem (Braam & Hessini, 2004). This patriarchy extends to all facets of institutions in their societies, including the legal systems, which greatly restrict the legality of abortion in most sub-Saharan African countries. In general, legal frameworks have significant power in underscoring values and giving legitimacy to culturally-constructed morality within societies (Braam & Hessini, 2004).

Knowledge of abortion's illegality has been associated with increased abortion-seeking behavior, indicating that restricted legality has limited efficacy in directly deterring women from having abortions (Sundaram et al, 2012). However, abortion in countries with restricted legality is more likely to be unsafe than in countries with more liberal abortion laws—therefore, restricting access through the legal system serves only to prevent women from having access to *safe* abortion decisions, but may have little effect on decreasing abortion-seeking behavior in general (Svanemyr & Sundby, 2007). In countries like Togo, women often resort to unsafe methods such as drinking traditional herbs mixed into teas, taking anti-malarial or ulcer medications, drinking bleach, or curettage performed by an unqualified individual (Haddadd & Nour, 2009).

*Social influences*

In many developing contexts, a woman's reproductive healthcare is completely controlled by her husband/partner, without her involvement (Osamor & Grady 2018; Senarath & Gunawardena, 2009). Decision-making autonomy has been linked with residence in certain regions of countries, urban vs. rural residence, age, education, socioeconomic status, and husband's occupation (Osamor & Grady, 2018; Gage, 1995; Chae et al, 2017; Haddadd et al., 2009).

The influence of autonomy on reproductive decisions extends to abortion, with women scoring higher on an autonomy scale significantly more likely to seek an abortion than those who scored lower (Mote et al, 2010). Additionally, women who involve their male partners in the process, and whose partners are supportive of their abortion decision, are more likely to have safe abortions than women with unsupportive partners (Sundaram et al., 2012).

The highly moralistic nature of societies such as Togo confers stigma to abortion, making women more likely to hide their current or past experiences with the procedure (Kumar et al., 2009; Orner et al., 2011; Svanemyr & Sundby, 2007). Though most sub-Saharan African women in the literature believe that abortion is morally reprehensible, many had still sought the procedure themselves. In most of these cases, sociocultural influences—including stigma, lack of resources, and pressure from outside forces—outweighed personal moral values (Svanemyr & Sundby, 2007; Koster-Oyekan, 1998). Despite a strong certainty that abortion was morally wrong, women often felt they had no choice but to end their pregnancies.

Abortion literature has extensively documented the unwillingness of women's reproductive healthcare providers to perform abortions due to the perceived immortality of terminating a pregnancy (Hord & Wolf, 2004; Aniteye & Mayhew, 2013; Schwandt et al., 2013). Even in contexts where abortion is legal in limited circumstances, like Togo, providers are generally not willing to perform the procedure, citing a dissonance between abortion and their perceived role as facilitators of life (Schwandt et al., 2013).

*Abortion in Togo*

The exact incidence of abortion remains unclear in Togo, but estimates in surrounding countries indicate it is likely high, with the West African region experiencing an induced abortion rate of 34 per 1,000 women aged 15-44 (Singh et al., 2018**).** Contraceptives, which could be an important tool for decreasing the incidence of unsafe abortion, have been historically under-utilized (Rahmane et al., 2002). Availability of contraceptives is a heavy influencer on their low use; less than half of clinics in Lomé had modern contraceptive methods stocked (Turner, Senderowicz & Marlow, 2016**).** Currently, Togo has an estimated 35% unmet need for modern contraceptive methods, which contributes to the burden of unwanted pregnancy—and, consequently, to the burden of unsafe abortion (Cahill et al., 2018).

Lacking in the literature are perspectives from women and reproductive healthcare providers on abortion decision-making in Togo. Understanding why women choose to terminate pregnancies—and how such decisions are made—is crucial to providing useful healthcare resources and to improving policy with the aim of decreasing the incidence of post-abortion mortality. There is a clear need assess the contextual influences of abortion

in Togo to inform both policy and potential interventions. Abortion literature often also fails to fully conceptualize abortion decision-making from a qualitative perspective, focusing instead on quantitative data on demographic factors, or qualitative studies that examine one or two influences rather than constructing frameworks to describe the process, especially in the Togolese context. This paper aims to fill that gap by proposing a conceptual model for abortion decision-making in Lomé, Togo.

## METHODS

*Study Context*:

We conducted this study at four reproductive healthcare centers in Togo's capital city of Lomé. Lomé is an urban area with a metropolitan population of about 1.5 million people, with residents of many ethnic groups and from different socioeconomic backgrounds (Enquête Démographique, 2015). We selected each of the four healthcare centers to provide diversity in reproductive healthcare facilities within Lomé. Selected facilities included one private reproductive healthcare clinic and three public hospitals of varying size, including a university teaching hospital, a regional hospital, and a large city hospital.

This study was conducted during July and August of 2017. Collaborators included administrators at each of the four healthcare centers and the Togolese Ministry of Health.

*Study design*:

This qualitative study is part of a larger mixed-methods research project aimed at assessing the burden and context of unsafe abortion in Lomé. Mixed qualitative and quantitative methods are appropriate because the larger project wished to both quantify and understand the public health impact of unsafe abortion in Lomé. The parent study has three parts: a review of approximately 10% of medical records at each of the healthcare facilities, quantitative surveys with both women and reproductive healthcare providers (25 and 15 at each hospital, respectively); and qualitative interviews with 10 women and 10 reproductive healthcare providers. This study focuses on these qualitative interview data from the parent study.

The qualitative study is based on a grounded theory approach, in that data collection and analysis culminated in an inductive theory derived from the data that explains the process of abortion decision-making in Lomé, and is validated by the data. Every aspect of study design was modeled after this grounded theory approach—we formulated interview guides and then iteratively refined them to go deeper into issues raised by participants, we purposively selected participants to fill gaps in the diversity of the sample, and we generated an inductive theory based on initial analysis and then validated it by returning to the data to ensure that they fit into the conceptual framework.

*Study Population*:

The study population consists of 10 women of reproductive age and 10 reproductive healthcare providers, all of who were recruited from the four clinic study sites. Women were eligible if they had participated in the survey portion of the parent

study, were between the ages of 18 and 49, and were fluent in French. Women of reproductive age, defined by the WHO as being between the ages of 15 and 49, are more likely to experience pregnancy and potentially have experience with unsafe abortion (WHO, 2006). We chose to exclude women ages 15-17 due to the inherent issue of consent among those who are not legally adults for US-based research purposes. Fluency in French was necessary because it is the lingua franca in Togo, a country composed of many ethnic backgrounds and languages. French was therefore the most inclusive language to choose for interviews, though fluency varies within Lomé, particularly based on educational status.

The results of the survey data from the parent study were used to recruit a diverse group of women to interview, and allowed us to select women of different ages, parity, educational attainment, beliefs about abortion, and past experiences with abortion.

We chose to interview reproductive healthcare providers because they provide advice and abortion services to women. In dealing with these women every day, reproductive healthcare providers have expertise in common complications linked to abortion, as well as women's thoughts on contraception, abortion, and post-abortion care. Providers were eligible for an interview if they worked at one of the four study sites in either the obstetrics or gynecology departments as a midwife, medical assistant, nurse, or OB-GYN and spoke French fluently. We sought to speak with providers who had previous experiences with abortion provision or counseling and/or post-abortion care, which is why we chose providers specializing in women's reproductive healthcare, but this was not necessary for participation.

*Data collection methods*:

We conducted in-depth interviews with each of the study participants to gain detailed, individual-level perceptions and experiences of abortion and abortion care in Lomé. Interviews offer a confidential setting and allow participants to have control over the data gathering process, which leaves them at liberty to share the thoughts and feelings they choose—therefore, interviews are a useful technique when studying a potentially sensitive topic such as abortion (Corbin & Morse, 2003). Interviews with women focused on their personal experiences with: family planning use and decision-making, abortion decision making and techniques, and experiences with abortion. Interviews with health care providers focused on their personal experiences with: family planning provision and counseling, abortion techniques and training, provision of post-abortion care, and barriers to safe abortion.

*Data Collection Process*:

Three members of the study team carried out the data collection; two lead investigators and one undergraduate research assistant. The lead investigators were trained in qualitative methods and trained the research assistant in in-depth qualitative interview techniques. All three interviewers discussed both interview guides in depth, including how and why we were going to be asking each question, and generated potential strategies for probing. All three interviewers were fluent in French.

We recruited women to interview from participants who completed a survey for the parent study. For the prerequisite survey recruitment, we identified participants at the time of their appointments in the hospitals' clinics devoted to gynecology, obstetrics, or

family planning. After a woman's consultation with a medical provider, the provider alerted the patient to our presence and verified that she was comfortable speaking French. A member of the research team then escorted the potential participant to the data collection room, where we read her an informed consent statement, verified that she was eligible for the study, and asked if she would like to participate in the survey.

We chose female patients to be interviewed by asking select survey participants at the time of the survey if they would be interested in participating in an in-depth interview about the same topics, with compensation of 700 FCFA in mobile phone credit (approximately $1.20). We purposively selected women for in-depth interviews based on characteristics revealed in their survey responses, including a demonstrated willingness to talk openly about abortion, previous experiences with contraception, and previous experiences with abortion. If women consented to participating in an interview, we obtained their mobile telephone number and called them within a few days to set up a time and place for an interview that was convenient to the participant. In general, interviews were conducted within one week of initial contact. Of the eleven women asked if they would be interested in participating in an in-depth interview, one declined due to lack of interest in speaking further about abortion.

We recruited healthcare providers for in-depth interviews using hospital gatekeepers, who introduced us to pertinent personnel within the OB-GYN departments at each of the health centers. We aimed to interview at least one gynecologist and one auxiliary provider from each health center. We telephoned providers who agreed to participate to set up an interview time and place that was convenient to the provider.

Providers were not compensated for their participation in the study. All ten providers who were asked to participate agreed to do so.

We conducted 10 in-depth interviews with providers and 10 with women. We determined that 20 total interviews was adequate to reach saturation of themes in both participant groups and overall within the data because our two samples were relatively homogenous in terms of education level and socioeconomic status (women) and hospital setting (providers). During data collection, saturation was assessed primarily through review of data as it was collected to identify repetition and emerging nuance of key themes. We knew that saturation had been reached once we started hearing the same types of responses across several interviews, and felt that we fully understood each facet of these topics.

*In-Depth Interviews*:

In-depth interview guides were initially developed based on existing literature on abortion and in conjunction with both our in-country collaborator (a Togolese physician) and a professor with significant expertise in the field of unsafe abortion. We pilot tested the women's interview guide with a resident of Lomé and rephrased a few questions to include more colloquial language. We pilot tested the provider interview with a midwife at one of the clinics, who helped with relevance of questions. We went through every question with a Togolese physician in the field and further modified the guides for clarity of phrasing. Additionally, some questions and probes were added throughout the data collection process to refine the guides and to go deeper into issues raised with subsequent interviews.

During women's interviews, we asked about personal experiences with and attitudes toward family planning/contraception, abortion, and post-abortion care. We also discussed stigma associated with abortion and the legality of abortion in Togo. We asked providers about their personal experiences in providing family planning, abortions and post-abortion care. All interviews were recorded using a digital recorder except for one, which was recorded using detailed notes due to functionality issues with the recording device. A member of the research team conducted each interview at a local café of the participant's choosing (women) or in a private room at one the hospitals (providers).

The Emory University Institutional Review Board determined that the study did not require IRB review as it did not meet the definition of research with human subjects. We obtained approval from the Comité de Bioethique pour la Recherche en Santé (The Bioethics Committee for Research in Health) of Togo.

*Data analysis*:

Interviews were transcribed verbatim in French by members of the research team and by Togolese transcribers. We then anonymized and checked the transcripts for accuracy prior to analysis. All data were kept in the original language to eliminate the time-consuming process of translation. All 20 transcripts (or, in one case, detailed notes) were entered into MaxQDA12 for data management and analysis (VERBI Software, 1989-2018). We analyzed the data by systematic coding based on a grounded theory approach whereby the codes arose from the data itself. Two members of the team conducted an inter-coder agreement exercise on a portion of the data once the codebook was complete to ensure consistent coding. We then developed an analysis plan to compare codes across variables

and to search the codes systematically to elucidate a complete understanding of the nuance and variation within the data.

After initial analysis of the codes, we constructed a theory based on the data to explain the entire abortion decision-making process (Charmaz, 2014). To do this, we identified all the themes related specifically to abortion and began categorizing them. Themes eventually came to fall in one of three categories of decision-making influences: access to abortion services, social acceptability, or financial resources. We then considered how these three spheres of influence overlapped and allocated the emerging themes as necessary. After initial construction of the conceptual framework, we validated the theory by ensuring that it was well grounded within the data through constant cyclical comparison, and refined the theory as needed to best fit the findings throughout the process of describing the results.

**RESULTS**

Results show there are three spheres of influences on abortion decision making amongst women in Lomé, Togo: *access to abortion services*, *financial resources*, and *social acceptability*. These three spheres overlap to influence how women decide on whether to have an abortion and on the abortion method.

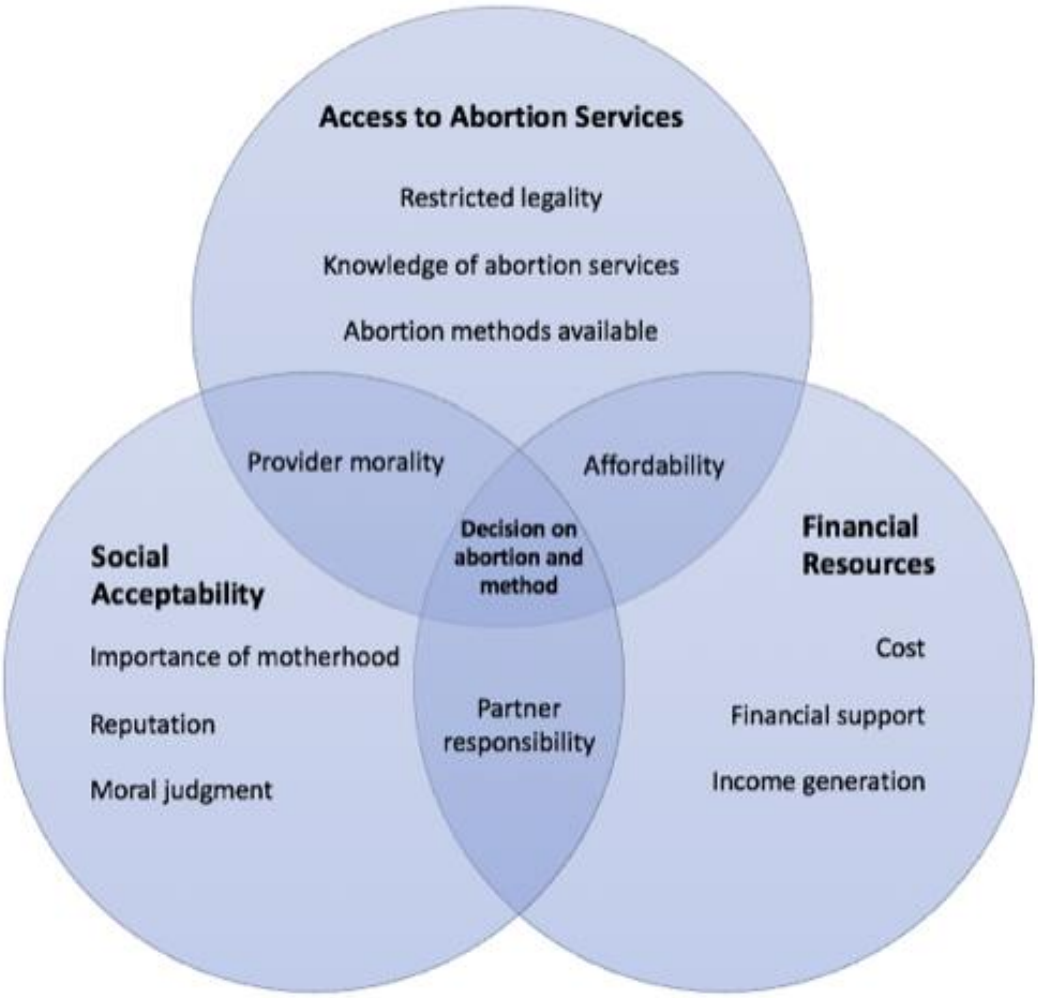


*Figure 2: Influences on a woman's decision on abortion and method*

### *Access to Abortion Services*

The first sphere of influence on women's abortion decision making is access to abortion services (see Figure 2). The availability of abortion services, or lack thereof, played a critical role in determining both whether a woman got an abortion and which methods of abortion were available to her. Three components of access include: *restricted legality*, *knowledge of abortion services*, and *abortion methods available*.

#### *Restricted legality*

Abortion is illegal in Togo except under the circumstances of rape, incest, fetal impairment, or if the mother's health is in danger. Due to these restrictions, formal abortion services are not freely available. Other informal options for abortion were often limited and unsafe. Although the lack of formal services posed a barrier to seeking an abortion, most women stated they were not aware that abortion was illegal, and none knew the circumstances in which it was legally permitted. Even among the few women who did know that abortion was illegal, none cited fear of legal repercussions as a deterrent to seeking the procedure. One woman did explain a case in her neighborhood where a young girl died due to an unsafe abortion, and the bereaved father consequently facilitated the imprisonment of those involved by informing the police of the incident, but this type of experience was uncommon. Legality per se was not a direct influencer on women's abortion decisions, but it caused a lack of formal services for abortion.

However, legality was an indirect factor that influenced many other aspects of the decision-making process. The illegal nature of abortion procedures made such services difficult to find, and available services often practiced unsafe abortion. One participant,

unaware of the law on abortion, assumed that abortion must be illegal due to the types of the procedures with which she was familiar:

> "I think if it was truly authorized, it would be more available in hospitals, where the risk is the same as for a consultation. Whereas [...most abortions] are done by people [who offer them] in their homes." - Woman, 22 years, single

*Knowledge of abortion services*

This limited availability of abortion services meant that finding a safer abortion required having previous knowledge of where to find services or which home remedies to use to abort a pregnancy. Many women who discussed their own previous experiences with abortions provided by clinicians stated they had previous knowledge of the clinician's willingness to offer abortion services or a personal connection with the clinician. One woman had an abortion performed by her brother-in-law, who was a nurse, while another woman went to a doctor who had previously performed an abortion for her friend.

Women stated that 'cold-calling' providers to seek an abortion did not seem to yield results; several women said that they had visited hospitals asking for an abortion and were turned away. Likewise, many of the providers stated that they had been approached about performing abortions, and most always refused. One provider, a male obstetrician-gynecologist, agreed to give a young girl an abortion because she was only fifteen years old and a strong student—he did not feel that one mistake should ruin her life. Other than this singular case, the provider expressed strong disagreement with abortion. Overall, successfully accessing an abortion required a personal connection with a qualified provider.

Knowledge of home methods to conduct an abortion was also necessary in the event that a woman did not know of a provider who could perform the abortion for her. Women

and girls recounted gossiping with their friends about potential methods of abortion, and counseled each other on which medications or home remedies to buy to induce abortions. Methods for inducing abortions discussed among friends included drinking coffee with an excess of added milk and sugar, mixing Guinness beer with lye, or acquiring specific herbs and roots to prepare into herbal teas.

Technology also aided women in learning about methods of abortion. One participant mentioned that there was information on which medications to take to induce abortion passed around among schoolgirls on the messaging application WhatsApp. A provider also mentioned the Internet as a source of knowledge for learning of specific abortion methods and medication names, which was echoed in the experience of one of the women. She explained that she fell pregnant while living abroad in Gabon, and asked one of her co-workers for advice. The co-worker advised her to go on Google or YouTube to discover the names of the medications to use to abort. The co-worker then gave her a secret password to use at a specific pharmacy to get the needed medications.

*Availability of methods*

Due to the difficulty in accessing an abortion from a trained provider, women seeking an abortion often had to turn to alternative methods. Many chose to visit clandestine clinics run by providers or unqualified individuals out of their personal homes. One of the midwives referred to these types of locations as *cliniques sauvages*, ('savage clinics'), due to the perceived risk of seeking an abortion from these sources. Most of the providers we interviewed recounted cases of serious complications women had suffered

after an abortion at a *clinique sauvage*; they spoke of perforated uteruses, protruding intestines, and putrid, infected wombs.

> "I received a post-abortion complication case from someone who did not know how to do it. He used spoons to curettage, scraped the uterus until he got to the stomach, and attacked the intestine. He pulled [the intestine] all the way down, and he cut it off as if it was the [umbilical] cord." – OB-GYN, male, private clinic

Some women were also aware of the risk in seeking an abortion at a *clinique sauvage*; one explained that they were often run by people who were completely unqualified to provide abortion services:

> "There are even people who are not specialists, who are not doctors, but they tried [to abort] a woman once and it worked, and so they say 'I provide abortions' (laughs). You see, no? Because it's a bit risky. It's risky, especially if you do not know the training of the person who is supposed to do the abortion." - Woman, 22 years, single

These 'savage clinics' were uniquely dangerous in that they were sometimes run by trained doctors (either as a side job to make money, or as a full-time occupation after retiring from formal healthcare), but sometimes run by unqualified individuals. This situation left the onus on the woman herself to determine who was a legitimately trained provider. Unsuspecting women had the illusion that they were seeking out a relatively safe abortion, but a procedure at an informal clinic could be catastrophic.

The most readily available methods, the home remedies, were also some of the least safe methods. Almost every woman and provider cited taking anti-malarial medicines, drinking herbal teas, and inserting sticks into the vagina as common methods of abortion. Other common, easy-to-access methods included drinking bleach or lye or taking an overdose of aspirin or other medications. These methods were the easiest to access: medicines were sold by street vendors in every neighborhood around the city, lye and

bleach were easily found at the small general stores populating every street corner, and herbal teas were mixed by traditional healers around Lomé. These accessible methods were also both cost effective and discreet, making them an ideal choice for a woman with limited options.

### *Financial Resources*

The second sphere of influence on abortion decision-making centered on financial resources. The main components of financial resources were *cost*, *financial support*, and *income generation*. Additionally, the Financial Resources sphere overlapped with the Access to Abortion Services sphere in the issue of *affordability*.

#### *Cost*

Women commonly described the financial burden of having children as a reason to seek an abortion. The Togolese government has succeeded in promoting birth spacing, explaining that spacing births allows more time and money to care for existing children. Most women interviewed believed that spacing births was ideal, especially because it could improve a family's financial situation. While spacing of births was primarily discussed in relation to contraceptive use, women also described terminating a pregnancy to achieve birth spacing because a previous birth was too recent and they wanted the resources to adequately care for the living child before having another child.

Monetary resources were also necessary to pay for prenatal care visits, the delivery appointment, and to raise the child after birth. Interestingly, the prenatal costs were at least as important as the future costs of having a child, if not more important. One of the

providers discussed a circumstance under which a woman came to him seeking an abortion, saying that she had no choice but to end her pregnancy. Upon further questioning, he got to the root of her concerns:

> "And I said to her, 'what's your real problem?' She told me she did not have the money to pay for prenatal consultations, she could not buy her medications. I said, 'Ah, ok! So if I agree to do your prenatal consultations for free, do you still have a problem?' And she said no." - OB-GYN, male, large teaching hospital

The doctor went on to explain that, several years after choosing not to abort her pregnancy, the woman came back to see him with her son and thanked the doctor for saving her child's life.

The immediate lack of money was an insurmountable obstacle to abortion for some women, with a common sentiment being that possessing few resources was an obligatory reason to abort a pregnancy, but others did not have the same point of view—another woman, for example, said that someone seeking an abortion due to lack of means should simply wait and have the child anyway, and that "eventually means would come" (Woman, 25, single). Women expressing this type of sentiment, that lack of resources was not an adequate excuse to have an abortion, were more likely to strongly believe in the immorality of abortion and to already have children themselves.

*Financial support*

Lack of familial or marital resources was another major influence on abortion decision-making. If the woman herself did not have means, she could still decide to keep the pregnancy if she had monetary support from her parents or male partner. This type of support could influence a woman seeking an abortion to change her mind. Many women were not financially independent; therefore, an offer of money from either family or a male

partner was enough to sway her decision. Likewise, if a woman was unsure of the identity of the father of her child, or if she was still in school and had no support from her parents, then she often felt that she had no choice but to abort the pregnancy.

Several women mentioned that their husbands had complete control over the family's finances, and that if a husband refused to give his wife money for her prenatal care visits or for expenses related to raising a child then she was obligated to abort the pregnancy. One participant had an abortion under these circumstances; when she became pregnant, her husband expressed his displeasure and refused to give her the resources to care for a new baby. With no other potential source of financial means, the woman felt forced to terminate her pregnancy.

*Income Generation*

A woman's own ability to generate income was an important influencer on her decision to seek an abortion. A few unmarried women described the difficulty of paying their own rent and food costs, and expressed anxiety at the thought of providing for a child with their meager means. Falling pregnant in this situation, especially if the father of the unborn child was not a stable presence in the woman's life, meant that she had no choice but to end the pregnancy.

Additionally, women discussed terminating a pregnancy if would interfere with their education or career. Finishing school was important to many of the women, and many discussed the unacceptability of showing up to school while pregnant. One mentioned that pregnant girls were formerly not allowed to continue schooling, and while pregnancy was now permitted in the classroom, negative attitudes toward pregnant schoolgirls prevailed.

Women saw education as a way to generate means and improve their lives, and anything that conflicted with their plans for the future, especially a pregnancy, was seen as undesirable.

Similarly, women discussed internships and employment as reasons to abort a pregnancy. In particular, women who were ambitious and who gained access to ways to further their career objectives were likely to terminate a pregnancy. One woman discussed becoming pregnant just as she was about to begin an important apprenticeship in the military:

> "At the time, my husband was gone [abroad]. I was pregnant when he left. Also, I had an important internship to do. I had a very important internship to do. He was gone, I was pregnant and I had an internship. So (*deep breath*) I can't really say that it was a good moment for us, it wasn't a good moment. So, we decided together to terminate the pregnancy." – (Woman, 31 years, married)

*Affordability*

At the overlap of the Financial Resources sphere and the Access to Abortion Services sphere lies the issue of affordability. In terms of method choice, the cheapest—and therefore most financially accessible—methods of abortion were also the least safe. Women with financial means were also more likely to have the social connections to access to a safe abortion provider and to be able to pay for the actual procedure, which could cost anywhere from $50-100 or more. Providers knew that their services were in high demand, and so they were at liberty to charge virtually any price for a safe abortion. One provider even revealed his perspectives on the personal economics of abortion vs. childbirth for a doctor, explaining that a patient who went through the entire childbirth process (including prenatal visits, the delivery itself, and postnatal check-ups) was more financially lucrative than a patient who wanted a sole abortion visit. For this provider, the financial reasoning

was the main reason he did not provide abortions. Alternatively, methods such as Nivaquine anti-malarial pills or lye could be easily found and purchased for as little as $1. In a country where the minimum wage is $2.35 per day, and where many people make even less, these unsafe methods could be a woman's only chance of ending a pregnancy she could not afford to bring to term.

### *Social Acceptability*

The third sphere of influence on abortion decision-making is social acceptability. This sphere is the most nuanced of the three, as attitudes toward abortion were very contextually specific and were influenced by concepts such as the *importance of motherhood*, *moral judgment*, and *reputation*. The Social Acceptability sphere overlaps with the Access to Abortion Services sphere in the theme of *provider morality*, and overlaps with the Financial Resources sphere in the theme of *partner responsibility*.

#### *Importance of motherhood*

In considering whether to end a pregnancy, women considered the social consequences of an abortion. First, motherhood is very important in Togolese society; a childless woman is not taken seriously by the community. Having a child is a rite of passage that signals a woman's transition to adulthood. Childless women commonly cited a fear of abortion; they were concerned that this may be the only child God would give her and the fear of being childless was a strong barrier against abortion. Similarly, all the women knew that an abortion could lead to complications ranging from infection to infertility to death. If a woman was childless, she also feared that an abortion may leave her infertile and

therefore expose her to the future social stigma of childlessness. Many women, even those who already had children, were more comfortable with a mother having an abortion because it was more likely for a justified reason (such as lack of financial support from her husband), and she already had a child so there was no chance of living with the stigma of secondary infertility.

Having fertile wives was also very important to men in Togo. To prove his masculinity, a man needs to be able to produce progeny to continue his family line; therefore, an infertile wife was no use for this goal. Women discussed the fear of being unable to produce children within their marriages and the potential consequence of divorce if she was unable to conceive. Women reported that men were aware of the potential for infertility after an abortion, and many actively rejected women who had previously aborted a pregnancy out of fear of choosing an infertile wife. Therefore, it was critical for women to keep their abortions secret to avoid damaging their marriage prospects.

In cases where a woman had an abortion before marriage but did not tell her husband ahead of their union, the potential discovery of the secret could be catastrophic. Women told countless stories of husbands abandoning their wives and kicking them out of the house if the wife revealed a past abortion. Importantly, not all men acted this way. One of the women we interviewed told us that she told her husband about a previous abortion before there marriage, knowing that she was risking rejection, but he accepted and appreciated her honesty.

*Reputation*

Another important influence on abortion decision-making was a woman's reputation in her community. Some women discussed their abortion intentions with family, some discussed with friends, and some discussed with both. There was much variation in this type of disclosure dependent on whom the woman felt comfortable in confiding. Younger girls were more likely to confide in their friends and hide the abortion from their families, while older women were more likely to keep the information within their families. Regardless of whom she told, every woman discussed the importance of keeping the abortion secret from the broader community.

All 20 participants mentioned the burden of unsafe abortion specifically on younger girls, explaining that schoolgirls were likely to make poor decisions in handling their unwanted pregnancies; they often attempted to keep abortion procedures secret to avoid shaming their families and face judgment by society. Most participants expressed distain for young girls who had abortions, referring to the actions of schoolgirls as "nonsense." Girls of this age were likely to have unsafe abortions and to hide their abortions because they feared revealing the truth to their parents.

Due to this emphasis on secrecy, young girls were more likely than their older counterparts to use cheap and easy to find home remedies to abort pregnancy. In addition to the lack of knowledge about where to seek safe abortion services, schoolgirls were also unlikely to be able to afford the high cost of a safe abortion. A panicked young girl worried about supporting a pregnancy and bringing shame on her family could easily stop at a corner shop after school to purchase chemicals or medications with her meager resources, then return home to induce an abortion in the privacy of her bedroom.

Importantly, the woman herself was not the only person whose reputation could be damaged from an abortion. Women spoke of how abortions reflected poorly on young girls' parents, which could lead to whispers in the community that the parents were inattentive. Rumors could spread that the daughter was promiscuous, that her parents allowed her to partake in bad behavior, or that her parents were not at the house enough to have instilled proper values. This blame was always placed solely on the parents of the pregnant woman, and never on the parents of the father of the baby.

This type of judgment and pressure led to forced abortions; several participants said that either they or someone they knew had been forced to abort by their parents to prevent bringing shame on the family. In one example, a mother (a relative of one of the participants) noticed that her young daughter was pregnant, and forced her to drink an herbal tea that she bought at the market despite the daughter's wish to keep the pregnancy:

> I: So [the girl] drank the herbs, and then what happened?
>
> P: After an hour, or perhaps several seconds, it started to burn her stomach. She started to bleed […] it was catastrophic […] I was there, they did it in the bedroom. We didn't know that's what they were doing in the bedroom, until the girl started rolling around on the ground, crying, crying. In the time it took us to go get a taxi […] oh, no!"
> – Woman, 25 years, married

The young girl died as a result of her mother's actions, leaving the entire family—including the participant, who was the young girl's cousin—devastated.

*Moral Judgment*

Much of the morality surrounding abortion was rooted in religion, with women describing abortion as being against their religious beliefs. Almost every woman and

provider equated abortion to ending a human life, stating that it was a sin and against the Bible's teachings to kill. Women believed that their communities would see them as criminals if they were to have an abortion. One woman mentioned that, in Catholicism, a woman who had a child out of wedlock or who had aborted her pregnancy could no longer take communion because she was no longer pure. There was also a common belief that God blessed women with children, and to abort a pregnancy would be to directly go against God's will. Therefore, fear of God was a common reason to not abort; if the fetus was a "work of art" and a woman terminated the pregnancy, she would have much to confess to God.

However, the strength of religious beliefs in the Togolese community did not necessarily preclude women from seeking an abortion if they felt they had no other option:

> "I know [abortion is] a sin, but I do not have the means […] I sinned and I am still asking God for forgiveness" - Woman, 30 years, married

Women strongly believed that God would punish them for their immoral actions, but often felt that this punishment was a more accessible choice than keeping their pregnancy.

Women also commonly reasoned that abortions were immoral because the fetus could grow up to be an important person:

> "Maybe this baby that you [want] to kill, maybe tomorrow he will bring more to the community. Tomorrow, he will be a doctor; tomorrow, he will be a president who will bring more, but you are [killing] him. How do you know that tomorrow he won't be powerful?" – Woman, 35 years, living with partner

In choosing whether or not to have an abortion, reasons for keeping a baby were far in the future, but reasons for aborting were more immediate concerns.

The strong religious and moral beliefs in the importance of children in Togo meant that a woman who had induced an abortion could be insulted and mocked by community

members, and that she would feel shame for her actions. All participants explained that abortion was wrong and that everyone in the community thought it was wrong. To go against these community norms was thus a difficult decision, but one that women made if they had enough reasons to abort regardless. Many of the women had previously induced abortions and every one of them thought it was morally reprehensible—but, in these cases, the strength of the access and financial resources influences were too powerful for morality to prevail.

*Provider morality*

At the intersection of Access to Abortion Services and Social Acceptability lies the influence of provider morality, which makes safe abortions from providers—even though illegal—even more difficult to access. Much like the rest of Togolese society, most healthcare providers were morally opposed to abortion. Several recounted stories of women coming to them to seek abortions with disgust, expressing personal offense that anyone would think that they provided abortion services. Several also discussed the tensions they felt between their work, which they saw as helping bring new life into the world, and abortion, which was seen as destruction of life:

> "By conviction, I do not do abortion. I help women to get pregnant. I cannot at the same time help women lose their pregnancy. It is not possible. We do not do one thing and its opposite." - OB-GYN, male, large teaching hospital

One provider also discussed his reasoning in the context of the Hippocratic Oath, which states that doctors cannot use their knowledge to take a life. An important factor here is the equating of a fetus with a full human life.

Other providers saw it as their duty to help women regardless of the circumstances. While this did not necessarily mean they were willing to provide abortions, they were more understanding and sympathetic, explaining that they could not judge a woman who had an abortion because they could never know the full context of the decision. In contrast to the providers who discussed "chasing" away women who came asking for abortions, these more sympathetic providers were more likely to speak with the woman about the consequences of abortion in an effort to change her mind. Regardless, all providers expressed that abortion was not at all tolerated at their various hospitals and that women who came seeking an abortion left disappointed.

Not only were providers morally against abortion, but many did not know the circumstances under which it was legal, indicating that they would be highly unlikely to help a woman who was legally eligible for an abortion. Some of the providers, namely the midwives and nurses, were also unaware that their post-abortion care training contained the same skills necessary to induce abortions. Provider views on abortion were either completely negative or neutral, but none of them expressed positive feelings towards abortion provision.

*Partner responsibility*

The influence of partner responsibility lies at the overlap of Social Acceptability and Financial Resources. The male partner in the relationship had complete control over whether or not he assumed responsibility for the pregnancy or not. If he was married to the woman, and they wanted a child together, he would often act as the breadwinner for the family. If the man did not want a child, then he could force the woman to abort the

pregnancy even if she did not want to. Likewise, a woman who had already decided that she did not want the pregnancy could be forced to keep it if the male partner wanted to have a child. If the woman chose to tell the man about the pregnancy, he was in a position to make the decisions about what was done. If there was dissonance within the couple, the woman had to go with the man's wishes, or face disobeying him and potential abandonment.

Alternatively, the male could choose not to take responsibility for the pregnancy, instead claiming that it belonged to someone else. In this case, the man could throw the woman out of his house and ask for a divorce, falsely accusing her of promiscuity and infidelity. According to the women, a man did not have to take responsibility for his actions, even if the pregnancy was a result of a refusal to use methods of contraception:

> "He says, 'no, no,' it's not his, he already said that he didn't want a child, why did she get pregnant?" – Woman, 33 years, married

Alternatively, in situations where the partners were not married and the woman thought she would have to get an abortion due to lack of means, the male partner could step up to take responsibility for the pregnancy. In this case, he could go to the girl's family and introduce himself, explaining that he was the father and he wanted to take care of the woman and her future child. This option was more susceptible to outside judgment due to the commonly casual nature of these types of sexual relationship. Regardless, the man could choose to go against the social judgment of having a child outside of a marital relationship and provide support for the woman he impregnated.

## DISCUSSION

There are three overlapping spheres of influence on a woman's decision to abort a pregnancy and on the methods she chooses in Lomé, Togo: access to abortion services, financial resources, and moral judgment.

Influences on abortion decision making in sub-Saharan Africa are documented in the literature, but often fail to provide a comprehensive framework of all the influences on the decision-making process, especially in the context of Togo (Rominski et al, 2014; Sundaram et al., 2012; Mote et al., 2010; Osamor & Grady 2018; Senarath & Gunawardena, 2009; Schuster, 2005; Koster-Oyekan, 1998; Svanemyr & Sundby, 2007). This study proposes a conceptual model for decision making to seek an abortion and the method of abortion, with the discovery that these two decisions are influenced by many similar factors. Additionally, the narratives from Togolese women and healthcare providers reported in this study show the nuances of the decision-making process, despite the broadly overarching spheres of influence. This study also gives voice to Togolese women themselves, a group often overlooked in the literature on abortion.

Our research findings support previous studies that detail demographic influence on abortion decision-making, including the influence of young age, low socioeconomic status, and marital status (Sundaram et al., 2012; Rominksi et al., 2014; Mote et al., 2010; Schuster et al., 2005; Gage et al., 1994). Spacing of births as a driver of abortion is a common theme in the literature explaining abortion reasoning and is also a theme echoed in our findings (Osamor & Grady, 2018; Mote et al., 2010). Our results also discovered parity to be an important influence on the decision-making process, whereby women who were already

mothers to one or more children used abortion to reduce family size and improve their family finances.

Our study found no direct influence of legality on abortion decision making, whereby women did not directly consider the restrictions of the law in choosing to abort their pregnancy. This is in line with studies in Ghana (Sundaram et al., 2012; Svanemyr & Sundby, 2007; Aniteye & Mayhew, 2013). However, our findings highlighted the important nuance of legally-restricted access as an indirect barrier. Therefore, even though the fear of the law itself does not influence abortion seeking, the existence of the law does indirectly influence abortion seeking by limiting access.

The literature indicates that social influences play a significant role in abortion seeking, which is also corroborated by our data. In many developing contexts, including Ghana, the husband is in control of his wife's reproductive healthcare (Osamar & Grady, 2018; Senarath & Gunawardena, 2009; Meekers & Oladosu, 1996; Becker et al., 2006; Acharya et al., 2010). This was also consistent in our findings, with men effectively exerting control over the abortion decision-making process through threats of divorce or abandonment. However, our findings are based on narrative evidence rather than quantitative indicators of empowerment pulled from surveys, and therefore include in-depth reasoning and context for the important role of men as decision-makers.

Abortion is highly stigmatized in many cultural contexts, and results in consequences including judgment and shame (Svanemyr & Sundby, 2007; Kumar et al., 2009; Orne et al., 2011; Koster-Oyekan, 1998). Women in our study discussed fear of societal repercussions as strong motivators to keep their experiences with abortion secret—which also led to use of less safe methods and fear of seeking care for

complications. Overall, societal influences are strong barriers to seeking safe abortions, and interventions aimed at reducing this stigma could be difficult.

Our study unearthed an important dissonance between provider duties and attitudes surrounding abortion. Healthcare providers, especially those trained in the field of women's health, have a duty to their patients to remain non-judgmental in all aspects of care (Schwandt et al., 2013). Previous research has found that providers in sub-Saharan Africa disapprove of adolescent sexuality, leading to a refusal to provide unmarried girls with contraception (Hord & Wolf, 2004). Similarly, our study identified a perceived moral challenge among providers in terms of abortion provision. Our study adds to the literature on abortion morality in that it combines perspectives from both women and reproductive healthcare providers, uncovering nuanced perceptions of several key players in the abortion process.

The health professionals in our study expressed that their job was to help women get pregnant (and therefore bring life into the world), and not to end life via abortion. This is at odds with ideals of reproductive healthcare providers as advocates first and foremost for *women*. Many providers in Togo rejected to treat women seeking abortions, refusing to recognize women as moral agents capable of making decisions about their own well-being. Until healthcare providers in Togo are willing to see women as human beings deserving of moral agency, and clarify their own role as facilitators of women's health rather than as decision-makers, the incidence of unsafe abortion in Togo will likely not decrease.

Health provider's knowledge of abortion methods and circumstances of legality of abortion was low, indicating that they would be reluctant to provide an abortion even where it was legal in Togo. Previous interventions had focused on improving post-abortion

care skills amongst providers. While this is important, it is equally important for providers to clarify their values and beliefs surrounding abortion (Turner & Page, 2008). Togolese law guarantees a woman's right to an abortion under circumstances of rape, incest, fetal malformation, or if dangerous to the mother's health; therefore, providers must be able and willing to provide abortions in these cases. Further education of providers is Togo is needed to clarify the legal status and circumstances of abortion in Togo. However, this type of education in an environment where abortion is socially unacceptable could benefit from the use of Ipas's Values Clarification and Attitudes Transformation (VCAT) exercises (Turner & Page, 2008). Future interventions could focus on this aspect of abortion care, which could help providers empower eligible women to seek safe and legal abortion—which would be a first step in improving provider's knowledge in Togo.

*Study limitations*:

One limitation of this study is that we only included women who spoke French. While French is the lingua franca of Togo, only people with a middle school education are generally fluent enough in French to participate in the study. Therefore, our sample is likely to include women who are more educated than the general Togolese population, and opinions and experiences on abortion may differ due to their education level. However, women interviewed also shared broader perspectives of others in their community, so we were able to capture normative community views on abortion to some extent.

In terms of methodological limitations, because our sample was restricted to women who were seeking healthcare at health centers in Lomé, our participants are more likely to be urban residents and willing/able to seek care. Therefore, our data does not capture the

views and experiences of rural Togolese women, or those who may choose to seek healthcare in places other than a hospital or clinic setting (i.e. traditional healers, self-medication etc.).

Further research should investigate influences of abortion decision-making among women with more variation in education status, as well as among rural Togolese women. Circumstances in rural areas in Togo may be completely different, leading to different decision-making influencers among this population. Focusing more on younger women could also be an interesting avenue of research, as many of our participants indicated that schoolgirls were most likely to seek unsafe abortion services. While abortion in general is an important phenomenon to understand, fully understanding unsafe abortions among Togo's youth could provide even more potential interventions aimed at reducing their burden specifically among school-aged adolescents.

*Conclusion*

In conclusion, this study among urban Togolese women reveals that there are four main spheres of influence on abortion and method decision-making. Access to safe abortions is an important issue due to limited legality of abortion in Togo, lack of knowledge of safe abortion services, and limited availability of safe methods. Financial resources influence the abortion decision-making process because successfully carrying a pregnancy to term or safely aborting requires access to financial means. Therefore, women discussed the necessity of aborting a pregnancy if she does not have money to support the child, has no one to lend her financial support, or if her means to acquire financial resources would be jeopardized by her pregnancy. Additionally, safe abortions are not

affordable for most the population, which pushes women towards unsafe methods. Finally, social acceptability—or lack thereof—is an influence on abortion decision-making because women are expected to be mothers in Togolese society and failure to conform to this norm results in harsh judgment; morality is shaped by religion, confers stigma to abortion, and can ruin a woman's reputation within her family or community. Our study also revealed the complete control that the male partner has over the decision to take responsibility for a pregnancy. The shame of having a fatherless child, along with the lack of financial support from a male partner, leads many women to abort their pregnancies. Finally, even if a woman is aware of the danger of informal abortion methods, provider morality makes safe abortions difficult to find, which forces women to seek out unsafe procedures or methods.

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# CHAPTER 4: CONCLUSIONS, IMPLICATIONS & RECOMMENDATIONS

Research on abortion is an important public health issue because maternal mortality due to unsafe abortion is completely preventable (Haddadd & Nour, 2009). Understanding how and why women make the decisions to have an abortion and which method to use is critical in recommending policy measures aimed at reducing the burden of unsafe abortion worldwide, especially in countries with limited legality, such as Togo (Gage, 1994; Ahman & Shah, 2011). The decision to have a safe vs. unsafe abortion is not always entirely in a woman's control, but presents an opportunity for reducing the incidence of unsafe abortion. To identify opportunities to improve women's abortion safety, it is important to understand the context in which it occurs and the influences on the abortion decision. By identifying three key spheres of influence on abortion and method decision-making, we pinpoint potential areas of intervention by public health programming and policy in Lomé, Togo.

## Public Health Implications

### *Women's empowerment*

The literature on abortion has highlighted women's empowerment within the abortion decision-making context. Several authors have discussed the importance of women's autonomy in fertility decision-making in general, applying the Theory of Planned Behavior and derived theoretical frameworks to fertility planning (Uphadyay et al, 2014; Ajzen & Klobas, 2013). Autonomy is a core issue contributing to empowerment, which is defined as the process by which someone who previously had no access to choice gains the

ability to choose (Kabeer, 1999). Empowerment is then at the epicenter of this issue of abortion decision-making.

Many of the women in our study were forced into their abortion decisions by overbearing mothers or irresponsible male partners; these women had no choice in their decision and were, according to Kabeer's definition of empowerment, clearly disempowered by social hierarchies in the context of Togo. However, a much larger number of women *felt* that they had no choice due to social circumstances or financial constraints. This is also a form of disempowerment; even though they were not being actively forced into an abortion by others, they still felt as though they did not have the ability to make choices regarding their future. In this situation, social pressures caused them to experience disempowerment, or to feel powerless as agents within the context of their own lives.

This lack of ability to make empowered decisions also led to circumstances where women received an unsafe abortion. The women who felt forced to abort their pregnancies by societal or financial constraints chose methods that were easy to hide from their moralistic community, and faced difficulty seeking healthcare when the abortion went terribly awry.

Empowerment is an important consideration in the context of abortion decision-making, especially if social norms are responsible for constraining a woman's right to choose her own reproductive future, or in limiting her access to safe abortion services. Interventions aimed at improving women's decision-making within the household could help women stand up to their families and husbands in the event that they feel forced into deciding to abort a pregnancy. Additionally, the literature indicates that women who were

able to confide in their husbands were more likely to make safer abortion choices (Sundaram et al., 2012; Mote et al., 2010). Interventions aimed at increasing agency could make women feel more equipped to discuss her planned actions with a husband or provider without fear of judgment, leading to an overall safer abortion decision.

*Provider education*

Women's healthcare providers play an important role in the abortion decision process for women in sub-Saharan Africa, as they are tasked with educating women about the procedures they perform and helping their patients achieve their fertility intentions in a safe and non-judgmental atmosphere. However, in contexts similar to Togo, provider beliefs have been a barrier to safe, legal abortion provision (Aniteye & Mayhew, 2013; Schwandt et al., 2013).

In this study, we found that providers were typically morally opposed to abortion and unaware of the circumstances in which abortion was legal. Many of the providers we interviewed expressed disgust with women who dared approach them for safe abortion services. However, safe abortion *is* legal in Togo under certain circumstances and women have a right to legally access those services if their situation allows. In order for women to access these safe, legal abortions, providers need to be accepting of the woman's right to terminate their pregnancies, and willing to perform the procedure. Provider counseling also plays a role in healthcare decision-making in a variety of contexts (Aniteye & Mayhew, 2013). Therefore, for Togolese women to be fully utilizing their legal right to a safe abortion, providers need to provide unbiased and comprehensive counseling in the event

of a pregnancy resulting from rape, incest, a fetal malformation, or if the woman's health is in danger.

Educating providers on the full legal code surrounding abortion is needed, and providing Values Clarification and Attitude Transformation exercises (developed by Ipas) with providers would further increase their understanding and tolerance of such an important women's health issue (Turner & Page, 2008).

**Policy Recommendations**

*Subsidize pre/post-natal and/or delivery care '*

One of the most commonly cited reasons to abort among women in our study was lack of financial resources. While providing for the child in the future was a concern for many women, others commonly discussed worrying about how they would pay for more immediate costs, such as prenatal care visits and the delivery appointment. In a context in which the minimum wage is $2.35 per day, women do not always have the luxury of thinking ahead; they must make financial decisions based on the money they possess during each specific moment in time. Therefore, a government initiative to subsidize pre-natal and delivery care costs could be a pro-natal policy for women who wish to keep their pregnancies. Likewise, subsidizing other costs for pregnant women, such as food or travel to the hospital, could greatly increase a woman's perceived self-efficacy in ability to adequately care for herself and her baby-to-be.

*Educate providers*

Our research identified that many providers are not fully aware of the Togolese legal code on abortion, and many do not know that their post-abortion care skills are also applicable to abortion provision. Until providers are fully aware of the situations in which they can provide legal abortion, know how to navigate the process in the courts, and are ready and willing to help counsel women through the process to acquire legal abortions, the law will never be fully implemented. Educating providers about their role in legal abortions and conducting Values Clarification and Attitude Transformation exercises could be important avenues for improving provider acceptance of abortion and encouraging them to support their female patients in any way they can. This would also be a first step to complete legalization in Togo; once providers understand the value of providing safe abortion services, they could be strong advocates for legalization.

*Legalize abortion*

Finally, legalizing abortion could be a difficult but effective way to remove many barriers women currently face to finding safe abortions. A central influence on abortion method decision making in our data was the difficulty in accessing a safe abortion due to the procedure's restricted legality. Legalizing abortion in any circumstance would make these procedures easier to find an essentially eliminate the entire access sphere of influences as more and more providers began offering abortions. While this will be difficult, as Togolese society is strongly morally against abortion in general, it would be the most effective way to ensure that women have access to safe places to end their pregnancies. Importantly, regardless of whether the procedure is legal, it will continue to happen.

Legalizing abortion would not necessarily encourage women to have abortions, but would simply give them a safe place to do so.

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