ENSIGN COLLEGE OF PUBLIC HEALTH, KPONG

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FACTORS UNDERPINNING COMPREHENSIVE ABORTION CARE AMONG ADULT WOMEN IN REPRODUCTIVE AGE IN THE NEW JUABEN MUNICIPALITY-KOFORIDUA

BY

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DECLARATION

I hereby declare that this submission is my own work towards the MPH, and that, to the best of my knowledge, it contains no material previously published by another person, nor material which has been accepted for the award of any other degree of the institution, except where due acknowledgement has been made in the text.

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ABSTRACT

This study investigates the underpinnings of CAC using data from clients and providers of CAC in the New-Juaben Municipality. Knowledge, attitudes and practices (KAP) model is adapted to assess the underpinnings of CAC. Quantitative and qualitative data were solicited from 129 clients and 10 health professionals, respectively, in health facilities that provide CAC in the New-Juaben Municipality. Convenience and purposive sampling techniques aided data collection process in five health facilities, namely, the Regional Hospital, Koforidua, Koforidua Poly Clinic, Magazine Health Centre, Effiduase Reproductive and Child Health Centre, and Asokore Reproductive and Child Health Centre. The findings indicate that knowledge/awareness of the clients on CAC is considerably high at 3.70 on a scale of 1 to 5. Well-known contraceptives include the pill, condom, and injectables. Nonetheless, there was not much awareness of where and how CAC can be obtained. For the health professionals, family planning, counseling, child welfare, anti-natal care, post-natal care, delivery service, maternity, and outpatients' department (OPD) are health centre services that made up CAC. More than not, clients exhibited accepting attitudes towards CAC. Findings Knowledge/awareness, attitudes and practices significantly explain 71.4% of the variability in CAC usage (p=0.000). When people are aware that safe abortion entails counseling and medication, and midwives and nurses are said to be providing family planning and safe abortion services, they gain enthusiasm to access CAC. Stigma and discrimination, restrictions by religion, time, affordability, accessibility, and negative attitudes of health staff pose challenges for clients to use CAC. The study recommends that CAC should be strengthened in terms of accessibility, finance, training of health staff, and public education. Future studies ought to focus on the quality of comprehensive abortion care.

DEDICATION

This work is dedicated to my husband, Mr. J. A. Allotey.
And to our children, Derrick Kpakpo Allotey, Samuel Adotey, and Ernest Adotei Allotey.

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LIST OF ABBREVIATIONS AND ACRONYMS

CAC	-	Comprehensive Abortion Care
CDC	-	Centers for Disease Control
CHDS	-	Community-based Health Planning and Services
GDHS	-	Ghana Demography and Health Survey
GHS	-	Ghana Health Services
GSSMI	-	Ghana Statistical Service Macro International
MOH	-	Ministry of Health
MVA	-	Manual Vacuum Aspiration
UNDP	-	United Nations Development Programme
WHO	-	World Health Organization

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

There is an increasing global realization that, to reduce child deaths and maternal mortality, women must not go through pain or fatal delivery processes (UNDP, 2016). As concerns about improving reproductive health rages on, the debate on abortion is certainly not an issue that can be swept under carpet. In the midst of these concerns, abortion – termination of pregnancy or fetal development – has attracted debate in Ghana, particularly, because of its prevalence of the safety of its handling. Abortion is, however, considered as a method of family planning and an effective way of preventing dangers from developing. For this reason, the factors underpinning comprehensive abortion care for adult women is the main focus of this study. A key factor is unsafe abortion.

Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries (World Health Organization, 2011). The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both. Unsafe abortion contends to be a major to maternal mortality in developing countries (Murray *et al.*, 2006; Ghana Statistical Service, GHSG and Macro International 2009). About 15% of women in Ghana aged 15-49 years is said to have had at least one abortion (Ghana Statistical Service, GHSG, and Macro International, 2009). Although this percentage gives an indication that abortion is prevalent in the country, there is confusion among experts and researchers that the Ghana's Abortion Law, the Consolidated Criminal Code, 1980 (Act 29), permits unrestricted access to

abortion care. Generally, the law provides limited access to abortion care at best (Norman *et al.,* 2015).

The legal provision in Act 29 indicates that abortion is permitted under some circumstances, such as when pregnancy is the result of rape, defilement, or incest; if the continuation would involve risk to the life of the pregnant woman; if the pregnancy will injure the woman's physical or mental health; or there is a substantial risk that the child may suffer from a serious physical abnormality or disease. The law in another breadth states that "Abortion is unlawful and both the woman and anyone who abets the offence by facilitating the abortion by whatever means, are guilty of an offense of causing abortion" (Morhe *et al.* 2007). Despite this legal background, it is a known fact that abortion is being done undercover and sometimes under unsafe and clinically unacceptable conditions by a considerable proportion of females, especially the adolescents (Adjei *et al.* 2015). This exposes many women to the dangers of improperly conducted abortion.

Abortion could be spontaneous or induced. Spontaneous abortion occurs without intervention. It is most commonly due to fetal chromosomal defects while, induced abortion results from medical or surgical intervention that can cause abortion. However, induced abortion is a safe medical procedure (Oppong-Darko *et al*., 2017). Whether spontaneous or induced, abortion demands a complete, well-delivered care to preclude subsequent degeneration of reproductive health of affected women. This has called for efforts from clinicians and health professionals to think about ways to deliver abortion care.

In 2006, The Ministry of Health and Ghana Health Service developed standards for the provision of comprehensive abortion care. Since then, midwives and physicians have been handed the authority to perform abortion, yet, in accordance with the law. Safe

abortion performed by a qualified healthcare provider has been part of the Reproductive Health Strategy of Ghana since 2003. Also, in Ghana, there is a wide range of services that the Ghana Health Service has brought on board to help reduce the hazards of induced abortion and maternal mortality. This includes family planning services to reduce the incidence of unwanted pregnancies and hence induced abortion; abortion services which are only included in the abortion laws of the country; post abortion complication services (PAC services); and education or the provision of information on abortion issues (Ghana Health Service, 2012).

To receive safe abortion, therefore, women who are pregnant must be able to access a comprehensive abortion care. By implication, the World Health Organization (WHO) views a comprehensive abortion care as carrying out the termination of unintended pregnancy by persons professionally trained to do so in an environment that conforms to minimal medical standards. It encompasses practices that eliminate hazardous circumstances before, during and after an abortion (Ahman and Shah, 2008). Ghana's narrative in terms of delivery of comprehensive abortion care shows that there is more to be done in the face of fact that, there is more to know about the underpinnings of comprehensive abortion care uptake among women adults.

The purpose of this study was to investigate the underpinnings of comprehensive abortion care uptake among women adults. A broad-base study dealing with various settlements of Ghana could provide a general understanding of the issue of interest in this study. This, however, does not preclude the possibility of obtaining credible information on comprehensive abortion care from a specified area in Ghana to give, yet, an understanding of what the situation might be in the specified area. This study investigated

the underpinnings of comprehensive abortion care among women adults at the New-Juaben municipality in the Eastern Region of Ghana.

1.2 Problem Statement

Maternal morbidity and mortality is a global public health concern. Unsafe abortions contribute substantially to maternal morbidity and mortality. There is evidence that whether abortion is permitted by law or not, unsafe abortions do occur (WHO, 2011). Abortion is legal and available under a wide scope of certain countries, but many abortions are performed outside legally authorized health services, many of which are unsafe (Dugal and Ramachandran, 2004; Fetters and Samandari, 2009). In sub-Saharan Africa, abortion is liberal in some countries while in other countries abortion is legal only when it preserves life (Sedgh *et al*., 2012). Even in the advanced worlds like the United States and Europe where abortion is largely legally permitted, there is evidence that some women rely on unsafe abortion (Centres for Disease Control and Prevention (CDC) and ORC Macro, 2005; Grossman et al. 2010; Jones, 2011).

There is a seeming limitation of abortion expressed in the legal proposition, "Abortion is unlawful and both the woman and anyone who abets the offence by facilitating the abortion by whatever means, are guilty of an offense of causing abortion", in Ghana's Abortion Law (Act 29) (Morhe *et al*., 2007). Although a section of the law postulates conditions under which abortion is legally permitted, the limitation is, in part, due to lack of knowledge on the abortion law. This exacerbates the socio-cultural perceptions against abortion thereby fueling a high level of stigma for those who need abortion care (Norris et al. 2011). Cultural, religious and traditional stigma against abortion does not only affect women, but also abortion service providers and advocates. Additionally, high cost of safe

abortion services greatly challenges safe abortion (Oppong-Darko, 2017; Esantsi et al. 2015). Studies have shown that one other reason that deters women from going in for safe abortion services is the high cost associated with it. Women who are found in the low wealth quintile (poor women) cannot afford legal abortion and may be forced to procure quack services (Sedgh, 2010).

Abortion-related deaths contribute significantly to the high rates of maternal mortality and morbidity in Ghana (Adjei *et al*., 2015). Induced abortion is said to account for 11 percent of maternal deaths behind haemorrhage (Sedge, 2010). A number of studies have focused on the socio-demographics of women who have undergone abortion or barriers to safe abortion services, outcomes of unsafe abortion and methods of unsafe abortion in Ghana (Morhee and Danso 2007; Rominski *et al*., 2012). However, there is a paucity of studies on the factors that influence comprehensive abortion uptake among adult women although in contemporary times the option for competent abortion care is more available than ever before. This study, therefore, sought to determine the underpinnings of comprehensive abortion care among adult women using data from the New-Juaben municipality.

1.3 Rationale of the Study

The subject of abortion is key to women's as reproductive health. Although there are some studies on abortion, there is a paucity of research on the factors underpinning the choice of comprehensive abortion care to adult women. For example, specific studies on what factors underpin the choice of abortion in the New-Juaben municipality or the Koforidua Township in the Eastern Region of Ghana is palpably difficult to find. This study, therefore, offers the opportunity to understand the peculiar issues regarding to the

factors contributing to comprehensive abortion care among adult women in the New-Juaben municipality. The study, therefore, offers information about abortion in the municipality that can be used by the Ghana Health Service and local health facilities for strategic planning to prevent the use of unsafe abortion methods which would otherwise be a preserve for many women who are disposed to such unsafe methods of abortion.

The findings of this study would also provide information to policy makers to inform decisions on comprehensive abortion care. This study would also inform other stakeholders such as the government of Ghana, nongovernmental organizations like International Pregnancy Advisory Services (IPAS), Planned Parenthood Association of Ghana (PPAG), Pathfinder International and Marie Stopes International Ghana, to increase their effort in the recast of unsafe-abortion related deaths and morbidities.

1.4 Conceptual Framework

The thinking that went into this study gives cognizance, first, to knowledge of abortion care; second, attitudes towards abortion care; and third, practices relative to abortion care. In effect, the Knowledge, Attitude and Practice (KAP) framework was employed in this study as the means by which the underpinnings of comprehensive abortion care can be extrapolated. The KAP framework has been espoused by several public health intervention researchers as a model that is used to critically understand the socio-anthropological and economic aspects of the public health concern in context (Launiala, 2009; World Health Organization, 2008; Wilkinson et al. 2017). Launiala (2009) for instance, argues that context-specific public health information is gathered through knowledge, attitude and practice (KAP) studies. Werner (1977) also adds that the KAP

studies often aim to identify indicators that can inform and improve the development and implementation of public health interventions.

In this study, knowledge, attitude and practice associated with comprehensive abortion care provides the context in which the underpinning comprehensive abortion care. Figure 1.1 illustrates the diagrammatic structure of the conceptual framework contemplated in this study.

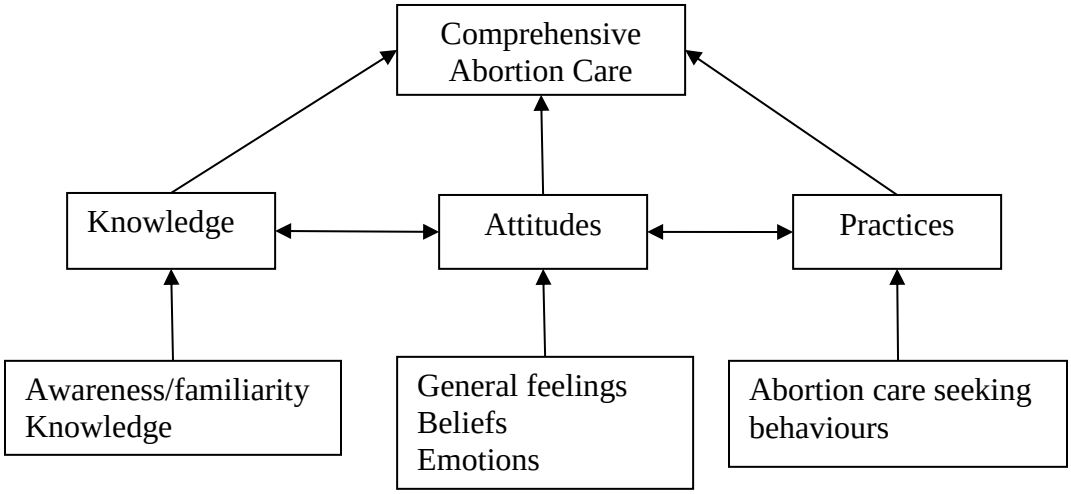


Figure 1.1: Conceptual Framework on Comprehensive Abortion Care [Modified from Launiala (2009)]

As indicated in Figure 1.1, Comprehensive Abortion Care is conceived as a derivative of knowledge, attitudes, and practices in respect of abortion. In other words, the status of comprehensive abortion care would be determined by the KAP. Each of the concepts: Knowledge, Attitudes and Practices, is formed by distinguished but closely interrelated variables. Knowledge simply supplies information of 'by what means' and 'how' people are made to know about comprehensive abortion care. So, familiarizations, awareness and specific knowledge of people must be tested. Closely related to knowledge

is ‘Attitudes’, and this reflect how people feel, their beliefs and emotions about abortion. In ideal situations, it is expected that both knowledge and attitudes are capable of resulting in actions or practices about abortion care seeking that correspond with them.

Public health professionals usually share the view that knowledge and beliefs are contrasting terms. Knowledge is implicitly viewed to be based on scientific facts and universal truths. This is fundamentally different from beliefs which refer to traditional ideas, which are erroneous from biomedical perspective, and which form obstacles to appropriate behavior and treatment-seeking practices (Good, 1994; Pelto and Pelto, 1997).

Petty and Cacioppo (1981) explained that the term ‘attitude’ is often used to mean a person’s general feelings about an issue, object or person. Akin to attitudes are a person’s knowledge, beliefs, emotions, and values, each of which can either be positive or negative. Pelto and Pelto (1997) pointed out that attitude is a derivative of beliefs and/or knowledge.

Practices, the third integral part of KAP models, make enquiries into health-related practices of people. These enquiries would normally be on what different treatment and prevention options are people disposed to as far as a health issue such as abortion is concerned.

The major criticism of a KAP model is its failure to explain ‘why’ and ‘when’ certain practices are chosen. Hausmann-Muela et al. (2003) have espoused that KAP surveys fail to explain the logic behind people’s behaviour. This view lays claim to the idea that practices or behaviour is explained by multiple factors emanating from socio-cultural, environmental, economic, and structural factors, and so on (Launiala and Honkasalo, 2007; Farmer, 1997). The KAP model has nonetheless been employed in several studies that have

produced most credible results and understanding of how people's knowledge base, beliefs systems and attitudes impact on their action decisions. This study was of the view that, some important factors that underpin people's choice of comprehensive abortion care can be accounted for through the KAP model.

1.5 Research Questions

In order to achieve the objectives of this study, the following research questions were posed:

1. What is the knowledge of adult women on comprehensive abortion care?
2. What are the attitudes and practices of adult women towards comprehensive abortion care?
3. What are the underpinnings of comprehensive abortion care among adult women?
4. What strategies emerge from this study to enhance the reproductive health of adult women?

1.6 General Objective of the Study

The general objective of this study was to investigate the underpinnings of comprehensive abortion care among adult women in the New-Juaben municipality.

1.6.1 Specific Objectives of the Study

The specific objectives of the study were to:

1. assess the knowledge of adult women on comprehensive abortion care.
2. describe the attitudes and practices of adult women towards comprehensive abortion care.

3. determine the underpinnings of comprehensive abortion care among adult women.
4. recommend strategies to enhance reproductive health of adult women based on the findings of the study.

1.7 Profile of the Study Area

The study area (Figure 1.2) was the New-Juaben Municipality in the Eastern Region of Ghana, and it accommodates the capital town of that region known as Koforidua. The area is the smallest of the 26 districts in the region. Like all districts in Ghana, New-Juaben has its own health problems, which need to be addressed in the context of Primary Health Care (PHC) and the local environment.

New Juaben Municipality is located in the Eastern Region of Ghana. It is the one of the six municipalities and covers a land area of 110 square kilometers with an estimated population of 217,389. It shares boundaries with East Akim Municipality on the north, Akwapim North District on the south, Yilo Krobo District on the east and Suhum Kraboa Coaltar District on the west.

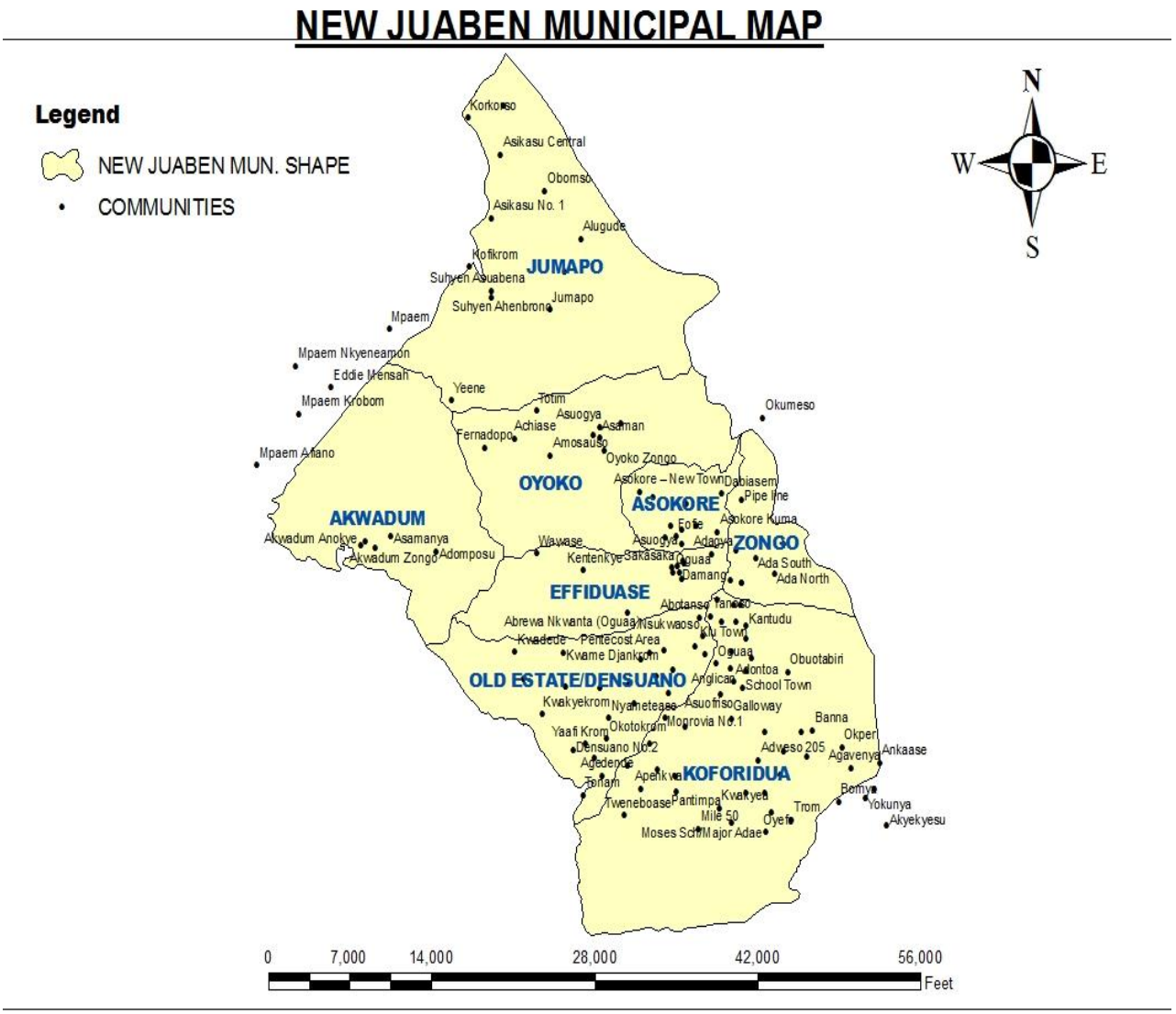


Figure 1. 2: Map of New-Juaben Municipality

(Source: New Juaben Municipal Health Report, 2017)

1.7.1 Demography

The New Juaben Municipality has a land area of 110.0 square kilometers with a total population of 217,389. The population density of the Municipality is 1,976 persons per square kilometer. The distribution of the population of the New-Juaben Municipality is presented in Table 1.1.

Table 1.1: Population Distribution

Population Distribution	**Number**	**Percent (%)**
Children (0 - 11 months)	8696	4
Children (12 - 23 months)	4348	2.0
Children (24 - 59 months)	17826	8.2
Children (5 - 14 years)	58695	27
Women (15 - 49 years (WIFA))	53043	24.4
Men (15 - 49 years)	43478	20
Men and Women (50 - 60 years)	17391	8
Men and Women (60+ years)	13912	6.4
Total	**217, 389**	**100**

Source: New-Juaben Municipal Assembly

The population distribution according to various sub-districts in the New-Juaben Municipality is as shown in Table 1.2.

Table 1.2: Population Distribution by sub-Municipals

No.	Sub-district	Number of recognized communities	Population	% of district population
1.	Jumapo	13	15165	7.0
2.	Oyoko	9	13650	6.3
3.	Effiduase	11	18426	8.5
4.	Asokore /Akwadum	20	23641	10.9
5.	Koforidua	12	46827	21.5
6.	Zongo	9	21552	9.9
7.	Adweso	38	51563	23.7
8.	Old Estate Densuano	25	26565	12.2
	TOTAL	**137**	217,389	100

Source: New-Juaben Municipal Assembly

1.7.2 Topography

The relief of the district is characterized by the continuation of the Kintampo Mampong-Kwahu scarp. The rest of the district is relatively flat with isolated hills dotted across the plains. The district is traversed by a number of rivers and streams. Notable among these is the river Densu and river Nsukwao. The vegetation is characteristically tropical rain forest with many big trees of economic importance

1.7.3 Climate

The Municipality falls within the equatorial rain forest zone. Rainfall is therefore abundant throughout the year with the peak between June and August. Temperatures range

from 20 – 29^{o} C throughout the year. The hottest months are February and March while the coolest months are July and August. Humidity is high throughout the year.

1.7.4 Infrastructure

The New-Juaben Municipality harbours Koforidua, the capital of the Eastern Region of Ghana, but the names are used almost interchangeably. Koforidua, therefore, has all the ministries and regional offices of state institutions expected of a regional capital in Ghana. It must be emphasized that New-Juaben Municipality is larger than the Koforidua Township. About half of the district is made up of the Koforidua Township. A couple of the Sub-districts are within the Koforidua Township. The New-Juaben district is urbanized.

1.8 Scope of the Study

This study area was the New-Juaben municipality otherwise popularly known as Koforidua. The choice of this municipality was, first and foremost informed by the researcher since the space of time and resource at disposal for this study was limited to cover more than one locality. Additionally, the choice of the New-Juaben municipality is due to the fact that the municipality is the capital town of the Eastern Region and has not only the Regional Hospital, but also various private health facilities which compliment one's appreciation of a fair distribution of health services and facilities in the municipality. There is, therefore, a considerable awareness of adult women in this municipality about the reproductive health care choices they are confronted with, and thus, give some useful characterization of women from whom the factors influencing comprehensive abortion care in the municipality can be studied. Adult women from the New-Juaben municipality were, therefore, the target group of interest in this study.

1.9 Organization of the Thesis

This study is organized into five chapters. Chapter One covers the introduction to the study including the background, statement of problem, objectives of the study, research questions, justification of the study, scope of the study, and the organization of the study.

Chapter Two covers review of literature and it presents the conceptual framework of the study followed by an extensive review of the meaning and knowledge of abortion. The review also touches on attitudes and practices associated with abortion without ignoring an empirical review of studies on abortion in Ghana.

Chapter Three describes the methods employed in conducting this study. This includes the study area; research philosophy; research design, data and source; study population; sampling procedure; data collection method, research instrument; methods of data analysis; experiences from the fieldwork and ethical consideration.

Chapter Four presents the data analysis and the results. The findings are presented under thematic areas, namely, knowledge, attitudes, factors influencing comprehensive abortion care, and emerging strategies for promoting reproductive health.

Chapter Five presents the discussion of results obtained relating to their effect of the factors influencing comprehensive abortion care and emerging strategies for promoting reproductive health.

Chapter Six presents the summary of the findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews pertinent literature that leads to the understanding of abortion or abortion-related issues. The review attempts to bring out the meaning of abortion and knowledge on comprehensive abortion care. The review also delves into the attitudes towards abortion to understand the acceptability or aversion of people to abortion. Other literature which tries to give relevant outlook on the factors influence uptake of abortion care is also reviewed.

2.2 Knowledge on Comprehensive Abortion Care

Abortion, in simple terms, is the expulsion of the foetus before viability. Others also like to see it as the termination of an unwanted pregnancy. The gestational age for viability depends on the country. However, irrespective of this definition, induced abortion is one of the commonest procedures performed throughout the world. It is estimated that about 25% of all pregnancies worldwide end in induced abortion. The proportion of pregnancies ending in abortion fell from 39% to 27% in developed countries, while it increased from 21% to 24% in developing countries between year 2010 and 2014 (Sedgh et al., 2017). Because of the clandestine nature under which abortions are performed (Ahiadeke, 2001), determination of the actual number is next to impossible. In settings including private and government institutions, when they are even performed, the procedure is disguised given the absence of legitimate medical diagnosis to justify the procedure.

Nonetheless, it is estimated that 20million abortions out of the 50million abortions are being performed under dangerous conditions, either by untrained providers or unsafe procedures, or both. The difference between levels of maternal mortality in developing and industrialized countries is greater than for any health indicator (Tinker et al., 2000). This finding comes as no surprise because the contributory factors to maternal mortality in developing countries have not been attended to. This logically puts women in developing countries at a higher risk of dying from unsafe abortion as compared to women in developed countries. Experts hold the view that many more women who have not died of unsafe abortion suffer serious long-term injuries and disabilities (Hord, 2004). Although abortion is pervasive, for the reasons that it attracts stigma, and is a taboo in certain cultures or has legal ramifications, it is not often reported.

Grimes *et al*., (2006) found that many women who undergo unsafe abortion are married, with unmarried youth making up a large proportion of women seeking induced abortion in urban areas, however, in developing countries, unsafe abortion rate peak among women aged 20-29 (WHO, 2007). These findings reveal that we are losing women from all the strata of the women population with grave consequences, married women dying and leaving their family behind.

Until the second half of the 20th century, abortion law was illegal in most countries and was associated with high illegal and unsafe abortion rate and a correspondingly high maternal morbidity and mortality. World Health Organization (1998) has seen the liberalization of abortion laws in almost every country of the European Union, United State and Canada which helped in promotion of contraception use (Petersen et al., 2016; Rahman et al., 1997).

Over the years the reproductive health policy of Ghana on reduction of unsafe abortion only dwelt on promotion of family planning, contraception and post abortion care but not provision of safe abortion within the confines of the law as recommended by World Health Organization (Ghana Demography and Health Survey, 1998)

Termination of pregnancy on medico-social grounds as indicated in the current law, is however, not readily available in institutions in the country. Thus, the law criminalizes abortion but gave quite liberal grounds on which legal abortion may be permitted in Ghana as unsafe abortion remains the major cause of maternal morbidity and mortality in the country (Lassey and Wilson, 1994; Aboagye 2000; Adam and Ntumy, 2005). In Ghana, safe abortion is permitted by law under the following situations/conditions:

a. If the pregnancy is the result of rape, defilement, or incest;
b. If there is substantial risk that the child, if born, may suffer from or later develop a serious physical abnormality or disease;
c. If continuance of pregnancy will involve risk to life of the pregnant woman or injury to her physical or mental health [Criminal Code (Amendment) Law, PNDC Law 102, 1985].

The law, meanwhile, has a lot of unanswered questions; how does a victim of rape or incest access safe legal abortion? Is she supposed to go the hospital and request for abortion directly or does she need a police report? The gray area has always been whether the meaning of mental health covers a rape or incest victim? The Ghana Health Service, nonetheless, keeps a documented protocol for comprehensive abortion care in which the condition of the victim is determined in the context of mental health by her ability to engage in productive activities; have fulfilling relationships with other people; adapt to change;

cope with adversity; and manage daily life throughout the life cycle. If continuing a pregnancy prevents a woman from performing any of the above-mentioned functions, she is entitled to a legal abortion.

Women seeking to terminate early pregnancy now have a choice between medical and surgical procedures. The two major drugs currently used in inducing abortion are mifepristone and methotrexate (Miller et al., 2005; Winikoff and Sheldon, 2012). Acceptability among consumers is particularly important for the success of medical abortion. The success depends on women's willing to complete the treatment regimen at home and wait for the drugs to take action. Methods of medical procedures for safe abortion care are manual vacuum aspiration (MVA) and dilatation and curettage (DNC). Medically abortion is typically considered a failure when surgical evacuation for any reason including incomplete abortion (Harvey et al, 2001). Although some women may desire the involvement of their partners when obtaining abortion care, male partners are not routinely involved in the abortion care process. Studies on how male involvement relates to women abortion practices may help guide health institutions considering incorporation of male partner in the abortion care.

Abortion care may be a significant area for partner inclusion because many seeking and obtaining abortion experience complex emotions and isolation which may desire the involvement of their partners (Lie *et al*., 2008). Women should be informed about their pregnancy options so that they can make an informed choice about their course of action. All women who require more support in deciding whether to continue the pregnancy or have an abortion should be identified and offered further opportunities to discuss them.

Globally, abortion related complication constitutes 13% of all maternal death. It is estimated that there are 28 procedures per 1,000 women in West Africa each year (Guttmacher Institute, 2010). In Ghana where the law restricts elective induced abortion, data to quantify the incidence of abortion are scarce. The existing data on incidence of abortion in Ghana come mainly from hospital records which are unavailable because records keeping is poor and induced abortion often are classified inaccurately.

Until 1985 when the criminal code of ethics was amended Ghanaian law prohibited induced abortion except when her life is threatened by the pregnancy. The law now says that abortion is not an offense for midwives and doctors in a government hospital or registered private hospital.

Since 1985, the law on abortion in Ghana headed towards liberalization, but there has been a delay in policy formulation and implementation. Hence, safe abortion services on medico-social grounds as permitted by the law are not readily available in government institutions (Marhe, 2006).

According to a survey of woman there were at least 15 induced abortions for every 1,000 women of from reproductive ages 15 to 45yrs (Ghana Statistical Service, Ghana Health Service and Macro International, 2009). As at 2007 a more 3% of pregnant woman and only 6% of those seeking an abortion on were aware of the legal status of abortion (Ghana Statistical Service, Ghana Health Service and Macro International, 2009).

2.3 Attitudes of People towards Comprehensive Abortion Care

In order to put the attitudes towards comprehensive abortion care into perspective, it is important to state an example from Colombia where the Ministry of Health of

Colombia establishment a pilot site for safe abortion and post abortion care service in the year 2000. The abortion care service was set-up at the mother-child health government clinics in Sihanoukville upon the acceptance of all women of reproductive age women from the generality of the population (Prada et al., 2013). Thus, the service attracted awareness of many people in the country. Discernibly, the aim of the establishment was to test how safe abortion and post abortion care service can be implemented pursuit to liberal abortion laws. Yet, in Columbia, many abortions continue to occur despite the fairly liberalized abortion environment in that country (Prada et al., 2013). This is just a microcosm of the situation on the large global scene. Even in the countries with well liberalized abortion environment, there is a remnant that uses unsafe abortion methods outside of the mainstream, legal abortion care let alone in countries with less liberalized abortion environment or in developing countries. This stands to reason that, there is an important component of the provision of safe abortion beside creation of service centres and even creation of awareness. This component is the attitudes of people towards abortion care. There is expansive literature on the attitudes or response of people to abortion which can be studied in two related perspectives – attitudes of abortion service providers and attitudes of abortion care seekers.

2.4 Attitudes of Abortion Care Providers towards Abortion

A number of studies have shown that nurses and midwives disliked being involved in 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 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, nurses seem 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 women'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, that is,

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).

The attitude of health care providers for comprehensive abortion care services is a matter of great importance which forms an integral part of the whole process of abortion care it affects the interaction with the women before, during and after the process of rendering the comprehensive abortion care services. Some providers exude the judgmental attitude through some gestures and comments being passed. Oppong-Darko et al. (2017) observed that some midwives in Ghana expressed abortion as being sinful and against their religion to assist in abortion care, albeit others felt it was good to save the lives of women. Supportive attitude, on the other hand, are also displayed by some providers as they try hard to understand the situation if the client, do not easily judge the client opting for abortion, and encourage and advise the client (IPAS, 2014; IPAS 2013). Some health care providers support the idea of training more nurses and midwives to carry out legal, safe and comprehensive abortion care services.

Religious beliefs played a role for some providers in deciding not to be involved in abortion services, as most health care providers contemplate on the decision to carry out comprehensive abortion care services based on religious and moral grounds. Despite personal or religious beliefs inhibiting the involvement, some providers are able to put aside their personal values from emotional and religious opinions and described themselves

favour response to abortion, viewing abortion care as part of their professional conduct (Mustapha, 2013; Oppong-Darko, 2017).

Health care providers sometimes also act as advocates. Some health service providers, sometimes, have views concerning who is to handle the abortion process based on experience. To this end, they request for ways and means to help amend some laws and policies that restricts women. Also they assist lawmakers in making of current laws and policies that affect abortion care (IPAS, 2013)

2.5 Attitude of Women in Reproductive Stage towards Comprehensive Abortion Care

The beliefs and concerns of clients receiving comprehensive abortion care services also carry a considerable influence on the procedures and their implementation. A study carried out in Ethiopia demonstrated that, 57% of a sampled population of reproductive women supported the fact that comprehensive abortion care is a safe practice while 43% had a negative view on it (Addis et al, 2015). In a study conducted on rural Ghana, it was observed that unmarried women were more likely to have abortion compared to married women. It is, therefore, Women with low level of education of up to secondary education were more likely to have induced abortion compared to women without education. This implies that there is accepting attitudes are exhibited by unmarried women and moderately educated women towards abortion more than married women and uneducated women (Adjei, et al., 2015). In another study at the Northern Region of Ghana, it was found out that reproductive health services were available in the community but received low utilization because of perceived negative attitude of health workers, including breach of confidentiality and social norms (Kyilleh, et al., 2018).

The subject of attitude of abortion care seekers in Ghana cannot go without mentioning that in matters of sexual reproductive health, perceived barriers to accessibility by service users comprise embarrassment or shyness, fear of safety, fear of family finding out, and cost of service (Thatte, et al., 2016). Thatte et al. (2016) also maintained that these barriers to seeking of sexual reproductive health service equally affect abortion care as it does to HIV/STI testing and contraception. It is important to note that, fear of safety and cost of service in respect of abortion directly reflects on the attitude of people to abortion care seeking. Especially in the absence of quality information about professional abortion care, then where people are introduced to fear of safety, this could distort their perception on comprehensive abortion care, thereby, exposing them to other methods of abortion which are offered as simple to use outside the care of abortion care providers. The move away from abortion care providers or professional abortion care facilities is further exacerbated by the idea of high cost of acquiring that professional service.

Although many women may receive the involvement of their partners when obtaining abortion care, male partners are not routinely involved in the abortion care process. Studies on how male involvement relate to women abortion practice may help guide health institutions considering incorporating of male partner in abortion care. Abortion care may be a significant area for inclusion because many seeking and obtaining abortion experience complex emotions and feelings of solution and may desire the involvement of their partners (Lie et al.,2008). Additionally, to potential benefit for women at individual level, the inclusion of male partners may improve women's access to safe abortion care globally (World Health Organization, 2015).

There is a lot of literature on professional abortion service providers' attitude to abortion. A larger part of this literature highlights the discriminating attitudes of these professionals. However, there is not as much research on the factors that affect women in their reproductive ages in seeking comprehensive abortion care. This study, therefore, provides an important opportunity not only to augment existing information about the factors that affect women in their reproductive ages in connection with abortion care, but also to provide empirical information about comprehensive abortion care in the New-Juaben municipality.

2.6 Accessibility of Family Planning Counseling involved in Comprehensive Abortion Care

To provide a service environment that protects the dignity of women seeking post-abortion care, necessary measures must be taken. Measures such as provider-training and values clarification exercises need to properly constitute the care to ensure that women are treated with respect in a manner that consequently prevents stigmatization and negligence. One must also ensure equitable access to family planning services, regardless of the uterine evacuation method used. The contraceptives which can be used after surgical or medical uterine evacuation treatment are the same, and most can be initiated on the day of treatment of an incomplete abortion with a few exceptions. Some evidence suggests that post-abortion clients are either more or less likely to be offered family planning counseling and services depending on which method of uterine evacuation they receive (Nielsen et al., 2009).

It is important that all providers and facilities treating women for incomplete abortion offer immediate and on-site family planning counseling and services as an integral

part of post-abortion care (Rasch et al., 2004), regardless of the uterine evacuation method. Post-abortion family planning uptake is high when quality services are offered before discharge (Ceylan, 2009).The structure and administration of services affect post-abortion clients' choice and access to family planning services. Service programs that are integrated under one administrative authority enhance access to family planning services post abortion, while vertical programs may result in fragmented service-delivery systems that are more difficult for clients to negotiate.

Studies in Cambodia and Tanzania found that post-abortion care clients served in facilities with on-site family planning services were significantly more likely to accept a contraception method than clients served in facilities that refer for family planning services (McDougall et al., 2009; Wanjiru et al., 2007). Family planning guidance indicates that helping a woman to initiate an effective method of contraception is an essential task in providing post abortion care, and it should not be deferred to a follow-up visit (Hatcher et al., 2009). Other studies have shown that women are most likely to begin using a family planning method if they can immediately obtain it at the time of their post-abortion care treatment, instead of returning for another visit or being referred elsewhere to obtain it.

In accordance with the policies and guidelines of the comprehensive abortion care process, the client is entitled to receiving family planning counseling services as part of pre-abortion care and post-abortion care. It helps to reduce issues of unintended pregnancies which go a long way to reduce the need for abortion (Jumbo, 2013). It was obtained from a study carried out in La General Hospital, Accra, that, 16 out of 21 clients received family planning counseling during the pre-abortion care. During this period, it was proven that clients received family planning counseling on whether to keep abortion

or not, the various family planning methods and their side effects, and types of contraception available (Kyere-Darkwah, 2016). Family planning empowers women and can save their lives. It can also help reduce poverty, slow population growth and ease pressures on the environment. Yet, family planning services often fail to reach those with the greatest need; the poor, those living in remote areas and urban slums and people with little education. Sometimes also, social costs and increased financial and time burdens on the health systems and providers limit the accessibility of clients to family planning counseling services (Salvelevia et al, 2003). Some studies demonstrated that, certain clients are offered family planning services based on the type of uterine evacuation method used. It was advised thereof that, health care providers must have immediate and on-site family planning counseling as an integral part of the post-abortion care (HIP, 2012).

2.7 Barriers in seeking Comprehensive Abortion Care

There is increasing recognition by the international community of how unsafe abortion is contributing maternal mortality. Shah and Ahman (2010) observed that the total number of unsafe abortion globally has increased to 21.6 million in 2008. The narrative is not any better in contemporary times as unsafe abortion is still a challenge yet to be addressed convincingly. However, there are so many barriers to safe abortion delivery.

In about 26% of the world's population, abortion is prohibited and is done only to safe the woman's life, that is, therapeutic abortion (Grimes et al., 2006). Even in those counties with more liberal abortion legal frameworks, there are other social economic and health systems barriers, such as stigma and discrimination, surrounding abortion that prevent adequate access to safe abortion and post-abortion care.

Studies have shown that, religion is the most important factor influencing the attitude and practices of health care providers toward induces abortions (Boötes 2000, Belton et al. 2009; Aniteye and Mayhew, 2013; Abeli and Gaber Mariam, 2011). Furthermore, abortion is perceived to be a sinful act according to various moral and religious views. These views, in different, ways prevent women from taking up comprehensive abortion care. However, some opinions explained the fact that abortion care is very salient reproductive right of women (Kyere-Darkwah, 2016; Helena, 2012; Addiset al, 2015). Some other factors that inhibit the provision of comprehensive abortion care include narrow interpretation of laws, technological limitations, and conscientious refusal of care and provider attitudes (IPAS, 2014).

According to a study carried out in Zambia by Jumbo (2013), barriers affecting comprehensive abortion care services were grouped into two which are supply barriers and demand barriers. Supply barriers included availability – where are no facilities available to render comprehensive abortion care services; and affordability, being the major demand barrier, affected the patronage of the comprehensive abortion care, since women are most times disadvantaged in wealth and resources both in time and monetary aspects. Weak health systems also contribute to problems of provider shortages together with lack of access to consistent supply of medications and contraception cares (Amplify Change, 2018).

2.8 Conclusion

This chapter has elucidated the state of knowledge on abortion. From the review, it emerged that the rate of abortion is not decreasing significantly. Rather, there is an increased trend in the number of women who resort to abortion. Nonetheless, there is a

major problem where many of the women who take to abortion are using unsafe methods of abortion and, unfortunately, increasing morbidity and mortality rate consequent to abortion. This necessitates the need for comprehensive abortion care. The study is conceptualized that knowledge, attitudes, and practices of people concerned with abortion are the main pillars by which the influence of comprehensive abortion care can be explained. The next chapter presents the methodology of the study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology which gives the systematic approach to this study. This section is organized to describe the research design, study population, sampling procedure and sample size, data collection instrument, data collection, validity and reliability, data analysis procedure, and ethical consideration.

3.2 Research Design

The study adopts a survey design. This was meant to allow the health facilities in the geographical field of study to be surveyed and be conversant with the characteristics of health facilities and people that were going to be engaged in the study. The survey design paved the way for subjects with relevant characteristics to receive maximum attention. Mixed methods constituted the approach to data collection and analysis. Therefore, both quantitative and qualitative data were utilized. This offered opportunity for the study to quantify phenomena with rich insight and be able to make generalizations, as well as be able to obtain in-depth information to explain phenomena or give insight into issues under study.

Quantitative and qualitative approaches have criticisms of their own. A major critique of the quantitative approach is that it falls within the positivist school of thought, thereby paying crucial attention to knowledge based on facts. As such, the quantitative method is strong in generating ideas for the purpose of generalization, but is weak in explaining human behavior (Saunders et al., 2009). The qualitative method lies within interpretative paradigm of explanations to reality and is strong in providing explanations

to human behaviour, beliefs, values and experiences. However, it is weak in finding cause for generalization (Patton, 2015). Combining the two methods is good for scientific research (Teye, 2012). The advantage of using mixed methods for this study is that it provides an opportunity for the strength of the two methods to be harnessed for data collection and analysis. By the mixed method, this study is able to obtain the insight and explanations to questions from comprehensive abortion care practitioners and users in a way that enriches the discussion on the factors underpinning comprehensive abortion care. Furthermore, to overcome other weaknesses arising from the use of both quantitative and qualitative methods, their strengths were built upon by means of triangulation as recommended by Tashakkori and Teddlie (2003). This approach was important because it helps in corroboration, complementarity, initiation and expansion (Onwuegbuzie et al., 2010).

To meet the objectives of this study, knowledge concerning comprehensive abortion care in the New-Juaben Municipality will be interrogated. This incorporates data from adult women visiting health facilities that provide comprehensive abortion care in the municipality, as well as views from selected reproductive health professionals from those facilities. Attitudes and practices of these people towards comprehensive abortion care will also be interrogated, whence the underpinnings of comprehensive abortion care will be determined.

3.3 Data Collection Techniques and Tools

Data collection was undertaken through administration of questionnaires and conducting of Key Informant/Expert Interviews (KIEI). The administration of questionnaires aimed to obtain quantitative data from adult women visiting the health

facilities at the instance of data collection. To achieve this, data enumerators were stationed at each of the health facilities of interest in this study over a period of five clear days during which they interacted with clients and administered the questionnaires to them. During the same period, a day was schedule for the interview of key informants who are health professionals in the line of providing comprehensive abortion care at the various health facilities.

A structured questionnaire was, therefore, the instrument of data collection from the adult women at the health facilities. The questionnaire was designed to solicit background data of the participants or clients. The background data indicated the age, sex, religion, level of education, occupation, income levels, marital status, and number of children alive. In addition to that, there were three sections; the first was an assessment of awareness and knowledge about comprehensive abortion care. This section incorporated questions that concern pre-abortion, actual abortion, and post-abortion issues. It comprised family planning, counseling, post-abortion care follow-ups, and other relevant issues. The next section provided data relating to the attitudes and practices of people towards comprehensive abortion care. This section attempted to identify accepting attitudes of people or their aversive attitudes to comprehensive abortion care and the practices thereof. The last section solicited reasons for non-patronage of comprehensive abortion care, as well as recommendations for enhanced patronage of comprehensive abortion care by adult women. The assessments were drawn by means of approval ratings anchored on a Likert scale response format which ranged from 1 to 5 where “1” represents the lowest approval level of the respondent and “5” indicates the highest approval level of the respondent (See Appendix 1).

The KIEI was conducted by the assistance of an interview guide which was the other instrument of data collection in this study. The interview guide contained key questions pursuant to the objectives of the study which aimed to direct the questions to the objectives of the study. Particularly, the interview guide was to provide keys that help to further explore opinions of health professionals on their knowledge about comprehensive abortion care, including attitudes and practices of parties to the provision of comprehensive abortion care, and ideas on how to increase patronage of comprehensive abortion care.

3.4 Study Population

The population of the study refers to the whole people or unit of interest in the study for the purpose of obtaining data (Patton, 2015). The population of this study was on two levels: first, any adult woman on visit to any of the health facilities providing comprehensive abortion care in the New-Juaben Municipality forms part of the population. Second, comprehensive abortion care professionals in the health facilities within the municipality were also members of the study population. For this reason, comprehensive abortion care practitioners and users of that care constituted the study population. This population comprised family planning service providers, abortion care providers, counseling providers, and all such practitioners whose work facilitates the provision of comprehensive abortion care. Comprehensive abortion care users is defined as women above age eighteen (18), which is the constitutionally accepted age by which one is an adult and no more than 49 years.

3.5 Sampling Procedure and Sample Size

Sampling is crucial in research because resources such as time, money, distance, and workload would not permit experimenting with a whole population (Leech, 2004). In

determining the sample size for the study, the key issue was to obtain women in their reproductive years. According to the Ghana Statistical Service (2014) out of 95,040 women of all ages in the New-Juaben Municipality, 61,193 are in their reproductive years. The proportion of women within the reproductive age bracket is, therefore, 64.4% in the New-Juaben Municipality. Based on this information the target sample size in this study was calculated using Cochran's (1963) sample size calculation formula:

$$n = \frac{1.96^2 pq}{e^2}$$

Where *n* is the sample size, *e* is the desired margin of error = 0.05, *p* is the estimated proportion of the population which has the attribute in question = 64.4% = 0.644, and *q* is derived from 1 – *p*. Effectively, the sample size is given by:

$$n = \frac{1.96^2(0.644)(0.356)}{0.05^2} = 142.2$$

The targeted sample size was, therefore, 142 women in their reproductive ages. This study employed a multi-stage sampling procedure in collecting data. Multi-stage sampling saves time and provides clearly defined steps through which participants in the study should be selected without bias.

The first stage of the sampling procedure resulted in the specification of relevant health centres and key informants. At this stage, the purposive sampling method is used to identify health centres on the basis of their accreditation to provide comprehensive abortion care. Consequently, it emerged that, at least ten (10) health centres within the New-Juaben Municipality have the authority to provide comprehensive abortion care. The comprehensive abortion care professionals in these health facilities were then purposively

sampled as key informants. Meanwhile, not all of the health facilities have been actively involved in providing that care for different reasons. For example, the Oyoko Health Centre, albeit authorized to provide comprehensive abortion care, is not doing so because since the transfer of the health professional who was in charge, there has not been a replacement. The existing health staffs are also not trained to provide abortion care. The case is not different with the Akwadum Health Centre since there has been no replacement after the retirement of the staff in charge of provision of comprehensive abortion care. At the Jumapo Health Centre as well, the personnel have not been trained to provide comprehensive abortion care.

The outcome for all such health facilities has been that the personnel are not empowered or emboldened to render comprehensive abortion care. On the basis of these considerations, five (5) health facilities that were actively rendering comprehensive abortion care were purposively retained as the health facilities from which users of comprehensive abortion care were recruited for the study. These health facilities include the Regional Hospital, Asokore Reproductive and Child Health Centre, Magazine Health Centre, Effiduase Reproductive and Child Health Centre, and Koforidua Poly Clinic.

Again, by the purposive sampling method, the leaders of the health professionals at the five health centres known to be actively providing comprehensive abortion care also provided insight in aid of the study. Senior nurses and/or midwives who preside over comprehensive abortion care delivery in their health centres. Two of these health professionals were contacted in each of the five health facilities. Thus, 10 health professionals were engaged in in-depth interview.

The second stage of sampling resulted in the recruitment of adult women; potential or active users of comprehensive abortion care. Convenience sampling method was employed to establish contact with adult women and to seek their participation in the study across the five health facilities that were actively rendering comprehensive abortion care. This sampling method was chosen because of the imprecision involved in knowing the actual number of adult women who would be visit the health facilities. However, the convenience method provided the space and time within which any adult woman visiting the health facility that was ready and willing to participate in the study at the instance of data collection could be part of the study. The participation of the adult women in the study was by means of questionnaire administration to obtain the views of the women on stated issues of comprehensive abortion care.

3.6 Pre-testing

Pre-test, according to Creswell and Clark (2006), is critical for quality assurance and inclusiveness in research. Pre-test provides the researcher a prior picture of what is to be anticipated in the actual period of data collection and offers the opportunity for corrections to be made to instruments and methods for data collection (Bryman, 2012). A pre-test was carried out prior to the data collection exercise using the instruments that were developed at the New Tafo Government Hospital in the Eastern Region of Ghana. This hospital is a health facility with clinical staff and midwives who offer family planning and abortion care. Twenty (20) adult women and four (4) health professionals participated in the pretesting exercise. Generally, the instruments proved to be material to achieve the objectives of the study and participants understood the questions that were posed without

ambiguity. A few corrections which surfaced in the pretesting exercise were used to further improve upon the data collection instruments.

3.7 Data Handling

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

3.8 Data Analysis Procedure

Findings from this study were synthesized from both quantitative and qualitative methods of data analysis. Data analysis helps to answer research questions and to establish patterns of knowledge out of available data (Creswell, 2013).

The qualitative data was analyzed by, first and foremost, transcribing, and afterward, organizing or structuring them thematically (Patton, 2015). Data analysis through the qualitative method provided understanding of what informs respondents' behaviour, opinion, knowledge, and perceptions (Castro et al., 2010). The thematic analysis helped to tease out themes from the qualitative data consequent to rigorous reading of textual recordings. Similar views were grouped under themes to which they must adhere in order to form patterns of thought. Verbatim quotes were used to emphasize significant points. In line with the ethical consideration of anonymity, respondents whose views were quoted were kept anonymous to protect their real identity.

The quantitative data was analyzed using STATA version 14. First, however, data from the questionnaires were entered in the Statistical Package for Social Sciences (SPSS)

to speed up the process of checking for errors and cleaning of data. The background data of the respondents was analyzed using descriptive statistics, particularly, frequencies and percentages. Binary Logistic Regression that treated contraception use (and by extension comprehensive abortion care) as a dependent variable and independent variables emerging out of demographic data, elements of knowledge on comprehensive abortion care as well as attitudes and practices on comprehensive abortion care formed the procedure of determining the underpinnings of comprehensive abortion care. Incidentally, Chi Square test was used to determine the dependence of comprehensive abortion care on other demographic factors.

3.9 Ethical Considerations

The success of every research depends on the consideration of key ethical issues (Burnham, 2008). This research was conducted bearing in mind high level of integrity. This was demonstrated by, first, submitting an introductory letter seeking permission of the management of the health facilities involved to undertake a study of this nature. The acceptance of the permission by management warranted that the study could engage health professionals at convenient time during the period of the study, and so it happened. The object of the study was communicated to the health professionals, notably, involved in the delivery of comprehensive abortion care.

Second, the study deployed informed consent forms for the data collection exercise to take place smoothly. Before interviews were conducted and questionnaires were completed by respondents, the purpose of the research was discussed and explained to participants. At all stages, permission was sought from the participants in the study before any exercise, either data collection or clarification of issues, was undertaken. Where

respondents were unable to read and/or write, research assistants provided assistance and explained issues to the appreciation of such respondents.

Finally, confidentiality, anonymity and privacy were assured the participants of the study. The object here was to prevent disclosure of data or identity of participants to any other party. The assurance to this effect was given to the participants in demonstrating that the study is not to expose any individual to harm.

CHAPTER FOUR

DATA ANALYSIS

4.1 Introduction

This chapter presents the analyses of data obtained from the field work undertaken in the study. The results have been discussed in light of the objectives of the study, specifically, to come to terms with the levels of knowledge about comprehensive abortion care, attitudes and practices towards comprehensive abortion care, and to determine that underpinnings of comprehensive abortion care. Subsequently, strategies for enhancing reproductive health of adult women is gleaned out of the data obtained in the study. A total of 139 respondents participated in the study. This comprised 129 clients to the selected health facilities and 10 health professionals of health facilities that provide comprehensive abortion care in the New-Juaben Municipality. Effectively, the Regional Hospital, Asokore Reproductive and Child Health Centre, Magazine Health Centre, Effiduase Reproductive and Child Health Centre, and Koforidua Poly Clinic were the areas where the field work took place. The analysis here made use of both quantitative from the clients and visitors and qualitative data in the form of interviews granted by the health professionals.

4.2 Background Information about Clients

The background data obtained from the clients include their distribution by age, gender, level of education, occupation, average monthly income, marital status, religious affiliation, attempts at birth, number of children, contraception use, and patronage of family planning service. The statistics from these points came, notably, from the clients of the health facilities who participated in the study.

4.2.1 Age

The ages of the clients from whom quantitative data was gathered ranged from 18 years to 49 years. The largest percentage (34.9%) of the clients represented those in 18-24 age-group. The percentage generally reduced in older age groupings indicating that a lot more of the participants in the study were younger. In the age group 30-34, the percentage of the participants was 24.0%. The percentage dropped sharply to 9.3% for those in the 35-39 age-group, and further to 4.7% and 3.9% in the 40-44 and 45-49 age-groups respectively. This implies that, it is not only people in their most sexually reproductive years that have participated in this study, but also people in their sexually active years. Their views were material to the discussions on comprehensive abortion care.

4.2.2 Gender

The majority (87.6%) of the clients were females with only 12.4% of males participating in the study. Rightly so, the study is predisposed to the knowledge, attitude, behavior and practices of adult women towards comprehensive abortion care. The large participation of females enhances the representation of the views women on the pertinent issues in the study.

4.2.3 Level of Education

A few clients, representing 7.8 percent, had no formal education. Nonetheless, 24.4% of the clients had Primary/Junior High School or Secondary/Senior High School level of education. A slightly higher percentage (27.1%) of the clients had tertiary level of education. Meanwhile, 12.4 percent of the clients also had technical education. Effectively, level of education was, generally, high among the clients.

4.2.4 Occupation

About two out of every five (41.1%) of the clients were traders. About half of that proportion (20.2%) represented the clients who were unemployed. Although there were civil/public servants (13.2%), artisans (12.4%), students (8.5%) and a very few others such as nurses, farmers and decorators, these are not comparable to the proportion that was unemployed. This means that considerable proportion of the clients had limited sources of economic livelihood apart from trading.

4.2.5 Average Monthly Income

A little less than half (49.1%) of the clients earned an average income of 100 to 500 Ghana Cedis per month. As income levels increased beyond 500 Ghana Cedis, the percentage of the clients became smaller. For example, 21.1 percent of the clients earned from 501 to 1,000 Ghana Cedis per month. Beyond 1,000 through 1,500 Ghana Cedis per month, the percentage of clients further reduced to 14.0 percent. At 2,000 Ghana Cedis per month, the percentage of the clients reduced to 1.8. About one out of every ten (9.6%) clients, however, earned less than 100 Ghana Cedis per month. It means, therefore, that 100 to 500 Ghana Cedis per month is the most probable range of income earned by the clients.

4.2.6 Marital Status

A little more than half (51.2%) of the clients represented those who were single. The clients who were married made up 38 percent of the participants in this study. For both of these categories, abortion and family planning services will be an important issue. Beside this, 6.1 percent of the clients were cohabiting with sexual partner (cohabitation). There existed 3.1 percent made up of clients who were separated with their sexual partners,

and 1.6 percent representing clients who had divorced their partners. Obviously, issues relating unwanted pregnancy will be important for most of these clients.

4.2.7 Religious Affiliation

The majority (78.4%) of the clients represented Christians, whiles about one out of every five (21.6%) was in the Islamic faith. It is very likely that the tenets of these religions will inform the views of the clients on abortion and family planning questions. For example, both religions principally frown vehemently on abortion and this might play an important role in the disposition of clients to abortion-related issues.

Table 4.1 presents the composite results of the background data obtained from the field work in the various health facilities contacted. Other information relating to the clients' experience with birth and contraception use is presented hereafter.

Table 4.1: Background Data of the Clients

Variables	Frequency	Percent
Total	**129**	**100**
Age Groups		
18-24	45	34.9
25-29	30	23.3
30-34	31	24.0
35-39	12	9.3
40-44	6	4.7
45-49	5	3.9
Gender		
Male	16	12.4
Female	113	87.6
Level of education		
No formal education	10	7.8
Primary/JHS/JSS/ Secondary/SHS/SSS	35	27.2
Commercial/Vocational/Technical	16	12.4
Tertiary	34	26.4
Occupation		
Unemployed	26	20.2
Artisan	16	12.4
Trader	53	41.1
Civil/Public Servant	17	13.2
Student	11	8.5
Decorator	2	1.6
Farmer	2	1.6
Nurse	2	1.6
Average monthly income (GHC)		
Less than 100	11	9.6
100 to 500	56	49.1
501 to 1,000	24	21.1
1,001 to 1,500	16	14
1,501 to 2,000	5	4.4
More than 2,000	2	1.8
Marital status		
Single	66	51.2
Married	49	38.0
Cohabitation	8	6.2
Separated	4	3.1
Divorced	2	1.6
Religious affiliation		
Christian	98	78.4
Islam	27	21.6

Source: Field Work, 2019

4.3 Description of Health Professionals Interviewed

The other group of respondents in this study were the 10 health professionals, two from each of the five health facilities that were the focal point of this study. To put the interviews into proper perspective, a description of the health professionals is presented.

In each of the health facilities, the two health professionals engaged were in the capacity of senior nurse and/or midwife. Overall, they have served in the professional health sector for no less than 19 years. The midwife engaged in interview at the Koforidua Regional Hospital, for example, had served in as a midwife in the health sector for 25 years. It is from this perspective that their insights have been used in the study.

The qualitative data was used to corroborate the quantitative data in order to produce synthesized information that gives account of relevant angles on the issues raised in the study. Exemplary quotes that give insight into issues under discussion were presented verbatim. In order to preserve confidentiality and privacy, pseudonyms have been used to identify the respondents whose responses present the rich context in which various emerging themes can be explained. The pseudonyms are given as follows:

Koforidua Regional Hospital

Senior midwife	Respondent 1
Nurse	Respondent 2

Koforidua Polyclinic

Midwife	Respondent 3
Nurse	Respondent 4

Effiduase Reproductive and Child Health Centre

Midwife	Respondent 5
Senior nurse	Respondent 6

Asokore Reproductive and Child Health Centre

Senior nurse	Respondent 7
Midwife	Respondent 8

Magazine Health Centre

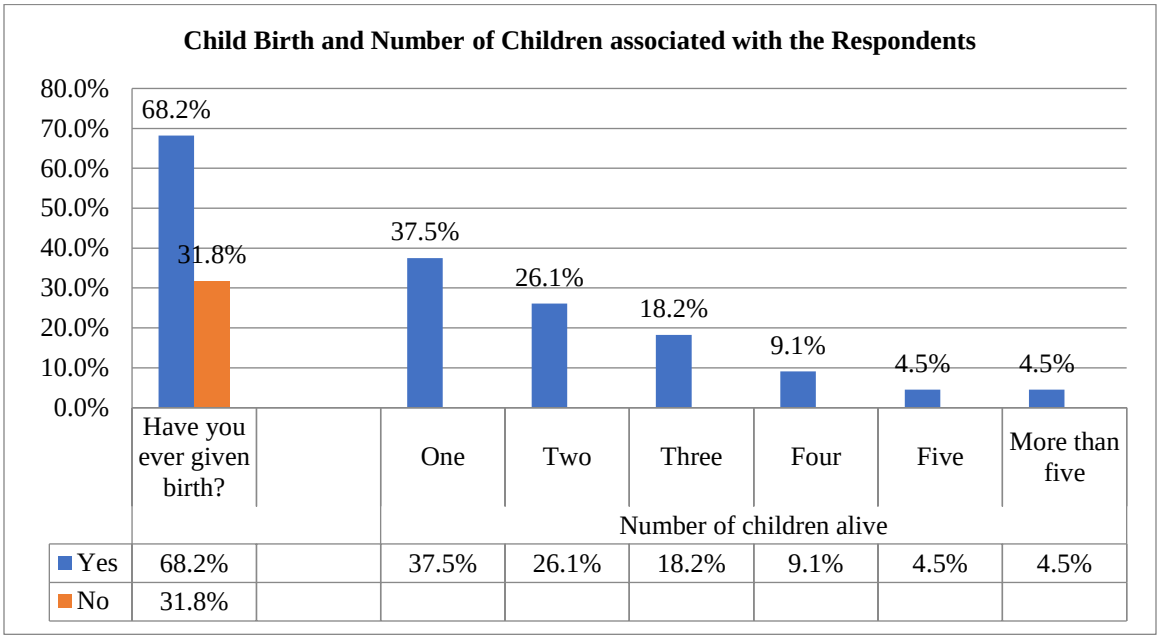
Midwife	Respondent 9
Nurse	Respondent 10

4.4 Clients Experience with Child Birth and Contraception use

This part of the analysis is on information about birth experience and contraception use. The information throws light on the position of the participants in the study regarding child birth, and their readiness or preparedness for children. It also attempts to provide results on predisposition of the participants to contraception use.

At the first instance, the results show that a little less than seven out of every ten (68.2%) clients have ever given birth. Following this, it emerged that the largest percentage (37.1%) of the clients who had ever given birth had one live child. About a quarter (25.8%) of the clients who had ever given birth had two children alive. With further increments in the number of children, the percentage of clients decreased. This gives the indication that the participants were wary or unable to host increasing numbers of children. Figure 4.1 explains the results.

Figure 4.1: Child Birth and Number of Children associated with the Clients



Source: Field Work, 2019

On the part of the clients who had never given birth, it appears that they have a reduced clamor over haste to give birth to their first child. In fact, the largest proportion constituting about a quarter (25.8%) of them could not tell the period in which they would like to give birth to their first child. Although this reflects a certain level of indecision on exactly when they want to give birth, it increases their likelihood of sustaining an unplanned pregnancy. However, the data shows an increasing tendency of the clients to delay their first child birth. As 24.2 percent of the clients wanted to give birth to their first child in no less a time than three years, a lower percentage (21.2%) of the clients wanted to give birth to their first child in two years' time. There is further a drop to 19.7 percent of the clients who wanted to give birth to their first child as close as a year's time. From these inclinations of the clients, there is a measure of restraint or caution at play in their bid to give birth to their first child. Table 4.2 shows the results.

Table 4.2: Time Projection for First Child Birth

Variables	Frequency	Percent
Total	**66**	**100.0**
In a year's time	13	19.7
In two years' time	14	21.2
In three years' time	16	24.2
More than three years' time	6	9.1
Don't know	17	25.8

Source: Field Work, 2019

Another instance in the analysis revealed how the clients have patronized contraception methods or family planning services. The results show that, 66.7% of the clients in this study have ever used a contraception method. Further, the last time these clients, amounting to 86 people, used a contraception method was any other period even as far as beyond two years. The largest percentage (48.8%) of these clients used a contraception method most recently in less than six months ago. The clients whose last time of using a contraception method ranged from six-months to one-year made up 14 percent, whiles 12.8 percent used contraception the last time in between one-year and two-years. It is interested to note, however, that the latest use of contraception method by as much as 24.4% of the clients occurred in more than two-years ago. It is observable that, depending on the type of contraception method used, the effectiveness of the method may decline with passage of time when a review is not carried out. Therefore, a long last-time-use of contraceptive may predispose the clients to unplanned pregnancy subject to the type of contraception method applied over the period. The results obtained are as shown in Table 4.3.

Table 4.3: Period of Last Use of Contraception

Variables	Frequency	Percent
Total	**86**	**100.0**
Less than 6 months ago	42	48.8
6 months to 1 year ago	12	14.0
Between 1 year to 2 years ago	11	12.8
More than 2 years ago	21	24.4

Source: Field Work, 2019

About three out of every five (63%) clients have sought family planning and counseling service in health facility at a point in time. This is illustrated in Figure 4.2.

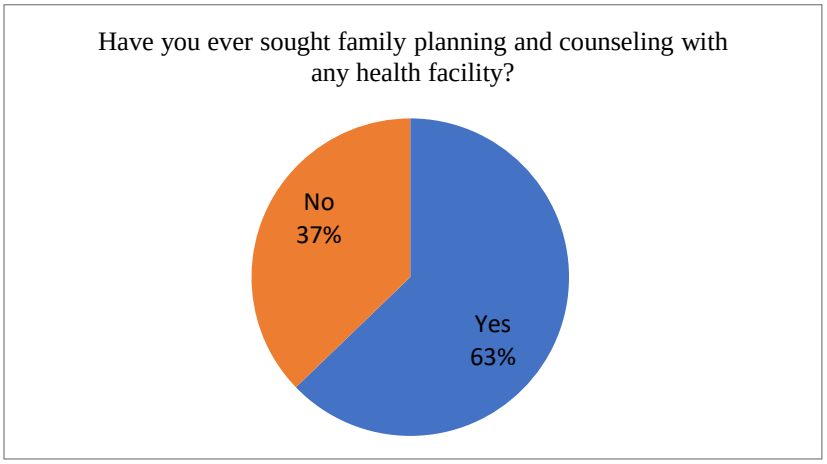


Figure 4.2: Family Planning and Counseling Seeking in Health Facility

Source: Field Work, 2019

4.5 Knowledge, Attitudes and Practices on Comprehensive Abortion Care

This section zooms into knowledge/awareness, attitudes, and practices (KAP) of the respondents on family planning and comprehensive abortion service. To begin, the respondents' knowledge on contraception was examined. The clients were posed with the question: "What types of contraception methods do you know?"

The responses to the question indicated that, majority (above 60%) of the clients have knowledge about contraception methods namely: pill, condom, and injectables. Specifically, more of the clients (76.7%) knew about condom than pill and injectables which made up 70.5 percent and 65.9 percent of the client's knowledge on contraception methods respectively. Besides this finding, more than half of the clients, polling 52.7 percent and 53.5 percent, were cognizant of Intra-Uterine Device (IUD) and implants as contraception methods. Apart from these grades of contraception methods, all others did not meet considerable awareness of the clients. Figure 4.3 gives a graphic presentation of the findings wherein clients indicated "No" when they considered that they have no knowledge of the method in question.

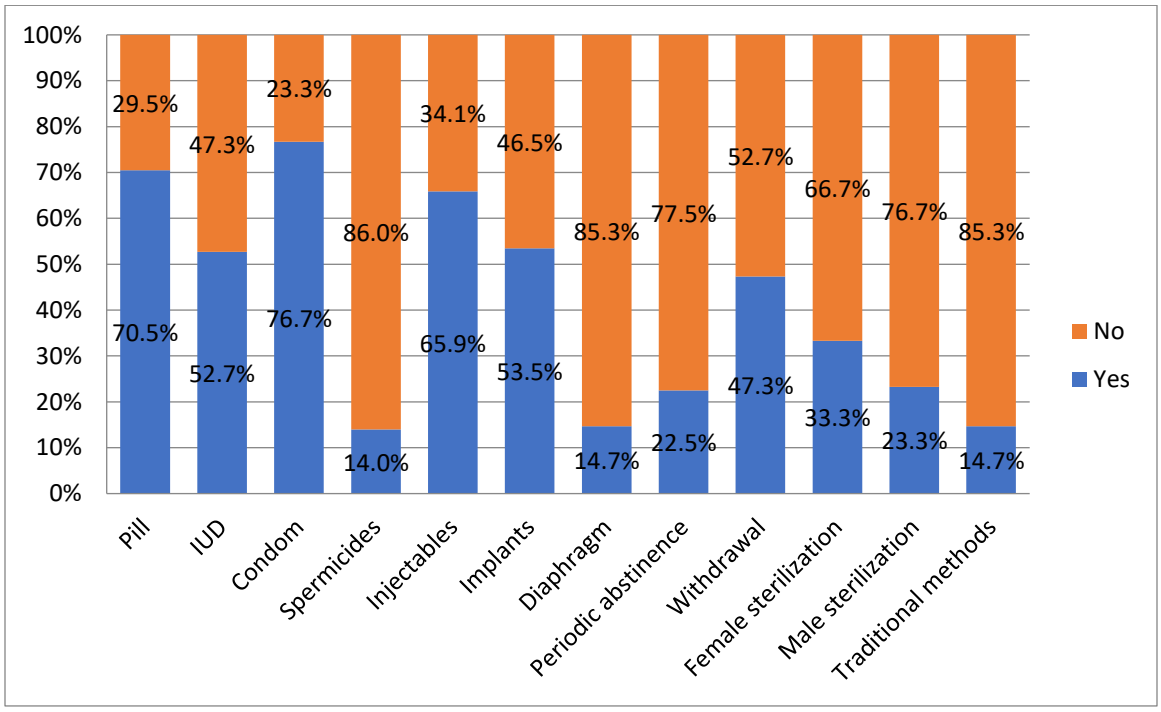


Figure 4.3: Knowledge about Contraception Methods

Source: Field Work, 2019

In a related enquiry, the clients were requested to indicate the contraception services that they knew were being provided in the health facility from which place they participated in this study. As it were, it was assessed whether or not the clients knew what the facility was providing in terms of contraception care. The results revealed that, majority (above 60%) of the clients knew that oral contraceptives (74.4%), injectables (70.5%), implants and condoms (63.6%) were services provided in their immediate health facilities. Therefore, oral contraceptives seem to have the most popular attraction in the health facilities patronized by the clients. There was 14 percent of the clients who had utterly no idea about the contraception services available in their immediate health facilities. Figure 4.4 presents the particulars of the results.

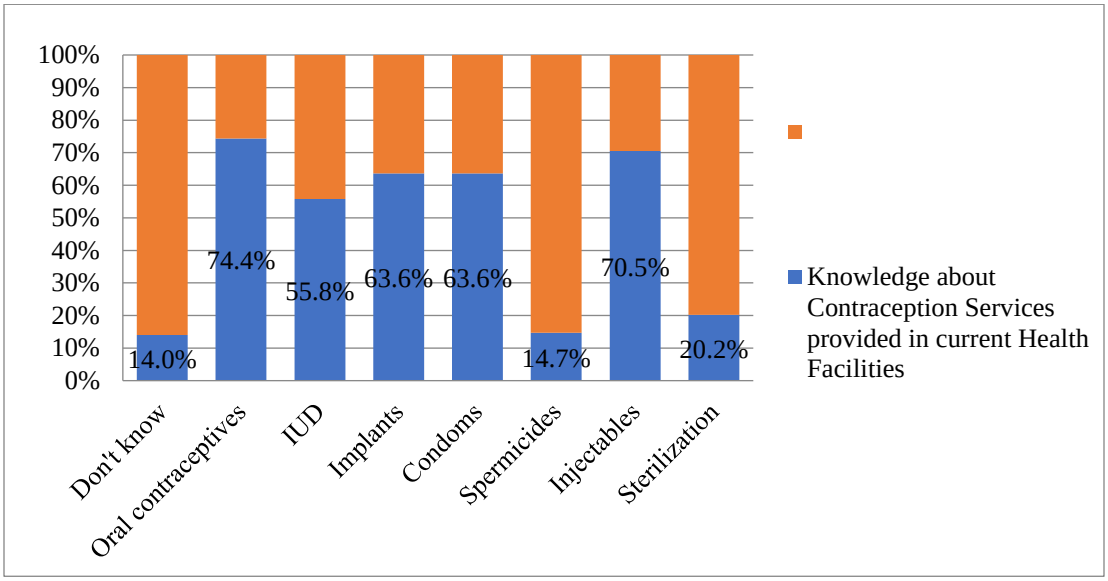


Figure 4.4: Knowledge about Contraception Service in current Health Facilities

Source: Field Work, 2019

An important consideration relative to knowledge of contraception is source of information on contraception. For this reason, the study enquired the source of information

on contraception methods for the clients. Generally, "Midwife" was indicated by more than half (56.6%) of the clients as their source of information on contraception. There were not as many clients that showed that friends or the media was their source of information as those who showed that neither friends nor the media was their source of information. To 53.5 percent and 50.4 percent of the clients, friends and the media have both not been the source of information on contraception. Still, 89.8 percent of the clients have not obtained information on contraception from their family members. This means that midwives are an indispensable source of information on contraception to the clients. The result is as illustrated in Figure 4.5.

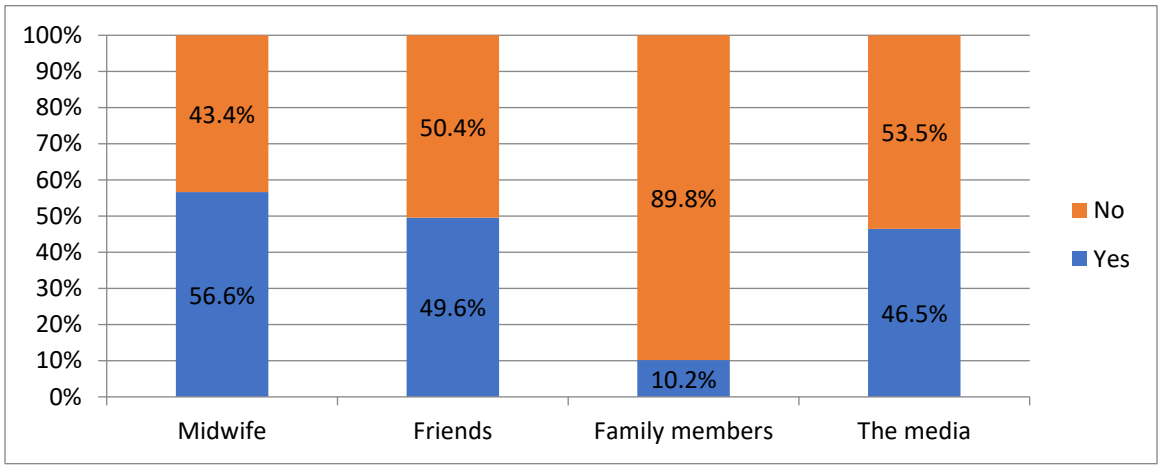


Figure 4.5: Source of Information on Contraception Methods

Source: Field Work, 2019

From the interviews granted by the health professionals in the field, there is ample information that corroborate much of the findings on knowledge about contraception and, to be more accurate, the source of knowledge on contraception methods to the clients. All the 10 health professionals engaged in the interview expressed high levels of precision in their explanation of the meaning of comprehensive abortion care. The common question

asked to them was, “How would you explain what is meant by comprehensive abortion care?” The common thread that ran through their submissions was that, comprehensive abortion care is the care provided by a trained health professional to clients who are seeking help in deciding whether and how to safely terminate their pregnancy and ensure good health thereafter. The view is more clearly exemplified in the submission of one senior midwife of the Regional Hospital, Koforidua who said:

> “Comprehensive abortion care is abortion care provided by trained personnel in a health facility, and after the abortion we take the client through family planning. We do not just terminate the pregnancy, but we advise the client on what to do” (Respondent 1, interview, March 13, 2019).

A midwife who superintends the family planning unit at the Koforidua Poly Clinic also had this to say to the epitome of the point just discussed:

> “Comprehensive abortion care is given to anybody who wants to terminate her pregnancy. So we counsel her so that she would know how the procedure will be like. After the procedure, we give post-abortion care to ensure that she will protect herself and not increase her risk of an unprepared pregnancy” (Respondent 3, interview, March 13, 2019).

As has been said, what is obvious is the profound knowledge of the health professionals on comprehensive abortion care. As health professionals, during their interface with clients seeking abortion or pregnancy care, they find themselves in a better position to educate adult women and to promulgate the benefit on comprehensive abortion care. Rightly so, when posed with the question, “Do you think that adult women have apprehended the meaning of comprehensive abortion care?” the health professionals held a strong view that it is not just the case that adult women have not understood this type of care. This is chiefly because the professional health staff provide education on

comprehensive abortion care to adult women through varied initiatives. For instance, the senior midwife of the Regional Hospital, Koforidua, answered the question as follows:

> "Yes. Because doctors do not have all the time to give information on abortion issues, we, as midwives, use our knowledge and influence to educate our clients, mostly those we interface when we are providing comprehensive abortion care" (Respondent 1, interview, March 13, 2019).

Another midwife at the Effiduase Reproductive and Child Health Centre intimated, in answer to the question, that;

> "They [adult women] know it [comprehensive abortion care] because we have been organizing groups and churches to give them education on it. Other than that, they cannot come to our health facility. They are aware of what we do here, and when they come, we explain it further to them" (Respondent 5, interview, March 12, 2019).

This position taken by the health professionals reaffirms the popular view of the clients that midwives, and by extension, professional health staff constitute their source of information on contraception methods. Still, the health professionals strongly believe that education of adult women on comprehensive abortion care must continue unabated, albeit effective so far. Some of them shared the view that, there is the difficulty for some professional health staff themselves to accept comprehensive abortion care holistically. Consequently, there is difficulty in accepting some of the methods therein. Because of such possibility, answering the question, "Would you say that health centres in Ghana have been effective in educating people on comprehensive abortion care?" has both positive and negative dimensions coming to the fore. The response that clearly exemplifies this viewpoint came from the senior midwife at the Regional Hospital, Koforidua. She said, in response to the question just reported, that,

> "Somehow, it has been effective. Some of the health personnel themselves have difficulty accepting some of the methods of comprehensive abortion care. For such individuals, it would be difficult for them to promulgate the comprehensive abortion care message" (Respondent 1, interview, March 13, 2019).

A critical part of assessing the knowledge of the clients on comprehensive abortion care involved the clients in responding to sets of statements under knowledge, attitudes, and practices using response format anchored on a 5-point approval scale ranging from 1 to 5 where 1 signifies the strongest level of disapproval and 5 indicates the strongest level of acceptance to a statement. Between these two extremes were all grades of approval scores on the various statements by the clients. The Mean and Standard Deviation of the responses were calculated by adding individual approval scores obtained on the approval scale 1 to 5 and dividing the result by the total number of clients. The Mean represented approval indicators ranging from 1 to 5 which indicated the state of the clients on the issues concerning comprehensive abortion care. Approval indicators closer to 5 reflect higher clients' knowledge/awareness on comprehensive abortion care. However, an approval indicator on scale 1 indicates highest level of rejection of disapproving attitudes and deepest disregard for practices that undermine comprehensive abortion care. In other words, approval indicators closer to 5, for attitudes and practices, signify that the clients are more favourably disposed to attitudes and practices that reject comprehensive abortion care. The resultant analysis provided a robust explanation of the level of knowledge and patterns of behaviour and practices of the clients relative to comprehensive abortion care.

In all, there were 9 statements under knowledge/awareness, and 16 statements under attitudes and practices. The Mean values or approval indicators were estimated for each statement in order to come to terms with the extent to which the clients accept a

particular statement. The reliability of the measures was also determined using the Cronbach's alpha and its associated Item-Total Correlations. The Cronbach's alpha is a value that falls between 0 and 1. Both the alpha and Item-Total Correlations determines the extent to which the statements used the same thing about the clients. Generally, the larger the Item-Total Correlation, the better it supports reliability. But Cronbach's alpha of 0.60 or more is regarded as an accepted measure of reliability (Field, 2000), and same was adopted in the study. First, the analysis on knowledge on comprehensive abortion care is presented.

4.5.1 Knowledge on Comprehensive Abortion Care

This part of the analysis directly pursues the first objective of this study, which is, to assess knowledge on comprehensive abortion care. The Mean, Standard Deviation, and reliability analysis were performed on nine (9) statements to determine the level of knowledge of the clients on comprehensive abortion care and reliability of the measures.

The initial statistics obtained was iterated to produce a more robust set of measures to assess knowledge on comprehensive abortion care. The iteration caused two of the nine statements to be deleted as it emerged that their deletion would rather increase the reliability of the measures. While maintaining a discretionary threshold value of 0.20 or more for Item-Total Correlation, the value of the first statement that was deleted is still lower than the threshold value. As is shown in Table 4.4, if the first variable, "Abortion is a criminal act in Ghana", with a small Item-Total Correlation of 0.044, was deleted, it would result in an increase in the Cronbach's alpha from 0.674 to 0.714. Yet, if the second statement, "If pregnancy is the result of rape, defilement or incest, abortion is permitted in Ghana" was deleted, the alpha would increase from 0.714 to an all-time-high of 0.723.

Table 4.4: Knowledge about Comprehensive Abortion Care (Reliability Analysis)

Variables	No. of items	Mean	Std. Dev.	Item-total correlation	Cronbach's Alpha if item deleted
Abortion is a criminal act in Ghana	126	3.41	1.32	0.044	0.716*
If pregnancy is the result of rape, defilement or incest, abortion is permitted in Ghana	126	3.52	1.26	0.197	0.681*
An ordinary person who has performed abortion in the community does not have what it takes to perform abortion	126	3.12	1.31	0.418	0.632
Abortion is unsafe if it is done outside of a licensed health facility	126	3.88	1.27	0.359	0.646
Health facilities providing family planning services are supposed to give abortion care	126	3.60	1.27	0.439	0.627
Safe abortion care entails counseling and medication	126	4.05	0.97	0.477	0.627
Midwives and nurses are required to provide family planning and safe abortion services	126	3.94	1.09	0.38	0.642
Women can walk into health facilities and request for abortion	126	3.75	1.08	0.611	0.595
I know where and how to obtain comprehensive abortion from a health facility	126	3.52	1.11	0.341	0.649
Grand Mean		**3.64**			
Cronbach's Alpha	**9**		**0.674**		

Note: (*) Deleted item

Source: Field Work, 2019

Consequently, an overall Cronbach's alpha of 0.723 was sustained for seven statements. Again, the results of the Mean, Standard Deviation, Cronbach's alpha and its associated corrected Item-Total Correlation after the deletion of two offending variables, is presented in Table 4.5. The table is the end-product of iterating the reliability statistics twice to produce the final results.

From the results in Table 4.5, the approval indicators obtained for the statements under knowledge on comprehensive abortion care ranged from 3.12 to 4.05 on the scale of 1 to 5. This means that the level of understanding of the clients on comprehensive abortion care is between a moderate standard and a high level. The overall approval indicator (Grand Mean=3.70) out of a maximum of 5 points shows that, generally, the clients have a high level of knowledge on comprehensive abortion care. The fact that "Safe abortion care entails counseling and medication" formed the most profound knowledge of the clients (Mean=4.05). Still, there was considerable knowledge that "Midwives and nurses are required to provide family planning and safe abortion services" (Mean=3.94). There is appreciable knowledge on the fact "Abortion is unsafe if it is done outside of a licensed health facility" (Mean=3.88). Also, knowledge that "Women can walk into health facilities and request for abortion" is high among the clients. All these aspects of knowledge of the clients on comprehensive abortion care had Means (approval indicators) higher than the sample mean (Grand Mean).

On the other hand, on the scale of 1 to 5, the knowledge of "where and how to obtain comprehensive abortion from a health facility" attained a Mean (approval indicator) of 3.52. This indicated the point at which the clients' knowledge on abortion care was lowest. The view that "Health facilities providing family planning services are supposed to

give abortion care" also scored 3.60. These scores are lower than the sample Mean (Grand Mean) and is indicative of a relatively lower knowledge on these specific views than the general knowledge of the clients on comprehensive abortion care.

Table 4.5: Level of Knowledge on Comprehensive Abortion Care

Variables	No. of items	Mean	Std. Dev.	Item-total correlation	Cronbach's Alpha if item deleted
An ordinary person who has performed abortion in the community does not have what it takes to perform abortion	126	3.12	1.31	0.319	0.723
Abortion is unsafe if it is done outside of a licensed health facility	126	3.88	1.27	0.368	0.709
Health facilities providing family planning services are supposed to give abortion care	126	3.60	1.27	0.459	0.685
Safe abortion care entails counseling and medication	126	4.05	0.97	0.427	0.694
Midwives and nurses are required to provide family planning and safe abortion services	126	3.94	1.09	0.440	0.690
Women can walk into health facilities and request for abortion	126	3.75	1.08	0.656	0.639
I know where and how to obtain comprehensive abortion from a health facility	126	3.52	1.11	0.424	0.694
Grand Mean		**3.70**			
Cronbach's Alpha	**7**		**0.723**		

Source: Field Work, 2019

4.5.2 Attitudes and Practices on Comprehensive Abortion Care

This section addresses the aspect of the study that is attitudes and practices of the clients on comprehensive abortion care and is linked to the second objective of the study, that is, the 16 statements under attitudes and practices followed the response format on the scale of 1 to 5 where 1 signifies utmost disapproval and 5 shows the strongest approval to the statements. The stronger the approval, the lower the level of accepting attitudes and the higher the clients are averse to comprehensive abortion practices. The initial Mean, Standard Deviation, and Reliability analysis of the responses given have been reported in Table 4.6.

At the initial stage, the Reliability statistics showed that, by deleting one of the statements, the Cronbach's alpha of the remaining statements would increase from 0.709 to an all-time high of 0.775, and this signifies a more reliable result. See Table 4.6.

Following the deletion of the statement, a more robust set of statements to determine attitudes and practices of the clients regarding comprehensive abortion care was sustained. The Cronbach's alpha shot up to 0.775 with all the Item-Total Correlations indicating an upward movement of more than 0.20. This gave a satisfactory indication that the measures are reliable.

Table 4.6: Initial Reliability Statistics for Attitudes and Practices on Abortion Care

Variables	No. of items	Mean	Std. Dev.	Item-total correlation	Cronbach's Alpha if item deleted
I prefer other sources of help to abortion care in public health facility	123	2.75	1.30	0.192	0.752
I don't want abortion care because I would not want to be added to the statistics	123	2.86	1.24	0.101	0.758
I will not be treated well by the nurses if I needed abortion at the health facility	123	2.45	1.13	0.535	0.723
My information will be divulged by the nurses if I undertook abortion in this health facility	123	2.41	1.12	0.315	0.741
I am not impressed with the services of nurses and midwives towards reproductive health care	123	2.50	1.13	0.48	0.727
Because of my religion, I am against abortion by any means	123	3.50	1.30	-0.085	0.775*
Nurses and midwives do not give productive information on reproductive health	123	2.25	1.15	0.426	0.732
Nurses and midwives have a laid-back attitude towards reproductive health	123	2.47	1.22	0.551	0.72
The costs of reproductive health care are often expensive	123	2.59	1.22	0.444	0.729
I will not seek contraception and family planning services from this health centre	123	2.63	1.27	0.227	0.748
Response to time in this health facility is not good	123	2.55	1.20	0.414	0.732
I am cautious of the side effect of family planning and abortion and would not want to engage in that service	123	3.10	1.31	0.226	0.749
The family planning service in this centre is not very active	123	2.45	1.28	0.543	0.72
The long distance from my residence to this facility would not help me to seek regular service	123	2.46	1.28	0.547	0.719
Information and communication about reproductive health in this centre is poor	123	2.48	2.15	0.272	0.757
I would be a bit hesitant to accept any family planning method or service from this health centre	123	2.57	1.28	0.556	0.718
Grand Mean		**2.62**			
Cronbach's Alpha	**16**		**0.750**		

Note: (*) Deleted item
Source: Field Work, 2019

The statements determining the attitudes and practices of the clients regarding abortion care obtained Mean values ranging from 2.25 to 3.10 on the maximum scale of 1 to 5 (See Table 4.7). This indicates a move away from attitudes and practices that disregard comprehensive abortion care to a more accepting one. The Grand Mean of 2.57 on the maximum scale of 5 lies in the lower half of the scale and it shows that, generally, attitudes and practices that reject abortion care are not aggravated. Particularly, the clients most strongly disapproved the view that "Nurses and midwives have a laid-back attitude towards reproductive health" (Mean=2.25). The clients also had a high disapproval against the view that their own "…information will be divulged by the nurses…" if they undertook abortion in the health facility (Mean=2.41). Other views that the clients appeared not to be in approved of were that they "…will not be treated well by the nurses…" if they needed abortion at the health facility (Mean=2.45); that the family planning service in the health centre is not very active (Mean=2.45); that "Nurses and midwives have a laid-back attitude towards reproductive health (Mean=2.47). On another breadth, the clients had a more indecisive posture on the view that they are "…no impressed with the services of nurses and midwives towards reproductive health care" (Mean=2.50). More emphatic of their indecisive posture were the views that "Response to time in this health facility is not good" (Mean=2.55); that "The costs of reproductive health care are often expensive" (Mean=2.59). The clients were most indecisive on the view that they are "…cautious of the side effect of family planning and abortion and would not want to engage in that service" (Mean=3.10).

Table 4.7: Attitudes and Practices on Comprehensive Abortion Care

Variables	No. of items	Mean	Std. Dev.	Item-total correlation	Cronbach's Alpha if item deleted
I prefer other sources of help to abortion care in public health facility	123	2.75	1.30	0.296	0.705
I don't want abortion care because I would not want to be added to the statistics	123	2.86	1.24	0.268	0.727
I will not be treated well by the nurses if I needed abortion at the health facility	123	2.45	1.13	0.550	0.750
My information will be divulged by the nurses if I undertook abortion in this health facility	123	2.41	1.12	0.309	0.768
I am not impressed with the services of nurses and midwives towards reproductive health care	123	2.50	1.13	0.507	0.753
Nurses and midwives do not give productive information on reproductive health	123	2.25	1.15	0.449	0.757
Nurses and midwives have a laid-back attitude towards reproductive health	123	2.47	1.22	0.550	0.749
The costs of reproductive health care are often expensive	123	2.59	1.22	0.443	0.757
I will not seek contraception and family planning services from this health centre	123	2.63	1.27	0.246	0.773
Response to time in this health facility is not good	123	2.55	1.20	0.415	0.760
I am cautious of the side effect of family planning and abortion and would not want to engage in that service	123	3.10	1.31	0.224	0.774
The family planning service in this centre is not very active	123	2.45	1.28	0.575	0.746
The long distance from my residence to this facility would not help me to seek regular service	123	2.46	1.28	0.558	0.747
Information and communication about reproductive health in this centre is poor	123	2.48	2.15	0.277	0.755
I would be a bit hesitant to accept any family planning method or service from this health centre	123	2.57	1.28	0.551	0.748
Grand Mean		**2.57**			
Cronbach's Alpha	**15**		**0.775**		

Source: Field Work, 2019

Regarding attitudes and practices on comprehensive abortion care, the interviews bring further insight into whose attitudes and practices might be of importance to the discourse on comprehensive abortion care. While it has emerged that clients appear to have a rather positive regard for the way and manner in which nurses and midwives handle issues of comprehensive abortion care, the attitudes of some adult women towards comprehensive abortion care appears to be unimpressive to nurses and midwives. From the interviews, many of the health professionals who intimated that adult women exhibit good attitudes towards comprehensive abortion also, on one side, expressed the concern that some adult women do not exhibit good attitudes. Despite this reality, the effort at creating awareness about comprehensive abortion care is believed to be yielding desirable results of bending good attitudes of women onto comprehensive abortion care. However, there is evidence that nurses and midwives ought to be mindful of their response to time in the health facility, lest it will feed into and aggravate negative impressions that clients may be having about their abortion service delivery.

There is, however, a sense in which the attitudes and practices of women regarding comprehensive abortion care might just be a reaction to the way that care is provided at health facilities. In that sense, the question "What is the nature of reproductive health service that your health centre provides to adult women?" was posed to the health professionals in the interview. A number of reproductive health service were mention to be the kind of services offered in the health facilities of the health professionals. Family planning, counseling, child welfare, anti-natal care, post-natal care, delivery service, maternity, and outpatient department (OPD) were some of the services mentioned. Some of the health professionals conveniently lamped the services they provide into

comprehensive abortion care. The senior midwife at the Regional Hospital, Koforidua, provided insight into how the services are normally provided.

> "When the client comes to the facility, we set her up on counseling to get a bit of history about them. We explain the methods to them. We have two methods: Medical abortion and Manual Vacuum Aspiration. Depending on what the client opts for, we lead them through it. After that, we take them through family planning" (Respondent 1, interview, March 13, 2019).

A nurse from the Effiduase Reproductive and Child Health Centre also stated the following:

> "When the client comes, depending on the gestation of the pregnancy, of which we are able to accept up to twelve weeks; if after counseling, the woman falls within the gestation period, then we give her the options we have. One option is that, the women can keep the pregnancy if she decides and, if after delivery, she cannot care for the child, then we will recommend adoption. Termination of the pregnancy is the other option. This can be done in two ways; the manual method where we normally do the Manual Vacuum Aspiration, or the medication method. Whatever the women chooses will be executed as is deemed fit. After whatever method adopted, the woman undergoes family planning and counseling to forestall future occurrence of unplanned pregnancy" (Respondent 6, interview, March 13,2019).

Although, the services mentioned by all the health professionals as being offered in their health facilities were common, especially, as far as family planning, counseling, anti-natal and post-natal care, and delivery services are concerned, the nuances of how the service is provided needs to be further explored. In this study, the health professionals were asked the question "Would you say that health centres have achieved the goal regarding eliciting positive response of adult women to comprehensive abortion care?"

The answers provided project the fact that, the health centres have performed well in eliciting the right responses from adult women. A midwife from the Asokore Reproductive and Child Health Centre stated that:

> "IPAS came to initiate a research that showed us that maternal deaths surrounding criminal abortion are alarming. Our health centre is ensuring that this reality trickles down to the local women. We are getting results from doing that" (Respondent 8, interview, March 14, 2019).

A midwife also interviewed from the Magazine Health Centre answered the question in the affirmative saying:

> "Yes, we are achieving positive response. Our family planning coverage has increased and maternal deaths due to unsafe abortion have reduced" (Respondent 9, interview, March 15, 2019).

The noteworthy aspect of the results thus far is that, generally, the level of knowledge of the clients regarding comprehensive abortion care garnered an overall indicator of 3.70 on a maximum scale of 5. This falls in the upper-half region of the scale and it shows that the clients had appreciable knowledge about comprehensive abortion care. Regarding attitudes and practices on comprehensive abortion care, the overall indicator of 2.57 on a maximum scale of 5 lies in the lower-half region of the scale and is an indication that, generally, the clients appeared not to have experienced attitudes and practices that undermine comprehensive abortion care, especially from nurses and midwives.

4.6 Underpinnings of Comprehensive Abortion Care

Another important aspect of this study, as stated in the third objective of the study, is to determine the underpinnings of comprehensive abortion care. A Binary Logistic Regression model composed of demographic variables, along with variables on knowledge/awareness and attitudes and practices on comprehensive abortion care. The model was informed by the assumption that if any of the clients ever used any contraception method, then there would be certain elements of knowledge/awareness of the method through family planning and counseling as would be provided in comprehensive abortion care as well as attitudes and practices in respect of comprehensive abortion care. Contraception use was preferred as a proxy to comprehensive abortion care because to ask the direct question to know whether a respondent has performed abortion or not would produce obvious results; egocentrism, the sense of stigma, and the feeling that abortion is sinful would produce undesirable results if that question was posed.

Contraception use, however, comes as a result of comprehensive abortion care in which a lot of counseling and choices are placed before the client who is then guided through the contraception method to which she (or he) is convenient. The Binary Logistic Regression was conducted to determine which factors underpin the use of comprehensive abortion care. The outcome variable (dependent variable): “Have you ever used any contraception method?” has two paths of outcome: “Yes” and “No”.

The logistic regression model produced significant results (Chi Square = 77.301; df = 24; and p = 0.000) showing that contraception use is significantly dependent on elements of knowledge/awareness of comprehensive abortion care and attitudes and practices regarding comprehensive abortion care. The elements of knowledge of

comprehensive abortion care and attitudes and practices regarding comprehensive abortion jointly explain up to 71.4 percent (Nagelkerke R Square = 0.714) of the variance in the choice of contraception use by the clients in this study (See footnote of Table 4.8).

In respect of contraception use by the clients, those who indicated "Yes", to wit clients have used a contraception method at some point in time, were treated as the reference category to allow for comparisons in the dispositions of the clients to contraception use and, by extension, comprehensive abortion care. The results obtained from the Binary Logistic Regression are presented in Table 4.8. The actual statements have been represented by their variable names (for example kab20), but to aid quick reference, Table 4.9 presents the actual statements which the variable names denote in same order in which they appear in Table 4.8.

The results show that the clients who tend to agree with the view that "Safe abortion care entails counseling and medication" (kab22) are more than eight times as likely to use some contraception methods as those who tend to disagree with the view (B=2.089; $p<0.05$; and Exp(B)=8.074). This result has much to do with increasing knowledge of counseling and medication that are imbedded in abortion care in health facilities. But where this knowledge is available to the clients, it is significantly associated with use of contraception method by the clients. The implication then is that there is more enthusiasm to access contraception methods when people are aware that it entails counseling and medication, perhaps, because they have had reason to believe that their need for contraception, and ultimately safety, is met through counseling and medication as is provided in a health facility. This result is in consonance with the next results regarding midwives and nurses. As the clients' approval to the view that "Midwives and nurses are

required to provide family planning and safe abortion services" (kab23) gets stronger, the probability that the clients used some contraception method increases several times compared to the clients who disapprove of the same view (B=2.900; p<0.01; and Exp(B)=18.170). Again, this may only be the result of increasing perception that midwives and nurses provide the kind of family planning and safe abortion services that meet the expectation of their client. In the light of that perception, these clients are inclined to seek help for contraception or comprehensive abortion care.

Another significant result is that, as the clients' approval to the view that "Women can walk into health facilities and request for abortion" (kab24) subdues and attracts a negative regard, the clients are 85.6% less likely to indicate that they ever used any contraception method (B= -1.941; p<0.05; and Exp(B)=0.144). This result speaks to the fact that, when women are not confident that they can easily access and/or be welcomed to health facilities to request for abortion then their chance of never being able to use any contraception method goes high. The results further show that as the clients' belief that they "…know where and how to obtain comprehensive abortion from a health facility" (kab25) gets stronger, they are more than four times as likely to have used a contraception method compared to the clients who have dwindling belief in same (B=1.461; p<0.05; and Exp(B)=4.310).

It can be observed from the interpretations of the results just presented that, the dimensions found to have significant explanatory power for the clients' use of contraception methods at some point in time are all related to knowledge or awareness of safe abortion how to obtain it.

Another significant aspect of the results furthers the elements that determine or underpin comprehensive abortion care and, for that matter, contraception use. In contrast with the earlier results, however, it can be conceived that these latter elements reflect attitudes and practices that inure to comprehensive abortion care or contraception use.

The first of this aspect of results shows that, as the clients' approval to the view that they "…will not be treated well by the nurses if [they] needed abortion at the health facility" (ap27) gets weaker, the clients are more than nine times likely to have used a contraception method compared to clients with increasing approval to same view (B = -2.279; $p<0.05$; and Exp(B)=9.771). Again relative to the interface between nurses and the clients, another result shows that the clients who have dwindling belief that their "…information will be divulged by the nurses if I undertook abortion in this health facility" (ap28) are 93.7 percent less likely, compared to those with increasing belief in same, to have used a contraception method (B=-2.760; $p<0.05$; and Exp(B)=0.063). This suggests that, there could be sentiments that nurses divulge clients' information, nonetheless, clients would have not, for that reason, moved away from using a contraception method. Conversely, there could be no serious sentiments that nurses divulge clients' information, yet, contraception use could lack. Therefore, the explanatory power of nurses divulging clients' information and contraception use is, rather, inconclusive.

In another results, the clients who were more "…cautious of the side effect of family planning and abortion and would not want to engage in that service" (ap36) rather than those who were lesser, were more than six times likely to indicate that they have used a contraception method at a point in time (B=1.907; $p<0.01$; and Exp(B)=6.732). This goes to show that previous experience with contraception through family planning and abortion

care has resulted in the exercise of extra caution on the part of the clients in dealing the side effects of receiving that care and, possibly, preventing the need to seek that care again.

Finally, age significantly explains the use of contraception method. The results show that for an extra reduction in age (q1) of the clients, they are 69.3 percent less likely to indicate that they have used a contraception method compared to the clients who are older (B=-1.181; $p<0.05$; and Exp(B)=0.307). This implies that, elder clients have had a better chance of having used a contraception method than would younger clients. The results are as shown in Table 4.8. As stated earlier, the separate Table 4.9 immediately after Table 4.8 gives the list of what the variable names in the logistic regression equation represents.

Table 4.8: Variables in the Equation of Comprehensive Abortion Care

Variables	B	S.E.	Wald	df	Sig.(*p*)	Exp(B)
kab20	-1.024	0.683	2.249	1	0.134	0.359
kab21	-1.246	0.656	3.606	1	0.058	0.288
kab22	**2.089**	**0.986**	**4.489**	**1**	**0.034**	**8.074**
kab23	**2.900**	**1.082**	**7.188**	**1**	**0.007**	**18.170**
kab24	**-1.941**	**0.862**	**5.067**	**1**	**0.024**	**0.144**
kab25	**1.461**	**0.688**	**4.511**	**1**	**0.034**	**4.310**
ap25	0.672	0.713	0.888	1	0.346	1.958
ap26	-0.423	0.593	0.510	1	0.475	0.655
ap27	**-2.279**	**0.905**	**6.343**	**1**	**0.012**	**9.771**
ap28	**-2.76**	**0.871**	**10.048**	**1**	**0.002**	**0.063**
ap29	-0.651	0.737	0.780	1	0.377	0.522
ap31	0.87	0.54	2.594	1	0.107	2.387
ap32	0.014	0.545	0.001	1	0.98	1.014
ap33	1.81	0.952	3.611	1	0.057	6.108
ap34	1.441	0.764	3.56	1	0.059	4.226
ap35	0.754	0.58	1.688	1	0.194	2.125
ap36	**1.907**	**0.642**	**8.824**	**1**	**0.003**	**6.732**
ap37	-0.875	0.806	1.179	1	0.278	0.417
ap38	-0.393	0.472	0.695	1	0.404	0.675
ap39	0.000	0.211	0.000	1	0.998	1.000
ap40	-0.986	0.636	2.405	1	0.121	0.373
q1	**-1.181**	**0.483**	**5.979**	**1**	**0.014**	**0.307**
q3	0.81	0.673	1.451	1	0.228	2.249
q5	0.461	0.587	0.615	1	0.433	1.585
Constant	-22.72	8.205	7.664	1	0.006	0.000

Note: Chi Square = 77.301 significant at $p = 0.000$

Cox & Snell R square = 0.511; Nagelkerke R square = 0.714

Source: Field Work, 2019

Table 4.9: List of Variables in the Binary Logistic Regression Equation

kab20	Abortion is unsafe if it is done outside of a licensed health facility
kab21	Health facilities providing family planning services are supposed to give abortion care
kab22	Safe abortion care entails counseling and medication
kab23	Midwives and nurses are required to provide family planning and safe abortion services
kab24	Women can walk into health facilities and request for abortion
kab25	I know where and how to obtain comprehensive abortion from a health facility
ap25	I prefer other sources of help to abortion care in public health facility
ap26	I don't want abortion care because I would not want to be added to the statistics
ap27	I will not be treated well by the nurses if I needed abortion at the health facility
ap28	My information will be divulged by the nurses if I undertook abortion in this health facility
ap29	I am not impressed with the services of nurses and midwives towards reproductive health care
ap31	Because of my religion, I am against abortion by any means
ap32	Nurses and midwives have a laid-back attitude towards reproductive health
ap33	The costs of reproductive health care are often expensive
ap34	I will not seek contraception and family planning services from this health centre
ap35	Response to time in this health facility is not good
ap36	I am cautious of the side effect of family planning and abortion and would not want to engage in that service
ap37	The family planning service in this centre is not very active
ap38	The long distance from my residence to this facility would not help me to seek regular service
ap39	Information and communication about reproductive health in this centre is poor
ap40	I would be a bit hesitant to accept any family planning method or service from this health centre
q1	Age
q3	Level of education
q5	Average monthly income (GHC)

4.7 Reasons for Non-patronage of Abortion Care

Having worked to determine the underlying reasons that explain the use of comprehensive abortion care and contraception, this section attempts to address the reasons for non-patronage of abortion care. Figure 4.6 presents the percentages of the reasons ascribed to non-patronage of abortion care by the clients in the study.

The results show that about three out of every five (61%) of the clients conceived that stigma and discrimination against abortion is responsible for non-patronage of abortion in the health facilities. More than half (54.2%) of the clients also held that restrictions on abortion by religion was responsible for non-patronage of abortion care.

There were as many clients (50%) who did think long distance to reach a professional health facility was responsible for non-patronage of abortion care as those who did not think this was a problem at all. More than two out of every five (45.8%) of the clients ascribed the lack of information to the cause for non-patronage of abortion. Also, about a quarter (26.3%) of the clients indicated that it takes too long to receive service in professional health facilities thereby reducing the inclination of people to patronize abortion care from such facilities. It seems that, the cost of service in professional health facilities, to a wider section of the clients, is not as expensive as it may seem. Therefore, to about four out of every five (over 80 percent) of the clients, it cannot be admitted as a reason for non-patronage of abortion care. Neither is the thinking that family planning centres do not promote dignity of clients nor absence of reproductive health professionals in the health facilities strong enough to warrant non-patronage of abortion care since over nine out of every ten (over 90 percent) clients did not think so.

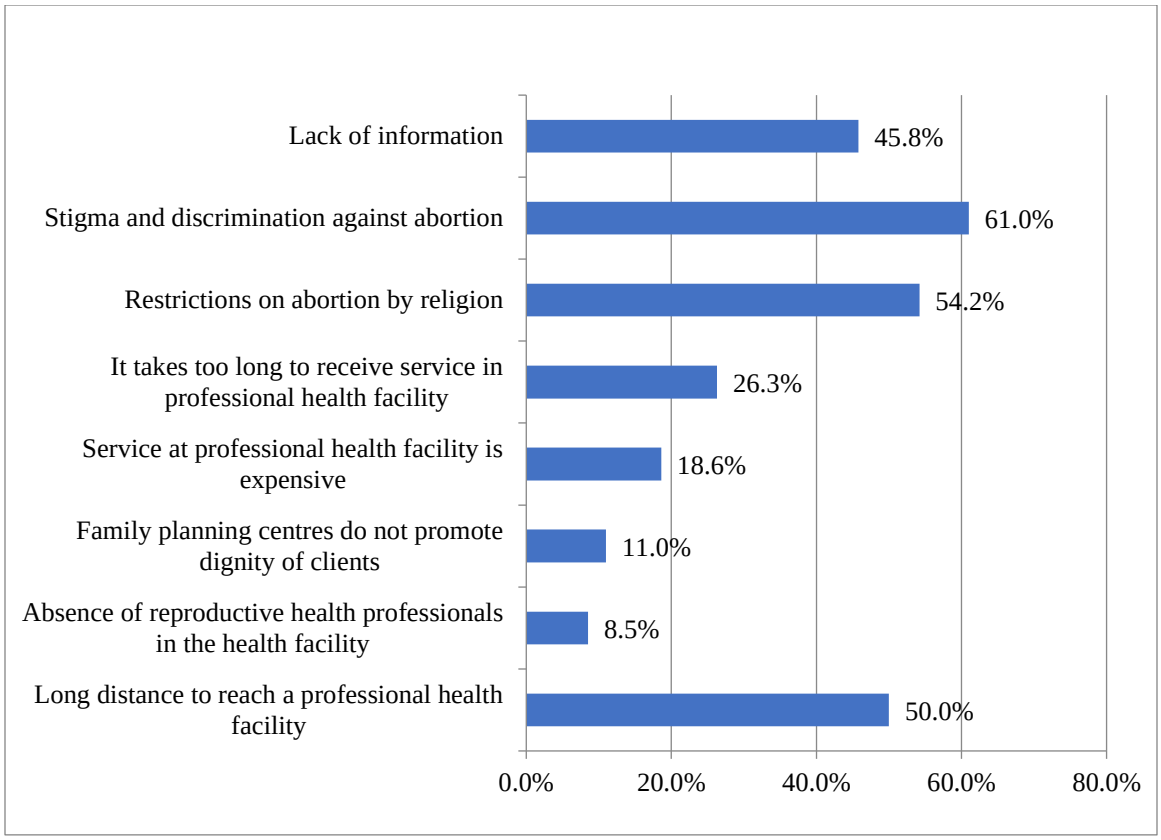


Figure 4.6: Reasons for Non-patronage of Abortion Care by the Clients

Source: Field Work, 2019

Bringing to light the information received from the interviews with the health professionals when they were asked to state reasons why adult women fail to seek family planning services from professional health centres, a number of issues emerged.

First, there is the issue of lack of time on the part of the women to seek the abortion service. Second, there is misconception or experience of some side effect abortion care or family planning which extinguishes women's initiation to seek of such care. Third, negative attitude of staff has the power to repel clients from seeking abortion care. Incidentally, these concerns of the health professionals interviewed come from experiences they have had from the own practices. These concerns are very much linked to why adult

women would not patronize reproductive health care from the facilities where the health professionals worked. A midwife from the Effiduase Reproductive and Child Health Centre elaborated her experience in this way:

> "People fail to seek family planning and abortion care because no matter how well you explained the care, if practices or experiences of the people changes from what they normally knew, for instance, as in their menstrual flow is not taking place, they tend to move away from the facility. Also, sometimes, the women want us (health professionals) to be at post every time. When they came and did not get served, especially on Sundays, they decide not to come to the facility. But, staff attitude towards clients is a factor that puts off the clients from seeking the care too" (Respondent 5, interview, March 13, 2019).

Another health professional interviewed from the Magazine Health Centre, put her views on the issue in these words:

> "Most of the mothers do not have time. But we have decided to go to them in their market areas and shops to give the family planning services and information as it is deemed fit. We educate them on the importance of family planning. So, they come to our facility instead of going to 'drug store' to buy over-the-counter medicines" (Respondent 10, interview, March 15, 2019).

Yet, a nurse at the Regional Hospital, Koforidua, intimated that the attitudes of staff, affordability, accessibility, stigma, and privacy are the key issues that prevent women from seeking professional family planning or abortion care from the health facilities. In spite of these, some of the women still seek the care "because of the unbearable challenges that are associated with unwanted pregnancy". But "poverty and conditions that will not allow the women to carry pregnancy or deliver compel them to seek for the care" (Respondent 2, interview, March 13, 2019).

4.7 Conclusion

The analysis has delved into issues that are central to comprehensive abortion care. In light of that issues concerning family planning and counseling, contraception and, of course abortion care have been analyzed from data obtained from the Regional Hospital, Asokore Reproductive and Child Health Centre, Magazine Health Centre, Effiduase Reproductive and Child Health Centre, and Koforidua Poly Clinic. The analysis shows that the clients (129) sampled from these health facilities have considerable knowledge or awareness about comprehensive abortion care. Meanwhile, the data showed that health staff have a rather benign attitude and practices more friendly to comprehensive abortion care compared to the clients of the various health facilities. Contraception use, as a proxy to comprehensive abortion care, is significantly dependent on elements of knowledge/awareness of comprehensive abortion care and attitudes and practices regarding comprehensive abortion care. Elements of knowledge of comprehensive abortion care and attitudes and practices regarding comprehensive abortion jointly explain up to 71.4 percent of the variance in the decision on contraception use by the clients in this study. Although, health facilities are required to provide comprehensive abortion care and many of them do so, the health facilities have had to find ways to close the distance between them and their clientele. Issues of negative staff attitudes, availability of time on the part of the clientele, affordability, accessibility, and individual preferences threaten to prevent women from seeking comprehensive abortion care from professional health facilities.

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This chapter summarizes the findings of the study. The issue of abortion is certainly an important topic due to increasing pressure to deal with unplanned pregnancies and the uncertainties that surround them. Fortunately, there is comprehensive abortion care to take care of a wide array of issues surrounding pregnancy and reproductive health. The major concern in this study was to find out the underpinnings of comprehensive abortion care. The study, therefore, had the objectives to assess the knowledge of adult women on comprehensive abortion care; examine the attitudes and practices of adult women towards comprehensive abortion care; determine the factors underpinning comprehensive abortion care among adult women; and recommend strategies to enhance reproductive health. The study was populated by quantitative data from 129 clients, mainly adult females, from five selected health facilities actively that provide comprehensive abortion care, as well as two senior health professionals from each of the five health facilities to furnish the study with qualitative data. Thus, mixed method was adopted in the study. The findings obtained from the study are presented as follows.

There were findings on the level of knowledge/awareness of the participants in the study on comprehensive abortion care, and also an examination of attitudes and practices of the participants in respect of comprehensive abortion care. In the analysis, Mean and Standard Deviation was estimated and reliability analysis indicated that the resultant measures were reliable. Binary Logistics Regression equation factoring elements of

awareness of comprehensive abortion care and attitudes and practices produced the significant underpinnings of comprehensive abortion care.

5.2 Main Findings

The clients of the health facilities who participated in the study were made up mainly of traders. There were students, public servants, and artisans, albeit in smaller proportions than those who were unemployed. The largest income bracket earned by the participants ranged from 100 Ghana Cedis to 500 Ghana Cedis whiles marital status showed that more than half of the clients were single. Nonetheless, about two-thirds (68%) of the participants have ever given birth, but were wary or unable to host increasing numbers of children. Similarly, about 63% of them have ever sought family planning and counseling with a health facility.

5.2.1 Knowledge about Comprehensive Abortion Care

The findings showed that majority (above 60 percent) of the clients have knowledge about contraception methods, namely, pill, condom, and injectables. Majority (above 60 percent) of the participants know that oral contraceptives, injectables, implants and condoms were services provided in their immediate health facilities. The study showed that midwifes were major sources of information on contraception method for the participants. Health professionals did not only exhibit profound knowledge on what comprehensive abortion care entails, but also, they interface with clients seeking abortion or pregnancy care and take that opportunity to educate clients on the comprehensive abortion care and its relevance. To the health professionals, their mode of education of the clients has produced effective outcomes. Previous studies have shown that clandestinely performed abortions abounds even in the regime where safe abortion has been widely advocated

(Ahiadeke, 2001; Mayers et al., 2005; Harries, 2009). Increased knowledge and awareness of both clients and health professionals promises to be a step in the right track towards reducing the incidence of unsafe abortion. From the findings of this study, a number of reproductive health service were mention by the health professionals to be the kind of services offered in the health facilities of the health professionals. Family planning, counseling, child welfare, anti-natal care, post-natal care, delivery service, maternity, and outpatient department (OPD) were some of the services mentioned. Some of the health professionals conveniently lamped the services they provide into comprehensive abortion care.

On a minimum scale of 1 to a maximum of 5, an overall Mean of 3.70 was obtained. The implication of this is that, generally, the clients have a high level of knowledge on comprehensive abortion care. The fact that "Safe abortion care entails counseling and medication" formed the most profound knowledge of the clients. On the other hand, knowledge of "where and how to obtain comprehensive abortion from a health facility" was indicated as the point at which the participants' knowledge on abortion care was lowest.

5.2.2 Attitudes and Practices on Comprehensive Abortion Care

Regarding attitudes and practices, the participants appeared to harbour more accepting attitudes and practices that are congenial in terms of comprehensive abortion care. The participants most strongly disapproved that nurses and midwives have a laid-back attitude towards reproductive health. While it emerged that clients appear to have a rather positive regard for the way and manner in which nurses and midwives handle issues in comprehensive abortion care, the attitudes of some adult women towards comprehensive

abortion care appears to be unimpressive to nurses and midwives. Despite this finding, the nurses' effort at creating awareness about comprehensive abortion care is believed to be yielding desirable results to bring good attitudes of women to bear on comprehensive abortion care. The reality about the nurses' effort is a big step to dispel the findings from previous studies that nurses have a resistance to provide abortion services (Cooper et al., 2005; Botes, 2000; Harrison et al., 2000). It also seems that the newly found effort of nurses to show positive attitudes towards comprehensive reproductive health is a milestone forward towards reducing unsafe abortion. This realization contradicts earlier observations that nurses and midwives have judgmental attitudes towards abortion patients (Mokgethi et al., 2006; Gmeiner et al., 2000; Harrison et al., 2000), and that nurses seem 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).

5.2.3 Underpinnings of Comprehensive Abortion Care

The Binary Logistic Regression model was used to determine the underpinnings of comprehensive abortion care. The regression model treated contraceptive use as the outcome variable, and knowledge/awareness of comprehensive abortion care and attitudes and practices in terms of comprehensive abortion care connoting the explanatory variables. Contraceptive use was adopted as the outcome variable and a proxy to comprehensive abortion care based on the reason that, contraception is already imbedded in it. To have received contraception care is then similar to having undergone a sort of comprehensive abortion care.

The findings showed that contraception use is significantly dependent on knowledge/awareness of comprehensive abortion care and attitudes and practices

regarding comprehensive abortion care. The elements of knowledge of comprehensive abortion care and attitudes and practices regarding comprehensive abortion jointly explain up to 71.4 percent of the variance in the choice of contraception use by the clients in this study.

The specific underpinnings with regards to knowledge of clients, where knowledge that safe abortion entails counseling and medication abounds to the clients, it is significantly associated with use of contraception method by the clients. This implies that there is more enthusiasm to access contraception methods when people are aware that safe abortion entails counseling and medication, perhaps, because they have had reason to believe that their need for contraception, and ultimately safety, is met through counseling and medication as is provided in a health facility.

As the clients' approval to the view that midwives and nurses are required to provide family planning and safe abortion services gets stronger, the probability that the clients sometime in the past used a contraception method increases several times compared to the clients who disapprove of the same view.

As the clients' approval to the view that women can walk into health facilities and request for abortion subdues and attracts a negative regard, the clients are 85.6% less likely to indicate that they ever used any contraception method. This implies that when women are not confident that they can easily access and/or be welcomed to health facilities to request for abortion, then their chance of never being able to use any contraception method increases.

As the clients' belief that they know where and how to obtain comprehensive abortion from a health facility gets stronger, they are more than four times as likely to have used a contraception method compared to the clients who have dwindling belief in same.

The specific underpinnings of comprehensive abortion care in terms of attitudes and practices revealed the following: as the clients' approval to the view that they will not be treated well by the nurses if they needed abortion at the health facility gets weaker, the clients are more than nine times likely to have used a contraception method compared to clients with increasing approval to same view.

The clients who were more cautious of the side effect of family planning and abortion and would not want to engage in that service, rather than those who were lesser, were more than six times likely to indicate that they have used a contraception method at a point in time. This goes to show that previous experience with contraception through family planning and abortion care has resulted in the exercise of extra caution on the part of the clients in dealing the side effects of receiving that care and, possibly, preventing the need to seek that care again.

With an extra reduction in age of the clients, they are 69.3 percent less likely to indicate that they have used a contraception method compared to the clients who are older.

The study further brought out some reasons for non-patronage of abortion care. Stigma and discrimination and restrictions on abortion by religion were found by the clients to be largely responsible for non-patronage of abortion care in facilities. This is largely consistent with the findings of Oppong-Darko (2017) and Esantsi (2015) who noted that there are obstructions to professional abortion care delivery due to stigma and

discrimination. Apart from these, this study found that long distance to health facility was pointed out. From the interview of the health professionals, lack of time, affordability, accessibility on the part of women to seek comprehensive abortion care, fear of side effects of abortion care or family planning, stigma, lack of privacy in providing abortion care and negative attitudes of health staff emerged as the factors that discourage patronage of abortion care in health facilities. Meanwhile, due to poverty and unbearable conditions that will not allow the women to carry pregnancy or deliver compel women to seek for the comprehensive abortion care.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter finalizes the study by drawing conclusion and making recommendations based on the findings of the study. In the conclusion, also, information implications of the findings for comprehensive abortion care are highlighted. The recommendations attempt to provide ideas to solve the challenges associated with comprehensive abortion care.

6.2 Conclusion

This study was undertaken in cognizance of the importance of comprehensive abortion care to adult women bearing in mind the complexities that unplanned pregnancies and pregnancy-related issues pose to them. Whiles it is non-negotiable for women to seek safe and comprehensive abortion care from health facilities to maintain a good maternal and child health, this study has paved the way to determine the underpinnings of comprehensive abortion care.

By adapting the knowledge, attitudes, and practices (KAB) model, this study has provided insight into the significance of the model in determining core factors affecting comprehensive abortion care. From the findings of the study, it can be affirmed that women who are clients to the health facilities involved in this study are knowledgeable or aware of comprehensive abortion care and some basis things it entails. For example, the knowledge that safe abortion care entails counseling and medication and is a reserve for profession health staff to provide was commonplace. Family planning and counseling, and contraception, namely, condoms, pill, and injectables were some of the parameters of care

which are well known. But it is incisive to mention that, the comprehensive abortion care in the health facilities is known by the health professionals as ranging from family planning and counseling, child welfare, anti-natal care, post-natal care, delivery service to maternity care. Although, generally, data demonstrated accepting attitudes and congenial practices towards comprehensive abortion care, the narrative from this study is that clients rather appear to have a positive regard for the way and manner in which nurses and midwives handle issues in comprehensive abortion care, the attitudes of some adult women towards comprehensive abortion care appears to be unimpressive to nurses and midwives. This implies that health professionals would need to do more work than they have already been doing to inform to their clientele.

The study confirms the position that comprehensive abortion care is significantly underpinned by knowledge or awareness of it, and attitudes and practices regarding comprehensive abortion care. In terms of knowledge, there is increasing enthusiasm to access contraception methods when people are aware that safe abortion entails counseling and medication. Increasing knowledge that midwives and nurses are required to provide family planning and safe abortion service increases the probability of making use of a contraception method. Where women are unaware that they can easily access health facilities to get abortion care, then their chance of not using any contraception method becomes more likely. Knowledge about where and how to obtain comprehensive abortion from a health facility also increases the probability of contraception use. Regarding attitudes and practices, the claim is that the tendency of people to think that they will not be treated well by nurses results in their failure to use a contraception method. Finally, it is more likely for people who have used contraception sometime to become cautious of the

side effect of family planning and abortion. Such people may not want to seek that care again. But Stigma and discrimination and restrictions on abortion by religion, lack of time, affordability, accessibility on the part of women to seek comprehensive abortion care, fear of side effects of abortion care or family planning, stigma, lack of privacy in providing abortion care and negative attitudes of health staff emerged as the factors that discourage patronage of abortion care in health facilities. In spite of dissenting views on comprehensive abortion care, it is compelling for women to seek the care due to poverty and unbearable conditions that will not allow them to carry pregnancy or deliver.

6.3 Recommendations

Based on the findings of the study the following recommendations have been proffered as way of enhancing reproductive health, especially, of adult females.

First, access to comprehensive abortion care should be strengthened. This is very critical because of the tendency of unsafe abortion to increase within the community. Not only that, but it is almost impossible to prevent unplanned pregnancy on a wider scope. The exigency to abort an unplanned pregnancy coupled with the need to ensure safe delivery makes access to abortion care important. Poverty could be stemmed down by ensuring that children are born under conditions that promote their development and give them enabling environment for quality growth. This should be done by providing as many as possible options for women's reproductive health care, and this should invariably include access to comprehensive abortion care. Access to comprehensive abortion care should be improved in the various health facilities especially closer to the community and the ordinary people. Improving access also means removing barriers impeding the use of comprehensive abortion care. Another way to improve access is to remove legal barriers.

It is important that the Ghana Health Service should draw a proposal for the removal of legislation that treats safe abortion as criminal both for health professionals and clients.

Second, as one of the important milestones to stem down to child and maternal mortality, authorities of the Ghana Health Service should ensure that comprehensive abortion care is adequately financed so that health professionals can deliver quality service to the people. The financial support should be geared at improving the facility to make it conducive for comprehensive abortion care. Equipment and medication should be adequately provided for smooth running of comprehensive abortion care. Issues of privacy or confidentiality in the provision of care are detrimental to the service. Adequate financing should make it possible for improving physical structures and make them amenable to privacy demands, especially, for clients of comprehensive abortion care.

Third, training of health professionals to provide comprehensive abortion care should be adequately met by the Ghana Health Service. Often times, the relationship between clients and health professionals, particularly, nurses and midwives has come under bad criticisms. The training should resource health professionals to deal with or address clients of comprehensive abortion in a dignifying manner. The health professionals should understand that comprehensive abortion care entails a gamut of services such as family planning and counseling, contraception, abortion, pregnancy and delivery services and so forth. Knowing how to relate with the client through the range of services should be treated as crucial in determining the quality of comprehensive abortion care. Nurses and midwives should be made to develop their conscience on the destructive consequences of divulging clients' medical information.

Fourth, steps need to be put in place to ensure that comprehensive abortion care is made affordable. Affordability should target the poor in society to ensure that those vulnerable and high risk groups are, despite their vulnerability, sidelined in delivery of comprehensive abortion care. Teenagers should, as much as possible, not be burdened with the cost of seeking comprehensive abortion care.

Above all, education and provision of information on comprehensive abortion care should be treated as integral to the effectiveness and efficiency of delivery of comprehensive abortion care. Health facilities should be motivated to undertake awareness creation and outreach programmes in which information about the care should be promulgated. The mass media can be instrumental in this awareness creation as well. Education on comprehensive abortion care should be undertaken both in the health facilities and outside of it. Young people should be educated on the effects of abortion and why it must be done safely. Health facilities can do a lot more of this by visiting schools with their teams for purposes of this education strategy.

6.4 Suggestion for Further Studies

The researcher is not ignorant of the fact that this study alone could not have studied all that there is to know about comprehensive abortion care. For this reason, it is recommended that further studies be undertaken to make the findings on comprehensive abortion care in the New-Juaben Municipality, and Ghana at large, more consolidated. Future studies can focus on the quality of comprehensive abortion care in health facilities so that knowledge about the care will not only be limited to its underpinnings, but also the nature of service that is presented in it. Such future studies can be approached from a purely quantitative dimension so that the findings can be as objective as possible.

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APPENDICES

Appendix 1: Questionnaire on Factors Underpinning Comprehensive Abortion Care Among Adults in Reproductive Age in New Juaben Municipality-Koforidua

Dear Respondent,

This questionnaire is meant to solicit your view on comprehensive abortion care in a study entitled, '**Underpinnings of comprehensive abortion care among adults in reproductive age in the New Juaben Municipality – Koforidua**'. Your response to this questionnaire would help provide sufficient data required to complete the study. You are under no compulsion to participate in the study except you willfully accept to do so to enable this study facilitate understanding and input to policy for comprehensive abortion. Your participation is greatly appreciated.

Please read and tick appropriate responses and write answers to the open ended questions.

SECTION A: BACKGROUND DATA

1. What is your age (years)?

[ ] 18-24
[ ] 25-29
[ ] 30-34
[ ] 35-39
[ ] 40-44
[ ] 45-49
[ ] 50 years and above

2. What is your gender?

[ ] Male
[ ] Female

3. What is the last school you attended?

[ ] No formal education
[ ] Primary/JHS/JSS
[ ] Secondary/SHS/SSS
[ ] Commercial/Vocational
[ ] Tertiary
[ ] Others (please specify) …….

4. What is your occupation?

[ ] Unemployed
[ ] Artisan
[ ] Trader
[ ] Civil/Public Servant
[ ] Others (please specify) ……

5. What is your average monthly income in GH¢?

[ ] Less than 100 [ ] 1,001 to 1,500
[ ] 100 to 500 [ ] 1,501 to 2,000
[ ] 501 to 1,000 [ ] More than 2,000

6. Indicate your marital status:

[ ] Single [ ] Separated
[ ] Married [ ] Divorced
[ ] Cohabitation [ ] Widowed

7. Indicate your religion:

[ ] Christian [ ] Traditional
[ ] Islamic [ ] Others (please specify)……

8. Have you ever giving birth?

[ ] Yes [ ] No

9. If "Yes" to question 8, what is the number of your children alive?

[ ] one [ ] four
[ ] two [ ] five
[ ] three [ ] More than five

10. If "No" to question 8, indicate the time you would like to give birth to your first child?

[ ] In a year's time [ ] More than three years' time
[ ] In two years' time [ ] I wouldn't like to give birth any time soon
[ ] In three years' time [ ] Don't know

11. Have you ever used any contraception method?

[ ] Yes [ ] No

12. When was the recent time you applied contraception?

[ ] Never used a contraceptive
[ ] Less than 6 months
[ ] 6 months to 1 year
[ ] Between 1 year to 2 years
[ ] More than 2 years

13. Have you ever sought family planning and counseling with any health facility?

[ ] Yes [ ] No

SECTION B: KNOWLEDGE/AWARENESS ABOUT COMPREHENSIVE ABORTION CARE ABORTION CONTRACEPTION

14. What type(s) of contraception methods do you know? *(Multiple answers allowed)*

[ ] Pill
[ ] IUD
[ ] Condom
[ ] Spermicides
[ ] Injectable
[ ] Implants
[ ] Diaphragm
[ ] Periodic abstinence
[ ] Withdrawal
[ ] Female sterilization
[ ] Male sterilization
[ ] Traditional methods

[ ] Other method (please specify) ……

15. What range of services do you know are being provided in thishealth facility? *(Multiple answers allowed)*

[ ] Don't know
[ ] Oral contraceptives
[ ] IUD
[ ] Implants
[ ] Condoms
[ ] Spermicides
[ ] Injectable
[ ] Sterilization

[ ] Other (specify) ……

16. What is your source of information on contraception methods? *(Multiple answers allowed)*

[ ] Midwife
[ ] Friends
[ ] Family members
[ ] The media
[ ] Other (please specify)……

Respond to each of the statements in the table below to indicate how much you agree or disagree with the issue raised by ticking (√) in the appropriate spaces.

	knowledge and awareness	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
17	Abortion is a criminal act in Ghana					
18	If pregnancy is the result of rape, defilement or incest, abortion is permitted in Ghana					
19	An ordinary person who has performed abortion in the community does not have what it takes to perform abortion					
20	Abortion is unsafe if it is done outside of a licensed health facility					

21	Health facilities providing family planning services are supposed to give abortion care					
22	Safe abortion care entails counseling and medication					
23	Midwives and nurses are required to provide family planning and safe abortion services					
24	Women can walk into health facilities and request for abortion					
25	I know where and how to obtain comprehensive abortion from a health facility					

SECTION C: ATTITUDES AND PRACTICES CONCERNING COMPREHENSIVE ABORTION CARE

Attitude and practices		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
25	I prefer other sources of help to abortion care in public health facility					
26	I don't want abortion care because I would not want to be added to the statistics					
27	I will not be treated well by the nurses if I needed abortion at the health facility					
28	My information will be divulged by the nurses if I undertook abortion in this health facility					
29	I am not impressed with the services of nurses and midwives towards reproductive health care					
30	Because of my religion, I am against abortion by any means					
31	Nurses and midwives do not give productive information on reproductive health					
32	Nurses and midwives have a laid-back attitude towards reproductive health					
33	The costs of reproductive health care are often expensive					
34	I will seek contraception and family planning services from this health centre					
35	Response to time in this health facility is not good					
36	I am cautious of the side effect of family planning and abortion and would not want to engage in that service					
37	The family planning service in this centre is not very active					

38	The long distance from my residence to this facility would not help me to seek regular service					
39	Information and communication about reproductive health in this centre is poor					
40	I would be a bit hesitant to accept any family planning method or service from this health centre					

SECTION D: REASONS FOR NON-PATRONAGE OF ABORTION CARE AND RECOMMENDATIONS

41. What do you think dissuades adult women from seeking family planning or abortion care from health professionals or health facilities?

[ ] Long distance to reach a professional health facility
[ ] Absence of reproductive health professionals in the health facility
[ ] Family planning centres do not promote dignity of clients
[ ] Service at professional health facility is expensive
[ ] It takes too long to receive service in professional health facility
[ ] Restrictions on abortion by religion
[ ] Stigma and discrimination against abortion
[ ] Lack of information

[ ] Others (please write them)

……

……

……

……

42. What do you recommend for effective comprehensive abortion care?

……

……

……

……

…….

Appendix 2: Interview Guide

Objective One

1. How would you explain what is meant by comprehensive abortion care?
2. Do you think adult women have apprehended the meaning of comprehensive abortion care?
3. Would you say that health centres in Ghana have been effective in educating people on comprehensive abortion care?

ObjectiveTwo

4. How has been the attitude of adult women towards comprehensive abortion care in your health centre?
5. What is the nature of reproduction health service that your health centre provides to adult women? Can you describe the procedure involved in service?
6. Would you say that health centres have achieved the goal regarding eliciting positive response of adult women to comprehensive abortion care? Why?

Objective Three

7. From you experience, what are the reasons why adult women fail to seek family planning services such as contraception and abortion care from professional health centres?
8. What do you perceive to be the reasons why adult women would not patronize reproductive health care from your health facility?
9. What is the major reason presented by adult women for seeking family planning services in your health centre?
10. Which reproductive health services do adult women seek in your health centre?

Objective Four

11. Can you specify the challenges against reproductive health service delivery in your health centre?
12. What strategies or recommendations would you offer to enhance comprehensive abortion care in your health centre?