ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG,
EASTERN REGION, GHANA

POST ABORTION CARE IN GHANA, A CASE STUDY OF TEMA GENERAL HOSPITAL, TEMA

By

DEBORAH DZIDZOR YAWA DEH

A Thesis submitted to the Faculty of Public Health in partial fulfilment of the requirements for the degree

MASTER OF PUBLIC HEALTH

MAY, 2016

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Supervisor: DR JULIANA YARTEY ENOS

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DECLARATION

I hereby certify that except for reference to other people work, which I have duly cited, this Project submitted to the School of Graduate Studies, Kwame Nkrumah University of Science and Technology, Kumasi is the result of my own investigation, and has not been presented for any other degree elsewhere.

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Dr. Juliana Yartey Enos _____ _____
(Supervisor) Signature Date

(Certified by)

Dr Christopher Tetteh _____ _____
(Dean) Signature Date

DEDICATION

I dedicate this research to my family, for their love, care, support and understanding and to all women in reproductive age battling with many obstacles or barriers in assessing post abortion care.

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I first of all am very to the Almighty God for the grace, courage and strength to complete this Master of public health course successfully.

This work would not have been completed without the assistance of some people. I wish in this section to acknowledge their support and say that I am grateful.

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DEFINITION OF TERMS

Abortion: The expulsion or extraction of the products of conception from the uterus before the embryo or foetus is capable of independent life.

Contraception: As a means of logical progression, contraception is necessarily anything that acts against conception, and therefore, anything that prevents the success of fertilisation or implantation.

Incomplete Abortion: Occurs when some products of conception, usually the placenta, remain inside the uterus.

Maternal morbidity: Serious disease, disability or physical damage such as fistula and uterine prolapse, caused by pregnancy related complications .

Maternal mortality: The death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Parity: The number of times a woman has been pregnant (number of children born dead or alive after viability)

Side effect: An effect of a drug other than the one it was administered to evoke.

Spontaneous abortions: Commonly called miscarriages: involuntary (not induced) interruptions of pregnancy or therapeutic abortions.

Self-induced Abortion: Self-induced miscarriage (induced) is an abortion (induced abortion) performed by the pregnant woman herself, outside the recognised medical system.

Unsafe Abortion: A procedure for terminating pregnancy either by person lacking the necessary skills or in an environment lacking minimal medical standard or both .

LIST OF ABBREVIATIONS/ ACRONYMS

CAC: Comprehensive Abortion Care

CI: Confidence Interval

ECOSOC: United Nations Economic and Social Council

FP: Family Planning

GHS: Ghana Health Service

HIV: Human immunodeficiency virus

ICPD: International Conference on Population and Development

IPAS: International Project Assistance Services

KATH: Komfo Anokye Teaching Hospital

MSI: Marie Stopes International

MVA: Manual Vacuum Aspirator

MHD: Municipal Health Directorate

NHIS: National Health Insurance Scheme

PAC: Post Abortion Care

R3M: Reducing Maternal Mortality and Morbidity

TGH: Tema General Hospital

UN: United Nations

US: United States

USAID: United States Agency for International Development

WHO: World Health Organization

ABSTRACT

INTRODUCTION

Every year, an estimated 78,000 women die from complications of induced abortions and 95% of the deaths related to induced abortion occur in under-developed countries. Unsafe abortion is on the rise and it accounts for an estimated 13% of pregnancy related deaths representing approximately 67,000 women every year .The available data on abortion suggest that overall worldwide abortion rate has declined, whereas the proportion of unsafe abortion has increased.

Post Abortion Care is defined as an approach for reducing mortality and morbidity from incomplete and unsafe abortion and resulting complications and for improving women's sexual and reproductive health, it has been identified as a key strategy by the international health community at the ICPD conference in 1994 to reduce maternal mortality in developing countries.

The aim of this study is to identify the barriers to safe abortion care and post abortion care utilization, ascertain the level of awareness on Ghana's abortion law, available services and post abortion care services provided in the country among women of reproductive age visiting the Tema General hospital.

METHOD

A cross-sectional survey was used to obtain quantitative data among the study population of 150 women of reproductive age (14yrs - 49yrs) and key informant interview, additionally using qualitative method of data collection; data were obtained from 10 key informants who were hospital staff. Participants were selected using simple random sampling technique from both outpatient department and obstetrics and gynaecological ward daily register.

RESULTS

65.3% had received post abortion care; whilst 34.7% had not received post abortion care. The mean age was 27 years. Knowledge on Ghana's abortion law was very low at 15%, the quality of service offered was low as it was more curative than preventive, was significant at 0.005, fear(30.7%), unfriendly attitude of healthcare providers(58%), the high cost of services (54%) and religious belief (58.7%) were the barriers identified all significant at 0.005.

CONCLUSION

The poor service provided was a major contributor to receivers of post abortion care defaulting and going in for unsafe abortion. Health facilities providing post abortion care service should endeavor to practice preventive measures more than curative.

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CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND INFORMATION

In settings where abortion is legally restricted or access to services is limited, women with unwanted pregnancies often resort to unsafe abortions and subsequently require urgent medical attention to treat complications and death. Women may also suffer incomplete spontaneous abortions (miscarriages) or complications of unsafe abortion that require medical attention.

Post Abortion Care (PAC) was developed to stem the maternal mortality and morbidity arising from unsafe abortions especially in countries with restrictive abortion laws. It is defined as an approach for reducing mortality and morbidity from incomplete and unsafe abortion and resulting complications, and for improving women's sexual and reproductive health and lives (Post abortion Care Consortium Community Task Force, 2002).

It was first articulated by International Project Assistance Services(Ipas), US based non-governmental organization in special consultative status with United Nations Economic and Social Council (ECOSOC), founded in 1973.

Ipas works around the world to eliminate deaths and injuries from unsafe abortion and increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion. PAC model was developed in 1991, and later published by the Post Abortion Care Consortium in 1995.

The role of safe abortion services in the improvement of women's health was recognized in the 1994 International Conference on Population and Development (ICPD). At this conference, participants agreed that "in circumstances where abortion is not against the law,

such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion" (ICPD, 1994).

1.0.1 Elements of post abortion care

The original Post abortion care model consisted of three elements drawn specifically from health care providers perspective without taking due cognizance of the need to accommodate the psychological and physical feelings of the client as well as the community who are the beneficiaries of the services. The three elements of the original Post abortion care model include the following:

1. Emergency treatment services for complications of spontaneous or unsafe induced abortions;
2. Post abortion family planning counseling and services; and
3. Links between emergency abortion treatment services and comprehensive reproductive health care provider perspective

(Adinma, 2012).

However in 2001, the Post abortion care Community Task Force expanded the model to five elements, tailored to provide the necessary ingredients for sustainable Post abortion care services by making them more client-oriented. The five elements are:

1. Community and service providers partnership for prevention of unwanted pregnancy and unsafe abortion, together with the mobilization of resources and ensuring that services reflect and meet community expectations and needs**;** This element of the model recognizes community members' vital role in treatment, prevention and advocacy efforts. Community health education and mobilization have been identified as key strategies to combat unsafe abortion, increase access to and quality of post abortion care programs, and improve women's reproductive health and lives.

2. Counseling to identify and respond to women's emotional and physical health needs and other concerns; post abortion care counseling covers more than fertility and contraception, although it must emphasize these elements and consists of more than information provision and sensitive communication. This counseling provides an opportunity to help women explore their feelings about their abortion, assess their coping abilities, manage anxiety and make informed decisions.

3. Treatment of incomplete and unsafe abortion and its complications including the use of manual vacuum aspirator (MVA); The first element of the original model and the focus of many post abortion care activities, treatment remains a critical part of care, because woman who have had an incomplete spontaneous or unsafely induced abortion will, in many cases, need uterine evacuation and other medical intervention. The revised model includes language recognizing that post abortion care does not always involve complications, and that complications are not always life-threatening but may be in the absence of swift and appropriate medical attention. It further recognizes that safe, effective treatment involves the use of vacuum aspiration wherever possible and includes standard infection prevention pre- cautions, informed consent, appropriate pain management, sensitive physical and verbal patient contact, and follow- up care.

4. Contraceptive and family planning services to help women prevent an unwanted pregnancy or practice birth spacing; The revised post abortion care model recognizes that some women receiving post abortion treatment need family planning services to help them space births, while others need contraceptive services because they have no plans to conceive.

Therefore, the model emphasizes the importance of overcoming barriers to offering family planning and contraceptive services during the same visit and at the same location as post abortion treatment. When a facility does not provide these services at the time of abortion-related treatment, the opportunity to provide them may be lost.

5. Linkage to reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in the providers' networks; When a facility is unable to provide needed services, it should have functional mechanisms in place for making referrals (either within the facility or to another one), receiving feedback from referral sites or providers, and performing follow-up which include:- consistent and accurate record-keeping, education about the prevention of sexually transmitted infections, including HIV, as well as screening, diagnosis and treatment, services addressing gender-based violence, including screening, counseling and referral, infertility diagnosis, counseling and treatment, nutrition screening and education, and treatment of nutritional deficiencies, hygiene education and screening, counseling and treatment for reproductive related cancers.

(Baird TL et al 2001, Adinma, 2012).

Women centered post abortion care was developed in 2005 as a step forward from the original Post abortion care strategy. It is a comprehensive approach to meeting each woman's medical and psychosocial needs at the time of treatment for abortion complications. In the course of providing women centered post abortion care by health care workers, factors influencing women's need for and access to care such as personal circumstances and living conditions are taken into cognizance to ensure quality service delivery (Adinma, 2012).

Post abortion care has found wide acceptance in developing countries as a very important tool in the combat of maternal mortality from abortion. In countries such as Nigeria and Ghana,

and many other developing countries of Asia, middle level providers especially Nurse-Midwives have been trained on Post abortion care and have been employed widely in the provision of abortion treatment services especially in rural areas (Adinma, 2012).

This concept was introduced into Ghana in 2003 by the Ghanaian government by introducing changes in its reproductive health policy, and issuing guidelines for the provision of comprehensive abortion care services (CAC), within the limits of the law (Ghana Health Service 2005) including post abortion care.

This was followed in 2006 by Safe Abortion Services as permitted by law by the Ministry of Health, in partnership with a consortium of international health organizations, including Ipas, Engender Health, Marie Stopes International (MSI), the Population Council, and Willows Foundation, launched the programme 'Reducing Maternal Mortality and Morbidity' (R3M).

The programme, aimed largely at health care providers, sought to increase access to Comprehensive abortion services (CAC) to reduce morbidity and mortality caused by unsafe abortion, and to widen access to family planning services to reduce the unwanted pregnancies that lead to abortions in the first place (Aboagye et al. 2007). The R3M programme was initiated in three regions—Accra, Ashanti, and Eastern—and within these regions, a total of seven districts were chosen, Since then, maternal mortality ascribed to abortions has decreased from 22-30% to 11% (Aparna S. et al 2014, Clark K et al 2013 , Opoku B 2012).

Women who have had an induced abortion are at special risk of repeat induced abortions (Guttmacher Institute, 2008; Williamson et al., 2009).

Although post abortion family planning counseling and service delivery is part of all post abortion care models, Post abortion care services have historically sought to reduce maternal mortality by treating the symptoms of hemorrhage and sepsis rather than by treating women's unmet need for family planning, thus overlooking the potential of post abortion care to

interrupt the cycle of repeat unplanned pregnancy, abortion and complications leading to maternal death. For many post abortion patients, the lack of access to the full package of post abortion care services quickly leads to another induced abortion, because fertility returns within two to three weeks after miscarriage or induced abortion.

This makes it essential to ensure that post abortion care and service delivery are offered to all women who present for emergency obstetric or post abortion care, regardless of the method of treatment (sharp curettage, electric or manual evacuation) or place of treatment (operating theatre or post abortion care treatment room) as well as to all postpartum women (Curtis et al, 2010).

International Project Assistance Services (IPAS) emphasizes contraceptive counseling and services as part of comprehensive abortion care. Information and contraceptive methods offered at the time of services are essential so that women can prevent repeat unwanted pregnancies and unsafe abortion. Family planning services for all women should include information and referrals to safe abortion for those who experience contraceptive failure (IPAS, 2011).

Studies have shown that majority of the time post abortion services offered at health facilities is mostly focused on family planning counseling neglecting the other components (WHO 2013).

Many countries ideology of Post abortion care services have over the years aimed mainly at reducing maternal mortality by treating the symptoms of hemorrhage, sepsis and family planning rather than addressing the other five elements or components of the post abortion care model. Women's crucial needs, such as financial, emotional supports and collaborations from community members to avoid stigma and rejection, etc. are being neglected. Strong evidence demonstrates the feasibility, acceptability, and effectiveness of providing all the

components of post abortion services to clients. Despite this evidence, many post abortion clients leave facilities without providers offering them counseling or emotional and financial care which are elements of the five components of comprehensive post abortion care model (USAID, 2011).

1.1 STATEMENT OF THE PROBLEM

The World Health Organization estimates that worldwide around 20 million unsafe abortions occur annually, more than 95% of which occur in less developed countries. Those abortions that are unsafe, performed by untrained practitioners working in unhygienic conditions, are responsible for about 80,000 preventable deaths of wo.men each year. Globally, 20 percent of all pregnancies end in induced abortions; nearly half of these abortions (around 20 million) are clandestine and generally unsafe. According to the WHO, about 180 to 200 million pregnancies occur every year globally, out of these, 75 million are unwanted pregnancies (WHO, 2007). It has also been estimated that in the year 2000, 19 million illegal or unsafe abortions were carried out, of which 18.5 million were in developing countries (Ahman & Shah, 2002).

1.1.1 CONSEQUENCES OF UNSAFE ABORTION

Unsafe abortion causes such long-term consequences as chronic pain, pelvic inflammatory disease, tubal occlusion and secondary infertility (WHO/Guttmacher Institute, 2010). Hospital records from developing countries suggest that 38–68% of women treated for complications of abortion are younger than 20 years (Guttmacher, 2010); while these data suggest that abortion complications take a high toll on adolescents, they represent only young women who make it to a hospital for treatment. The World Health Organization (WHO) estimates that 10–50% of women who have an unsafe abortion need medical care; some women who experience spontaneous abortion also need treatment (WHO, 2014) Complications from spontaneous

abortions and unsafely induced abortions pose a serious global threat to women's health and lives.

Unsafe abortion and its consequences impose heavy economic and health burdens on women and society. Every year, unsafe abortion accounts for around 70,000 deaths worldwide (13% of all pregnancy-related deaths) and an estimated 5 million women are hospitalized for the treatment of serious complications related to abortion, such as sepsis or haemorrhage, with many suffering long-term ill-health as a consequence. The vast majority (95-97 %) of these deaths occurs in the world's poorest countries, and is at their highest in Africa. Almost half of all unsafe abortion deaths occur amongst adolescents, girls under the age of 19 (WHO, 2007).

1.1.2 SITUATION IN GHANA

According to a study conducted in the late 1990s in southern Ghana, 17 abortions were observed for every 1,000 women of reproductive age(Singh et al., 2009).The level of abortion in Ghana appears to be lower than in Western Africa as a whole, where the rate stands at 28 per 1,000 women (Singh et. al., 2009). According to the Ghana Maternal and Health Survey report for the year 2007, abortion rate in Ghana is 0.4 per woman; 7% of all pregnancies end in abortion and 15% of women aged 15-49 have ever had an abortion. About 15 abortions are performed for every 1,000 women of reproductive age (15-44) each year.

In 2014, unsafe abortion accounted for 15 per cent of maternal deaths in Ghana, impeding the country's efforts at achieving the Millennium Development Goals five, which was primarily aimed at reducing maternal mortality by 75 % by 2015 (IPAS,2014).

In accordance with the data on abortion by age, first pregnancies are more likely to end in abortion than second or higher order pregnancies (11 percent compared with 7 percent or

less). These findings indicate that in Ghana, abortion is used more commonly to delay the start of childbearing than to limit the number of children (Opoku, 2012).

The human costs of unsafe abortion are dramatically apparent in Ghana. While most causes of maternal mortality have declined since 1987, abortion-related complications and deaths have risen in some parts of the country from 13.1% to 26.5% in 2000, making it the leading cause of maternal death. In 1994, before government intervention, unsafe abortion provision in Berekum district led to a temporary spike in maternal mortality of 790 deaths per 100,000 live births (Aboagye et al., 2007).

Post abortion care provides all the necessary services to help prevent women from going in for unsafe abortions but over the years many providers concentrate on treatment of complications and family planning ignoring the other components or elements thus causing previous clients to still go in for unsafe abortion services.

Globally from 1990 to 2010, the percent of maternal mortality due to abortion has decreased from 13% to 9% and in the same period, the number of maternal deaths declined by 45% due to the introduction of post abortion care (USAID 2015).

The tragedy of unsafe abortion is that it is the most easily preventable cause of maternal death (WHO, 2014).

1.2 SIGNIFICANCE OF STUDY

The findings from the study will identify barriers to the utilization of safe abortion care and post abortion care service, patient's adherence to counseling offered during post abortion care and also ascertains the level of awareness or knowledge on safe abortion care and post abortion care services. It will also help inform the organization of programs to educate women of reproductive age on abortion, its complications and adherence to counseling

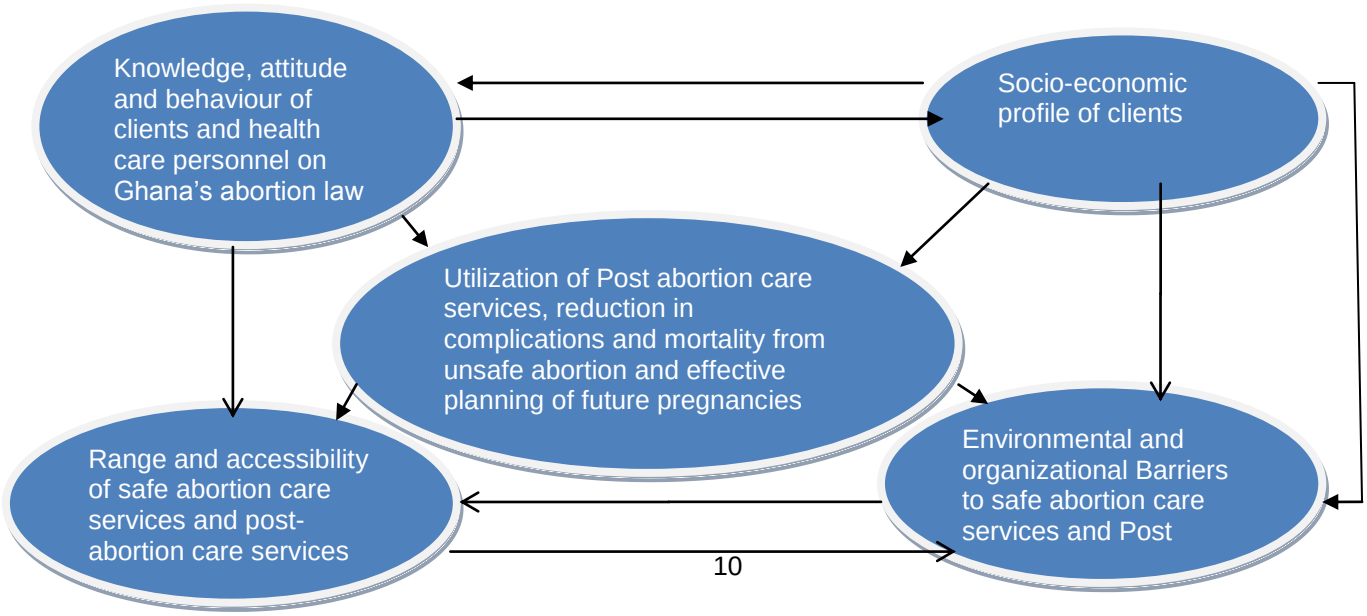
offered and also inform formation of policies to enable women utilize health facilities offering safe abortion care services.

1.3 CONCEPTUAL FRAMEWORK FOR THE STUDY

Many factors contribute to the utilization of post abortion care services among women of reproductive age and these include socio- demographic characteristics such as the age, education, occupation and income as well as past abortion history.

The knowledge of women on Ghana's abortion law and safe abortion care services can boost up utilization of post abortion care services. The accessibility of post abortion care services and the range of services available affect its utilization. The attitude and behaviour of health care personnel's can also influence an effective utilization of post abortion care services. Again, environmental, social and organizational barriers can affect the uptake of post abortion care services; when safe abortion care is provided at the same time and facility where a woman receives Post abortion care services it leads to a reduction in the complications and mortality from abortion and effective planning of future pregnancies.

Figure 1.1: **CONCEPTUAL FRAME WORK**



1.4 OBJECTIVES

The objectives of the study are;

1.4.1 GENERAL OBJECTIVES

- To identify barriers to utilization of safe abortion care and post abortion care services of women in reproductive age (14-49 years) visiting Tema General Hospital.

1.4.2 SPECIFIC OBJECTIVES

- To ascertain the level of awareness in women of reproductive age (14 -49 years) visiting Tema General Hospital and the healthcare providers of Tema General Hospital on available safe abortion and post abortion care services provided the hospital.
- To assess awareness and the knowledge of women of reproductive age (14 – 49 years) visiting Tema General Hospital and healthcare providers in Tema General Hospital on Ghana's abortion law.

1.5 RESEARCH QUESTIONS

To operationalize the above mentioned objectives, the following questions were explored:

- What is the level of knowledge women have on abortion, its law, services and post abortion care services provided in Ghana?
- Do the women adhere to counselling provided during post abortion care?
- What are the barriers to safe abortion care and post abortion care service utilization?

1.6 PROFILE OF STUDY AREA

The study was conducted at the Tema General Hospital which is in the Tema metropolis of the Greater Accra region of Ghana. The Tema metropolis has three Sub-Metropolitan Councils namely; Tema West, Tema East and Tema Central. Tema Metropolis is a coastal district situated about 30 kilometers East of Accra, the Capital City of Ghana. It shares boundaries in the northeast with the Dangme West District, south- west by Ledzokuku Krowor Municipal, north-west by Adentan Municipal and Ga East Municipal, north by the Akuapim South District and south by the Gulf of Guinea. The Ashaiman Municipal is an in-lock enclave within the Tema Metropolis.

The estimated 2015 population of Tema Metropolis is 403,943 (as projected from the 2010 Census), making it the second largest-populated of the ten districts in the Greater Accra Region, after Accra Metropolis.

Table 1.1: Distribution of 2015 Population, Tema Metro

TARGET	% POP Dist by AGE-GROUP	Tema East	Tema Central	Tema West	TOTAL
CHILDREN 0-11 MONTHS	4.0	4,337	3,955	5,350	13,642
CHILDREN 12-23 MONTHS	7.7	8,348	7,613	10,299	26,260
CHILDREN 24-59 MONTHS	8.3	8,998	8,207	11,102	28,307
CHILDREN 5-14 YEARS	20.0	21,683	19,775	26,752	68,209
WIFA 15-49 YEARS	**24.0**	**26,019**	**23,730**	**32,102**	**81,851**
MEN 15-49 YEARS	23.3	25,260	23,038	31,166	79,463
MEN/WOMEN 50-60	5.9	6,396	5,834	7,892	20,122
MEN/WOMEN 60+	6.8	7,372	6,723	9,096	23,191
TOTAL	**100.0**	**108,413**	**98,874**	**133,758**	**341,045**
% POPULATION		31.8	29.0	39.2	100
Children 6-59 Month	0.18	19,514	17,797	24,076	61,388
Children less than 5years	0.20	21,683	19,775	26,752	68,209
Expected Pregnancy	0.04	4,337	3,955	5,350	13,642

Source; 2010 population census, 2014

The Metropolis has a Total Fertility Rate of 2.3. The General Fertility Rate is 68.3 births per 1000 women aged 15-49 years. The literacy level in the metropolis is higher (94.8 %) in males than that of females (87.8%), about 31.5 % are engaged as service and sales workers, 20.2 percent in craft and related trade and 10.4 percent in Elementary occupations. About 22.5 percent are engaged as managers, professionals, and technicians.

The district has over 40 health facilities where maternal health services are offered. The biggest health facility is the Tema general hospital where the study was conducted is located in the industrial city of Tema, a government hospital and the main referral center for the Tema metropolis.

The hospital is located at a very strategic area within the Greater Accra Region, serving other towns such as Tema west, Tema east, Ada, Dodowa, Ashaiman and central health districts. The hospital serves 533,963 people according to the latest census, in the largest industrial and port city of Ghana. The hospital has ten wards with a total bed complement of 280.It provides 24 hour Specialist and General Services to both Out-patients and In-patients. For the month of September and October 2015, the obstetrics and gynecological department had a total of 188 abortion cases, both induced and spontaneous. . The maternal health (obstetrics and gynecology) department has three obstetrician/ gynecologist (specialist), ten medical doctors, sixteen nurses and other supporting staff.

Tema General offers health service to peri-urban, urban and urban slum locations.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviews literature from similar studies on post abortion care.

2.0 MAGNITUDE OF THE PROBLEM

Each year, an estimated 210 million women throughout the world become pregnant and about one in five of them resort to abortion. Out of 46 million abortions performed annually, 19 million are estimated to be unsafe (Ahman & Shah, 2004). Unsafe abortion accounts for an estimated 13% of pregnancy related deaths representing approximately 67,000 women every year (Opoku B, 2012).Annually, an estimated 78, 000 women die from complications of induced abortions and 95% of the deaths related to induced abortion occur in under-developed countries (Donnay, 2000).

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both (WHO, 2014). The burden of unsafe abortion lies primarily in the developing world; the highest rates are in Africa and in Latin America and the Caribbean, followed closely by South and South-East Asia (WHO, 2014).

The available data on abortion suggest that overall worldwide abortion rate has declined, whereas the proportion of unsafe abortion has increased (WHO, 2014).

Currently, according to global statistics, 85 million unintended pregnancies occurred in the developing countries (Opoku B, 2012). Out of this figure, as much as 40 million ended in abortions. The abortion rate puts Africa in the lead with 97%, Latin America 95%, Asia 40%, and Eastern Europe 13 % respectively. Interestingly, the rate of safe abortions in the developed countries is 100% with a poky per cent for Africa (WHO, 2014).

2.1 CONSEQUENCES OF UNSAFE ABORTION

The consequences of unsafe abortion include death, disability and long term psychological effects and impact on families including parental loss. Unsafe abortions are estimated to be associated with 47,000 related deaths, 5 million women with disabilities with 220,000 children becoming motherless, annually.

The data further show that maternal mortality from unsafe abortions is higher in countries with major restrictions to abortion and areas with strong stigma (IPAS, Ghana, 2014). Meanwhile, the figures are lower in countries where abortion is available upon request or under broad conditions (IPAS, Ghana, 2014).

Women usually seek abortion for a variety of reasons, including limiting family size, delaying childbearing or contraceptive failure, lack of access to contraceptives, or as a result of rape. Unmet need for family planning is the root cause for induced abortion, legal or illegal (Guttmacher Institute, 2008; Williamson et al., 2009). Furthermore neglecting the other components or elements of post abortion care form the greater cause of induced abortion (Ipas 2014)

2.2 AVALIABLE DATA ON INDUCED ABORTION

In Ghana, unsafe abortion remains a major public health problem despite the liberalization of the law on abortion over two decades ago; many women still obtain unsafe abortions due to lack of knowledge about the law at the population and provider levels. Induced abortion is the second largest direct cause of maternal mortality in Ghana, second only to hemorrhage. Data on induced abortion are not available in the Ghana Demographic and Health Surveys, and the most common data available are usually hospital-based or the results of small surveys. Over the period 1972-1994, of the 22 published studies conducted in Ghana on induced abortions, only one did not use hospital-based data. Different authors have provided various estimates of

induced abortion in Ghana, based mainly on small samples and hospital data: Bleek and Asante-Darko (15% in 1973), Lamptey et al. (25% in 1981-82), Nabila and Fayorsey (13% in 1991), Taylor and Abbey (22% in 1992), Ahiadeke (17 per 1,000 women aged 15- 49 years in 1998), Geelhoed et al. (22.6% among women aged 15-49 years in 1999), Turpin et al. (38.8% in 1994), and Adanu et al. (31% in 2005). The Ghana Maternal Health Survey 2007 provides data on abortion from a nationwide sample of 10,370 women aged 15-49 years; 15% of these women reported having had at least one abortion in their lifetime.in the recent Ghana demographic and health survey the abortion rate is 45 %(GDHS 2014)

2.3 BARRIERS TO UTILIZATION OF SAFE ABORTION SERVICES

Ipas Ghana conducted a study on health care provider's knowledge on Ghana's abortion law and the evidence obtained suggested that many health care providers are unaware of the abortion law (Lithur 2004; Ipas 2008).

Other Studies have also shown that substantial proportions of providers are either unaware of all allowable conditions for an abortion or believe that it is illegal (Morhe et al. 2007; Aniteye and Mayhew 2013; Payne et al. 2013). Many feel that providing abortions conflicts with their religious values, and view women seeking an abortion with suspicion (Aboagye et al. 2007). Lack of knowledge of the law, coupled with social and religious stigma, drives the practice underground, resulting in clandestine procedures from untrained providers or attempts at self-inducing an abortion (Hill et al. 2008; Aniteye and Mayhew 2013) (Payne et al. 2013).

According to a study conducted by the Alan Guttmacher Institute in 2010, abortion is the second leading cause of death for women in Ghana, and more than one in ten maternal deaths are the result of unsafe abortion (Guttmacher,2010). Ghana is one of the few African countries where abortion is legal on some specified grounds; however, one of the major

problems surrounding the law is the lack of awareness about it, consequently only 3% of pregnant women and 6% of women seeking an abortion are aware of Ghana‘s abortion laws (Sundaram, Juarez, Bankole, and Singh, 2012). These women seek unsafe abortions from quack doctors ,drug peddlers ,traditional , pharmacists and midwives, or try to self-induce the abortion themselves, resulting in a staggeringly high number of abortion-related ill health and deaths. By contrast, legal abortion in industrialized nations has emerged as one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death (Hogberg & Joelsson, 1985).

In February 2007, Pathfinder conducted a community opinion survey in six districts in the Upper East Region and four districts in the Northern Region , Seeking understanding of the knowledge, attitudes and practices regarding abortion among women and men of reproductive age (15-49), a total of 994 women and 102 men were interviewed.

The community survey explored attitudes and knowledge about three issues: abortion, abortion law, and the practice of abortion. The results showed that only 3 percent of the women interviewed reported that abortion is allowed according to the law in Ghana, 43 percent thought it was illegal, and 54 percent did not know.

Almost 13 percent of men believed it was legal, 61 percent thought it was illegal, and 27 percent did not know.it was also identified from the study that though the government has promoted safe abortion under certain conditions as part of reproductive health, the participants interviewed are under pressure from the pervasive social stigma which reduces public impetus to promote knowledge of the law and access to services (Pathfinder 2009).

2.4 BARRIERS TO UTILIZATION OF POST ABORTION CARE SERVICES

2.4.1 Type and quality of service provided

A study nationwide conducted in Ethiopia on factors affecting utilization of post abortion care, showed that an estimated number of 17 patients are seen in hospitals for post abortion complications in a month and complications due to abortion were also reported from low-level facilities, which do not provide post abortion care services,

This study revealed that utilization of post abortion care service was better (31.4%) as compared to other similar settings. Knowledge of women towards elements of Post abortion care and type of abortion were significantly and independently associated with utilization of Post abortion care services (Zemene A et al, 2014).

In a recent survey of 437 health practitioners in Southeastern Nigeria, comprising mostly of Doctors and Nurse-Midwives, as high as 75.5% of the respondents were aware of Post abortion care services, although only 35.5% used manual vacuum aspirator (MVA) (Adinma et al., 2010). In a related survey of 431 health care professionals in the same area, only 41% had been trained on Post abortion care counseling (Adinma et al.2010). These attest to the need for the intensification of Post abortion care training programs to widen the provision of Post abortion care services to all parts of the country (Adinma, 2012).

In Zimbabwe the standard practice is that abortion clients had to obtain contraceptives from a nearby maternal and child health facility for a nominal fee. A study found that clients receiving standard Post abortion care services were more than three times as likely to experience an unplanned pregnancy in the 12 months following an abortion as Post abortion care clients who were offered ward-based family planning services and methods for free, after adjusting for marital status; desire to have another child, and previous contraceptive use (Johnson et al., 2002). Program implementers note that providing additional family planning

counseling at follow-up visits is also an important factor in reducing repeat abortions (Johnson et al., 2002; Savelieva et al., 2003).

A recent study in Kpehsie sub Metro in Accra-Ghana , of 250 women of reproductive age showed that respondent 65.2% were more than 25 years old and over (7 1.6%) of the respondents had ever been pregnant. Out of these, 87.1% had their children alive. Whilst 25.7% had miscarriage and 43% intentionally tempered or terminated their pregnancies. However, 68% of abortion clients usually do not request for contraceptive after treatment, 60% health providers do not usually provide contraceptive counseling and services for abortion clients. Also 78% of abortion clients are not given appointment to talk to someone else for contraceptives and family planning in general. Concerning organization of post abortion care services at La hospital, the health facility usually provide Pre and post abortion counseling services to clients. Furthermore, follow up is not done due to limited resources, lack of zeal to do it, and poor communication (Graham et al 2005).

The results of a study conducted at the Komfo Anokye Hospital (KATH), Kumasi Ghana on the quality of post abortion care showed that the quality was very poor. It was curative and not preventive. Improving overall reproductive health and post abortion care was not the core of obstetrics and gynecology training and residents continued traditional practice of dilatation and curettage. KATH provided treatment oriented services—curative care—for post abortion complications, not post abortion care as framed by the International Project Assistant Services (IPAS). Post abortion care was lacking. A vast majority (90%) of the cases were treated by medical interns and residents. More than 50% of patients could not obtain pain medication, even when requested. Of the cases, 25% delayed seeking care. Provider-client interaction was poor. Women substituted abortion for contraceptive use and had repeated abortion. Of the cases observed, 70% never used contraceptives. Family planning counseling was not always

provided. Only 7% received contraceptive counseling and referral to a family planning clinic, while only 3% requested contraceptive method.

Evidence suggested there was inadequate knowledge of the legal status of abortion among abortion seekers. A de facto illegal nature of abortion prevails, even though in Ghana there has been a flexible abortion law since 1985. Knowledge of legality was also low in the medical environment and setting. Abortion was still considered as illegal even by the physician/nurses and death records avoided abortion as cause of death. (Saifuddin Ahmed et al., 2001; Morhe Es. et al., 2007; Tagoe-Darko et al.2003).

2.4.2 Attitude and perception of women in reproductive age (14 -49 years)

In a recent study conducted by Guttmacher institute in Rwanda where abortion is legally restricted and access to safe abortion care is limited, poor and rural women are particularly likely to develop abortion complications .That likely stems in large part from a reliance on self-induced abortion, rather than abortions obtained from trained providers. Moreover, women who experience complications also faced problems in accessing post abortion care services.

Among all Rwandan women who suffered abortion complications and needed medical care, 30% did not receive it from a health facility, likely because not enough facilities were equipped to provide post abortion care and because many women wanted to avoid feeling stigmatized or mistreated as they often are when they do show up for care. The disparity between poor women and non-poor women was stark, however: Some 38–43% of poor women did not obtain facility-based treatment, compared with 15–16% of non-poor women.

Poor women were also more likely to entirely forgo necessary medical care when facing abortion complications than their non-poor counterparts. These women were especially likely to suffer debilitating consequences (Guttmacher Institute 2014)

A qualitative study at the Komfo Anokye Hospital on the stigma factor of Post abortion care service within the facility showed that a social stigma was attached to pregnant, unmarried women and this increased the likelihood that unmarried women would undergo unsafe abortion.

Recognition of this social stigma usually led to fear, shame and embarrassment as well as a decline in initial communication with family members. Fear of reaction of parents, family and friends increased secrecy. Generally, absence of stigma was dependent on this secrecy.

The social stigma had serious effect on their lives. Social interaction with friends and families suffered and fear of disclosure affected people financially and prevented them from seeking support, it was also found out that young unmarried females are accused of bringing shame and embarrassment to the family and community and are severely beaten, sometimes tragically resulting in death.

Stigma attached to pre-marital pregnancy and general societal attitude manifest through embarrassment in the patients and hostile reaction from family members resulted in the women not utilizing post abortion care services provided at the health facility (Tagoe-Darko E.et al, 2013).

2.4.3 Cost of post abortion care services

It was also found that, although post abortion care literally can be life-saving or at least critical to preventing serious illness or disability, obtaining that care often represented a significant economic burden, especially at the individual and family level.

Another study conducted in Uganda by Guttmacher institute in 2014 found that the majority of women surveyed who had received treatment for unsafe abortion complications had experienced a decline in financial stability from the costs of their post abortion care: Some 73% had lost wages, 60% had, had children deprived of food or school attendance or both, and 34% had faced a drop in the economic stability of their household. At the national level, the costs were also significant: An estimated $14 million according to the study is spent each year to treat the complications of unsafe abortion in Uganda.

2.4.4 Attitude of healthcare providers

A systematic review of thirty- six studies on the knowledge and attitude of healthcare personnel's in fifteen countries from Sub Saharan Africa including Ghana and Southeast Asia from 1977 to 2014, showed that majority of the healthcare providers were generally uncertain of the legal status of abortion in their countries. A thematic analysis of the data indicated that health providers from Sub Saharan Africa and South –East Asia have negative feelings about induced abortion; these feelings were manifested in a judgmental approach towards women with unwanted pregnancies who requested an induced abortion based on their moral, religious, ethical, or philosophical beliefs (Rehnstrom Loi et al, 2015)

CHAPTER 3

METHODOLOGY

3.0 STUDY DESIGN AND METHOD

A mixed method design which uses both qualitative and quantitative method were employed for the study. A cross-sectional survey was used to obtain quantitative data among the study population of 150 women of reproductive age (14 yrs-49 yrs.) and key informant interview using qualitative method of data collection was used to obtain information from 10 key informants who were hospital staff. It is the appropriate study design to ascertain knowledge and gain insight into reasons for certain life choices in sensitive situations .It is relatively cheap and of shorter duration as compared to other study designs. Participants were selected using simple random sampling technique from both outpatient department and obstetrics and gynecological ward. The study site was the Tema General Hospital the study duration was from February 2016 to March 2016.

3.1 DATA COLLECTION TECHNIQUES AND TOOLS

The data collection tools comprised of questionnaires with closed and open ended questions and interview guides. The instruments were administered to the selected sample of the population, following explanation of the procedure and obtaining informed consent. Data were collected on socio-demographic characteristics, reproductive health history, knowledge on Ghana's abortion law and facilities offering safe abortion services and barriers to post abortion care utilization.

Pre-testing of the questionnaire was undertaken at the Tema Polyclinic. This health facility offers post abortion care services and has similar characteristics as the Tema General Hospital.

Two research assistants, who are nursing students, were trained to assist in data collection. They had knowledge in reproductive health issues and could communicate effectively in the local language (Twi).

3.2 STUDY POPULATION

The study population was women in their reproductive age (14-49 years) visiting Tema General Hospital. Respondents were recruited for the study based on their age ,were within the reproductive age (14-49 years) and must be residents of Tema metropolis and surrounding towns .

3.3 STUDY VARIABLES

Table 3.1: Description of study variables

Variable	Operational definition	indicator	Scale of measurement	Objective addressed
Age	Age at last birthday	Age in completed years	Continuous	1
Education	Highest educational level attained	Primary Secondary vocational Tertiary	Nominal	1
Occupation	Economic activity of respondents	Artisan Civil servant Trader Student Unemployed Other	Nominal	1
Marital status	Current marital status	Single /boyfriend Married Divorced Widowed Cohabitate	Nominal	1

STUDY VARIABLES CONTINUED				
Religion	Religious group	Christian Muslim Traditionalist Other	Nominal	1
Residence	Area where respondent resides	Urban Peri-urban Rural Urban slum	Nominal	1
Parity	Number of children alive	As reported by respondents	Continuous	1
Knowledge on abortion law	Information respondents have	Legal Illegal Don't know	Nominal	1
Facilities offering abortion services	Locations of facilities offering safe abortion services	As reported by respondents	Nominal	2
Knowledge on post abortion care	Services provided	As reported by respondents	Nominal	2
Source of information	Who gave information	Midwife/nurse Friend Relative Media Other	Nominal	2
Barriers to abortion and Post abortion care	Attitude of providers Cost Time Distance	As reported by respondents	Nominal	3

3.4 SAMPLING

The sample size was determined using the following assumptions (Level of significance of the population was taken to be 95%, $Z\alpha/2 = 1.96$). A 5% level of precision ($d = 0.05$) and 50%

proportion of women satisfied with Post abortion care service (P = 0.5). Therefore the total sample size for this study was 150 women seeking Post healthcare service including 10% none respondent rate.

3.4.1 Sampling Technique

150 respondents were selected from Tema General Hospital through random sampling using the hospitals outpatient and in-patient daily register by selecting every second patient registered , a maximum of 20 and minimum of 10 participants were selected daily for the study this was done based on the average attendance per month .

This was done simultaneously from both the ward and outpatient departments for the duration of the study; this was to ensure that each client had an equal opportunity to be a part of the study and to reduce bias. The inclusion criteria were women who had experienced abortion within the last 12 months.

The 10 key informants were selected conveniently for the interview.

3.5 PRE-TESTING

The questionnaire was piloted at Tema Polyclinic. Although this facility was not used for the research study the pre-testing helped to determine ease of understanding, appropriateness and other characteristics of a questionnaire that influence its success.

3.6 DATA HANDLING

Data collected from respondents were handled with confidentiality. Privacy was ensured during the period of interview and filling of questionnaire. Assistance was given to respondents who were illiterates by interpreting the questions to them, and recording their responses. There was periodic compilation of completed data.

3.7 DATA ANALYSIS

Data collected was entered using Excel and exported to STATA(version12) for analysis. Data were presented in tabulated formant based on simple proportions for socio-demographic and health service indicators.

The data obtained from key informant interview was transcribed and analyzed with Excel.

3.8 ETHICAL CONSIDERATION

Ethical approval was obtained from the Ethics Review Committee of Ensign College of Public Health and Ghana Health Service (GHS). Institutional approval was obtained from the Municipal Health Directorate (MHD) and the Head of Tema General Hospital where the study was conducted. Signed up individual informed consent was obtained from each participant before the questionnaire were administered

3.9 LIMITATIONS OF STUDY

The study did not seek information from other patients visiting Tema General Hospital; it was limited to the Gynecological department.

3.10 ASSUMPTIONS

- It was assumed that women in their reproductive age accessing post abortion care services will have similar views on abortion as those not seeking abortion services at the facility, because of the clandestine nature and stigma associated with abortions in the Ghanaian culture, women who have had an abortion outside the facility are unlikely to admit to the experience and unlikely to be truthful about their experience and perspectives. Hence the decision to limit the study to women seeking post abortion care services at the Tema General Hospital.

- Results generated from the study areas can represent the entire Municipality but will only reflect the views of women who have had an abortion experience.

CHAPTER FOUR

ANALYSIS AND RESULTS

This chapter presents the results of data gathered from respondent's visiting Tema General Hospital.

Out of the total number of one hundred and fifty (150) respondents used for the study, ninety–eight (65.3%) had received post abortion care, while fifty-two (34.7%) had not received post abortion care.

4.0 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Among the respondents who took part in the study, eighty-three (55.3%) were aged between 17-26 years, sixty-seven between 27 -49 years, no respondent was younger than 17 years and older than 49 years .the mean age was 26 years.

It was noted that majority, hundred and forty-four (96%) of clients interviewed have had some form of formal education the highest level being secondary level (both senior and junior) seventy-four (49.3%) .

With regards to their occupation sixty-nine (46%) was artisans and traders. Forty-eight (32%) were unemployed, students formed thirty-six (75%) of the sample.

Concerning their marital status, eighty-six (58.7%) of respondents interviewed were single whereas fifty-six (37.3%) were married and six (4%) of the respondents were cohabitating.

One hundred and twenty-three (82%) of respondents interviewed were Christians while twenty-three (15.3%) were Moslems, three (2%) were traditionalist and one (0.7%) was not affiliated to any religion.

Majority seventy-eight (52%) of respondents were peri- urban residents whilst seventy (46.7%) were urban residents forty-three (28.7%) of the respondents were urban slum residents.

Concerning parity majority, fifty-two (34.7%) of respondents experienced pregnancy once and the least twenty-one (14%) experienced pregnancy thrice as at the time of the study, of the total number(150), seventy-nine (52.7%) of respondents interviewed did not have children while seventy-one (47.3%) had two (2+) or more children alive.

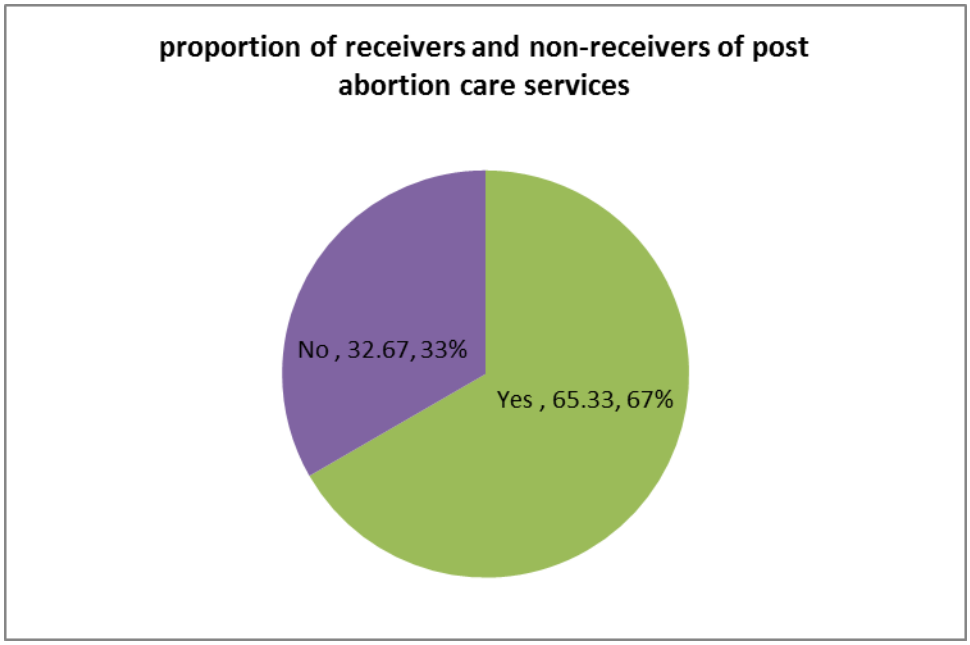
Table 4.1: Socio-demographic characteristics of the respondents (n=150)

Variable	Frequency	Percentage
Age		
17 - 26	83	55.3
27 – 49	67	44.7
Educational level		
No formal education	6	4
Primary	27	18
Secondary (senior and junior)	74	49.3
Post -secondary (vocational, tertiary)	43	28.7
Occupation		
Artisan/trader	69	46
Civil servants	28	18.7
Private company	5	3.3
Student	36	8
Unemployed	12	24
Marital status		
Single/boyfriend	80	53.3
Married	56	37.3
Cohabitating	6	4
Divorced /widowed	8	5.3
Religion		
Christian	123	82
Moslem	23	15.3
Traditionalist	3	2
Atheist	1	0.7
Residence		
Peri- urban	78	52
Urban	27	18
Urban slum	43	28.7
Rural	2	1.3
Parity		
One	52	34.7
Two	41	27.3
Three	21	14
More than three	36	24
Number of children		
None	79	52.7
One	33	22
Two	21	14
More than two	17	11.3

Source: Field survey, 2016

Socio-demographic differences between receivers and non-receivers of post-abortion care services, from the study 65.3% of the respondents had received post-abortion care services before whiles 34.7% had not received post-abortion care services before. Receivers were and non-receivers differed by age, occupation, parity and number of children alive ($p < 0.05$).

Figure4 .1: A pie chart showing receivers and non-receivers of post abortion care.



Source: Field survey 2016

Table 4.2: Relationship between Socio- demographic characteristics and characteristics of receivers and non-receivers of post- abortion care services.

Predictive variable	**Receivers 98(65.33)**	**Non-receivers 52(34.67)**	**P-value**
Age		\\	0.013
17 - 26	47(47.9)	36(69.2)	
27 - 49	51(52)	16(30.8)	
Occupation			<0.032
Artisan/trader	52(53)	17(32.7)	
Civil servants	18(18.4)	10(19.2)	
Private company	3(3)	2(3.9)	
Student	16(16.3)	20(38.5)	
Unemployed	9(9.2)	3(5.8)	
Parity			
One	22(22.5)	30(57.7)	0.000
Two	26(26.5)	15(28.9)	
Three	18(18.4)	3(5.8)	
More than three	32(32.7)	4(7.7)	
Number of children alive			
None	42(43.3)	32(66.7)	
One	22(22.7)	11(22.9)	<0.050
Two	19(19.6)	2(4.2)	
More than two	14(14.4)	3(6.3)	

Source: Field Survey, 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary.

4.1 BARRIERS TO UTILIZATION OF SAFE ABORTION SERVICES

4.1.1 Knowledge on Abortion law

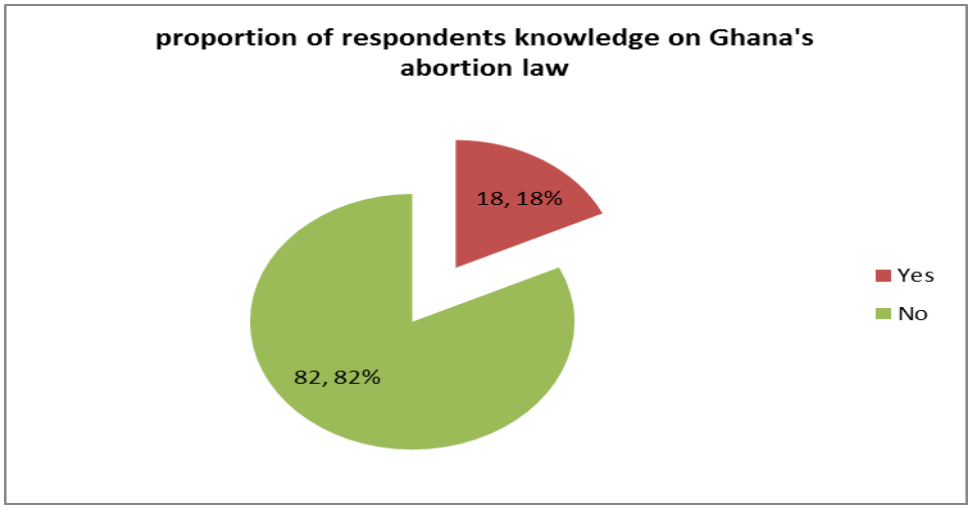
82% of the respondents said abortion was illegal, while 18% said it was legal. When asked if they will go to a hospital to seek abortion eighty-four (56%) said yes whiles sixty-six (44%) said no.

Table 4.3.: Respondents knowledge on Ghana's abortion law

Predictive variable	**Frequency**	**Percentage**
Is Abortion Legal		
Yes	27	18
No	123	82
Will you seek abortion care from a hospital		
Yes	84	56
No	66	44

Source: Field survey, 2016

Figure 4.2.: A pie chart showing respondents knowledge on Ghana's abortion law



Source :Field survey ,2016

Respondents were compared based on their knowledge on abortion law in issues of socio-demographic variables, they differed by age, educational level and occupation ($p < 0.05$).

Table 4.4: Relationship between socio-demographic characteristics of respondents and knowledge on Ghana's abortion law.

Predictive variable	**Abortion is legal** 27(18.00)	**Abortion not legal** 123(82.00)	**P-value**
Age			0.035
17 - 26	10(37)	73(59.2)	
27 - 49	17(62.9)	50(40.7)	
Educational level			<0.001
No formal education	0(0.0)	6(4.9)	
Primary	2(7.4)	25(20.3)	
Secondary (senior and junior)	9(33.3)	65(52.9)	
Post -secondary (vocational, tertiary**)**	16(59.3)	27(21.9)	
Occupation			<0.033
Artisan/trader	6(22.2)	63(51.2)	
Civil servants	10(37)	18(14.6)	
Private company	5(3.3)	4(3.3)	
Student	36(24.00)	28(22.76)	
Unemployed	12(8.00)	10(8.13)	

Source: Field Survey, 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary

A simple linear regression analysis of respondent's knowledge on abortion law and receivers and non-receivers of post- abortion services was significant at 0.000, increase in knowledge on abortion law is 0.14 times depending on the education provided to respondents who had received post- abortion care before.

Table 4.5: Simple linear regression respondent's knowledge on Ghana's Abortion law and education

Variable	**Co-efficient**	**Standard error**	**P-value**	**Confidence interval**
Age	0.1414371	0.0381847	0.000	0.066 , 0.217

Source; field survey, 2016

4.1.2 Knowledge on safe abortion services

Respondents were interviewed on the knowledge they have on safe abortion services, when asked if they had heard of safe abortion services sixty-one (40.7%)of the respondents said yes, while eighty-nine(59.3%) said they have never heard of such a thing. out of the 40.7% who had heard of safe abortion services ,were asked if they knew of any facility providing such services, forty-one(62.1%) said yes whiles twenty-five(37.9%) said no.

When asked if they had accessed any of the facilities in terminating the index pregnancy 84(56%) said yes whiles 66(4%) said no.

Out of the 84 respondents majority 39(46.4%) accessed the facility with the help of a friend and minority 8 (9.5%) by a health care provider.

Table 4.6: Knowledge on safe abortion services n=150

Variable	Frequency	Percentage
Heard of safe abortion services		
Yes	61	40.7
No	89	59.3
Know facility offering such service		
Yes	41	62.1
No	25	37.9
Have you assessed the facility to terminate index pregnancy	84	56
Yes	66	44
No		
Who helped assess the facility		
Friend	39	46.4
Relative	14	16.7
Partner	13	15.5
Myself	10	11.9
Healthcare provider	8	9.5

Source: Field survey 2016

Respondents were compared based on their knowledge on safe abortion services in issues of socio- demographic variables, they differed by age, educational level, residence and parity (<0.005).

Table 4.7: Relationship between Socio - demographic characteristics of respondents and knowledge on Safe Abortion services.

Predictive Variable	**Yes** **61(40.7)**	**No** **89(59.3)**	**P –value**
Age			0.003
17 - 26	25(40.9)	58(65.2)	
27 - 49	36(59)	31(34.8)	
Educational level			<0.004
No formal education	3(4.9)	3(3.4)	
Primary	8(13.1)	19(21.4)	
Secondary (senior and junior)	23(37.7)	51(57.3)	
Post -secondary (vocational, tertiary)	27(44.3)	16(17.9)	
Residence			<0.018
Peri- urban	25(40.9)	53(59.6)	
Urban	18(29.5)	9(10.1)	
Urban slum	17(27.9)	26(29.2)	
Rural	2(1.3)	1(1.1)	
Parity			<0.034
One	14(22.9)	38(42.7)	
Two	16(26.2)	25(28.1)	
Three	12(19.7)	9(10.1)	
More than three	19(31.2)	17(19.1)	

Source: Field Survey, 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary

4.2 SOCIO-ECONOMIC CHARACTERISTICS OF RESPONDENTS

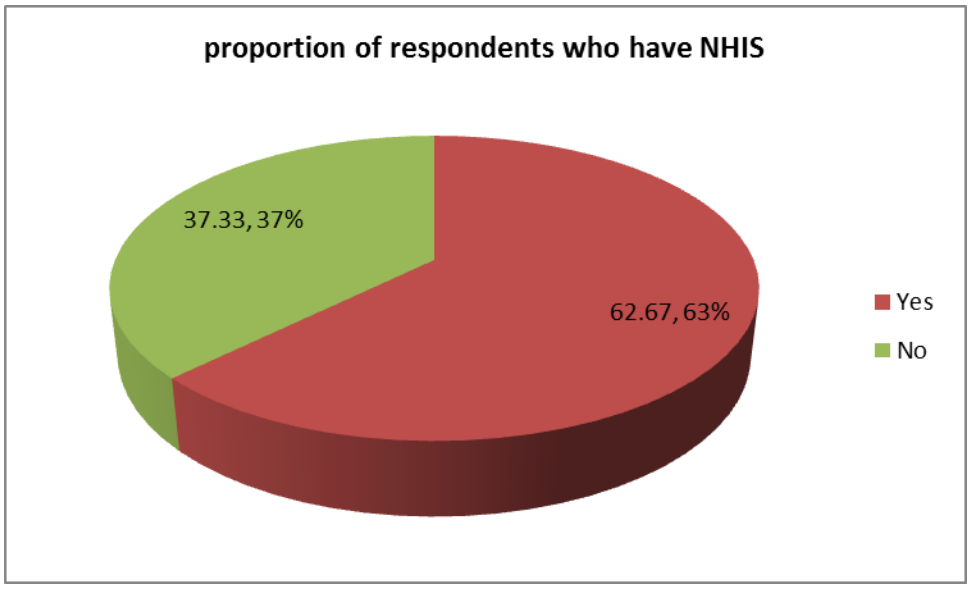
Among the respondents that took part in the study, sixty (40%) earned regular income whiles ninety (60%) did not earn regular income. Out of the one hundred and fifty respondents one hundred and thirty-nine were with partners of this the majority of their partners were artisans 40.3%, 13.7% were students and 5% were unemployed. Out of the one hundred and thirty – nine respondents 84.89% received some kind of support from their partners whiles 15.1% have no support from their partner, the commonest support received amongst the respondents is financial 57.9%.

Table 4.8: Socio-Economic characteristics of respondents (n=150/139)

Variable	Frequency	Percentage
Earn regular income (N=150)		
Yes	60	40
No	90	60
Occupation of partner		
Artisan	56	40.3
Civil servant	40	28.8
Private	17	12.3
Student	19	13.7
Unemployed	7	5
Receive support from partner(N=139)		
Yes	21	15.1
No	118	84.9
Type of supports		
Companionship	47	38.8
Advice(counsel)	2	1.7
Financial	70	57.9
Religious (prayers)	2	1.7
Receive financial support from relatives when pregnant(N=150)		
Yes	35	23.3
No	115	76.7
Do you have NHIS		
Yes	94	62.7
No	56	37.3

Source: Field survey 2016

Figure 4.3: A pie Chart showing respondents who have NHIS



Source: Field survey, 2016

Socio-economic differences between receivers and non-receivers of post-abortion care services, from the study 65.3% of the respondents had received post-abortion care services before while 34.7% had not received post-abortion care services before. When receivers were compared with non-receivers in issues of socio-economic variables, they differed by the occupation of their partner and the possession of an NHIS card ($p < 0.005$).

Table 4.9: Relationship between Socio-economic characteristics and receivers and non-receivers of post –abortion care services

Predictive variable	**Receivers 98(65.3)**	**Non-receivers 52(34.7)**	**P –value**
Occupation of partner			0.001
Artisan			
Civil servant	40(43.9)	16(33.3)	
Private	30(32.9)	10(20.2)	
Student	13(14.3)	4(8.3)	
Unemployed	5(5.5)	14(29.2)	
	3(3.3)	4(8.3)	
Do you have NHIS			0.048
Yes			
No	67(68.4)	27(51.9)	
	31(31.6)	25(48.1)	

Source: Field survey 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary

Analysis on the socio –economic status of respondents against their knowledge on abortion law and safe abortion services was not significant at p-value <0.005.

4.3 POST ABORTION CARE SERVICES

4.3.1 Reproductive Health History

Respondents who had experienced more pregnancy more than once ninety-eight(65.3%), where asked if they experienced any problem during their previous pregnancy, fifty –six(65.3%) said yes and forty-two(49.4%) said no . only sixty-five of the respondents could remember the problems, the common health problem experienced was Gyaneacologically

related thirty-four(52.31%) of this, the common Gyanea related problem is abdominal pain with bleeding nineteen (32.3%) .

Out of the one hundred and fifty respondents interviewed eighty-two (54.7%) present termination as their first whiles sixty-eight (45.3%) had terminated pregnancy more than once.

The association between respondents who had previous terminations of pregnancy against receives post-abortion care showed a significant difference at p-value 0.005.

The socio-demographic differences of respondents terminating pregnancy before were significant at p-value 0.005 with age, parity and the number of children the respondents has.

Table 4.10: Relationship between Previous terminations of receivers and non-receivers of post abortion care services, n=150

Predicting variable	**No previous terminations 82(54.7)**	**Previous terminations 68(45.3)**	**P –value**
Received PAC before			0.000
Yes	39(47,6)	59(86.8)	
No	43(52.4)	9(13.2)	
Socio –demographic status			
Age			0.000
17 - 26	56(68.3)	27(39.7)	
27 – 49	26(31.7)	41(60.3)	
			0.000
Parity			
One	52(63.2)	0(0.0)	
Two	20(24.4)	21(30.9)	
Three	6(7.3)	15(22.1)	
More than three	4(4.9)	32(47.1)	
Number of children alive			0.005
None	47(60.3)	27(40.3)	
One	21(26.9)	12(17.9)	
Two	6(7.7)	15(22.4)	
More than two	4(5.1)	13(19.4)	

Source: Field survey 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary

Out of the 150 respondents interviewed 103(68.7%) abortion were induced whilst 47(31.4%) were spontaneous. When asked if they would want to conceive again 117(78%) respondents said yes whilst 33(22%) said no.

4.3.2 Type Post –abortion care services received by respondents

Out of the total number of one hundred and fifty (150) respondents participating in the study, ninety –eight (65.3%) had received post abortion care, while fifty-two (34.7%) had not received post abortion care. Out of the 98 receivers, 43.8% had been managed for complications and counseled, 2.1% had been managed for complications, counseled and reviewed in addition.

Table 4.11: Characteristics of respondents who received post abortion care and the type of service received n=150

Variable	**Frequency**	**Percentage**
Received PAC		
Yes	98	65.3
No	52	34.7
Type of PAC service received		
Management of complications+ counseling	42	43.8
Only counseling	8	8.3
Management of complications+ counseling+ review	2	2.1
Only management	41	42.7
Management of complication +review	3	3.1

Source: Field survey 2016

A multivariate linear regression analysis on previous terminations using predictors age, educational level, occupation, parity, number of children and if received post abortion care before to show the determinants for women going in for unsafe abortions after receiving Post

abortion care ,showed a high significance of 0.000, with a 66% variability amongst the predicting variables .The differences in the predicting variables was significant with educational level, occupation, parity, number of children and if received post abortion care before with the exception of age.

Table 4.12: Multivariate linear regression of previous termination of pregnancy n=150

Predicting variables	**Co-efficient**	**P –value**	**Confidence interval**
Educational level	-0.913	0,004	-0.015, -0.030
Occupation	0.614	0.002	0.02 ,0.09
Parity	0.494	0.000	0.42 ,0.57
Number of children	-0.236	0.000	-0.30 ,-0.17
Received PAC	0.124	0.028	0.01 , 0.24

Source: Field survey, 2016

Of 117 respondents on questions about adherence to counseling,57(48.7%)had indicated having adhered to counseling offered while 60(51.3%) indicated they had not due to some reasons 20% indicated their religion was against it and 30 % saw no need for it..

Table 4.13: Adherence to counseling offered at health facility n=117

Variables	**Frequency**	**Percentage**
Adhere to counseling		
Yes	60	51.3
No	57	48.7
Why no		
Religion against it	12	20
Cannot afford	14	23.3
Not necessary	18	30
Fear of side effects	7	11.6
Partner not in favor	9	15

Source: Field survey 2016.

4.4 BARRIERS TO UTILIZATION OF POST ABORTION CARE SERVICES

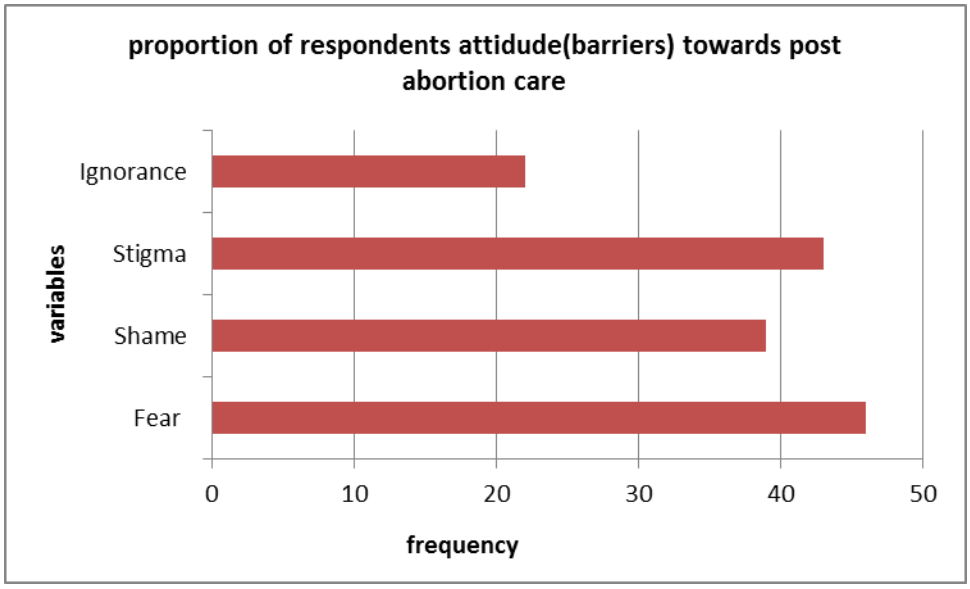
Table 4.14 demonstrates respondents' response on barriers to post abortion care services. It was found that 46 (30.7%), 39 (26%). 43 (28.7%) and 22 (14.7%) of respondents interviewed had fear, shame, stigma and were ignorant respectively towards post abortion care uptake. Another observation from the results, was health care providers attitude, 63 (42 %) and 87 (58%) of the respondents considered the attitude of healthcare providers to be friendly and not friendly respectively, other barriers were cost of the service 52 (34.7%), 17 (11.3%) and 81 (54%) or the respondents considered the cost to be affordable, cheap and expensive respectively, many considered the proximity of the facility to their residence was near and when asked if their religious belief played a role in the non-uptake of PAC services 88 (58.7%) responded in the affirmative.

Table 4.14: Barriers to utilization of post abortion care services

Variable	Frequency	Percentage
Respondents attitude		
Fear	46	30.7
Shame	39	26.
Stigma	43	28.7
Ignorance	22	14.7
Healthcare providers attitude		
Friendly	63	42
Not friendly	87	58
Cost of service	52	34.7
Affordable	17	11.3
Cheap	81	54
Expensive		
Proximity to facility	101	67.3
Near	49	32.7
Far		
Religious belief	88	58.7
Yes	62	41.3
No		

Source: Field survey 2016

Figure4.4**: A bar chart showing respondents attitude towards post abortion care, n=150**



4.4.1 Differences in response on barriers to Post abortion care services of receivers and non- receivers of post abortion care service.

The cost of post abortion services was found to be generally affordable for both receivers (65.3%) and non-receivers (34.7%) of post abortion care services. 48.1% of respondents who received post abortion care service said healthcare providers were not friendly, 51.9% of respondents who did not receive post abortion care service said healthcare providers were not friendly.

Although 22 (42.3%) of the respondents have no religious belief as barrier in assessing post abortion care services, they did not access post abortion care services. About 32.7% of the respondents who did not receive post abortion care services live far (about 20 - 40km) from the health facility.

Table 4.15: Relationship between the barriers of post abortion care utilization and receivers and non- receivers of post abortion care.

Predictive variable	**Receivers** 98(65.3)	**Non- receivers** 52(34.7)	**P -value**
Respondents attitude			0.015
Fear	25(25.5)	21(40.4)	
Shame	31(31.6)	8(15.4)	
Stigma	28(28.6)	15(28.9)	
ignorance	14(14.290	8(15.4)	
Healthcare providers attitude			0.001
Friendly	38(38.8)	25(48.1)	
Not friendly	60(61.2)	27(51.9)	0.050
Cost of service			
Affordable	32(32.7)	20(38.5)	
Cheap	12(12.2)	5(9.6)	
Expensive	17(11.3)	27(51.9)	0.042
Proximity to facility			
Near	66(67.4)	35(67.3)	
Far	32(32.7)	17(32.7)	0.031
Religious belief			
Yes	58(59.2)	30(57.7)	
No	40(40.8)	22(42.3)	

Source: Field survey 2016

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary

4.5 KEY INFORMANT INTERVIEW

4.5.1 Healthcare personnel knowledge on Ghana's abortion law

Out of the ten key healthcare providers interviewed two said abortion was legal, five said it was illegal and three said it depended on the condition.

4.5.2 Healthcare provider's knowledge on Post abortion care

When asked what the components of post abortion care were, out of the ten healthcare staff majority five said it was management of complication and family planning counseling, two said it was management of complication ,family planning counseling and personal hygiene and three said it was management of complication, family planning counseling ,personal hygiene and adolescent education.

4.5.3 Types of Post abortion Care services provided by facility

When asked which of the services were provided in the health facility seven out of ten ,seven said management of complication and family planning services, while three said management of complication, family planning counseling and adolescent education.

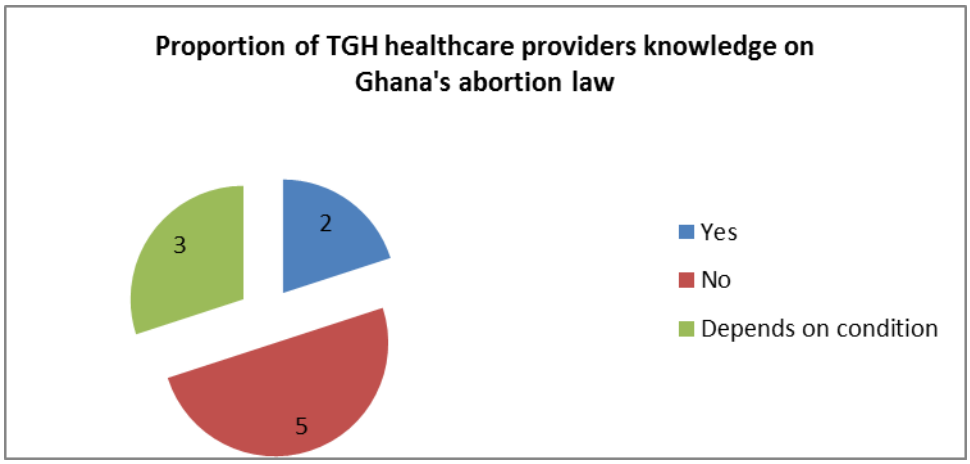
Table 4.16: Healthcare providers knowledge on Abortion and post abortion care n=10

Variable	**Frequency**	**Percentage**
Is abortion legal		
Yes	2	20
No	5	50
Depends on condition	3	30
Components of PAC		
Mgt of complication + FP	5	50
Mgt of complication +FP+ personal hygiene	2	20
Mgt of complication+ FP+ personal hygiene+ adolescent edu**.**	3	30
Type of service PAC provided in health facility	7	70
Mgt of complication +FP	3	30
Mgt of complication+ FP +adolescent edu.		

Source: field survey 2016

Note: Mgt –management of complication, FP- family planning, edu-education

Figure 4.5: A pie chart showing TGH healthcare providers knowledge on Ghana's abortion law



Source: Field survey 2016

CHAPTER FIVE

DISCUSSION

This study assessed factors or barriers influencing the uptake of post abortion care services.

5.0 BARRIERS TO UTILIZATION OF SAFE ABORTION SERVICES

5.0.1 Knowledge on Ghana's abortion law

The study showed that knowledge on Ghana's abortion law is very low, only 15% of the respondents knew abortion in Ghana was legal, despite the efforts made by governmental and non- governmental organizations to promote safe abortion services this anomaly is still an issue of concern. It can be deduced from this study that the less people are aware of the legality of abortion in Ghana, the less likely are they to assess safe abortion services and post abortion care services. This results are similar to a study conducted by Pathfinder 2007 ,in a community opinion survey in six districts in the Upper East Region and four districts in the Northern Region , Seeking understanding of the knowledge, attitudes and practices regarding abortion among women and men of reproductive age (15-49), a total of 994 women and 102 men were interviewed. The results showed that only 3 percent of the women interviewed reported that abortion is allowed according to the law in Ghana, 43 percent thought it was illegal, and 54 percent did not know (Pathfinder, 2007).

Age, education and occupation were significantly associated with awareness of abortion law in Ghana (0.005), from the study respondents below the age of 27 had the lowest awareness 37% at a significant value of 0.035, respondents with post-secondary education had the highest awareness 59.3% at a high significant value of 0.001, test of association with their occupation showed students having the highest knowledge on Ghana's abortion law 24% at a significant value of 0.033.

Many studies have shown awareness on Ghana's abortion law amongst healthcare providers is low, from the study out of ten healthcare providers interviewed only two were aware abortion is legal in Ghana.A similar study conducted by Ipas Ghana in 2008, suggested that many healthcare providers were unaware of Ghana's abortion law (Lithur 2004; Ipas 2008).

From the study three out of the ten healthcare providers interviewed said the abortion law is only legal depending on the severity of the condition of the pregnancy which is similar to study conducted on healthcare providers knowledge on abortion law which showed that substantial proportions of healthcare providers are either unaware of all allowable conditions or believe that it is illegal (Morhe et al. 2007; Aniteye and Mayhew 2013; Payne et al. 2013).

Furthermore many feel providing such services conflicts with their religious belief. Lack of knowledge of the law, coupled with social and religious stigma, drives the practice underground, resulting in clandestine procedures from untrained providers or attempts at self-inducing an abortion (Hill et al. 2008; Aniteye and Mayhew 2013) (Payne et al. 2013).

The knowledge on Ghana's abortion law was significantly associated with receiving Post Abortion Care services, an increase in knowledge on abortion law is 0.15 times depending on the education provided to respondents who had received post- abortion care before ,suggesting that when women are aware of the law it increases their uptake of post abortion care. Looking at it from another angle the number of times a woman had received post abortion care services determines the level of awareness or knowledge of the abortion law .

5.0.2 Knowledge on safe abortion services

The study revealed that 40.7% respondents had some knowledge on safe abortion services, when asked if they knew facilities offering such services out of the 61 respondents 62.12% said yes, the three most common facilities mentioned are Mariestopes Ashiaman, Meridian clinic Tema new town and lagoon clinic Teshie Nungua 56% of the respondents had assessed

this facilities, 46.43% assessed this facility through friends, only 9.52% assessed these facilities through a healthcare provider.it can be deduced from the study that the healthcare providers are lacking in helping women access safe abortion care services thus causing them to rely on friends who lead them to certain facilities, the question is: - are these facilities really offering safe abortion services? This happens to be a major contributor to assessing unregistered facilities and unqualified practitioners leading to unsafe abortions.

The following substances were used by the respondents who did not access any facility in terminating pregnancies , cytotec purchased from pharmacies and drug peddlers were used by quite a number of the respondents, others drink herbal concoctions, some mix coca cola with paracetamol, beer or sugar concentration and coffee, others grind broken bottles into fine powder and mix with beer, water or milk, some individuals insert wooden sticks and herbal soaps into the vagina, some said they drink Guinness and lime concoctions. These findings are alarming, self –termination of pregnancies leads to the increase in maternal death and lifelong complications. With these issues some women still do not assesse facilities offering Post abortion care services.

5.1 BARRIERS TO UTILIZATION OF POST ABORTION CARE SERVICES

5.1.1 The type and quality of service provided

The study revealed that 98 (65.3%) of the respondents had received post abortion care services before, the components of post abortion care received by this respondents showed that majority 43.8% had their complications managed, medications provided and received counseling with no review and only 2.1% received management, counseling and review. When asked what counseling was offered all the respondents said only family planning. It can be deduced from this findings that, the facility happens to be offering only two of the three components of the original post abortion care model; emergency management and family

planning counseling, this could also be the case of other health facilities in the country. This has caused women to default and still go in for unsafe abortions.

A similar study in Zimbabwe on standard post abortion care revealed that clients receiving standard Post abortion care services were more than three times as likely to experience an unplanned pregnancy in the 12 months following an abortion as Post abortion care clients who were offered ward-based family planning services and methods for free (Johnson et al., 2002).Another study on post abortion care service conducted in Kpesi Sub Metro in Accra-Ghana revealed that , of 250 women of reproductive age ,78% of abortion clients are not given appointment to talk to someone else for contraceptives and family planning in general. Furthermore, follow up is not done due to limited resources, lack of zeal to do it, and poor communication (Graham et al 2005). These findings are similar to results from the study .

Findings from interviews with the healthcare providers revealed that their knowledge on what post abortion care is more curative service than preventive it was no wonder fifty percent of the health providers defined post abortion care as management of complications and family planning counseling with no review.

A similar study conducted in Komfo Anokye Hospital (KATH) located the Ashanti region of Ghana; showed that the quality of post abortion care was very poor. It was curative and not preventive. Improving overall reproductive health and post abortion care was not the core of obstetrics and gynecology training and residents continued traditional practice of dilatation and curettage. KATH provided treatment oriented services—curative care—for post abortion complications, not Post abortion care as framed by the International Project Assistant Services (IPAS). More than 50% of patients could not obtain pain medication, even when requested. Of the cases, 25% delayed seeking care. Women substituted abortion for contraceptive use and had repeated abortion. Family planning counseling was not always provided. Only 7%

received contraceptive counseling and referral to a family planning clinic, while only 3% requested contraceptive method.

Sixty- eight (45.3%) of respondents who had received post abortion care before had terminated pregnancies more than once. The association between respondents in Tema General Hospital who had received post abortion care services and terminated pregnancies more than once 59 (86.76%) was highly significant (0.000).This is disheartening ,this indicates that post abortion care services provided by facilities is not effective and this anomaly must be addressed accordingly otherwise the mortality and morbidity from unsafe abortion will not decline.

The association of the socio-demographic differences of respondents terminating pregnancy more than once was significant (0.005), respondents aged 17 – 26 (39.7%) and 27 – 49 (60.3%) was highly significant at (0.000), the number of times respondents were pregnant was also significant (0.000) especially those who had more than three parity, 32(47.6%) defaulted and the number of children the respondents had was also significant (0 .005).

This suggest women above the age of 27 who have being pregnant more than three times will default even after receiving post abortion care. In actual fact the issue should be the opposite where women who receive post abortion care services not going in for termination of pregnancy

This happened to the case of a nationwide study conducted in Ethiopia; this study revealed that utilization of post abortion care service was better (31.4%) as compared to other similar settings. Knowledge of women towards elements of Post abortion care and type of abortion were significantly and independently associated with utilization of Post abortion care services (Zemene A et al, 2014).

The study also revealed that the kind of services the respondents received at the facilities they visited is also a major contributor for women going in for unsafe abortion services more than once in their lifetime, as a result of receiving components of the original post abortion care services which is management of complications and counseling, this components do not address women's crucial needs, such as financial, emotional supports and collaborations from community members to avoid stigma and rejection, etc. are being neglected.

From further enquiries concerning reasons for defaulting, majority had indicated that even though they were advised on how to use family planning methods they didn't see the need or felt it was not necessary. They further indicated that their reasons for going in for unsafe abortions were not addressed. Apart from that they did not have the funds to seek services from facilities offering safe abortion care. Others said their emotional needs were neglected when all they wanted was for someone just to hear them out. The health staff were either rude or ignored them.

A few said they left the hospital without receiving counseling on preventing unwanted pregnancies and all the respondents said no follow up was done to check on them or to ensure that referrals were followed through. All these reasons were issues that arise when the initial Post Abortion Care model was developed , thus the need for a reform the current model and if fully provided by healthcare providers and facilities such issues will not arise.

Strong evidence from a study conducted by USAID demonstrated that the feasibility, acceptability, and effectiveness of providing all the components of post abortion services to clients reduces the incidence of unsafe abortions, despite this evidence, many post abortion clients leave facilities without providers offering them counseling or emotional and financial care which are elements of the five components of comprehensive post abortion care model (USAID, 2011).

The study also showed that 51.3% did not adhere to the counseling offered at the health facilities majority 30% considered it not necessary and 15% of the respondents partners were not in favor; non- compliance to the counseling offered is also a major contributor to the repeated unsafe terminations of pregnancies

5.1.2 Attitude of women towards post abortion care

The study showed that many of the respondents 30.7% were afraid (fear) to utilize post abortion care and 28.7% because of stigma, which was not the case of a similar study conducted in Rwanda by Guttmacher that showed that Among all Rwandan women who suffered abortion complications and needed medical care, 30% did not receive it from a health facility, not because facilities were not equipped to provide post abortion care but because many women wanted to avoid feeling stigmatized or mistreated as they often are when they do show up for care(Guttmacher Institute 2014).

A qualitative study at the Komfo Anokye Hospital on the stigma factor of Post abortion care service within the facility showed that a social stigma was attached to pregnant, unmarried women and this increased the likelihood that unmarried women would want undergo unsafe abortion. Recognition of this social stigma usually led to fear, shame and embarrassment as well as a decline in initial communication with family members. Fear of reaction of parents, family and friends increased secrecy, it was also found out that young unmarried females are accused of bringing shame and embarrassment to the family and community and are severely beaten, sometimes tragically resulting in death (Tagoe-Darko.E et al, 2013).

5.1.3 Cost of post abortion care services

The study also revealed that cost of post abortion care services is quite high low. 54% considered it to be expensive, 34.7% of respondents interviewed said cost of post abortion care services is affordable. If the cost of post abortion care is high it will deter most people from patronizing the service and vice versa which was the outcome in this study. There was a high significant association of the cost of post abortion care service with the receivers and non-receivers of the service.

This is similar to a study conducted in Uganda by Guttmacher institute in 2014 found that the majority of women surveyed who had received treatment for unsafe abortion complications had experienced a decline in financial stability from the costs of their post abortion care: Some 73% had lost wages, 60% had, had children deprived of food or school attendance or both, and 34% had faced a drop in the economic stability of their household. At the national level, the costs were also significant: An estimated $14 million according to the study is spent each year to treat the complications of unsafe abortion in Uganda (Guttmacher, 2014).

5.1.4 Proximity to health facility

It was revealed from the study that proximity to the health facility was not a major barrier, 67.3% of the respondents, majority interviewed were closer to the health facility, which was not the case of a study on post abortion care family planning uptake conducted in New Juaben municipality Ghana, that showed that, majority (74.6%) of institutions where post abortion care services were provided together with on-site family planning services at the same department, whilst (22.3%) at different department and (2.5%) in different facilities uptake was low especially in different facilities the distance was far.

A test of association of locations of post abortion care services from this study had significant influence (<0.001) on people's patronage of post abortion care services. The researcher suggested is essential to provide a confined place for the operation of post abortion care service at vantage locations or within the same department offering post abortion care so that people will be able to receive post abortion care services in its totality. This implied that proper location of post abortion care services will result in an increase usage of post abortion care services in particular areas (Abrah P., 2014).

5.1.5 Attitude of healthcare providers

Another major barrier revealed from the study was the attitude of the healthcare providers, 58% of the respondents considered healthcare providers as not being friendly, in line with observations from a study conducted in Komfo Anokye Hospital, Kumasi Ghana, which showed that provider-client interaction was poor. There was a significant association (0.001) with receivers and non-receivers of post abortion care.

A systematic review of thirty- six studies on the knowledge and attitude of healthcare personnel's in fifteen countries from Sub Saharan Africa including Ghana and Southeast Asia from 1977 to 2014, a thematic analysis of the data indicated that health providers from Sub Saharan Africa and South –East Asia have negative feelings about induced abortion; these feelings were manifested in a judgmental approach towards women with unwanted pregnancies who requested an induced abortion based on their moral, religious, ethical, or philosophical beliefs (Rehnstrom Loi et al, 2015).

5.1.6 Religious beliefs

Lastly the study revealed that the religious belief of the respondents interviewed also played a significant role in the uptake or utilization of post abortion care, 58.7% of the respondents religious belief did not support utilization of abortion and post abortion care services, similar to the findings of a study conducted in New Juaben municipality, Ghana. The study showed that 50.5% of respondents' religion does not support utilization of Post abortion care services. It was revealed that the support of a religion to post abortion care services has insignificant association (0.003) with the utilization of post abortion care services (Abrah P., 2014).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

The conclusions drawn are based on the findings derived from the study and their respective discussion.

6.0 CONCLUSION

The findings outlined led to the following conclusions about post abortion care services in Tema General Hospital.

Judging from the findings of the study it was concluded that the socio-demographic characteristics such as age, educational level, occupation, parity and number of children was significantly associated with the uptake or utilization of post abortion care services. Many receivers of post abortion care were aged 27 - 49 years (32.7%), with regards to their occupation 74.5% of the receivers were employed, 32.7% had being pregnant more than three times and 43. 3% had no children alive.

Furthermore the level of awareness on Ghana's abortion law, is very low at (15%) amongst women in reproductive age and also amongst healthcare providers (20%) making it difficult for them to assess facilities offering safe abortion services, especially with misconceptions on the legality of the service hence engaging the service of drug peddlers, quack doctors and seeking advice and guidance from friends and partners which results in developing complications and in some cases death.

Many of the respondents 86.7% who had received post abortion care before had repeated abortions; the study suggested that the kind of post abortion services offered at the facilities were two of three components of the original post abortion care model and not the five components of the comprehensive post abortion care service developed by Ipas.

With regards to the barriers of post abortion uptake : non-compliance of the women to counseling offered at the health facilities, the unfriendly attitude of the healthcare providers (58%), the fear (30.7%) and stigmatization (28.7%) experienced by the respondents, the high cost of the service (54%) and religious belief (58.7%) are major contributors to the non-uptake or utilization of post abortion care services .when this barriers are addressed there would be a tremendous increase in the utilization of post abortion care services to help reduce the complications and death from unsafe abortion services.

6.1 RECOMMENDATIONS

Based on the outcome of the study the following recommendations have been made;

Tema General Hospital and Other health facilities

- Healthcare providers in the facility should endeavor to practice preventive measures more than curative.

- Also routine sensitization of healthcare providers, facility managers, and other staff as well as community leaders and other stakeholders to increase support for the treatment of post abortion care clients should be seen as a priority and as the first step in all post abortion care programs (as much of a priority as MVA and other technical training).

- In addition to this ,efforts should be made by the health facility to make the cost of post abortion care services affordable to encourage utilization of the care.

- Also the facilities can incorporate or establish adolescent clinic within their facilities where education, counseling and help can be offered to the youth.

Ghana Health Service

- The health service can collaborate with the media in organizing and developing programs to educate the public on Ghana's abortion law, safe abortion services and its

importance and also educate the public on how to prevent unwanted pregnancies and the consequences of unsafe abortion.

Ministry of Health

- The ministry should ensure that, Comprehensive Post abortion care pre service training for all cadres of health care providers (physicians, nurses, clinical officers) should be considered a priority in the health sector.

- Post abortion care country programs such as the R3M program by the Ministry of Health, should attempt to designate model clinical sites with high Post abortion care caseloads for regional training centers to ensure clinical mastery of important post abortion care clinical skills.

- The Ministry should continue to identify effective methods to motivate and encourage both providers and managers to ensure that adequate family planning and other important reproductive health (RH) services are routinely offered as an integral part of post abortion care.

- Also they should develop mechanisms for supportive supervision check on health facilities frequently to ensure that the new components of the post abortion care model is practiced and followed diligently.

- They can also collaborate with Governmental and non-governmental organizations related to health to increase awareness through the mass media and organized programs at communities to increase patronage of Post abortion care services.

- The ministry must again put measures in place to monitor facilities offering safe abortion services and post abortion services to do the right thing and also fish out the fake doctors and drug peddlers to reduce the incidence of complications and death arising from unsafe abortion.

- Also the Ministry should put measures in place to intensify educating healthcare providers on Ghana's abortion laws.

- A recommended strategy for the Ministry in collaboration with communities and civic education to reduce stigma and shame of pre-marital sexual activity and pregnancy is the use of traditional forms of public acceptance and recognition of onset of sexual relations and education during puberty rites and initiation ceremonies.

- The Ministry can also look into some Governmental and non-governmental organizations that are willing to fund operations research to determine feasible, acceptable, and effective ways to provide linkages to appropriate reproductive health services to improve upon the health of women to reduce morbidity and mortality.

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APPENDICES

APPENDIX A: i) INFROMED CONSENT FORM

Study Title: Post Abortion care in Ghana, A case study of Tema General Hospital

Part 1. Participant Information

Introduction

We are from Ensign College Of Public Health and we are conducting a study that involves research to assess knowledge on abortion services and post abortion care in Ghana. This participant information leaflet explains the research study you are being asked to join. Please take all the time you need to read it carefully. You may ask the research team questions about anything you do not understand at any time. You are a volunteer. You can choose not to take part and if you join, you may quit at any time. There will be no penalty if you decide to quit the study.

Why you are being asked to participate,

You are being asked to take part in this study because you are a patient in Tema General Hospital. Specifically, we are interested in talking to women of reproductive age (14 -49 years).

Procedures

If you agree to be part of the study, a trained project staff will ask you a series of survey questions alone for approximately 60-90 minutes. Your responses will be recorded on paper and later entered into a computer database by study staff. The questions will only begin after you have agreed to be in the study and have signed the consent form. As a participant, if you agree to participate in this study, data from your responses may be used as part of the study to determine the knowledge on abortion and post abortion care.

Risk and Benefits

We anticipate no risk to you. There is no direct benefit to you for being in the study; however, study outcomes may lead to better understanding of women reasons for going in for abortion.

Confidentiality

We will not record your name on any of the study documents. The information you provide in this survey will be known only by you and the research team. Your responses will not be shown to other participants or community members. The original paper survey forms will be destroyed once data entry is complete.

Voluntariness and Withdrawal

Your participation in the study is completely voluntary and you reserve the right not to participate, even after you have taken part, to withdraw. This is your right and the decision you take will not be disclosed to anyone. It will not affect the care that will be offered to you at the health facility now or in future. If you join the study, you can change your mind later. You can choose not to take part and you can quit at any time. There will be no negative consequences if you choose not to participate in the study. Please note however, that some of the information that may have been obtained from you without identifiers, before you chose to withdraw, may be used in analysis reports and publications.

Cost/Compensation

Your participation in this study will not lead to you incurring any monetary cost during or after the study.

Who to contact

This study has been approved by the Institutional Ethics Committee of Ensign College of Public Health. If you have any concern about the conduct of this study, your welfare or your rights as a research participator if you wish to ask questions, or need further explanations later, you may contact Deborah Deh (0502718051) of Ensign College Of Public Health.

Do you have any questions?

Part 2. CONSENT DECLARATION

Left thumbprint of participant

"I have read the information given above, or the information above has been read to me. I have been given a chance to ask questions concerning this study; questions have been answered to my satisfaction. I now voluntarily agree to participate in this study knowing that I have the right to withdraw at any time without affecting future health care services"

Name of **participant**_____

Signature of **Participant**_____

Date / /20_ _

Name of **witness**_____

Signature of **witness** _____

Date / /20

Name of **investigator**_____

Signature of **investigator** _____

Date / /20_ _

ii) PARENTAL CONSENT FORM (if under 18 years old)

Study Title: Post Abortion care in Ghana, A case study of Tema General Hospital

Dear Parent or Guardian: We are from Ensign College Of Public Health and we are conducting a study that involves research to assess knowledge on abortion services and post abortion care in Ghana. Your child is being asked to take part in this study because she is a patient in Tema General Hospital. Specifically, we are interested in talking to women of reproductive age (14 -49 years).
In order for your child to participate in this study, we need your consent.

Procedures
If you agree to your child taking part in this study, a trained project staff will ask her a series of survey questions alone for approximately 60-90 minutes, her responses will be recorded on paper and later entered into a computer database by study staff. The questions will only begin after you have agreed to her participation and have signed the consent form. As a participant, data from her responses may be used as part of the study to determine the knowledge on abortion and post abortion care.

Risk and Benefits
We anticipate no risk to her. There is no direct benefit to her being in the study; however, study outcomes may lead to better understanding of women reasons for going in for abortion.

Confidentiality
We will not record her name on any of the study documents. The information she provides in this survey will be known only by you and the research team. Her responses will not be shown to other participants or community members. The original paper survey forms will be destroyed once data entry is complete.

Voluntariness and Withdrawal
Her participation in the study is completely voluntary and she reserves the right not to participate, even after she has taken part, to withdraw. This is right and the decision taken will not be disclosed to anyone. It will not affect the care that will be offered to her at the health facility now or in future. Please note however, that some of the information that may have been obtained from her without identifiers, before she chose to withdraw, may be used in analysis reports and publications.

Cost/Compensation
Your daughter's participation in this study will not lead to her incurring any monetary cost during or after the study.

Please carefully read and sign this parental consent form. If you have any questions or would like further information, please call Deborah Deh (0502718051) of Ensign College Of Public Health

Name of child: _____

In connection with and consideration of my child's (named above) participation in the study and related activities, I, on behalf of my child and myself, my heir(s), personal representative(s) and assign(s), hereby represent and agree as follows:

- I understand that my child will be a participant in a study and related activities, and I hereby give permission for her to serve in that capacity.

- I understand that my child will not be harmed in any form and her information provided will be confidential.

☐ Please check box if you do not consent to this statement. This box, if left unchecked, means that you do consent to any publications or media release.

- I, the undersigned, certify that I am the parent or legal guardian of the child (named above) and that I have the right to make decisions concerning my child's welfare.

I CERTIFY THAT I AM 18 YEARS OF AGE OR OLDER AND THAT I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, AND I SIGN IT VOLUNTARILY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

Parent/Guardian's Full Name: _____

Signature: _____

Date: _____

Left thumb print of parent/guardian

APPENDIX B: QUESTIONNAIRE

DATE…… QUESTIONNAIRE NO. ----------

INTERVIEWER CODE---------- ID NO. ----------

SECTION A

INTERVIEWER TO NOTE:

Answer questions 1-4 from the patient's folder or relevant books

SECTION B-SOCIO-DEMOGRAPHIC INFORMATION

1. Age ----------
2. Parity ----------
3. How many previous termination(s) client had ----------
4. What category is the index pregnancy?(based on history) i)Induced ii)spontaneous

SECTION C-SOCIO-CULTURAL/ECONOMIC BACKGROUND

5. What is your marital status? ----------

   i) married ii) single (boy-friend) iii)divorced/separated
   iv) cohabitating

6. What is your religion? ----------

   i) Christian ii) Islam iii) traditionalist iv) atheist

7. What is your educational level? ----------

   i) none ii) primary iii) secondary iv) tertiary (post-secondary)

8. Place of residence ----------

9. Residence category ----------

   i) urban ii) peri-urban iii) urban slum iv) rural

10. Type of accommodation ----------
    i) Compound house ii) semi-detached iii) detached iv) flats

11. Type of occupation----------
    i) trader ii) civil/public servant iii) artisan (seamstress, hairdresser)
    iv) farmer v) student vi) unemployed vii) other (please state)

12. Do you earn regular income? i) yes ii) no

13. What is the occupation of your partner) ----------

i) trader ii) civil/public servant iii) artisan (tailor, mason, carpenter, etc)
v) student vi) unemployed vii) other (pleases specify)

14. Do you receive any support from your partner? i) yes ii)no

15. If yes, what forms of support do you regularly get from your partner? ----------
i) financial ii) companionship iii) religious (prayers) iv) counsel(advice)
v) occupational vi) other (please specify)

16. Did you receive any financial assistance from your relative while pregnant?
i) yes ii)no

17. Do you have NHIS? i) yes ii)no

18. Do you think your financial state contributed to the termination of this and other pregnancies?
i) yes ii) no iii) don't know

SECTION D-REPRODUCTIVE HISTORY

19. How many times have you being pregnant? ----------

20. How many children do you have? ----------

21. How old is your last child? ----------

22. Have you ever had any pregnancy related problem? i)yes ii) no(skip to

23. If yes, what problem did you have? Please state----------

24. Would you want to be pregnant again? i) yes ii) no

25. Did you plan the index pregnancy? (the one that was just aborted) i)yes ii) no

26. If yes, what was /were reasons for termination? ----------

27. If no, why was it not planned? ----------

28. Did you want this (index) pregnancy? i) yes ii) no

29. If no, what did you intend to do with it? i) Keep it ii) terminate it

30. Did you do anything to end this pregnancy? i) yes ii) no

31. If yes, what agent did you use? Please state----------
---

32. Did you have to go somewhere to terminate this pregnancy before coming here?
i) yes ii)no

33. If yes, where did you go? ----------

34. Who helped you in assessing this place? ----------

i) partner ii) relative iii) friend iv) healthcare provider
vi) other (please state)

SECTION E-SAFE ABORTION AWARENESS

35. Have you heard about safe abortion services? i) yes ii) no

36. If yes, do you know of facilities that provide such services? i) yes ii) no
If yes, please name them----------

37. Do you think it is legal to terminate a pregnancy in Ghana?
i) yes, it is legal ii) no ii) don't know

38. Would you go to a hospital to seek for termination of pregnancy if you don't want it?
i) yes ii) no

39. If no, why not? ----------

40. What can you do to prevent unsafe abortion? Please state----------
---

SECTION F-POST ABORTION CARE

41. Have you received post abortion care services before? i) yes ii)no

42. If, yes what services were provided? Please state----------
---

43. Did anyone talk to you about how to prevent unwanted pregnancies? i) yes ii) no

44. If yes, who? ----------
i) friends ii) relatives iii) media iv) books v) healthcare personnel
vi) other please specify

45. Did you adhere to any of the counseling offered at the facility?
i) yes ii) no iii) partially

46. What was the healthcare provider's attitude during this period?
i) Friendly ii) not friendly iii) other please specify----------

47. If no why? Please state ----------
---

48. What will you suggest to be done to improve upon post abortion care services?

THANK YOU

APPENDIX C: KEY INFORMANT INTERVIEW

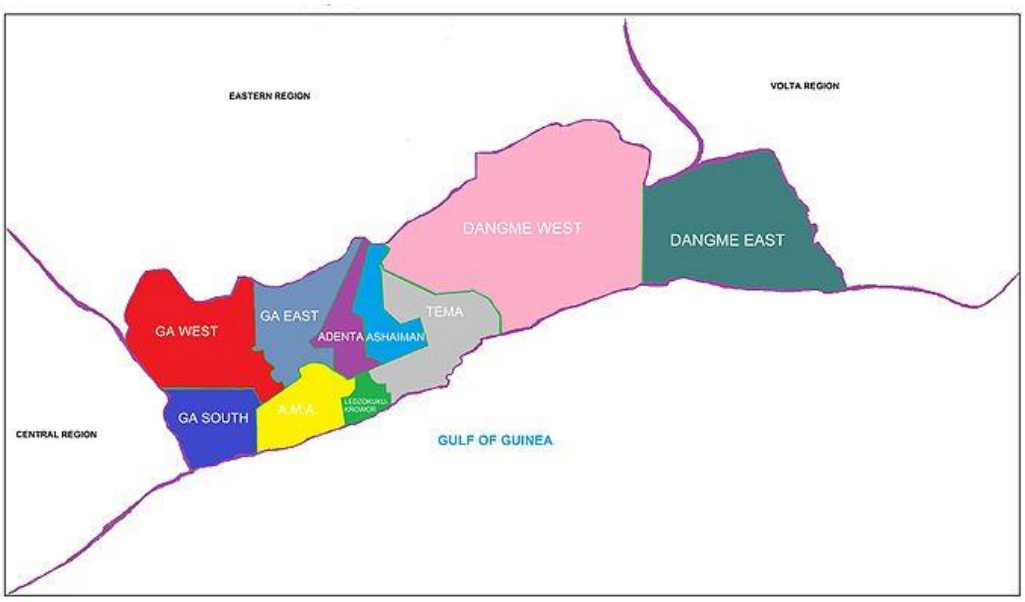
DATE----------

Name---------- Position ----------

1. Do you think abortion is legal in Ghana?
2. What do you know about Post abortion care?
3. What type of post abortion care services do you provide here?
4. What do you think are the barriers to clients assessing the health facility for such services?
5. What has been done to solve such issues/problems /barriers?
6. Do clients adhere to counseling provided at the facility?
7. What do you think should be done to help improve upon post abortion care services?

APPENDIX D: MAP OF TEMA MUNICIPALITY

I)



II)