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SCHOOL OF PUBLIC HEALTH

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UNIVERSITY OF GHANA

CLIENTS' PERCEPTION OF COMPREHENSIVE ABORTION CARE AT LA GENERAL HOSPITAL IN ACCRA

BY

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DECLARATION

I, hereby declare that this thesis is the result of my own original research conducted under the supervision of Dr. Emmanuel Asampong of the School of Public Health, University of Ghana. No part of this thesis has been presented for another degree in any University. All sources of borrowed materials have been duly acknowledged.

…….. ……

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DEDICATION

I dedicate this thesis to the Lord Almighty, my provider and defender.

To my lovely husband Mr. Kofi Kyereh-Darkwah and my children:

Nana Yaw Kye Kyereh-Darkwah

Akua Gyaa Kyereh-Darkwah

Abena Serwaa Kyereh-Darkwah

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ABSTRACT

Introduction: Comprehensive Abortion Care (CAC) service is aimed at providing safe abortion and post abortion care in order to reduce the risks associated with unsafe abortion. The main objective of this study was to explore clients' perceptions of CAC at the La General Hospital.

Method: This was a qualitative study using In-depth interviews to explore clients' perception of CAC among women who visited the CAC unit of the La General Hospital. The participants were purposively selected and interviewed upon exiting from the facility. In all, 21 participants were conveniently selected for the study.

Results: The results indicated that participants sought CAC service for safe termination of their pregnancy, treatment of incomplete abortion and treatment of intrauterine fetal death. Overall, the participants were satisfied with the CAC service received at the R3M unit. They all admitted that they were treated with politeness and courtesy by the nurses, midwives and the medical doctors at the facility. Most of the participants also expressed satisfaction with the pre-abortion family planning counselling and pain management by the medical personnel during the abortion procedure. However, a few of them complained about inadequate information on family planning during the pre-service counselling. Three main barriers to the utilization of CAC service identified were the lack of financial access due to unemployment, inadequate knowledge on where to locate CAC service facilities and the fear of being stigmatized, should they be seen accessing the service by relatives, neighbours and friends.

Conclusion: The study concluded that there is the need for information on the availability of CAC service in the various health facilities to be provided at the community level and in schools. The Ghana Health Service need to provide more CAC service units in various healthcare facilities across the country.

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INTEGRI PROCEDAMUS

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LIST OF ABBREVIATIONS

CAC	:	Comprehensive Abortion Care
D&C	:	Dilatation and Curettage
D&E	:	Dilatation and Evacuation
EVA	:	Electric Vacuum Aspiration
GHS	:	Ghana Health Service
HIV	:	Human Immune Virus
ICPD	:	International Conference on Population and Development
IPPF	:	International Planned Parenthood Federation
JCAHO:		Joint Commission on Accreditation of Health Care Organizations
MDG	:	Millennium Development Goal
MOH	:	Ministry of Health
MVA	:	Manual Vacuum Aspiration
PAC	:	Post-Abortion Care
PNDC	:	Provisional National Defense Council
QHP	:	Quality Health Partners
R3M	:	Reducing Maternal Morbidity and Mortality
SRH	:	Sexual and Reproductive Health
U.K.	:	United Kingdom
WHO	:	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Maternal morbidity and mortality has become a major public health concern in recent years. The World Health Organization (WHO 2012), estimates that approximately 800 women die every day from preventable causes related to pregnancy and childbirth globally. Statistics indicate that 99% of all maternal deaths occur in developing countries, higher in rural and poor communities and young adolescents face a higher risk of complications and death as a result of pregnancy than older women. In 2013 alone, 289,000 women were reported to have died following complications in pregnancy and childbirth (WHO 2013).

Many women seeking abortion usually resort to unsafe abortion practices. Anecdotal information indicate that very often, abortions are performed by unqualified persons in an unsafe environment and sometimes by untrained persons in unsafe environment. It is for such reasons that the Comprehensive Abortion Care (CAC) was initiated in Africa by the International Planned Parenthood Federation (IPPF). Ghana being part of the Africa Region Member Associations was committed to addressing the need for safe abortion and comprehensive services. This culminated in the rendering of CAC services in some selected health care facilities in the country (IPPF, 2009).

Abortion constitutes a major threat to the health and social life of many women around the globe and it is a major contributor to maternal mortality in many nations (WHO, 2013). Despite being a persistent and preventable pandemic, abortion still remains one of the most neglected sexual and

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reproductive health problems today (Grimes et al., 2006). Abortion refers to a termination of pregnancy before the foetus is capable of extra uterine life (WHO, 1996) or 'the loss of pregnancy before the foetus is viable (Ghana Health Service, 2003). Abortions are either induced or spontaneous. Induced abortions are those caused by deliberate interference whereas spontaneous abortions are those, which occur naturally without any deliberate interference (WHO, 1996).

The WHO (2012) estimates that globally, of the 210 million pregnancies that occur annually, about 80 million are unplanned and 46 million end in abortion. Of the 46 million annual abortions an estimated 22 million abortions are performed unsafely each year resulting in the death of an estimated 47,000 women each year. These deaths represent 13% of all pregnancy-related mortality, and in some countries as much as 25% of maternal deaths (WHO, 2007). In addition, it is estimated that every year at least five million women and girls are hospitalized for treatment of complications of unsafe abortion, which can lead to temporal or permanent disability such as infertility (WHO, 2012; Shah and Ahman 2009; WHO 2007). Furthermore, nearly 46% of all women who die from unsafe abortion are younger than 24 years (WHO, 2012).

Ultimately, unsafe abortions account for about 20 percent of the total burden of maternal mortality plus long-term reproductive ill health (WHO, 2007). Women who access unsafe abortion services might not receive appropriate post abortion care. Also medical back up is unlikely to be immediately available should an emergency such as sepsis, haemorrhage, genital and intestinal injuries, perforated uterus arise; and the woman might delay seeking care for complications because the abortion is clandestine (Yeboah, 2012).

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Just like any other Sub-Saharan country, abortion is a widespread phenomenon in Ghana (WHO/Guttmacher Institute, 2010; Oliveras, 2006; Ahiadeka, 2001; 2002). Historical studies confirm the widespread practice of unsafe abortion across different religious, ethnic and socioeconomic groups (Ampofo, 1970; Lassey, 1995; Anarfi, 1996; Nabila and Fayorsey, 1996; Kenyah, 2000; Kluffio et al., 2002; Oliveras; 2006). A study by Oliveras (2006) reveals that 47% of women in urban Accra have terminated one or more pregnancies. Kluffio et al. (2002) also found out that, 50% of women receiving maternity care at the Korle-Bu Teaching Hospital report of a previous history of abortion. Nationally, available data indicates that even though most causes of maternal mortality have declined since 1987, abortion related complications and deaths have risen in some parts of the country from 13% to 26.5% in 2000 (Geelhoed et al. 2005). Nevertheless, abortion is noted as the second leading cause of maternal death in Ghana, and more than one in ten maternal deaths (11%) are the result of unsafe abortion (Guttmacher Institute, 2010).

In the two Teaching Hospitals in Ghana, the Korle-Bu and Komfo Anokye, abortion complications make up to 50% of all gynaecological admissions (Ampofo, 1970; Turpin, Danso and Odoi, 2001; Aniteye 2002). Thirty per cent of maternal deaths are due to unsafe abortions according to data from studies at Korle-Bu Teaching Hospital in Accra, (Aboagye and Akosa, 2000). These deaths and disabilities could be prevented through sex education, family planning, and the provision of safe legal induced abortion and care for complications of abortion (WHO, 2012). Therefore, eliminating unsafe abortion is one of the key components of the World Health Organization's Global Reproductive Health Strategy (WHO, 2004).

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Maternal mortality reduction has been a focus of major international initiatives for the past two decades. These include the International Conference on Population and Development (ICPD) in 1994 in Cairo, the Fourth World Women's Conference in 1995 in Beijing, and the Millennium Summit in 2000. Unsafe abortion was recognized as a major public health problem at the International Conference held on Population and Development (1994) and participants called for prompt, high quality and sympathetic medical services to treat the complications of unsafe abortion. In addition, governments were tasked specifically to address the tragic consequences of unsafe abortion and it was agreed that in circumstances where abortion is not against the law, such abortion should be safe (United Nations, 1994). This was followed by another declarations by governments at the United Nations Assembly in 1999 that in circumstances where abortion is not against the law, health systems should train and equip health-service providers and take other measures to ensure that such abortion is safe and accessible (United Nations, 1999).

1.2 Problem Statement

In developing countries, one out of every 75 women die of pregnancy or childbirth-related causes, compared to one out of every 7,300 women in developed countries (WHO/Guttmacher Institute, 2010). According to the WHO (2012), about 3 million women in developing countries engage in unsafe abortions that result in complications leading mainly to maternal deaths and infertility. The proportion of maternal deaths from unsafe abortion is particularly high, especially in Africa, than in any other developing region (Shah and Ahman, 2009). It is estimated that, unsafe abortion in Africa is 700 times more likely to lead to death than unsafe abortion in developed countries (Abay, 2002). Despite the reforms in the abortion law, Ghanaian women have little or no information on seeking quality abortion services in approved facilities. Moreover, in as much as the quality of

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abortion services is now easily available to every Ghanaian woman, they still seek dangerous and illegal abortion services which pose serious complications. The Government of Ghana recognizing that unsafe abortion is widespread in the country and that a high proportion of them are conducted in unsafe manner has taken various initiatives over the past decades aimed at increasing access to safe abortion care in the country. These include the amendment in 1985 of the 1969 abortion law, which prohibits abortion except when it potentially endangers the health of the woman. This study therefore aims at exploring the clients' perception of Comprehensive Abortion Care (CAC) at the La General Hospital in the Greater Accra Region.

1.3 Research Questions

The following research questions will guide the study:

1. What is clients' perception of the quality of CAC service at LA General Hospital?
2. What is the level of satisfaction of clients with CAC service at LA General Hospital?
3. What are the barriers to accessing Comprehensive Abortions Care (CAC)?

1.4 Objectives

1.4.1 General Objective

The overall objective is to explore clients' perception of Comprehensive Abortion Care (CAC) in La General Hospital.

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1.4.2 Specific Objectives

1. To assess clients' perception of the quality of CAC services at La General Hospital.
2. To examine clients' level of satisfaction with the CAC service at La General Hospital.
3. To identify barriers in accessing Comprehensive Abortion Care (CAC) at the La General Hospital.

1.5 Significance of the Study

Comprehensive reproductive health care is still out of reach for several women in Ghana, particularly those in rural areas due to several reasons. To reduce the morbidity and mortality associated with unsafe abortion, the full range of abortion-related services should be provided to women, including safe termination and treatment of incomplete abortion, as well as modern contraception post-procedure. It would share light on clients' perception of the CAC services, their level of satisfaction and barriers to accessing the service. The results would be relevant for policy formulation for the progress of the achievement of Reducing Maternal Morbidity and Mortality (R3M) which seek to improve maternal health. It would also contribute to the available literature on comprehensive abortion care in Ghana.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the relevant literature on clients' perception of comprehensive abortion care in Ghana and around the world. Focus is laid on support for comprehensive abortion care at the international level, the provision of comprehensive abortion care in Ghana, and clients' perception of comprehensive abortion around the world.

2.2 The Incidence of Induced Abortion in Ghana

A number of studies have provided evidence that demonstrate the widespread practice of unsafe abortion across different religious, ethnic and socioeconomic groups in Ghana (Ampofo, 1970; Lassey, 1995; Anarfi, 1996; Nabila and Fayorsey, 1996; Kenyah, 2000; Kluffio et al., 2002; Oliveras, 2006). The prevalence of obtaining an induced abortion varied greatly in the studies reported. The highest rate reported was by Kluffio et al. (2002) who found that 50 percent of women receiving maternity care at the Korle-bu Teaching Hospital had previous history of abortion. Agyei et al. (2000) and Oliveras (2006) both found that 47 percent of the female participants in their study reported at least one pregnancy underwent an abortion sometime in their life. Morhe *et al*. (2012) found 36.7 percent of the adolescents in their sample outside of Kumasi had experienced an abortion. Ahiadeke (2001; 2002) reports an abortion rate of 27 per 100 live births using data from the Maternal Survey Project. Krakowiak- Reed et al., (2011) found 20 percent of their community-based sample outside Kumasi had at least one abortion. Oliveras *et al*. (2009) found between 10 percent and 17.6 percent of women in their study reported their previous pregnancy ended in induced abortion. Geelhoed and colleagues found a prevalence of induced

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abortion of 22.5 percent, which falls in the range reported elsewhere (Mote, Otupiri and Hindin, 2010). Glover et al. (2003) found that 70 percent of ever-pregnant youth in their sample reported attempting an abortion. Sundaram *et al*. (2012) state approximately 10 percent of the sample for the 2007 Maternal Health Survey reported having had an abortion in the five years prior to the survey.

There is not much information on the pathways through which women seek care, but often they will inform a midwife or health professional that they know and trust. They are then either scared away or told that abortion is illegal, counselled against it on religious and moral grounds, or referred to a reproductive health facility; for example the family planning clinic to see a doctor. The woman may or may not get the abortion done at this clinic. The outcome of her referral depends on the doctor's decision (Population Council of Ghana, 2008).

A study conducted at the Korle-Bu Teaching Hospital in Accra found that 18 percent of gynaecology admissions in 2000 were related to complications of induced abortion. Furthermore, of the total of 105 maternal deaths recorded at the same hospital, 14% were due to complications of induced abortion (Srofenyoh, 2003). The 2007 Ghana Maternal Health Survey reports that more than one in 10 maternal deaths result from complications of induced abortion; thus, making complications from induced abortion the second leading cause of maternal death in Ghana (Ghana Statistical Service et al. 2009).

Concerning the demographic characteristics of abortion seekers Oliveras et al., (2008) found that women reporting past abortion experience were younger and more likely to be unmarried. They

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were also more likely to be better educated (Oliveras et al., 2008). Similar observations were made by Ahiadeke (2001) in an earlier study using a population-based sample. He found that the majority of women who reported having an induced abortion were younger than 30 years, nulliparous and more likely to be Christian than Muslim. Furthermore, better educated women had greater odds of obtaining an abortion. All of those reporting an induced abortion during the study period had had a previous abortion (Ahiadeke, 2001).

2.3 Comprehensive Abortion Care

Comprehensive Abortion Care includes increasing access to modern contraception to prevent unintended pregnancy, improving the quality and accessibility of post abortion care and expanding access to safe, legal, voluntary and affordable abortion care. It refers to the set of services that includes safe induced abortion for all legal indications, treatment of incomplete and unsafe abortion, contraceptive and family planning services to help women prevent an unwanted pregnancy or practice birth spacing, counselling, and other reproductive health services (Lugaliki, 2014).

Women's access to safe abortion is strongly supported by the United Nations bodies, other international bodies, donor governments, and non-governmental organisations. There is increasing pressure from these international bodies for countries with strict abortion laws to make reforms of the applicable laws and policies (Crane and Hold-Smith, 2006).

The Programme of Action of the International Conference on Population and Development (ICPD) established abortion as a major public health issue. Governments at the ICPD conference agreed

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that abortion should be safe where legal, but that it is up to nations to determine their own laws. Governments also agreed that abortion should not be promoted as a method of family planning (Grimes et al., 2006). While there is no agreed definition of "as a method of family planning," abortions in cases of rape, incest, and threat to the life or health of the woman should not be considered as belonging in this category. Many reproductive health providers also consider that in making abortion readily available to women, they are not "promoting" abortion as a choice (Crane and Hold-Smith, 2006).

The role of the World Health Organization is to provide advice and training to member states in order to strengthen the capacity of health systems. For over three decades, WHO has assisted governments, international agencies and non-governmental organizations to plan and deliver maternal health service, including managing complications of unsafe abortion and providing high-quality family planning services (Tsegay, 2011).

WHO also acknowledges safe abortion care include services that are provided by trained health workers, supported by policies, regulations and a functional health infrastructure, including equipment and supplies (WHO, 2006). Practices and performance of abortion outside of these conditions can add up to the higher occurrences of unsafe abortion. At the Special Session of the United Nations General Assembly in June 1999, governments agreed to train and equip health-service providers and to take other measures that ensure abortion was safe and accessible. The session emphasized on developing health systems that safeguard women's health and help them legally practice their reproductive health (WHO, 2003).

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2.4 The Provision of Comprehensive Abortion Care in Ghana

The abortion law in Ghana was modified in 1985 to allow abortion under specific circumstances (Population Council of Ghana, 2008; 2009; Appiah-Agyekum, 2014). Ghanaian law allows abortion to save a woman's life and to protect her mental and physical health (Appiah-Agyekum, 2014). Abortion is also allowed if the pregnancy is as a result of rape or incest, mental health reasons, a minor who is pregnant, if continuation of the pregnancy would put the mother's life in danger or the pregnancy would cause a serious disease or deform the baby for life (Population Council of Ghana, 2008). In Ghana, the laws on abortion (PNDC Law 102; 1985) apart from defining the conditions under which abortions can be legally done also directs that abortions be done only by persons registered with and so authorized by the Ghana Health Service, Nurses and Midwives Council or the Medical and Dental Council in a facility registered for that purpose by the Private Hospitals and Maternity Homes Board (for private facilities) or the Ghana Health Service (for public facilities) (Appiah-Agyekum, 2014)

In 2006, a consortium of six agencies—Engender Health, Ipas, Macro International, Marie Stopes International, Population Council, and Willows Foundation—came together to provide technical and financial support to the Government of Ghana to roll-out CAC services. The consortium collaborates with the Government of Ghana in expanding women's access to modern family planning and comprehensive abortion care. The consortium's program titled "Reducing Maternal Morbidity and Mortality" (R3M) aims to reduce unwanted pregnancy and severe complications and deaths caused by unsafe abortions (Population Council of Ghana, 2008).

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Consequently, a good number of health care facilities, both private and public, as well as healthcare personnel including midwives and other community outreach workers have been trained and registered to perform abortions guided by the conditions set by the law and the Ministry of Health's guidelines on abortion (Appiah-Agyekum, 2014).

In Ghana, CAC which comprises safe-abortion services and post-abortion care, lies within the domain of midwives and obstetricians. The Ghana law on abortion (PNDC Law 102) requires that abortions are performed only by medical practitioners (interpreted as doctors). Before 2006, midwives were only eligible to provide post-abortion care whilst the doctors performed both post-abortion care and safe-abortion services. Following the development of the Ghana Health Service Standards and Guidelines for comprehensive abortion care (2006), training of midwives in the provision of safe-abortion services then commenced and currently midwives are reportedly providing CAC (Aniteye and Mayhew, 2013)

The study by the Population Council of Ghana (2008) provides details of some of the various types of CAC services offered in health care facilities. According to the results of the study most safe abortions were done by Manual Vacuum Aspiration (MVA) or medication abortion. The provision of MVA was higher compared to medical abortion as seventy-five percent of the providers offered MVA services compared to 67 percent who offered medication abortion. Also half (50%) of the providers offered both (MVA and medication abortion). Electric Vacuum Aspiration (EVA), Dilatation and Evacuation D&E), Dilatation and Curettage (D&C) were offered by a small proportion of the providers.

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The Population Council study also revealed that most providers in both public and private sectors had received pre-service training on some aspect of abortion care during their pre-service training. These skills include training on providing abortions (75 percent), Post Abortion Care (83 percent), counselling/behavior change communication on dangers of unsafe abortion (67 percent), counselling on pain management (83 percent) and family planning counselling (67 percent).

Despite this, knowledge of the Ghana Standards and Protocols on CAC is found to be low among both private and public health care personnel. Similarly, knowledge on the specifics of CAC is limited. In the population Council study, only one provider had a detailed knowledge about post-procedure care and management of medication abortion while 25% had detailed knowledge in pre-procedure care and complication of medication abortion.

Additionally, it was found that both WHO and the Ghana Standards Protocols on CAC which include speculum exam, assessment of the size of the uterus, and confirming pregnancy with a pregnancy test are not routinely followed in the health care facilities surveyed by the Population Council of Ghana (2008). However, these three actions were more likely to occur in consultations in the private sector than in the public sector facilities and also at much higher levels. For instance the Population Council of Ghana (2008) found that speculum examination was 94 percent in private health facilities compared to 40 percent in public health facilities; assessment of uterus was 87 percent in private health facilities compared to 44 percent in public health facilities, and doing or referring a pregnancy tests was 98 percent in private health facilities compared to 50 percent in public health facilities. These practices points to the low standard of practice of CAC in Ghana especially in public health care facilities.

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2.5 Barriers to Accessing Comprehensive Abortion Care

Studies identify a wide range of factors including personal, moral and religious views, in which abortion was perceived by some as akin to murder or as a sin; whereas others viewed access to safe, legal abortions as an important component of a woman's right to reproductive autonomy and choice impacting the perception of health professionals towards abortion (Abdi and Gebremariam 2011; Gebreselassie et al., 2010). The available literature has classified the factors that influence the perception of health care personnel towards abortion into human rights and quality of life, religion, gender and stigmatization unpreparedness and ambivalence and access and quality of care (Ulrik et al., 2015).

2.5.1 Gender, Stigma and Victimisation

Several studies have documented the use of gender, stigma and victimisation to deny women access to safe abortion. In a recent study Harries, Cooper, Stebel and Colvin (2014) found that nurses and midwives stated that women should give birth and care for their children and expressed the view that induced abortion was 'terminating motherhood'. Thus nurses and midwives considered that women who choose an abortion denied their role as mothers and thus rejected their identity as women (Harries et al., 2014; Mayers, Parkes, Green and Turner, 2005).

However, there are differences between male and female health personnel regarding attitudes towards induced abortion. Female health care providers have been reported to have more conservative attitudes than male personnel (Djohan, Indrawasih, Adenan, Yudomustopo and Tan, 1993). Mesganaw, (2010) holds a different view. According to his findings, the beliefs that abortion was "outside the scope of practice" and "against personal values" were significantly

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associated with not intending to provide surgical or medical abortions; however, religious affiliation was not associated with these outcomes. A marginally significant difference suggested that female medical personnel may be more likely than males to intend to provide medical and surgical abortions (Mesganaw, 2010).

There are also differences in health care providers' attitude towards abortion in relation to the participant's age (Phuapradit, Sirivongs and Chaturachinda, 1986). Phuapradit and colleagues observed that younger nurses had more liberal attitude towards abortions than older nurses. Experience in providing abortion care has also be noted as a factor that influence the attitude towards abortion. Providers who had safe abortion practice were 2.57 times more likely to have favorable attitude towards safe abortion than those without practice. Similarly, providers who knew the law governing abortion were 1.77 times more likely to have this favorable attitude than those who lack this knowledge (Abdi and Gebremariam, 2011).

2.5.2 Religious barriers

Several studies have identified religion as the most important factor influencing the attitudes of health care providers towards induced abortions. (Botes, 2000; Belton et al., 2009; Aniteye and Mayhew, 2013, Abdi and Gebremariam 2011). Aniteye and Mayhew (2013) found that most prominently, abortion providers in Ghana experience conflicts between their religious and moral beliefs about the sanctity of (foetal) life and their duty to provide safe-abortion care. The religious views of obstetricians were tempered by their exposure to international debates, treaties, and safe-abortion practices and better awareness of national research on the public health implications of

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unsafe abortions. Midwives were more driven by fundamental religious values condemning abortion as sinful. In addition to personal views and dilemmas, 'social pressures' and the actions of facility managers affected providers' decision to (openly) provide abortion services. In general healthcare personnel influenced by religion believed that only God can decide between life and death and that abortion was a sin (Ulrika et al., 2015).

However, in a recent study from South Africa, the nurses viewed abortions differently, depending on whether they were medical or surgical (Cooper et al., 2005). The nurses in this study maintained that medical abortion was in the hands of the woman and therefore the woman, not the nurse, had to answer to God for her actions (Cooper et al., 2005).

2.5.3 Negative Attitudes of Health Care Personnel

A number of studies have found that nurses and midwives disliked being involved with abortion services, and they commonly reported hesitance in providing these services (Harries et al., 2009; Klingberg-Allvin et al., 2007; Mokgethi et al., 2006; Warenius et al., 2006; Mayers et al., 2005; Botes, 2000). For instance Klingberg-Allvin et al., (2007) found that among midwifery students in Vietnam the main reason for choosing midwifery as a profession was to care for women in labour and delivery, and hardly any of the students wanted to work in the area of abortion services. Similar attitudes were reported among physicians (Harries et. al., 2009). Furthermore, health facility managers in South Africa expressed difficulties when recruiting, retaining and scheduling health care providers for induced abortion procedures (Mayers et al., 2005; Harries et al., 2009). Studies have also found that nurses' resistance to providing abortion services was a powerful barrier

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against access to safe abortion services, with nurses' and midwives' strong opposition to abortion affecting rural women in particular (Cooper et al., 2005; Botes, 2000; Harrison et al., 2000).

Additionally, nurses and midwives have judgmental attitudes towards abortion patients (Mokgethi et al., 2006; Gmeiner et al., 2000; Harrison et al., 2000). In general, the nurses seemed to withdraw from the patients and ignored their responsibilities as caregivers (Payne et al., 2013; Mngadi et al., 2008; Mokgethi et al., 2006; Botes, 2000). Furthermore, participants from both sub-Saharan Africa and Southeast Asia alleged they could not provide holistic nursing care to women undergoing an induced abortion because they had negative feelings about the woman's decision (Klingberg-Allvin et al., 2007; Harrison et al., 2000). The nurses and midwives also acknowledged that these women received inadequate care due to the poor relationship between the nurse and the patient (Mngadi et al., 2008; Klingberg-Allvin et al., 2007).

On the other hand, a study by Cooper et al., (2005) gave a positive view on nurses' and midwives' attitudes towards abortion. In this study, the nurses expressed a strong interest in medical abortions. In a recent study, health care providers, in general, preferred medical abortions, as this required minimal involvement on their part in the abortion process (Harries et al. 2012). Furthermore, early termination of pregnancy (i.e. menstrual regulation) was more accepted among health care providers than second-trimester abortions (Harries et al. 2012; Djohan et al., 1993).

Other constraints identified in literature in relation to quality abortion care were lack of training, lack of staff accountability (Nguyen et al, 2007), poor supervision and regulation (Dovlo, 2004) as well as some individual level barriers and organization constraints (Say and Foy, 2005). In

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South Africa, it has been found that stigma, lack of enforcement, inadequate support to health providers to deliver abortion services and the overburdening of the small number of facilities that provide the services have combined to make safe abortion largely inaccessible (Pathfinder 2007).

2.6 Clients Perception of Safe Abortion Care Services

Women's evaluation of abortion care is strongly associated with ratings of the client-staff interaction (Zapka et al., 2001). Women who valued the doctor's efforts to help them feel comfortable, the staff's respect for their privacy and respectful treatment by the receptionists. Given the sensitive nature of abortion care and the fact that women may feel vulnerable to receiving judgmental treatment, it is not surprising that these factors emerged as important (Slade et al., 2001; Picker Institute and Kaiser Family Foundation, 1999). The behavior of staff other than doctors was associated with women's overall care evaluation, suggesting that efforts to improve quality of care should focus on how all members of the staff, not just clinical staff, treat patients (Zapka et al., 2001).

Becker et al., (2011) found that the quality of care is generally viewed favourably. High proportions of women said they were treated well by the staff, that the service was easy to access, that the facility was clean and that the doctor who attended to them was technically skilled. High proportions also felt they had received adequate pain management and sufficient information about the procedure and self-care at home afterwards. The proportion reporting that they had been offered post-abortion contraceptives was also high.

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According to Oliveras, Larsen and David (2005) the perceived adequacy of information and counselling women received was associated with women's overall evaluation of care. Becker et al., (2011) in their study on clients' perception of safe abortion in Mexico City found that service evaluation was more positive among those who felt they received sufficient information about how to take care of themselves at home following the abortion. A study by the Population Council of Ghana (2011) also made similar observations about clients' perception of medical abortion. The study results demonstrates that safe abortion providers took clients through counselling and allowed clients to choose a method, approximately 93 percent of the clients reported that providers gave them sufficient information on methods during their first counselling consultation. During the initial consultation with service providers on the various methods of pregnancy termination, 88.7 percent of the clients indicated that MVA/EVA was mentioned and discussed with them. Almost all (99.4 percent) indicated that the medical abortion process and eligibility requirements were discussed with them. About 46 percent (212) of clients who came to the health facility had some particular pregnancy termination method in mind. Among these clients, about half (50.9 percent) had medical abortion in mind, about 48.1 percent had termination by MVA/EVA in mind and the rest mentioned Cipro, D&C. The result also showed that the majority, 90.2 percent and 92.0 percent respectively indicated they had the opportunity to ask questions and chose a preferred method for their pregnancy termination (Population Council of Ghana, 2011).

Windy, Moazzam, Rintaro, Wantania, Chushi, and Kenji (2015) found among clients in Indonesia that clients who were given information about pregnancy complications, wished to ask questions, were willing to return to the same hospital for follow-up, would recommend others due to good attitude of providers and good management of private hospitals.

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Kumbi1 et al., (2014) found that despite the preparedness of facilities to manage abortion complications, some patients were delayed from receiving services because of requirement to pay before getting services, and to buy drugs and supplies from other sources. Patient-provider interaction was generally satisfactory as viewed by the participants. Majority (88.3%) of clients felt that Post Abortion Care (PAC) services maintained confidentiality. Patients were not informed about the steps of each procedure. Nearly two-thirds of service providers informed the clients about the cause of their problem, but only 50.5% of them informed the client of the outcome of treatment. Information provision regarding important precautions and warning signs was very low in all study facilities. Only 53.4% of clients left the facilities counselled about family planning and 44.7% with contraceptives to take home. Majority of the patients responded that they were satisfied with services they obtained. Dissatisfaction included maltreatment by service providers, and inconvenient setup of service delivery. Client assessment was principally based on last menstrual period and bimanual pelvic examination in most of the facilities. Service providers do not usually stick to infection prevention and universal precautions.

The Population Council of Ghana (2008) provides extensive analysis on the provision of information and counselling to clients seeking safe abortions in health care facilities in Ghana. The authors found that overall, the interpersonal communication between providers and clients was satisfactory at both the private and public health institutions. However, the providers from the private sector interacted better with the clients than the providers from the public sector. In particular, issues of privacy and confidentiality were not addressed in the public sector to the same extent as in the private sector. These may reflect differences in training of public and private sector providers as well as availability of physical space.

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Additionally, information provision on contraceptive options was the weakest part of the service package in the public sector, and the strongest part in the private sector. The results indicate that on almost every aspect of contraceptive information and service provision, the private sector facilities far out-perform the public sector facilities. These are areas that need to be strengthened in both types of facilities. For example, over a fifth of the consultations in the private sector and less than one in ten consultations were clients informed that fertility could return within 10 days post-abortion. In addition, in at least a quarter of the consultations, clients were not asked about their fertility intentions. Interesting enough even when contraceptive options and services are provided, information was not provided on methods that both protect against pregnancy and sexually transmitted infections.

Another variable that is significant in measuring client percent of quality of comprehensive abortion care is staff talking with women about how they might feel emotionally after the abortion. Staff provision of emotional and psychological information and support may be helpful, since women may not have anyone else with whom they feel comfortable discussing their abortion. Consequently, Becker et al., (2011) recommends that abortion care staff should routinely incorporate information about post-abortion emotions into their counselling practices. However, it is critical that any information provided on post-abortion must be evidence based (Major et al., 2009)

Service accessibility and features of the facility environment were associated with women's overall evaluation of care (Zapka et al., 2001). Women's feeling about the length of time it took to get

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their appointment was found to be of high importance to clients receiving abortion care (Wiebe and Sandhu, 2008). In Ghana, it was found that acceptability of medical abortion procedure was very high; about 81 percent of the clients indicated that they will use the method again if they had to, while about 90 percent indicated that they will recommend the method to their family and friends; approximately 85 percent of the providers were satisfied with the procedure (Population Council of Ghana, 2011).

Similarly, Becker et al., (2011) found that the convenience of the hours, the waiting time at the care site and the cleanliness of facility were all associated with women's overall service evaluation of abortion care service in Mexico city, suggesting that these factors should be targeted in quality improvement efforts. Becker and colleagues study also indicated that women's reports about whether they saw abortion protesters at the site did not correlate with their overall views of the service. This may indicate that women differentiate between what happens outside the facility and what happens inside, as others have suggested (Zapka et al., 2001).

Despite the fact that clients may have a limited ability to evaluate the technical competence of their doctors (Lewis, 1994) it is interesting that their confidence in the technical skills of their doctor was associated with their overall rating of care. Becker et al., (2011) found that clients who sought safe abortion in Mexico City felt confident in the doctor's technical skill.

Studies have found that age, education and marital status were associated with abortion care satisfaction (Oliveras et al., 2005; Zapka et al., 2001; Bulut and Toubia, 1999). In a recent study Becker et al., (2011) found that parity was the only social and demographic characteristic associated with women's overall evaluation of abortion care. Women who had never given birth

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rated their care less favourably than those who had. Two reasons account for these differences in opinion. The first is that women who have ever given birth may be more accustomed to pregnancy, gynaecologic procedures and pain (Becker et al., 2011). The second reason is that women who had never given birth considered the abortion more painful and were more worried and anxious during the procedure than women who had, and therefore rated their abortion experience more negatively (Lafaurie et al., 2005)

There are also differences in overall ratings of abortion care by type of abortion procedure or by site of care (Rørbye, Nørgaard and Nilas, 2005; Slade et al., 2001). Becker et al. (2011) found that among women in Mexico City, care was evaluated just as favourably at the primary health center as at the hospitals. This is important because it indicates that expanding abortion care at the primary health level, a decision that may improve efficiency and reduce the costs of the service will not lead to reductions in client satisfaction (Hu et al., 2009)

Differences also exist among clients with incomplete medication abortions and those with complete medication abortions on the evaluation of the service quality. Lafaurie et al., (2005) found that clients who had incomplete medication abortions rated the service quality more poorly than those who had complete abortions. In contrast, Becker et al., (2011) observed that clients who had incomplete medication abortions did not rate the service quality more poorly than those who had complete abortions. Moreover, the overall service quality rating among women who reported being offered a choice of abortion procedures was not significantly different from the rating among those not offered a choice (Becker et al., 2011).

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2.7 Theoretical Framework

The service quality model popularly referred to as SERVQUAL is used in this study. SERVQUAL is an instrument for assessing customer perceptions and expectations of service quality in service organizations. In short, it is based on the gap measures of expectation and perception of patients regarding the quality of health care services (Parasuraman et al., 1988). The service quality model was developed by Parasuraman in 1985, was later refined in 1988 and was reviewed in 1991 to evaluate the perceived quality of healthcare services. It has been extensively accepted and utilized as a generic instrument that captures the multidimensionality of healthcare service quality.

The SERVQUAL instrument consists of 22 pairs of statements that measure consumer's expectations and perceptions of service performance; and these statements are loaded into 5 dimensions of service quality including reliability, responsiveness, assurance, empathy and tangibles.

Reliability is the ability to perform the promised service accurately and dependably. It means that the service is accomplished on time without any errors (Parasuraman, 1991).

Responsiveness is the willingness to assist patients and provide prompt service (Parasuraman, 1991). Keeping customers waiting with no apparent reason can create a low perception of quality.

Assurance is the ability to be knowledgeable, to show courtesy and to convey trust and confidence (Parasuraman, 1991). It includes the following features: competence to perform service, politeness and respect for customers and effective communication with the customer.

Empathy is provision of care and the ability to show compassion towards customers. It includes approachability, sensitivity, and understanding patients' needs (Parasuraman, 1991).

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Tangibles refer to the appearance of physical facilities, equipment, personnel and communication materials. The conditions of physical surroundings such as cleanliness and noisiness are also tangible features of care (Parasuraman, 1991). Parasuraman (1988) used these five dimensions to form an assessment of service quality based on the comparison between expected and perceived services.

In general, service quality is divided into two main components; namely, technical and functional quality (Gronroos, 1984; Parasuraman et al., 1985. Technical quality (clinical quality) refers to the technical diagnosis and procedures (e.g., surgical skills). It is the ability of hospitals to achieve high standards of patient health through medical diagnosis, procedures and treatment, and ultimately creating physical or physiological effects on patients (Brook and Williams, 1975). It is essentially what the customer receives from the service provider and how well the diagnostic and therapeutic processes are applied. In other words, the technical quality includes the competence and clinical skills of the doctors and nurses, the laboratory technicians' expertise in conducting tests and so on (Tomes and Ng, 1995).

Functional quality or client quality refers to the manner of delivering the services to the patients (e.g. attitudes of doctors and nurses toward the patients, cleanliness of the facilities, quality of hospital food, etc.).This definition is consistent with the statement by Øvretveit (1992) that client quality relates to the patients perceptions of the service regarding friendliness of service provider, timely delivery and information given by service provider, etc.

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Since most patients lack medical expertise for evaluating the technical attributes of healthcare professional, the service marketing approach, which focuses on functional quality perceived by patients, has been widely used to evaluate the health services (Buttle, 1996; Dursun and Cerci, 2004). Ideally, the quality which is defined from the point of patients' view is a perceived service quality and is explained as the consumer's judgment about excellence of overall health services including every aspect of service such as technical, functional, environmental and administrative, based on perceptions of what is received and what is given (Zeithaml, 1988). In another word, the perceived service quality can be defined as a difference between patients' expectation and perception on health services including every aspect of service such as technical, interpersonal, environmental and administrative (Zeithaml, 1988). However, the technical quality cannot be evaluated by patients due to their lack of expertise (Newcome, 1997) in the medical field, while the client (interpersonal) quality can be assessed by patients (Chimed-Ochir, 2010).

The SERQUAL is the most widely tested and evaluated instrument for the generic measurement of perceived quality (Davies et al., 1999). This instrument was frequently applied in for-profit services in developed countries. However, a number of researchers have evaluated the quality of health care using this tool in public hospitals. For instance, Dean (1999) investigated the applicability of a refined SERVQUAL instrument, consisting of 15 statements, in both medical care and health care settings of Australia. The study results revealed a four-factor structure which approximates, in both environments, the dimensions identified by Parasuraman et al. studies (1988). Assurance and Empathy were the most important dimensions in the health care environment, while Reliability/Responsiveness dimensions came first in the medical care environment. However, Wisniewski and Wisniewski (2005) had applied a modified SERVQUAL

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instrument, consisting of 19 items, for a colonoscopy clinic in Scotland. They found that although patient overall satisfaction with the services was high, improvements were needed in specific service dimensions, especially the reliability dimension

In the context of developing countries, Narang (2010) adopted 20- item scale that had been initially developed by Hadded et al. (1998), to measure patients' perceptions of health care services in India. The study reveals that the four factors -health personnel practices and conduct, health care delivery, access to services and, above all, adequacy of resources and services- were perceived positively by patients. Pakdil and Harwood (2005) applied SERVQUAL construct for measuring patients' satisfactions in Turkey by calculating the gap between patients' expectations and perceptions. The study found that patients are highly satisfied with all elements of service quality; specifically, "adequate information about their surgery" and "adequate friendliness, courtesy" items. However, Robini and Mahadevappa (2006) investigated patients' satisfactions of service quality in selected hospitals based in Bangalore, India. Data collected from 500 patients revealed that expectations exceeded their perceptions in 22 items of service quality. The assurance dimension got the least negative score in all hospitals. In contrast, Sohail (2003) found that patients' perceptions exceeded their expectations for all items of services provided by private hospitals in Malaysia.

The SERQUAL model is therefore applied to study the clients' perception of CAC service in the La General Hospital in Accra. It is relevant to this study because it helped the researcher to look at how clients perceive timely delivery of the CAC service (Responsiveness), how patients' confidentiality, trust and respect (Assurance) were handled, how pain was managed (Empathy), the performance of the CAC according to WHO and IPAS protocol (Reliability) and the availability of equipment and supplies (tangibles).

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CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methods adopted in conducting the study. The aspects discussed in this chapter include study design, study area, study population, sample size, sampling techniques, data analysis, ethical issues and limitations of the study.

3.2 Study Design

The case study design was used for the purpose of exploring in-depth clients' perception of Comprehensive Abortion Care Service at the La General Hospital. Case study refers to an empirical investigation of a particular compulsory occurrence within its real life context using multiple source of evidence. It involves an in-depth exploration of bounded process or individuals system based on extensive data collection (Creswell, 2002). A case study as a bounded system means that the study is located within a geographical area and is bounded by a limited number of informants providing the data for the study. In this study the cases under examination are clients who visited the R3M Unit of the La General Hospital for CAC service. The reason for this is to get a deeper understanding of the issue being studied in order to come out with the most information rich of each case studied.

The important of the case study to this study is that it is flexible and adoptable to processes, people and context and provides some of the most useful methods in research (McMillan and Schumacher, 1997). This case study design involving clients who visited the La General Hospital for CAC service would provide a better understanding of clients' perception of CAC service not only in La

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General Hospital but also an understanding of how clients' experience and perceive the provision of CAC in R3M Units in Ghana.

Researchers have criticized case studies as being weak in terms of generalizability and validity (Bogdan & Biklen, 1992; Woolcott, 1995). In this study this weakness was overcome by clearly specifying what the case is, what the unit of analysis is and the use of mixed method. As noted earlier, the case for this study is the perception of the quality of CAC service and the units of analysis are the clients' who visited the R3M unit of the La General Hospital for CAC service.

3.3 Study Approach

The study made use of qualitative approach. Consequently in-depth interview was used in gathering data through client exit interview. Participants were interviewed at the point where they were about to be discharged from the CAC unit. The qualitative method was adopted because the study aimed to understand some aspects of social life through the generation of words rather than numbers as data for analysis (Brikci and Green, 2007). This study is aimed at discovering how clients' perceive the comprehensive abortion care service, their satisfaction with the service and some of the barriers hindering their access to comprehensive care through the use of in-depth interview.

3.4. Study Area

The study was undertaken at the La General Hospital, a state owned medical facility established in the year 1963 and accredited to a District Hospital status in the year 2004. Some years past, it used to be a Polyclinic before getting upgraded and acquiring a General Hospital Status. It has a

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surgical theatre, laboratory, physicians and specialists and other paramedics working around the clock throughout the week. It is one of the leading institutions providing Vasectomy Service in the Municipality. The facility has a modern Reducing Maternal Mortality and Morbidity (R3M) unit for the provision of family planning and Comprehensive Abortion Care Services. The R3M unit is staffed with doctors and midwives trained by Ipas on the provision of Comprehensive Abortion Care. The La General Hospital is also one of the referral facilities in the La Dade-Kotopon Municipality for major complications such as abortion related cases. The hospital is located at the South La Estate close to the La Township making it accessible by both the rich and the poor.

3.5 Study Population

The study population for this study was all women of reproductive age between 14 and 49 years who accessed the CAC service at the La General Hospital. This included women who had come for pre-counselling for safe abortion, those requesting treatment for abortion complications and those undergoing post abortion care counselling for family planning and contraceptive use.

3.6 Sample Size

A total of 21 women participated in the study. This sample size was used because it was realised that theme saturation, a point where new data collected no longer brought additional insights to the stated objectives was reached after the twenty first in-depth interview. The recruitment criteria was women who had come to access CAC service and were exiting from the facility. Though this figure is small it follows the qualitative research tradition of choosing smaller samples with the aim of developing an in-depth understanding of the phenomena under study.

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3.7 Sampling Technique

The selection of participants for this study was done through the use of purposive sampling technique. Purposive sampling involves intentional selecting special groups of people who are in the position to answer the research questions or they have characteristics that typify the participants sought by the research (Cohen et al., 2000). According to Bailey (1994), the advantage of the purposive sampling is that the researcher can use his or her skill and prior knowledge to select participants. Kumekpor (2002) stated that in applying the purposive sampling technique the units of the sample are selected not through random procedures but by intentionally picking them for the study due to either their characteristics or the fact that they satisfy certain criteria. Therefore in this study, the researcher intentionally handpicked only clients who visited the facility CAC. This sampling approach was used to avoid selecting other clients who come for family planning and other services.

3.8 Data Collection Instrument and Technique

Data for the study was gathered through the use of in-depth interview guide. Also, a digital voice recorder, field notebooks, pencils, pen and files were used to aid in the data collection process.

In-depth interviews are designed to reveal the underlying motives of the interviewee's attitudes, behavior, and perception (Branthwaite and Patterson, 2011). In-depth interviews are open-ended and guided discussion that involves conducting thorough individual interviews with a small number of participants. The main objective is to discover their perspectives on a particular situation, idea and programme (Boyce, 2006). The in-depth interview guide therefore allowed the participants to give detailed expression of their thoughts and behavior without drawing attention to them. Additionally, the in-depth interview guide allowed the researcher to explain or clarify

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questions that the participants did not understand, thus eliciting more useful response from participants.

Before the commencement of data collection, permission was sought from the Regional Director of Health Services, the Medical Superintendent of the La General Hospital and the Head of the R3M unit. The client exit method was used in the data collection process. The researcher informed the midwives and doctors at the R3M unit to inform the clients seeking CAC that there is a researcher who would like to discuss their experience of the abortion procedure at the unit with them after the procedure. The researcher waited for the client to be discharged before the start of the interview. The interviews were conducted in Ga and Twi languages and lasted for 45 minutes each.

Each interview began by establishing rapport to create a relaxed atmosphere and a trusting relationship. After this, the purpose of the study was explained to the participants and they were assured of confidentiality of the information they were to provide. The consent of participants was requested verbally and written by signing or thumb printing the consent form before each interview was stated. Participants were also informed about their rights to withdraw from the study at any given time and participation was voluntary. With their permission, the interviews were audio-taped and field notes were taken by the research assistant.

Also, because qualitative interviewing is generally much less structured and usually flexible (Bryman and Bell, 2007) the researcher adjusted the questions in response to the replies given by the participants. Thus, the researcher pursued other lines of questioning but did not deviate from

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the main theme of the study. As a result of the use of the in-depth interview the researcher had the opportunity to regulate the order of the questions and the participants have the possibility to expand their ideas and speak in great detail about the events leading to the abortion and the abortion experience.

3.9 Validity and Reliability

Reliability and validity are measures that demonstrate the trustworthiness and credibility of a research. Validity refers to the extent to which the data collection method or research method describes or measures what it is supposed to describe or measure (Lancaster, 2005). Borg and Gall (1991) noted that a new test instrument should be field-tested with a population similar to that from which the sample of the study will be taken. To ensure that the research instrument is valid, the interview guide was pre-tested with five (5) clients who visited the La General Hospital for CAC service. The analysis of the pilot test led to rewording of some of the phrases in the interview guide.

Reliability refers to the extent to which a research instrument produces consistent result. To enhance the reliability of the study, the interview guide was subjected to the scrutiny by the thesis supervisor and the Ethical Review Committee of the Ghana Health Service who made recommendations which were included in the interview guide. The external validity of this study was however low due to the fact that, the generalizability of this particular study may not be representative of clients utilizing CAC service in various R3M units in Ghana.

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3.10 Data Analysis

The interview data were transcribed verbatim from the audio-tape into written English and the transcripts were read manually and emerging themes picked. The audio-tape was replayed several times to ensure that the transcriptions has been done verbatim. Transcription of data was augmented with field notes taken during data collection. The information from the transcription was evaluated and analyzed thematically. The themes that emerged were used to address the objectives of the study.

Whilst reading through the transcripts, particular attention was given to statements of similar meaning that were present in most of the relevant data. The researcher then develop themes by putting together statements with similar meaning after reading through the transcripts several times.

In order to present the exact information obtained from participants and to minimize distortion of data the interviews were always transcribed the same or the following day that the interview had taken place. As Merriam (1998) observed the right way to analyze data in a qualitative study is to do it simultaneously with data collection. Notes and memos were also used so that the scenery of the interview were not forgotten. In the process of analysis the recorded versions of the interviews were replayed while reading through the transcripts so that the feeling of the spoken word were not lost.

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3.11 Ethical Consideration

Ethical clearance was obtained from the Institutional Review Board, the Ghana Health Service Ethical Review Committee for the study through a letter explaining the objectives and the purpose of the study. Permission was also sought from the Regional Director of health Services, the Medical Superintendent of the La General Hospital and the head of the R3M unit before the study was conducted. Verbal consent was obtained from all the participants after explaining the purpose of the study to them. Participants were allowed to ask questions about anything that they did not understand which was answered to their satisfaction to clear all doubts. They were also assured of confidentiality and anonymity. They were also informed of their right to refuse to answer a question or withdraw from the study at any point in time. Pseudo names were used instead of the actual names of the participants interviewed. Privacy was assured by not asking sensitive questions and the data was used strictly for the purpose of this research.

3.12 Limitations of the Study

A major limitation of the study is that participants were selected from one healthcare facility. Conducting the interviews on the facility's premises mighty have led to good responses from clients for fear of being victimized by personnel, although confidentiality was assured.

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CHAPTER FOUR

RESULTS

4.1 Introduction

The main thrust of this study is to examine clients' perception of comprehensive abortion care service at the La General Hospital. This chapter presents the analysis of data collected from participants. Key themes and categories from the data have extracted, presented and discussed here. In the service of this task, exemplary narratives have been thrusted into the discussions not only to embellish the discussions but also as a measure to remain as closely as possible to the voices of the participants as they represent (to a rather high degree) certain patterns found in the sample.

4.2 Participants Characteristics

A total of 21 women who visited the R3M unit at the La General Hospital to seek for abortion service participated in the study. Majority of them (12 out of 21) were between 18 and 25 years, all of them were Christians, majority were single and unmarried (57.1%), had secondary education (71.4%); were unemployed (71.4%) and came from different locations in Accra namely, La, East Legon, Ashiaman, Nungua and Osu.

Four main themes were developed from the analysis. These were the reproductive history of the participants, clients' perception of the quality of CAC service, the client's satisfaction with CAC service, and barriers to accessing CAC service. The names appearing in the analysis are pseudo-names and does not represent the true identity of the participants interviewed.

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4.3 Reproductive History

The reproductive history of participants which had influence on their decision to seek abortion was examined to further probe into the reasons for abortion. The results showed that nine (9) out of twenty-one (21) participants, representing (42.8%) were pregnant for the first time and three participants each had been pregnant two times, three times, five times and six times, respectively. The result indicates that 57% of the participants had no children. Among the remaining nine (9) participants, three (3) had one child, four (4) had three children and lastly two (2) had five children.

All the participants had knowledge of at least one contraceptive method. This finding was not surprising as most of the demographic surveys conducted in Ghana since 1993 reported a universal knowledge of modern contraceptive method among women aged 15 to 49 years. However, most of them (12 out of 21) had never used contraceptive. This may be due to the relatively young age of majority of the sampled participants knowing that the young ones usually feel shy as well as the fear of being stigmatized

All the participants mentioned that the current pregnancy that resulted in abortion was unwanted/unplanned. Most of the young and unmarried reasoned that they wanted to get pregnant at a later date when they are married. On the other hand the matured and married participants did not want to give birth again since they already had two or more children. For instance Amerley who already had five children wanted to stop child bearing in order to effectively care for the five children she already had. Such participants were worried that any additional child would worsen their already bad financial situation

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It was also found that fifteen (15) of the participants were having abortion for the first time. Six (6) had previous history of abortion with all of them having had abortion two times or more. These abortions were not performed in this same center, however, the women go to the center for post abortion care. Further probing revealed that three (3) participants bought medications from pharmacy/drugstores to self-induce the abortion at home. However, they were unsuccessful in terminating the pregnancy. All the three participants admitted that after the use of the medications either the pregnancy was still there (incomplete abortion) or they were bleeding profusely. They therefore sought medical treatment at a health facility. One participant described how she used cytotech to abort her pregnancy but was not successful. She narrated her story as follows:

> *The first time … was when after the birth of my first boy. I thought he was too young for me to give birth to another child. For this pregnancy I bought cytotech to do it. I have to tell you the truth. I used the cytotech to abort it but not all the foetus came out. So I went to … hospital where I was asked to do a scan. After that the doctor and the midwife removed it for me* (Amerley, a mother of four, IDI)

It is evident from the above narrative that the bad experiences with self-induced abortion is one of the reasons why some of the participants sought CAC services from the hospital in order to avoid a repeat of any complications.

4.4 Reasons for Seeking Comprehensive Abortion Care

Many reasons were given by participants when asked why they opted for abortion instead of carrying the pregnancy to term. These reasons range from unemployment to economic hardship and adding extra burden on the family. These reasons are discussed in detailed in the following subs-sections.

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4.4.1 Lack of Access to Finance

The analysis revealed that majority of the participants were influenced by lack of access to finances due to the fact that they did not have jobs. Akweley an 18 year old girl for instance said:

> *The first reason for coming for this abortion is that I am from a poor family background. Also I am not working and the man who got me pregnant is also not working. I am still living with my family and dependent on them. If I should give birth that would be an additional burden on my family.*

Another lady Abena, a 21 year old girl also reiterated her resort to abortion with the following quote:

> *I come from a poor background and cannot keep the pregnancy. I live with my single mother and with the financial problems we have at home, it will be difficult to keep the pregnancy now.*

The state of financial difficulty that some of the participants found themselves in made them lack monetary resources that could enable them take care of themselves during the term of the pregnancy as well as taking good care of the child when it is born.

Related to the need to avoid future hardship is the unemployment status of the men responsible for the pregnancies. Most of the participants said the men who impregnated them were not working. This means that they would have to shoulder the responsibility of taking care of the pregnancy alone as well as when the child is delivered. Coupled with the fact that they themselves were not working, the burden of caring for the child when born would be pushed to their parents who may be unprepared to care for a "fatherless" child. For example one participant asserted that:

> *I come from a poor family and the boy who impregnated me is an apprentice. He does not even give me money for my upkeep. Whenever I ask him money, he would give so many excuses. He doesn't even pick my calls anymore. I can't take care of the child alone when*

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> *the baby is born and I don't want the child to suffer in life like myself so I have to abort the pregnancy* (Dokua, SHS graduate from Osu, IDI)

It is clear from the above statement that seeking abortion was seen as an escape route to enduring hardship during pregnancy and upon delivery.

4.4.2 *Need to Complete School/Apprenticeship Training*

Another reason that was discovered as influencing the decision to seek abortion was the need to complete school and apprenticeship. Some of the participants were not ready to start a family because they were unmarried and were either in school or under apprenticeship training. Adjovi, a participant in her final year provided the following explanation:

> *…You see although, I come from a poor family, my parents want me to complete my education with good grades, enter the university, get a job and become a good person in the future. I can therefore not keep the pregnancy because I am still in school.*

In the thinking of this participant, carrying the pregnancy to term would not make her complete her schooling thus jeopardizing her chances of achieving her life dreams. This was emphasized by another participant with the quote:

> *I have aims and objectives in life, I must get rid of it and move on life* (Adjovi, an 18 year SHS student, IDI)

Similarly, participants who were under apprenticeship express sentiments of wanting to complete their apprenticeship training. Tawiah a 26 year old apprentice narrated that:

> *It was not my intention to abort this baby but because I am still an apprentice, I cannot keep the pregnancy. If I had completed my apprenticeship I would have given birth. If I should stop the apprenticeship, my money would go waste. I raised the money to pay for the apprenticeship training myself. If I give birth now, I have to take care of myself and the baby by myself. Also, by the time the baby is*

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> *old enough for me to come back to work I won't be able to raise the money to repay for another apprenticeship training.*

It is clear from the above narratives that participants do not want their education or apprenticeship training to be interrupted by unwanted pregnancy. Giving birth would mean that they would have to stop schooling or apprenticeship training to cater for the child. To avoid this interruption, they had to seek for comprehensive abortion care.

4.4.3 *Fear of Parents and Partners*

Another factor that influenced the participants to seek abortion was the fact that some of them were afraid of the reaction of their parents and partners. This was the case of most of the participants who were below 25 years. They were afraid of their strict parents who would not tolerate pregnancy out of wedlock. In the narration of a participant for instance, she noted that:

> *"I decided to abort because I was scared of my parents. My parents are strict and would not tolerate being pregnant when I am unmarried. I do not want them to be ashamed of me in the society. They might throw me out of the house onto the street. Therefore as soon as I knew I was pregnant I asked my friend who knew someone who had aborted before for her advice and help. She looked for information about where I can go to have the abortion and told me about two places and what to do. My boyfriend was working so he gave me money to undertake the abortion* (Faustina, a 21 year old SHS graduate, IDI)

In the case of another participant, although the parents of the boyfriend were in support of her carrying the pregnancy to term, her parents wanted her to abort because they could not stand the shame associated with their daughter getting pregnant out of wedlock. She noted the words of her parents as:

> *…a big disgrace for us if the church and members in the church got to know of the pregnancy* (Akweley, an 18 year old SHS student, IDI)

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Other participants were afraid that their partners would end the relationship with them and stop taking care of them if they discover that they were pregnant whilst still under apprenticeship. This fear is borne out of the fact that the man may not be ready for fatherhood and therefore deny responsibility for the pregnancy. Additionally, the fear is borne out of the possibility of losing the financial support from a new partner who has become a "savior" providing for their financial sustenance. The following statement is indicative of this situation.

> *I met this man not long ago. He is the only one supporting me with chop money as I am alone in Accra with my sister. He might have decided to marry me but if a child comes in early at this stage he might change his mind and abandon me like the first one. So I didn't tell him I was pregnant and he doesn't know I have come to abort the pregnancy. I just borrowed the money from a friend to come for the safe abortion* (Tawiah, a 26 year old apprentice, IDI)

The above statement is indicative of fear associated with either parents or partners getting to know that one was pregnant when it should not.

4.4.4 *Fear of Stigmatization*

The fear of societal stigmatization of women who get pregnant out of wedlock featured in the narratives. Some participants mentioned that they were afraid that neighbours would call them names and label them as bad persons or prostitutes. For this reason they had to be in hiding whilst seeking solution on how to deal with the pregnancy. The pregnancy had restricted their movements in terms of social and religious activities. A participant in statement noted:

> *My neighbours speak badly about girls who get pregnant. They say that you are a bad girl. Some of the boys would be laughing at you and calling you by different names. They would say you always pretend to be a good girl but you are a bad girl having sex around* (Agnes, a 21 year old SHS graduate, IDI).

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4.4.5 *Denial of Responsibility by Partner*

The data revealed that some of the participants had come for the abortion because their partners had refused responsibility for the pregnancy. Thus, in order to avoid giving birth to a fatherless child and shouldering the responsibility of taking care of the child alone, the option was for them to seek abortion. Adjorkor a 21 year old girl said in the statement:

> *...I would not have come for the abortion if he had accepted that he was responsible. I fear abortion and I did not want to do abortion throughout my life but because he is not willing to accept the pregnancy it would be a shame for me to give birth to a child without a father. People would insult me. I also have to look after the child alone so my parents thought the best way is to abort it. I don't like the pregnancy and my mother too does not like the pregnancy so I have to come and abort.*

For some other participants, the behaviours of the men responsible for the pregnancy gave them the impression that these men were not willing to accept responsibility for the pregnancy. A description of this impression was noted as follows:

> *My boyfriend was not willing to make a decision with me concerning the pregnancy; he won't call me and he won't pick my calls. I therefore had to take the decision to abort by myself. He didn't understand my situation. The past few days I was really miserable, so it's obvious that I do not need a boyfriend to get on with my life. I will focus on my studies* (Naki, a catering student from Nungua, IDI)

4.4.6 Having Too Many Pregnancies or Too Close Pregnancies

Some participants also explained that their reason for seeking abortion was due to closeness of space among their children and also to avoid having too many children. For some of these participants, they had failed to use a family planning method and therefore saw abortion as a family planning method option to deal with the unplanned pregnancy. A typical description of this situation was as follows:

> *I thought my baby was too young to have another baby again. I was not using a family planning method so this pregnancy took me by surprise and realizing that my baby is not even a year old, keeping this pregnancy will not help (*Selorm, a mother of four, IDI)

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Thus, for this participant, she was coming for a comprehensive abortion care to remove a dead fetus after she had tried to self-induced abortion with herbal medicine.

4.5 Client Perception of the Quality of CAC Service

4.5.1 Perception of Service Accessibility

Clients' perception about accessibility of the comprehensive abortion care was measured by location of the service, the time between arrival and being attended to at the CAC unit, the procedure time and the cost of the service.

All participants perceived that the R3M/CAC unit was not difficult to locate. The ease of locating the R3M unit was based on the fact that most of them (15 out of 21) had already received direction to the unit from the people who gave them information about the availability of the service within the hospital. One participant narrated this as follows:

> *I got to know about the abortion centre through my grandmother. She helped one of my auntie's children to abort her baby at this hospital. So it was she who directed me here when I told her of my situation and intention to abort the pregnancy* (Akua, 18 year old SHS girl from Ashiaman)

Another participant also had this to say:

> *It was a friend who had been here before who directed me. So I knew exactly where to find the place where the abortion is done* (Tawiah, 26 year old apprentice from Nungua).

A few of the participants (6) however came to the hospital to ask for the location of the R3M centre from either the nurses working in the hospital or clients who had gone to seek other services. The

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field observation indicates that the R3M unit is located on the left side of the main gate just opposite the main car park and the Out Patient Department. It is therefore easy for people seeking abortion to locate the unit.

Concerning the time spent at the facility before being attended to, it was discovered that almost all the participants perceived that they did not have to wait long before they were attended to. They were attended to immediately they arrived at the unit. When asked to describe the time they have to wait to be attended these participants gave positive evaluations such *I did not* wait *for long, it was within a short time, immediately I came, it did not take a long time, You don't have to wait for long ... they call you as soon as they see you sitting or waiting etc*. However, a few (3) of the participants mentioned that they were made to wait for a longtime before they were attended to. This annoyed them and added more pain and psychological distress to their situation. This is how one participant explained her experience.

> *The waiting time is too long. They made me wait far too long. They postposed it before and made me come today but I have to wait for more than two (2) hours because the nurses said the midwife was busy with some students. Because of that I became hungry and felt dizzy after going through the procedure* (Ewoenam, a 36 year old mother of five from La).

Generally, such delays do not occur in the facility. Delays are just occasional occurrences as most of the participants acknowledge the prompt provision of services clients need from providers in the facility.

Interestingly all the participants perceived that the time spent to perform the abortion procedure (procedure time) was short because for most of them the procedure did not last for more than 30

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minutes. Further analysis of the data revealed that most of the participants thought the procedure was going to take a longer time but were surprised at how short the abortion procedure was completed, mostly in less than an hour leading to their immediate discharged to go home.

> *There is nothing wrong with the whole procedure. It was faster than I thought. I thought it was going to take the whole day but the whole procedure did not go beyond even 30 minutes. I came this morning and they have already finish for me to go home* (Akushika, a 21 year old apprentice from Nungua).

All the participants also perceived that the operating time of the facility was very good. They were happy that they can come very early to the centre which was always opened for them to be attended to. One participants emphasized that the first time she intentionally came early to make enquiries about the availability of the service from nurses who reported early to work, she met midwives who work at the R3M unit already at post. She was given immediate attention and asked to report back on scheduled day for the medical doctor to perform the procedure for her. On the scheduled day, she went early and the procedure was done for her. This is how she evaluates the operating time of the unit:

> *I think the way they do their things here is very good. They come early so when you are in they would do it for you to go home. You can have time to rest and go home and nobody would know you were coming from here* (Ajovi, a 19 year lady from Nungua, IDI).

Fifteen (15) participants believed that the cost of the service was affordable or okay for them whilst six (6) participants maintained that the price was high. The affordability of the CAC service is captured in the narratives of two participants below:

> *The price was cheap. I thought it was going to be expensive. When I asked my husband and he said he was not having enough money I became worried and restless. I have to go to friends and family to look for more money. But now I am really happy because the problem was quickly solved and the price is okay"* (Adjeley, a 31 year old fishmonger from La, IDI).

Another participant full of smiles and laughter with her head bowed down admitted ‘

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*… it is okay. They have safely aborted the pregnancy for me which has made me free (*Ewoenam, a 36 year old mother of five from La, IDI*).*

It can be inferred from the above narratives that the cost was affordable because they perceived it was lower than the financial cost of carrying the pregnancy to term. This include the cost of caring for themselves during the pregnancy (including ante-natal visits), the cost of delivery and the cost of the upkeep of the child when delivered. It was also perceived affordable when compared to the social cost/stigma attached to giving birth out of wedlock or having births at close intervals which is frown upon by society.

Participants who perceived the cost of the service to be too high based their arguments on comparison of cost of the service in the studied facility to that of other health facilities. They reasoned that the cost of the same service was cheaper in other abortion clinics as explained by one participants as follows:

> *The cost of the service is a bit too high. I was charged GHC 500. My friend told me when she did her abortion at another government hospital, she was charged GHC 300. I don't know why I have to pay GHC 500 here* (Borteley, a 33 year old client from Ashiaman, IDI)

It is obvious from the above narrative that this participant lack information on various types of abortion services available at the unit and the associated cost of each service. This finding points to the necessity of the midwives and the nurses at the unit to always inform clients of the type of abortion service available and their costs.

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4.5.2 *Perception of Family Planning Counselling*

According to the guidelines for the CAC procedure, clients are supposed to be given family planning counselling before the abortion procedure and after the abortion procedure. The results of this study demonstrates that most of the participants (16 out of 21) were given pre-abortion family planning counselling. Further analysis of the data proved that for some of the participants family planning counselling was given to keep the pregnancy or not, the need for family planning and education on the types of contraception available, etc. They were also counseled on procedure options for each of the family planning methods and their side effects. Furthermore, they were made to choose their family planning methods and advised on how to use it or a date is fixed for them to go for their choice of long-term family planning method.

However, some of the participants interviewed perceived the family planning information provided as very scanty as it only involved the midwife telling them they '*need to do family planning'* and that there is this particular long-term contraceptive method which is suitable for them. Further analysis of the data revealed that most of the matured participants (25 years and above) perceived that enough contraceptive information was provided whereas most of the participants under 25 years perceived that little or scanty contraceptive information was provided to them. One participant described this shortcoming of the family planning information as follows:

> *She (the midwife) did not say anything to me about family planning except that she asked me why I wanted to abort the pregnancy which I explained to her. She then said that I will have to do the 5 years family planning. But she did not tell me which medicine she would give me,… when I should come for it and what would be done to my body because I hear for some of the family planning methods they would insert it into your body. I also know that some of the family planning methods have side effects which I am afraid of.* (Maabena, a trader from Ashiaman. IDI).

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It is clear from the above narrative that the midwife is by this scanty information restricting the client to only long-term contraceptive information and usage whilst there are a wide range of short-term contraceptive methods available.

Further analysis of the data produced evidence that this way of prescribing the contraceptive method by some midwives had resulted in some of the clients experiencing severe side effects of contraceptive methods and had therefore stopped taking contraceptives. Consequently they became pregnant and had reported to the CAC unit for abortion. This is the case of one of the participant who described her challenge with the contraceptive information and side effects as follows:

> *She did not talk to me much about family planning except that she asked why I didn't come for family planning at the unit. I told her I have once done it here before but I was feeling dizzy so I had to stop the family planning. Then she asked why I didn't come for her to change the family planning method for me (*Adwoa, a 34 year old trader from East Legon).

Most of participants reported that they were not given post abortion family planning counselling. Some of the participants confirmed that the midwife or the medical doctor who performed the abortion service did not say anything about family planning to them after the procedure. This means that these women have missed the opportunity to have information to prevent pregnancy in the short-term or long-term. The following account from a participant's experience throws more light on this situation in the facility:

> *She did not say anything about the family planning methods. But the first time I came she spoke to me about family planning. She told me that after the abortion procedure they would give me a family planning injection which would protect me for 5 years and another one for 10. So I must choose one. I told the midwife I would like the 5 years one but would like to discuss my decision with my mother first* (Naa Shormeh, a 21 year old SHS graduate from Nungua)

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Despite the shortcomings of the family planning counselling, it was found that most of the participants were of the view that the family planning information provided them was important. Some of the participants reasoned that it was an important eye opener for them and they wanted the information to be shared in their community because of the massive benefits women and society would derive from using family planning methods. One participant stated that,

I really appreciate it because I always hear of family planning but don't know anything about it ... but now I know (Agnes, a 19 year old SHS graduate, IDI)

Besides, the family planning counselling offered the participants the opportunity to know more about the existence of more contraceptives methods which some of the participants did not know about. They initially knew of the pills and the condom but have come to know more contraceptive methods. Some of them also reasoned that if they had known of the availability of the various contraceptive methods and how affordable they were at the unit, they would not have gotten themselves pregnant in the first place and seek for abortion afterwards. In the opinion of some of the participants the family planning methods information was very educative to the extent that it cleared their doubts and fears of using them. The following two narratives by two participants indicate how clients seeking abortion perceived information they were given on the family planning methods.

> *The family planning counselling is very educative for me. I have always been scared of what would happen to me if I do the family planning because I don't have a child. But she (the midwife) convinced me that whether I have a child or not I can be on any of the family planning methods* (Adjovi, from Nungua, IDI)

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> *I see it (family planning) to be vital because I have decided not to do family planning again because of the problems I was having with the method I was using. But with the counselling she gave me, I think I have gotten a method to be using again which can solve my problem because I don't want to do abortion again* (Serlorm, from East Legon, IDI)

The above accounts indicate how the participants in the study perceived counselling on family planning methods in the La General Hospital CAC facility.

4.5.3 Perception of Information on Fertility after Abortion

A revelation relating to family planning information provision suggested participants were not given adequate information. Many participants (11 out of 21) indicated that they were not given information on fertility-related issues after abortion. This probably explains why some of the participants such as Odarley with three children, have multiple abortions.

> *I have three children and this is my third abortion. I realize that I often get pregnant just after I have come for an abortion. The midwife gets angry with me saying I have not done family planning when I perfectly know I am very fertile. She said she will give me some of the one month or three months contraceptives. But after the procedure she did not say anything about the family planning again. She just said I must take very good care of myself and be careful not to get pregnant again and come for another abortion because she will not do it for me* (Odarley, 27 year old mother of 3 children. IDI).

From the narrative above, it is safe to conclude that this client is likely to get pregnant again and seek for another abortion because she had not been provided with the information that can help her delay or prevent pregnancy.

4.5.*4 Provision of Information on Types of Abortion*

It is very important that clients seeking abortion service are informed about the various types of abortion services available at the health facility. This would help clients to make informed choices about the type of abortion service and the consequences in terms of side effects. This will inform

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their choices based on their financial strength and circumstances of the pregnancy. In this study, out of the twenty-one (21) participants, only a few (6) were provided with information on the types of abortion services available at the Centre. They were made aware of the availability of both medical and surgical abortion procedures and informed of the option that was applicable to their situation as captured in the narrative below:

> *…She told me that if the pregnancy had been two months or less she would have given me some medicine which would make the pregnancy come out like blood. But because my pregnancy is three months she will do D&C for me. So I think she is doing a very good job* (Naa Shormeh, a 21 year old SHS graduate from Nungua, IDI)

The remaining 15 participants affirmed that they were not informed of the various types of abortion procedures. It was gathered that after the medical personnel had examined the scan and interviewed the client, they proceeded to perform the abortion. This situation is captured in the account of a participant:

> *The midwife did not explain the various types of abortion procedures to me. When I told her I was one month pregnant she just gave me the medicine to insert and come back in three days' time. She wrote a list of medicines for me to go home and take and told me that if I am in pains I should just lie down* (Delali, an apprentice from Nungua, IDI)

It is obvious that very often clients are not provided with adequate information to enable them know exactly what they are getting. This frowns on the patient charter which requires medical personnel to inform clients of procedure options and medications to use.

4.5.5 *Perception of Pain Management Information and Pain Management*

It is an essential part of CAC provision that clients are given information on pain and how it would be managed. The findings showed that most of the participants (18 out of 21) were given pre-

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abortion pain management information. They were told they would experience pain during the abortion procedure. They were, however, assured that they would be given anti-pain medication so they must not be scared during the procedure. The pre-abortion pain management information provided contributed greatly to the success of the procedure without any complication. Since the pain management information made the clients aware of pain during the abortion procedure, they knew what was going to happen to them in the procedure room and therefore prepared themselves towards it. This is exemplified in the quote below:

> *The doctor already told me that I will have pains but I have to be cool. I don't have to be jittery otherwise I will be weak. So because he had already explained the procedure to me everything went on well. I knew what was going to happen so I also plan towards it and cooperated to manage the pain* (Ewoenam, a 36 year old mother of five, IDI).

Another participant also had this to say:

> *I was afraid but the way they (midwife and doctor) talked to me before the procedure took away the fear and made me feel comfortable during the procedure (*Rebecca, 31 old trader from Ashiaman, IDI).

Thus, the participants valued the effort of the medical personnel to control the pain and help them feel comfortable during the abortion procedure. From the narrative it is clear that the information provided to the participants enabled them comport themselves and behave appropriately during the abortion procedure.

It was also found that whereas a few of the participants were given information on post-abortion pain management, most of them were not given information on how pain would be managed after the abortion procedure. One participant described her situation after the procedure in the following quote:

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> *She (the midwife) did not give me medication. The midwife told me to just lie down to calm down the pain after inserting the medicine. I don't know what would happen because I only ate in the morning* (Naa Shormeh, a 21 year old SHS graduate from Nungua, IDI).

4.5.6 *Perception of Privacy and Confidentiality*

It was found that majority of the participants believed that the midwife and medical doctor who performed the abortion procedure made sure that their privacy was not breached. The participants maintained that the theatre room was locked before the procedure began. Findings showed that in situations where the procedure was performed by the midwife, it was only the medical staff present in the theatre with the client. However, if the procedure was performed by the medical doctor then, it was the midwife who joined the medical doctor. Participants explained that they felt safe and their privacy was respected. As noted by one of the participants with the quote:

> *My privacy was well respected. The door was locked so that nobody would come inside. It was only the two of them, the doctor and the midwife and myself* (Maabena, a trader from Ashiaman, IDI)

Even though a couple of participants said that their privacy was breached. This is because the midwife allowed two other nurses to join her in the theatre whilst the procedure was going on. Checks revealed that the said nurses were students undergoing training to practice the provision of safe abortion. This practice is allowed, however because the midwife did not informed the patient that the nurses were students undergoing training, she thought her privacy has been violated.

4.6 Client Satisfaction with CAC Service Received

Client satisfaction with healthcare service is an important measure of the quality of healthcare as it affects clinical outcomes, patient retention and medical malpractice claims. Patient satisfaction

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is an effective indicator to measure the success of care providers and facilities. This is because client satisfaction and dissatisfaction indicate patients' judgment about the strengths and weaknesses of the service being given to them.

Three main abortion services were sought by the participants. Majority of the participants fifteen (15) sought for safe termination of their pregnancy. Also three (3) participants sought for treatment of incomplete abortion and another three (3) participants sought for treatment of intra-uterine fetal death. It was observed that all the participants in the study were taken through the essential elements required for comprehensive abortion care. All of them admitted their vital signs were taken. They were made to take pregnancy tests and a scan at the CAC unit in order for the medical personnel to determine the gestation period of the pregnancy. It was observed that although some of the participants could tell the gestation period of the pregnancy they were required to go for the scan in order that the exact gestation of the pregnancy is determined. The analysis also revealed that participants were provided with information on family planning, types of abortion services available and the cost, pain management, post abortion care and fertility after abortion. It is therefore safe to conclude that to a large extent the medical personnel at the R3M unit are adhering to both WHO and the Ghana Standards Protocols on Comprehensive Abortion Care which include speculum exam, assessment of the size of the uterus, and confirming pregnancy with a pregnancy test.

4.6.1 Participants' Satisfaction with Client-Provider Interaction

The results demonstrate that all the participants interviewed were satisfied with the care they received at the comprehensive abortion care unit at the La General Hospital. Participants were

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satisfied with various aspects of the care they received at the unit. Participants gave positive evaluations of the client-provider interaction. They were satisfied with how the staff of the unit talked to them in a friendly and polite manner. This made them feel comfortable and respected by the medical staff of the unit. Participants on several occasions mentioned how the medical personnel from the midwives and nurses at the reception, scan room and in the procedure room took their time to talk to them, explained the issues to them and gave them directions on where to go for a particular service. A positive evaluation of the client-provider interaction is described below:

> *Nobody shouted at me. They are nice people especially the midwife. She spoke to me like a Christian mother. She encouraged me to keep it (the pregnancy) no matter the circumstances but after listening to me she said she will do the abortion for me and then do a family planning for me* (Ewoenam, a 36 year old mother of five from La, IDI).

Another participant also said

> *The midwife held my hand and helped me to the recovery ward to lie do. She is a very nice person. All the nurses here are nice and friendly. They don't shout on people as I thought* (Adjorkor a 21 year old girl, IDI).

They were satisfied with how the midwife patiently took her time to talk to them in a friendly manner. Some of the participants were shocked by this friendly attitude of the midwife. This is because they expected her to be harsh and maltreat them. Rather she was patient, consoling, supportive and friendly.

4.6.2 Participants' Satisfaction with Family Planning Counselling

Other participants were satisfied with the pre-abortion family planning counselling. They were happy to be educated on the various family planning methods available. For some of them, the

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first time they ever heard or got to know of some of the long term family planning methods was during the pre-abortion family planning session. Others had their doubts and fear of some of the family planning methods cleared. Some of them said they had discontinued the use of some contraceptives because they experienced side effects which caused them great discomfort. Satisfied with the family planning counselling, some of them admitted they were even willing to educate their friends on family planning and encourage them to use it. A typical description of this satisfaction is presented below:

> *I like the family planning counselling. I did not know anything about family planning. So therefore I consider the information she gave me is very sufficient. She said I was fertile so I need to be on family planning to avoid further abortion. She taught me how to use the pill or the injection which will last long and give me peace of mind to focus in life (*Abena, a 21 year SHS graduate, IDI)

> *The family planning is good because through that I have gotten to know other methods that I can use that would not give me problems and can explain to my friends who have bad perception about family planning to start using it because it would help us a lot (*Tawiah, a 26 year old apprentice, IDI)

These participants having been counselled on family planning methods available were even willing to share the information with other people.

4.6.3 Participants Satisfaction with Pain Management

Furthermore, participants gave positive evaluation of the pain management by the midwife and the medical doctor during the abortion procedure. They mentioned that the doctor and the midwife were skillful at managing the pain during the procedure. Some of them appreciated how the midwife helped them to control the pain during the process by psyching them up with comforting words and reassuring them that the procedure would end within a short time. She also taught them

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the strategy of breathing through their mouth to calm down the pain. Some praised the midwife for helping them control the pain after the abortion procedure because she helped them to the recovery ward, and monitored them from time to time. Consequently they felt that the procedure was less painful and less difficult than they had anticipated as expressed in the statement of one participant below.

> *I am satisfied with the whole procedure. I know that there is another abortion unit in another hospital where the procedure is difficult and painful. But the doctor took his time to do it for me. I think that the way he did it, which is the way it should be done. He did not shout on me* (Dorcas, a trader from Nungua, IDI)

4.6.4 Clients Satisfaction with Environment and Facilities of the CAC Centre

Some of the participants were satisfied with the availability of facilities such as the recovery ward where they go to lie down for the pain to calm down. They were satisfied with this because it allowed them to spend some time at the unit to make sure they were strong enough before they went home. Some of them were happy that on the recovery ward, the midwife and medical doctor observed them and attended to them when there were any complications. As noted by a participant:

> *I think the unit is good and the procedures are very good. For instance I hear at other places as soon as the doctor finishes the procedure you have to go home. However, at this place they allow you to lie down for a while. I think this is good because they can observe what would happen to me immediately. For instance I was feeling dizzy after the procedure so it was good they allow me to lie down for a while (Borteley, 23 year old client from Ashiaman, IDI)*

The availability of the recovery ward therefore made the participants to think that they were being properly cared for and monitored by competent medical personnel who would attend to their needs should there be any complications. Additionally, the participants admitted that the CAC unit is very neat. Participants were surprised that even though the La General Hospital is an old hospital, the facilities at the R3M unit are modern and the place was kept neat by the staff. They therefore

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described the R3M unit as a nice place to be. The neatness of the R3M unit made the participants felt comfortable whilst waiting to be attended to. The neatness of the place also assured the participants that there are modern facilities and equipment within the CAC unit to cater for their procedure.

4.7 Barriers to Accessing CAC

Participants were worried about four major barriers to accessing the CAC service. The first was information on where CAC service could be obtained, the second was money to pay for the cost of abortion service and the third was fear and the last was stigmatization. These barriers are discussed in detail below.

4.7.1 Lack of Information on the Availability of CAC Service

All the participants maintained that they did not know of which healthcare facility to go for safe termination of their pregnancy. A good number of the them (18) have to ask friends, relatives such as sisters, aunties and grandmothers to direct them to "a good" clinic where they can obtain safe abortion because they were afraid of the potential risks and complications of getting it from quack medical personnel. The search for a good clinic is informed by rumors from their neighbourhood and media reports of many tragic stories regarding illegal or unsafe abortions. Most of them had the perception that abortion is dangerous and would suffer from severe complications including even death if they did not get a good clinic for the abortion. Some of the participants mentioned they have head of complications such as death, infertility, pelvic inflammatory disease and uterine perforation after undergoing illegal abortion. A 23 year old participant recounted how her decision

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to look for a good clinic was influenced by the recent death of a lady from self-induced abortion in her neighbourhood:

> *Recently a certain lady died in the vicinity and it was rumoured that her boyfriend gave her medicine to abort the pregnancy. I don't want to end up like her. Others also use all sort of concoctions which make them bleed and become sick and very slim. When that happens everybody would know that you have had abortion (*Oboshie, a 23 year old apprentice from Osu, IDI).

Another participant recounted how women in the neighbourhood who resorted to self-induced abortion with herbal concoctions become infertile and unable to give birth for the rest of their lives. That influenced her decision to look for a good clinic.

> *I hear some sisters in the neighbourhood had used herbal mixture to abort their pregnancy in the past and ever since, they have never been pregnant again. Some have been divorced because of that. That is why I have to wait and look for this hospital for the abortion* (Agnes, a 19 year old SHS graduate, IDI).

4.7.2 Fear of Complications

The search for a good clinic is generated by fear of complications resulting from unsafe abortions undertaken by individuals at home. Most of the participants mentioned that they felt nervous about the upcoming abortion procedure especially the severe pain they have heard is associated with abortions. This fear and anxiety were caused by misinformation and myths surrounding abortion as Shormeh admitted:

> *I was scared because my friends told me the equipment they use for the abortion are metals.*

Another participant also described her situation below.

> *I was worried about how to find a good hospital for the abortion. I did not want to hurt myself as I have heard others have done to their womb. I cried hard at night and told myself not to be hurt since it is painful and I might die. I finally had to tell me friend who told me about this place and another hospital in Ashiaman where I live. But I had to come here because I don't want anybody to see me* (Borteley, 23 year old client from Ashiaman, IDI)

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Participants were also concerned with the need for competent health personnel to perform the abortion for them. Even though they wanted to get rid of the pregnancy, they would not put their lives at risk in the hands of incompetent medical staff in some hospitals. Amaki from La Akrowah was faced with this situation and explained her reason for coming for the CAC service from La General Hospital as follow:

> *There is nearby hospital in my area that also performs abortion. But my brother would not allow me to go there because he does not trust their skills in managing abortion. Moreover, I always attend a general hospital because the personnel are experienced, matured and have no bad record. I don't attend private hospitals. Moreover, I don't want to go to a hospital where the pain would be severe* (Amaki, 22 year old girl from La, IDI)

4.7.3 Fear of Stigmatization

Another barrier identified was fear of stigmatization. In most Ghanaian communities, abortion is considered murder and stigmatized. Consequently, the participants wanted to keep their abortion secret. They did not want to be seen coming from an abortion clinic. Although participants were looking for "a good clinic" they were not interested in a healthcare facility that was close to their neighbourhood for fear of being seen by neighbours. This shows that participants were much interested in keeping the abortion procedure secret as expressed in the following quote:

> *I did not go to the abortion centre in my vicinity. News of abortion easily spread around and I don't want people to know about my pregnancy and start insulting me that I am a wicked person or a murderer. I prefer this hospital because it is far away* (Rebecca, 31 old trader from Ashiaman, IDI)

The need for secrecy explains the reason why some of the abortion clients interviewed had to come all the way from Ashiaman, Nungua, East Legon and Osu even though there are CAC facilities closer to these communities.

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4.7.4 Lack of Finance

The other abortion barrier they were worried about is finding money to pay for the cost of the service. Most of them admitted that they were also worried about the possible medical expenses involved in the abortion. This was a big burden for them because majority were unemployed and for some of them the worst part was that their partners were also not working to support them financially. The problem of finance is also compounded by the need to conceal the pregnancy and the abortion intention from parents in the case of some of the teenagers or partners who might be in position to support them financially. Further probing suggested that most of the participants were not from very poor background that would make it difficult for their parents to pay for the abortion service. But because they wanted to hide the abortion from their parents, they had to look for the money themselves. They have to consult friends and other relatives to ask about the prices of safe abortion in some of the hospitals where the service is available. They were given different price ranges. Some were told the abortion would cost GHC 300, others were told it was going to be GHC 1,000 and still others were told the procedure would cost GHC 500 or 150.

The analysis of the data revealed that a few (4) participants informed their relatives of the pregnancy and obtained financial support from their mothers, grandmothers or siblings for the procedure. These participants would have preferred not to inform their relatives about the pregnancy if they had gotten financial assistance from their male partners. Also ten of the participants discussed their concerns with their partners and asked for financial support. One participants described how she got her financial resource as follows:

> *When I found out that I was pregnant, I called my boyfriend directly to tell him about the pregnancy and the fact that I wanted to abort it because of our situation at home. When he agreed I told him to prepare money for the abortion* (Akua, 18 year old SHS girl from Ashiaman, IDI).

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The rest had to use their own savings or borrow money from their friends due to refusal by their boyfriends. This refusal had caused the participants to delay going for the abortion. This delay had caused them great emotional pain and psychological distress because they have to get rid of the pregnancy before it becomes too obvious for people to see. A typical case is Ewoenam from Osu who said:

> *I asked him to give me the money for the abortion but he kept telling me he was not responsible for it and even if he is responsible he is not having the money now so I should fixed myself up because I caused it. I have no option but to go from one friend to another to borrow money to do it and be free.*

It is clear from the above quotes that abortion is a complicated and difficult decision for most of the participants, not to mention the possible thoughts of the negative outcomes afterward. The participants had to seek information about where CAC service is available, carefully choose a creditable abortion clinic which is able to offer secrecy and anonymity to have the abortion done. However, due to inexperience, lack of information on locating the CAC facilities and limited financial resources, they underwent great physical and psychological stress before the abortion. Even when they have information on where to locate the CAC facility, lack of financial support meant that participants had to delay their abortion to obtain enough money needed and hence increased the risks to physical health. Thus, some of them have to go home after being told of the cost of the abortion to look for more money to pay for the cost of the procedure. Mabena for instance had to go back to her husband to ask her for additional money because the GHC 200.00 she brought was not enough to pay for the service.

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CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

This study aimed at examining the perceptions of clients about CAC service in the La General Hospital. This chapter discusses the findings of the study in relation to its set objectives. The findings are discussed in relation to the perception of quality of CAC service, the client satisfaction of the CAC service and barriers to the use of CAC service.

5.2 Perception of Quality of Comprehensive Abortion Care

Perception of quality of CAC service before, during and immediately after the abortion procedure is a very important determinant of whether clients would like to repeat abortion at the same healthcare facility or not. Participants gave positive impressions about the accessibility of the CAC service. The CAC unit was easy to identify as it was located at the main entrance of the hospital. However, before reporting to the CAC unit, some of the participants did not have information about the availability of CAC service within the hospital. They sought information from friends and family members to get information on the availability of the service. This caused unnecessary delay in seeking the CAC service by some clients. This finding is consistent with that of Goodman et.al (2006) who also noted that awareness and access to safe abortion care are two of the major barriers for women to get safe abortion services. The finding is also consistent with Becker et al., (2011) which found that clients thought that service accessibility was good; 24% said it was very easy to get an appointment at the site, and 60% said it was easy. This means there

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is the need for all healthcare facilities providing CAC service to make their service known to the general public through various media platforms.

Also the waiting time to be attended to and the procedure time for the safe termination of the pregnancy were short. Client were attended to immediately they arrived at the unit and the procedure lasted between 20 to 30 minutes. Thus, the responsiveness aspect of the service is high here as the CAC providers were available to provide prompt and timely service to the client. The result confirms the observations of several studies. For instance Liambila et al., (2015) in a study of abortion in service in private facilities in Kenya found that most clients (88%) reported that the waiting time was reasonable with no significant differences between study sites. Also Weiebe and Sandhu (2008) found that waiting times for an abortion in Canada are significantly shorter, particularly in private clinics. Becker et al., (2011) study in Mexico also found that most clients considered the hours of operation to be convenient. However, they noted that total time spent at the facility the day of the abortion was rated less favorably. The CAC unit is doing very well by quickly attending to the clients immediately they arrive since any further delay at the facility could cause them to be anxious. This is because most of the clients interviewed wanted their abortion to be secret. They did not want their parents, relatives and other members of their community to know of the abortion because of the stigma attached to it. The result is however contrary to the result of Baker, Akgun and Assaf (2008) who study of 472 patients in Turkey found that responsiveness and reliability dimensions get the lowest expected scores of all dimensions.

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It is discernable from the data the tangible aspect of the CAC service was high. This is because it was found that there were a number of medical doctors, midwives and nurses available to attend to clients. Also, the R3M unit has equipment such as a scanning machine, ambu-bags, suction apparatus, oral air ways and oxygen apparatus. There are also facilities such as a recovery ward with eight (8) beds, toilet, running water, a polytank fitted with a pumping machine, a blood bank, a generator set and torch light in case both the electricity and the generator power go off. The centre is also neat and very quiet. This findings contradict the observation of Jabnoun and AL.Rasasi (2005) whose study of six hospitals in the United Arab Emirates found that the tangibles dimension had the lowest score of expectation of all five dimensions.

The empathy aspect of the CAC service was found to be high as illustrated by the way the participants described the way pain was managed during and after the abortion procedure. The perceived quality of pain management was very high as reported by the participants. All the participants interviewed reported that they were given pain relievers to control the pain during and after the abortion procedure. The medical personnel also educated the clients on how to act during the procedure. For instance, they were advised to take in deep breath to minimize pains during the abortion procedure. The medical personnel attending to them during the procedure consistently reassured them that the procedure would soon be over for them to be relieved of any pains and anxieties. The words of reassurance prepared the clients making them take their mind off their discomfort regarding the associated pains and anxieties. These findings are consistent with the findings by Becker et al. (2011) in a study of CAC provision in Mexico City in the United States. They found that the quality of care is generally viewed as high. Most of women said they were treated well by the staff, that the service was easy to access, that the facility was clean and that the

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doctor who attended to them was technically skillful. They also perceived that they had received adequate pain management and sufficient pre-abortion information about the procedure and self-care at home after the abortion.

Service reliability on the other hand is average. From the data collected the participants believed that the midwives and medical doctors performed the abortion procedure to the satisfaction of the clients. Despite the high appraisal of the perceived quality of CAC service experienced by the participants, some weaknesses were observed regarding the provision of information on the various aspects of the CAC service. The first weakness was the inadequate provision of family planning counselling information. However, family planning counselling is a critical component of CAC service provision. Nurses and midwives have an important role in providing education on different contraceptive methods as well as contributing to safe abortion care (Correa & Petchesky, 2013). According to IPAS (an international NGO) protocol, all women should be counseled before and after the abortion procedure to discuss their fertility desires and contraceptive needs.

However, most of the participants were not given enough information on the various family planning methods available. They were provided with just a few long-term family planning methods that the midwives thought would be appropriate for their situation during the pre-abortion family planning counselling session. This amounts to keeping the clients in the dark on family planning information that can help them take control of their reproductive lives and decision making. The recommendation of the long-term family planning methods were also not based on the medical eligibility of the client for the method. Such recommendation should have been done

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after examining the medical condition of the client, her reproductive needs and the suitability of the contraceptive method for her.

The weakest part of information provision was the provision of post-abortion family planning counselling. Most of the participants were not given family planning counselling after the procedure. This means that some of the clients left the unit without any method to prevent future pregnancy or how to delay childbirth or space births, a situation that Verma (2006) describes as *"failing her twice"*. The young and unmarried girls who were still in school or undergoing apprenticeship also left the CAC unit without much contraceptive information and method to postpone motherhood whilst the married also left the CAC unit without any contraceptive information and method to space births or end childbearing. For these clients, the risk of getting unwanted pregnancies and seeking for repeated abortions is very high. The number of women patronizing the abortion service at the facility without receiving adequate information on family planning methods from providers can be considered as a missed opportunity by the facility and its staff to educate their clients who have great need for contraception.

These findings are discouraging since contraceptive education is important for all women who undertake abortion or experience miscarriage. International organizations such as the USAID and WHO recommend an interval of at least 6 months before pregnancy in order to reduce the risk of adverse maternal and perinatal outcomes (USAID & ESD, 2009). This calls for more attention to be paid to the provision of adequate and appropriate family planning information at the centre. The fact that most of the participants have intention to postpone motherhood, delay pregnancy and a few intended to end childbearing points to a critical demand for the family planning counselling

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service. This finding is contrary to the observation made in an earlier study by the Ghana Population Council (2011) that a high number of CAC clients were given more information on family planning. The Population Council found that CAC providers took clients through counselling and allowed clients to choose their preferred method

Another weakness of quality of the CAC service was the provision of information on the types of abortion service available. They were not informed of the availability of medical and surgical abortions and why a particular procedure should be used to abort their pregnancy. The medical personnel made the choice of abortion procedure based on their assessment of the results from scan and pregnancy test. This contrasts the patient charter which requires that patients be provided with information on the medical procedures and options available to them. According to Sedgh et al., (2012) women have a right to be fully informed of their options for health care by properly trained providers, including information about the likely benefits and potential adverse effects of proposed procedures and available alternatives. Such information which is sensitive to her needs and perspectives must be complete, accurate and easy to understand, and be given in a way that facilitates a woman being able to freely give her fully informed consent. The finding is contrary to the result of the Population Council of Ghana (2011) which showed that the majority, 90.2 percent and 92.0 percent respectively of study participants had the opportunity to ask questions and chose a preferred method for their pregnancy termination. The result showed that the reliability dimension of the CAC service is weak as found by Wisniewski and Wisniewski (2005) and therefore need to improve upon.

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Lastly, the assurance aspect of the CAC service at the La General Hospital was high. This is because all participants maintained that they were treated with respect and courtesy and their confidentiality respected.

Cost of the CAC service was also seen generally as affordable by the participants. Almost all the participants in the study agreed that the cost of the CAC service was 'cheap' or 'affordable'. The service's affordability contributed to its accessibility and acceptability by the clients. The low cost of the service also promoted its utilization by the clients. The affordability of the CAC service was also promoted by the fact that most of them already had information about the cost of the service before arriving at the facility. Two factors explained the clients' financial preparedness for the service before going to the facility. First, they did not want providers to turn them away or criticize them for not having the money to pay. Secondly, the clients were determined to terminate the pregnancy at all cost because that was the only option left for them to prevent personal and family disgrace, interruption of schooling or apprenticeship training and go avoid future economic hardship that might result from early or multiple childbirth. These explain why some the clients had to borrow money from relations and friends to pay for the service. Thus, instead of cost of service being a barrier to CAC service utilization, its affordability and social concerns rather promoted it accessibility and usage. This finding is not consistent with findings from earlier studies by Henshaw and Finer (2003), Sethna and Doull (2007), and Jones and Kooistra (2011) which found that the cost of abortion process was a barrier to accessibility of the service. For instance the study by Sethna and Doull (2007) in Canada found that almost 20% of women who accessed abortion in a clinic reported that the fees were too high.

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5.3 Satisfaction with Comprehensive Abortion Care Service

Findings from the study shows that clients were generally satisfied with various aspect of the CAC service which include the client-provider interaction, the family planning counselling, pain management, and availability of equipment, supplies and medications were indications about the nature of service being offered in the La General Hospital facility. All the practices related to the CAC service such as pregnancy test and scan were done at the unit to the clients' satisfaction. The clients were also highly satisfied with the availability of facilities such as the recovery ward. They were also satisfied with the interpersonal communication between them (clients) and the medical personnel based on mutual respect.

The study further observed that the medical personnel were non-judgmental but rather friendly and treated them with respect by showing concern for their plight. This attitude made the participants felt relaxed to speak in detail about their condition. This finding support the observation of past studies that demonstrate high client satisfaction with the client-provider interaction (Crow & Hampson, 2002; Donabedian, 2003). These studies observed that such respectful treatments as provider's patience, concern, and attentiveness found to have a crucial impact on clients' satisfaction with the service.

Additionally, result showed that the nurses and midwives did not have judgmental attitudes towards abortion patients which is contrary to past studies where nurses were found to have condemned abortion and were judgmental of abortion patients (Mokgethi et al., Gmeiner et al., 2000; Harrison et al., 2000). The nurses and midwives in this study were rather seen by the

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participants as performing their duties and responsibilities towards clients who had come to the CAC unit for service as expected of them.

Another area where participants' satisfaction with the CAC service was high is the aspect of privacy they received before, during and after the abortion procedure. In CAC service unit it is the duty of medical personnel to protect the information given by clients by creating a respectful environment, with physical space for assuring privacy (Becker et al., 2011). It is widely recommended by experts and researchers that CAC and healthcare providers must have multiple skills for establishing rapport with abortion clients in an empathic manner and to treat them with dignity, so that the women would feel comfortable in sharing their abortion history with care providers (Leonard & Wringler, 1991; Wiebe & Sandhu, 2008). The fact that the participants were satisfied with the way the medical personnel respected and protected their privacy indicated the professionalism attached to service delivery in the unit. The participants rated the conduct of midwives in the unit high as they always locked the door to the abortion procedure room and the fact that the patient is always alone with the medical personnel they were supposed to see in the procedure. The procedure room is also located in a corner making it possible for clients to enter the room without being seen by other medical personnel and other clients in the R3M unit. The CAC unit is therefore doing well to protect the privacy of the clients they treat at the unit at La General Hospital. However, the procedure room needs expansion and further improvement.

5.4 Barriers to CAC Service Utilization

Four main factors were identified as hindering the access to the CAC service. The first factor that delayed their access to the CAC service was how to locate a facility for the service. All the

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participants admitted that they did not know of the existence of the R3M unit for the CAC service. They had to seek information from friends and relatives which compromised the issues of getting privacy for clients and hence the unwillingness for some of them to access the service. Thus, the major barrier was knowledge of the CAC service unit and access to the CAC service. This finding is consistent with that of Goodman et.al (2006) who also noted that awareness and access to safe abortion care are two of the major barriers for women to get safe abortion services. This situation calls for more advocacy and awareness creation on the new liberalized abortion law and the availability of CAC service units in selected healthcare institutions in Ghana. Secondly, the fear of abortion complication delayed the decision to seek early CAC service. This may be as result of participants hearing of complications from unsafe abortions from backstreet providers and untrained medical personnel. Thus, participants have the fear that the CAC service is also as dangerous and painful as the unsafe abortions conducted by backstreet providers.

Thirdly, the delay in accessing CAC service was due the cost of the service. Cost of the abortion service has also been found as a barrier in some studies. For instance Alemu (2010) that Lack of money and the perception of safe abortion service being expensive as barriers to women seeking safe abortion service. In the present study, even though majority of the participants perceived the cost of CAC service to be affordable, one of the reasons for the delay in getting money for the service was that most of the participants were unemployed and therefore had difficulty in getting money to pay for the service. This explains the reason why some of them had to borrow money

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from friends, whilst others were given money by their family relations and friends. Some also had to look out for a healthcare facility where the cost of service was affordable.

The fourth factor was fear of being stigmatised and therefore the need for secrecy in seeking abortion thus causing delay in accessing CAC service. Similar observation have been made by Hill, Tawiah-Agyemang and Kirkwood (2009); Alemu, 2010; Gammeltoft, 2003; Henry and Fayorsey, 2002; Baiden 2007. For instance in Ghana Hill, Tawiah-Agyemang and Kirkwood (2009) found that respondents perceive abortions as illegal, dangerous, and bringing public shame and stigma to them and their families. Also Gammeltoft (2003) study in Vietnam found that despite the relatively easy accessibility of abortion services, young women and men experienced stigma and expressed feelings of regret, believing that they had committed a sinful and immoral act which is resulted from their family and religious perception about abortion. These feelings led them to keep their abortion as a secret (Gammeltoft 2003). Within the Ghanaian context, the social context of abortion and pre-marital sex, pre-marital pregnancy or pregnancy out of wedlock serve as barrier to seeking CAC service. In the Ghanaian context, pregnancy outside marriage is frowned upon in many Ghanaian communities. Besides, abortion is stigmatized because it is a taboo subject. Abortion is considered as immoral, murder and sinful act in the society (Alemu, 2010; Baiden, 2007; Baiden et al. 2006). It is perceived as a shameful act and that only immoral women engage in it (Baiden et al. 2006; Lithur, 2004; Henry and Fayorsey, 2002; Baiden 2007). Consequently, all the participants wanted to keep their abortion secret. For this reason, even if there were healthcare facilities within their communities which provided CAC services, they would not seek for safe abortion from these facilities. They would rather to go to a distant healthcare facility that provides CAC service. By so doing, they avoid the possibility of being seen by neighbours. As

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observed by Olukoya et al., (2001) most of unmarried girls want abortion in secret and within short time as abortion is immoral in many societies .This explains why most of the participants had to travel long distances to the La General Hospital for the service. It is important to note that participants were not afraid of stigmatization from medical personnel as indicated in past studies (Harries et al. 2014; Mayers et al., 2005). They were also not stigmatized by medical doctors as found by Mayers et al. (2005).

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CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter presents the summary of the study, the conclusions and some recommendations that can help ensure that CAC services are rendered in a manner that can enhance its optimal utilization.

6.2. Conclusions

The provision of CAC services at the R3M unit has made CAC service available and accessible to women living in the catchment area of the La General Hospital and beyond. Four out of the five dimensions of service quality; namely, tangibles, responsiveness, empathy and assurance, were strong in the study. The responsiveness dimension of the service such as short time spent at the unit before being attended to and short duration of the abortion procedure, were positively perceived by the clients. The clients also perceived the tangible dimension of the service such as the availability of equipment and facilities and supplies, neatness of the R3M unit received high perception from clients. The empathy dimension of the CAC such as the patient-provider interaction, the respect accorded them, the protection of their privacy, the quality of pain management information received and management of pain during and after the abortion procedure were also evaluated more positively by the clients. Clients were satisfied with the perceived competence of the medical personnel at R3M unit, their demeanor, friendly attitude and willingness to provide the CAC service. There were friendly and qualified midwives and doctors

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available to render CAC services. However, the reliability dimension of the CAC service was weak. The provision of information on post-abortion, types of contraceptives, types of abortion services available and fertility after abortion was weak.

6.3. Recommendations

From the foregoing, the following recommendations are made to improve CAC services in the La General Hospital.

1. The Ghana Health Service must put in more efforts in educating the general public on the availability of CAC service unit in the various health facilities. This can be done through media publicity, talk shows and campaigns on dangers of unsafe abortion.

2. Healthcare service providers must strengthen the provision of family planning counselling by providing more information on the various types of methods available to enable clients make informed choices to meet their needs. The Ghana Health Service must ensure that all categories of healthcare workers trained in to have basic knowledge of family planning.

3. The Ministry of Health and the Ghana Health Service must conduct studies and organize seminars to understand the attitudes and beliefs around abortion. This would help the two organizations to tailor messages to communities so as to demystify the myths surrounding abortion. This can be done using the radio, television and drama aimed at explaining the dangers of unsafe abortion and the benefits of obtaining safe abortion from accredited healthcare facilities.

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4. The limitations of this study were that participants were selected from one health care institution. Future research should focus on participants from multiple healthcare institutions from different parts of the country. Also, future research should focus on providers' perspectives of CAC services and clients seeking those services. Lastly, future research should be quantitative and should include the opinions of men and boys who impregnated the women seeking CAC service

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REFERENCES

Abdi, J., & Gebremariam, M.B. (2011). Health providers' perception towards safe abortion service at selected health facilities in Addis Ababa. *African Journal Reproductive Health. 15(1):31–6.*

Agyei, W.K.A., Biritwum, R.B., Ashitey, A.G., & Hill R.B. (2000). Sexual behavior and contraception among unmarried adolescents and young adults in Greater Accra and Eastern Regions of Ghana. *Journal of biosocial Science.* 32(4): 495-512.

Ahiadeke, C. (2002). The incidence of self-induced abortion in Ghana: What are the facts? *Research Review*; 18(1): 33-42

Ahiadeke, C. (2001). Incidence of induced abortion in Southern Ghana. *International Family Planning Perspectives*; 27(2): 96-108.

Alemu, F. F. (2010). Minors' Awareness about the new Abortion Law and Access to Safe Abortion Services in Ethiopia: The Case of Marie Stopes International Ethiopia Centers in Addis Ababa

Aniteye, P., & Mayhew, S. (2013). Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation. *Health Research Policy and Systems; 11:1–14.*

Baiden, F., Amponsa-Achiano, K., Oduro, A.R., Mensah, T.A., Baiden, R., & Hodgson A. (2006). Unmet need for essential obstetric services in a rural district in Northern Ghana: complications of unsafe abortions remain a major cause of mortality. *Journal of Royal Institute of Public Health. 120(5):421–6.*

Baiden F. (2007) Making safe abortion services accessible in Ghana. *Journal of Women's Health. 18(12):1923–4.*

Bakar, C., Akgun, S. H. and AL Assaf, F. A., (2008). The Role of Expectations in Patient Assessments of Hospital Care, *International Journal of Health Care Quality Assurance, 21 (4), 343- 355.*

Belton, S., Whittaker, A., Fonseca, Z., Wells-Brown T., & Pais, P. (2009). Attitudes towards the legal context of unsafe abortion in Timor-Leste. *Reproductive Health Matters. 17(34):55–64.*

University of Ghana http://ugspace.ug.edu.gh

Branthwaite, A., & Patterson, A. (2011). "The power of qualitative research in the era of social media", *Qualitative Market Research: An International Journal, 14 (4) 430 - 440*

Buttle, F., (1996), "SERVQUAL: review, critique, research agenda", *European Journal of Marketing*, 30, (1), 8-32.

Cooper, D., Dickson, K., Blanchard, K., Cullingworth, L., Mavimbela, N., & von Mollendorf, C. (2005). Medical abortion: the possibilities for introduction in the public sector in South Africa. *Reproductive Health Matters. 13(26):35–43.*

Correa, S. & Petchesky, R. (2013) Reproductive and Sexual Rights: A feminist perspective. In: *McCann C& Kim S. (Eds.) Feminist Theory Reader: Local and Global Perspectives. New York: Routledge: 119-132.*

Davies, B., Baron, S., Gear, T., & Read, M. (1999). Measuring and managing service quality, *Marketing Intelligence & Planning*, 17(1), pp.33-40.

Dean, M. Alison, (1999),"The Applicability of SERVQUAL in Different Health Care Environment", Health Marketing Quarterly, 16 (3), 1- 21.

Djohan. E., Indrawasih, R., Adenan, M., Yudomustopo, H., & Tan, M.G. (1993). The attitudes of health providers towards abortion in Indonesia. *Reproductive Health Matters* 1(2):32–40.

Dursun, Y. and Cerci, M., (2004), " Perceived Quality : A Study on Patient Satisfaction and BehavioralFactors", Erciyes Universitesi Iktisadi ve Idari Bilimler Fakiltesi Dergisi, 23; 1-16.

Gammeltoft T. (2002) Induced abortion and moral dilemma. *Culture, Medicine and Psychiatry 13(26): 313–338.*

Geelhoed, D.W., Nayembil, D., Asare, K., Schagen van Leeuwen, J.H. & Roosmale J. (2002). Contraception and induced abortion in rural Ghana. *Tropical Medicine and International Health.* 2002. 70(8): 708-716.

Glover, E.K., Bannerman, A., Pence, B.W., Jones, H., Miller, R., Weiss, E., & Nerquaye-Tetteh J. (2003). Sexual health experiences of adolescents in three Ghanaian towns. *International Family Planning Perspectives.* 29(1): 32-40.

Gmeiner, A.C., Van Wyk, S., Poggenpoel, M., & Myburgh, C.P. (2000). Support for nurses directly involved with women who chose to terminate a pregnancy. *Curationis. 23 (1):70–8.*

Goodman, N. Sackett, A. & Vasilver, R. (2008). *Bridging the Gaps: Implementation of Comprehensive Abortion Care in Ethiopia.* Department of Family Health, Ministry of Health. Addis Ababa.

University of Ghana http://ugspace.ug.edu.gh

Grönroos, C. (1984). A service quality model and its implications. *European Journal of Marketing.* 8; 36-44

Harries, J., Stinson, K., & Orner P. (2009). Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. *BMC Public Health.9:296-302.*

Harries, J., Lince, N., Constant, D., Hargey. A., & Grossman, D. (2009). The challenges of offering public second trimester abortion services in South Africa: health care providers' perspectives. *Journal of Bio-social Science. 44(2):197–208.*

Harrison, A., Montgomery, E.T., Lurie, M., &Wilkinson. D. (2000). Barriers to implementing South Africa's termination of pregnancy Act in rural KwaZulu/Natal. *Health Policy Plan. 15(4):424–3*

Henry, R., & Fayorsey, C. (2002). *Coping with Pregnancy: Experiences of Adolescents in Ga Mashi,* Accra, Calverton, MD, USA: ORC Macro.

Klingberg-Allvin, M., Van Tam, V., Nga, N.T., Ransjo-Arvidson, A.B., & Johansson, A. (2007). Ethics of justice and ethics of care. Values and attitudes among midwifery students on adolescent sexuality and abortion in Vietnam and their implications for midwifery education: a survey by questionnaire and interview. *International Journal of Nursing Studies. 44(1):37–46.*

Krakowiak-Redd D, Ansong D, Otupiri E, Tran S, Klanderud D, Boakye I, Dickerson T., & Crookston B. (2011). Family planning in a sub-district near Kumasi, Ghana: Side effect fears, unintended pregnancies and misuse of medication as emergency contraception *African Journal of Reproductive Health*; 15 (3): 121

Lithur, N.O. (2004) Destigmatising abortion: expanding community awareness of abortion as a reproductive health issue in Ghana. African Journal of Reproductive Health. 8(1):70–4.

Mayers, P.M., Parkes, B., Green, B., & Turner, J. (2005) Experiences of registered midwives assisting with termination of pregnancies at a tertiary level hospital. *Health South Africa Gesondheid 10(1):15–25.*

Mesganaw, F. (2010). Achieving the maternal health millennium development goals in Ethiopia: where are we and what needs to be done? Addis Ababa, Ethiopia. *Ethiopian Journal of Health and Development. 11 (3) 24-33*

Mngadi, P.T., Faxelid, E., Zwane, I.T., Hojer, B., & Ransjo-Arrvidson, A.B. (2008). Health providers' perceptions of adolescent sexual and reproductive health care in Swaziland. *International Nursing Review. 55(2):148 55.*

Mokgethi, N.E., Ehlers, V.J., & van der Merwe, M.M. (2006). Professional nurses' attitudes towards providing termination of pregnancy services in a tertiary hospital in the North West province of South Africa. *Curationis. 29(1):32–9*

University of Ghana http://ugspace.ug.edu.gh

Morhe, E.S.K., Tagbor, H.K., Ankobea, F., & Danso, K.A. (2012). Reproductive experiences of teenagers in the Ejisu-Juabeng district of Ghana. *International Journal of Gynecology and Obstetrics.* 2012; 118(2):137-40

Morhe, E.S.K., Morhe, R.A., & Danso, K.A. (2007). Attitudes of doctors toward establishing safe abortion units in Ghana. *International Journal of Gynaecology Obstetrics. 98(1):70–74.*

Mote, C.V., Otupiri, E., & Hindin, M. (2010) Factors associated with induced abortion among women in Hohoe, Ghana. *African Journal of Reproductive Health*. 14(4): 115-121

Narang, R. (2010). Measuring Perceived Quality of Health Care Services in India. *International Journal of Health Care Quality Assurance, 23 (2), 171-186.*

Newcome, L.N. (1997). Measuring of trust in health care. *Health Affairs.* 16(1), 50-51

Oliveras, E. Ahiadeke, C., Adanu, R.M., & Hill A.G. (2006) Clinic-based surveillance of adverse pregnancy outcomes to identify induced abortions in Accra, Ghana. *Studies in Family Planning*. 2009; 39(2): 133-140

Olukoya, A. A. Kaya, A., Ferguson, B.J. & AbouZahr, C. (2001). Unsafe Abortion in Adolescents. *International Journal of Gynaecology & Obstetrics75 (2):137-147.*

Øvretveit, J. (1992). *Health Service Quality*, Blackwell, Oxford.

Pakdil, Fatma. And Harwood, N. Timothy., (2005), "Patient Satisfaction in a Preoperative Assessment Clinic: An Analysis Using SERVQUAL Dimensions, *Total Quality Management, 16 (1), 15- 30.*

Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1985). A conceptual model of service quality and its implications for future research. *Journal of Marketing*, 49 (4), 41-50.

Parasuraman, A., Berry, L.L. & Zeithaml, V.A. (1991). Understanding Customer Expectations of Service. *Sloane Management Review*, Spring, pp.39-48.

Parasuraman, A., Berry, L.L. & Zeithaml, Valarie A. (1988). SERVQUAL: A Multiple-Item Scale for Measuring Consumer Perceptions of Service Quality, *Journal of Retailing*, 64 (1), 12-40.

Parasuraman, A., Zeithaml, V.A. & Berry, L.L. (1988), SERVQUAL : a multiple-item scale for measuring consumer perceptions of service quality. *Journal of Retailing*, 64(2), 12-37.

Paul, M., Gemzell-Danielsson, K., Kiggundu, C., Namugenyi R., & Klingberg-Allvin M. (2014) Barriers and facilitators in the provision of post-abortion care at district level in central Uganda - a qualitative study focusing on task sharing between physicians and midwives. *BMC Health Service Research. ; 14:28.*

University of Ghana http://ugspace.ug.edu.gh

Payne, C.M., Debbink, M.P., Steele, E.A., Buck, C.T., Martin, L.A., & Hassinger, J.A. (2013). Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers. *African Journal Reproductive Health. 17(2):118–28.*

Robini, R. & Mahadevappa, B. (2006). Service Quality in Bangalore Hospitals- An Empirical Study, *Journal of Services Research, 6 (1), 59- 84.*

Srofenyoh, E.K. and A.T. Lassey. (2003). Abortion care in a teaching hospital in Ghana, *International Journal of Gynecology and Obstetrics*, 82(1): 77-78.

Sundaram, A., Juarez, F., Bankole, A., & Singh, S. (2012). Factors associated with abortion-seeking and obtaining a safe abortion in Ghana. *Studies in Family Planning* 2012; 43(4): 273-286.

Tomes, A. &Ng, S.C.P. (1995).Service quality in hospital care: the development of in-patient questionnaire. *International of Health Care Quality Assurance, 8(3), pp. 25-33*

USAID & ESD (2009) HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy. ESD Washington, DC.

Warenius, L.U., Faxelid, E.A., Chishimba, P.N., Musandu, J.P., Ongány, A.A. & Nissen E.B.M. (2006). Nurse midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reproductive Health Matters 14(27):119–28*

Wisniewski, Mik. and Wisniewski, Hazel., (2005), Measuring Service Quality in a Hospital Colposcopy Clinic, International Journal of Health Care Quality Assurance; 18 (3), 217-228.

World Health Organization (2012). Safe abortion: technical and policy guidance for health systems. 2nd ed. Geneva: WHO.

Zeithaml, V.A. (1988). Consumer perceptions of price, quality and value: a means-end model and synthesis of evidence. Journal of Marketing; 52, 2-22.

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APPENDIX I: INTERVIEW GUIDE

My name is Jennifer Miriam Kyereh-Darkwah, a student studying for Master of Science (MSC) in Applied Health in Social Science degree at the University of Ghana, in the School of Public Health. I am conducting the research entitled "**Clients' Perception of Comprehensive Abortion Care at the La General Hospital in Accra"** as a part of the requirements of the MSC degree in Applied Health. I would be grateful if you could assist me achieve this aim by answering these questions.

A. DEMOGRAPHIC INFORMATION

1. Kindly tell me a little about yourself
   i. Age
   ii. current marital status
   iii. Level of education
   iv. Religious affiliation
   v. Ethnic origin
   vi. Occupation
2. How many times have you been pregnant in your life?

   Probing Question

   - How many children do you have now?
3. Have ever lost pregnancy before?

   Probing Questions

   - How many pregnancies?
   - Through what means did you lose the pregnancy?

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B. PERCEPTION OF ABORTION

4. What comes to your mind when you think of abortion?
5. In your community, have you seen or heard of other women who have performed abortion?
6. Where do women seek abortions in your community?

Probing Questions

- What method of abortion do women use?
- Why do women seek abortion in your community?

7. What do you know about the abortion law in Ghana?
8. Where did you get information on the abortion law?
9. What do you think about the current abortion law in Ghana?

C. PERCEPTION OF COMPREHENSIVE ABORTION CARE

10. How did you identify the service delivery unit when you got in to the La General Hospital?
11. What do you think about the waiting time to get the service?
12. What is your perception of time spent at the facility on the day of the abortion procedure?
13. What do you think about the cost of the abortion procedure?
14. What would you say about the attitude of the following health personnel towards you at the CAC unit

    a). medical doctor
    b). Nurses and midwives
15. Kindly tell me how the following medical staff treat you or made you feel at the CAC unit

    a). medical doctor

    b). Nurses and midwives

    c). Receptionist

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16. What type of information were you given during the counselling and information session?

    Probe for:

    - Type of abortion procedure available
    - Pain during abortion procedure
    - Management of pain during abortion procedure
    - How patient will feel emotionally after the abortion
    - Self-care after abortion
    - Family planning counselling and contraceptive use

17. Did the medical staff respect your privacy during physical examination and treatment? How?
18. What information was given to you during the post abortion family planning and counselling? Probe for:
    a. Information on fertility after abortion
    b. Contraceptive information
    c. Contraceptive method offered
19. What would you say about the post abortion family planning and counselling?
20. What would you say about the environment of the facility?

D. QUALITY OF CAC SERVICE

21. How would you described the facilities and equipment at the CAC unit?
22. What is your opinion on the medical supplies available at this CAC centre?
23. What do you think about the way the medical staff talked to you during the counselling session? Respectful or not respectful? How?

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24. How would you describe the information given to you during the post abortion family planning and counselling? Probe for reasons for answer.
25. What do you think about the way the medical staff managed the pain during the abortion procedure?
26. How would you describe the technical skills of the following:
    a. Medical doctor?
    b. Nurses/midwives
27. How would you described the abortion care at this CAC facility? Probe reasons for answer.

E. LEVEL OF SATISFACTION WITH CAC SERVICE

28. Are you satisfied with the service at this CAC facility? Why?
29. Would you recommend this CAC facility to relatives and friends? Why?
30. What do you think can be done to improve on the CAC service delivery in this facility?

F. BARRIERS TO COMPREHENSIVE ABORTION CARE

31. In your opinion, what are the key barriers to women's access to safe abortion services in your community?

Probing questions

- What do community people say about abortion?
- What do people in your community say about people who seek abortion?
- What role do men play with regards to abortion in your community?
- Is there a health facility in your community where safe abortion can be done?
- Would you feel comfortable going to a health facility in your community?Give reasons for your answer?

Thank you for your time and participation

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Appendix II: Consent Form

My name is **Jennifer Miriam Kyereh-Darkwah**, a researcher conducting a study into clients' perception of Comprehensive Abortion Care at La General Hospital. The findings of this survey is for academic purpose only. Your participation is completely voluntary and you can withdraw from the survey after having agreed to participate without any problem to you or your treatment. You are free to refuse to answer any question on the Comprehensive Abortion Care that is asked in the questionnaire. All your responses will remain strictly confidential. It will only be used for research purposes. Your name will not appear on your interview guide, and your responses will not be linked to your identity at any time.

Signing this consent indicates that you understand what will be expected of you and are willing to participate in this survey. If you have any questions about this survey you may ask me or contact my supervisor at the School of Public Health, University of Ghana, Legon. If you agree to participate in this study, please provide your signature/thumb print below.

Signature: …….. Date: …….

Thumb Print: ……. Date:…….