UNIVERSITY OF CAPE COAST

QUALITY POST-ABORTION CARE SERVICES IN THE GREATER ACCRA REGION

KENNETH SETORWU ADDE

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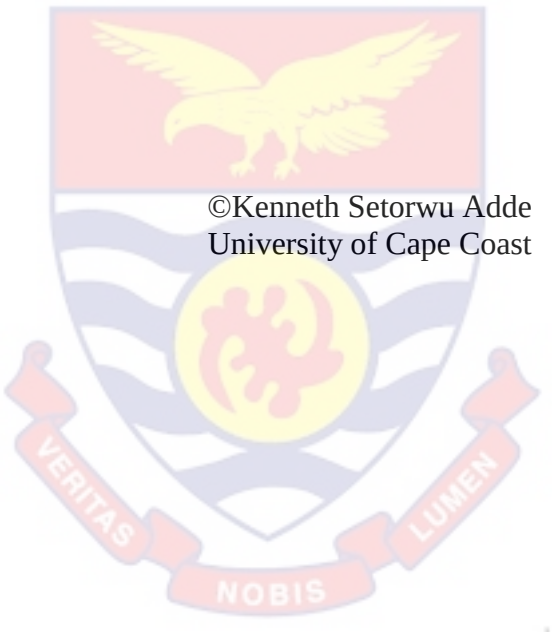

UNIVERSITY OF CAPE COAST

QUALITY POST-ABORTION CARE SERVICES IN THE GREATER ACCRA REGION

BY

KENNETH SETORWU ADDE

Thesis submitted to the Department of Population and Health of the Faculty of Social Sciences, College of Humanities and Legal Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Doctor of Philosophy degree in Population and Health

NOVEMBER 2024

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:..... Date:.....

Name: Kenneth Setorwu Adde

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature: ..... Date: .....

Name: Prof Joshua Amo-Adjei

Co-Supervisor's Signature: ..... Date: .....

Name: Prof Kobina Esia-Donkoh

ABSTRACT

The provision of high-quality post-abortion care (PAC) services is critical to reducing maternal mortality since it is a key component in lowering abortion-related morbidity and mortality. However, there is paucity in literature pertaining to the synthesis between PAC service providers and of the clients' views on quality PAC services. The study assessed the quality of PAC services in Greater Accra. The study adopted the interpretivist philosophical position to social sciences research. Primary data was collected from 34 PAC clients and service providers selected from 7 health facilities. Data was managed and managed using QSR NVivo 12 plus computer software. The analyses followed the thematic analytic procedures. The results showed that quality of PAC services is based on three dimensions of quality which are structural, process and outcome. The ability of health facilities to provide an enabling environment for privacy and confidentiality was a key component of structural quality. The low doctor to patient ratio affected the provision of prompt attention to clients. Concerning process quality, PAC was provided with the client-centred approach. This was, however, affected when the proportion of clients outweighed the service providers. Regarding the outcome dimension of quality PAC services, both service providers and clients consider the PAC services to be of quality; however, they held divergent views on what constitutes the quality of PAC services. It is therefore recommended that the management of health facilities take steps to ensure all health facilities have an enabling environment for the provision of PAC services.

KEY WORDS

Induced Abortion

Service Providers

Clients

Post-Abortion Care

Quality

Spontaneous Abortion

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DEDICATION

To my family

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LIST OF ABBREVIATIONS

CAC	Comprehensive Abortion Care
D&C	Dilation and Curettage
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
ICPD	International Conference on Population and Development
IUD	Intra Uterine Device
MA	Medical Abortion
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MVA	Manual Vacuum Aspirator
OPQ	Optimizing Performance Quality
PAC	Post-Abortion Care
RMNCAH	Reproductive Sexual Maternal neonatal Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

Human welfare and progress have become central in global development efforts, and governments all over the world have committed to promoting these concerns. Guided by development frameworks such as the Millennium Development Goals in the recent past, and currently, the Sustainable Development Goals, it is expected that the socio-economic and health of the world's population will improve appreciably by 2030 (Sachs, 2012; Sachs, Schmidt-Traub, Mazzucato, Messner, Nakicenovic& Rockström, 2019).

It has been argued that a healthy population would lead to the achievement of these goals and objectives towards human development and the welfare of societies (Mensah, 2019). This argument has been expanded, and since the 1995 Beijing Platform for Action, there has been much attention on health, and importantly, the reproductive health of women (Stevenson-Graf, 2021). Nevertheless, Sub-Saharan Africa (SSA) has the highest rate of unmet reproductive health needs (Darroch & Singh, 2011). To advance the reproductive health of women, countries have taken steps to liberate and expand access to sexual and reproductive health and rights (SRHR) services for women and girls who are usually vulnerable to SRHR concerns (Narasimhan et al., 2020). Consequently, between 1995 and 2003, several African nations, including Benin, Burkina Faso, Chad, Guinea, and Mali, have amended their abortion laws to allow abortions where pregnancies are the consequence of rape, incest, foetal impairment, or hazards to women's health

(Aniteye & Mayhew, 2019). Subsequently, other frameworks like the Maputo Protocol, Addis Ababa Declaration, and recently, the Nairobi Convention were developed (Asnake & Bishaw, 2012; Munyati, 2018). While the Addis Ababa Declaration primarily focused on mitigating global health inequity (Asnake & Bishaw, 2012), the Nairobi Convention focused generally on access to reproductive health services, and particularly, rights to these services including safe abortion.

To achieve these intentions related to women's reproductive health, a careful attention has been placed on providing information and services to reduce unintended pregnancy as well as enhance safe abortion services. These notwithstanding, unintended pregnancies remain high worldwide (Ameyaw, Budu, Sambah, Baatiema, Appiah, Seidu & Ahinkorah, 2019). Nearly 14 million unintended pregnancies are reported across the globe each year; of this figure, 44 percent are reported among young women in sub-Saharan Africa (SSA) (Ameyaw, Budu, Sambah, Baatiema, Appiah, Seidu & Ahinkorah, 2019). In the event of an unintended pregnancy, the woman is faced with a decision to keeping the pregnancy or terminating it. In choosing the latter, the woman can either have a safe or unsafe abortion.

According to the World Health Organisation (WHO), unsafe abortion is the induced termination of pregnancy that occurs in areas with low medical standards and/or performed by inexperienced health professionals whereas abortions occurring in facilities with high medical standards and performed by experienced, trained professionals constitute safe abortion (Åhman & Shah, 2011). The WHO further categorises unsafe abortion as less safe and least safe. Less safe refers to the situation where abortions fit just one of these two

requirements: performed by a trained health provider using an obsolete method or performed by someone using a safe method (such as misoprostol) without enough information or assistance of a trained provider/person (Barot, 2018). On the other hand, least safe abortions meet none of the accepted criteria. That is, unsafe abortions are performed by inexperienced individuals utilising risky methods such as sharp tools or poisonous substances (Barot, 2018).

A 2017 study indicated that 55.7 million abortions occur globally on a yearly basis, with 45.1% (25.1 million) of these cases of abortion being classified as unsafe (Ganatra, Gerdts, Rossier, Johnson Jr, Tunçalp, Assifi, & Alkema, 2017). The situation is much dire in SSA where nearly 97% of abortions are unsafe (Gebremedhin, Semahegn, Usmael & Tesfaye, 2018). This disproportionately high incidence of unsafe abortion in SSA has been linked to the restrictive abortion law in most SSA countries (Juma, Ouedraogo, Amo-Adjei, Sie, Ouattara, Emma-Echiegu & Bangha, 2022). In Ghana, the prevalence of unsafe abortion in 2017 was 64.1% (Boah, Bordotsiah & Kuurdong, 2019).

Most low-income countries around the globe have restrictive regulations on abortion. For instance, compared to 80% of high-income countries that allow abortion under socio-economic circumstances, only 16% of low-income countries including countries in SSA grant such permission (WHO, 2015). Similarly, Ghana permits abortion under certain instances which include pregnancy being as a result of rape, incest, or in situations where the pregnancy is assessed to be a threat to the physical or mental health of the woman (Aniteye & Mayhew, 2019). The situation is a threat to the

attainment of SDG Target 3.1 which seeks to reduce maternal mortality to 70 per 100,000 births. Evidence from a 2018 Guttmacher report indicates that in countries with least restrictive abortion regulations, 87% of the abortions are reported as safe: in moderately restrictive countries, safe abortion is 42% while in most restrictive countries, only 25% of abortions are safe (Barot, 2018). Available literature suggests that abortion remains a major public health concern in developing countries (Say et al., 2014; Ameyaw et al., 2019), which raises concerns about the context of access and quality of abortion services that are offered. These notwithstanding, the evidence points to the fact that millions of abortions occur each year (Sedgh et al., 2016; Starrs et al., 2018), hence highlighting a need for mitigating strategies that manages residual side effects from abortions and remediates unsafe abortions.

To promote safe abortion and remediate the effects of unsafe abortions, post-abortion care (PAC) services need to be strengthened. The concept of PAC was first introduced in 1991 by Ipas and later reiterated as a key component in managing unsafe abortions during the 1994 International Conference on Population and Development (ICPD) which was held in Cairo, Egypt (Cleeve, 2019; Izugbara, Wekesah, Sebany, Echoka, Amo-Adjei & Muga, 2020). During this conference, leaders from 179 countries, including SSA, pledged to promote safe abortion by strengthening the availability of PAC services to those who may need it (Izugbara et al., 2020; Juma et al., 2022).

Post-abortion care (PAC) refers to a set of critical emergency interventions that is administered to all women who appear with problems related to abortions (Post Abortion Care (PAC) Consortium, 2015). This

intervention comprises five essential components; namely, community and service provider partnerships, post-abortion contraceptive counselling and provision, linkages to reproductive and other health services, treatment of adverse health effects or complications aggravating from either spontaneous or induced abortions, and providing counselling services to meet the emotional and physical needs of women who have had an abortion (Cleeve, 2019; Owolabi, Biddlecom & Whitehead, 2019). The effective implementation of these tenets of PAC is critical to reduce the risk of maternal mortality and avert adverse health complications from abortion-related complications. These complications that are most likely to be reduced by PAC services include "incomplete abortion, haemorrhage, infection, uterine perforation, anaesthesia-related complications, uterine rupture" (WHO, 2022).

PAC is considered a public health imperative, regardless of the legal context of induced abortion. However, available evidence indicates that there are disparities in the distribution and accessibility of PAC services, particularly in SSA (Izugbara et al., 2020). Often, these disparities are in favour of urban areas. A study conducted in Zambia revealed that there were high rural-urban disparities in terms of accessibility to PAC services, with 85 percent of urban dwelling women having access to PAC services (Campbell, Aquino, Vwalika & Gabrysch, 2016). Another study from Kenya has also found significant rural-urban disparities in the accessibility to PAC services (Mohamed, Izugbara, Moore, Mutua, Kimani-Murage, Ziraba & Egesa, 2015). In Ghana, similar patterns have been reported where accessibility to and the capacity of health facilities to provide PAC services were disproportionately higher in urban areas than in rural areas (Owolabi, Riley, Otupiri, Polis &

Larsen-Reindorf, 2021). Aside the rural-urban disparities, there are significant differences in who provides PAC services to clients. A study conducted in Nigeria, showed majority of PAC services were provided by physicians (54%) while 46 percent of PAC services are rendered by mid-level service providers like nurses and midwives (Bankole, Adewole, Hussain, Awolude, Singh & Akinyemi, 2015). Evidence from Uganda (Bacon, Ellis, Rostoker & Olaro, 2014) have also revealed that lower-level cadre of health care professional provide most of PAC services.

Despite the disparities in the distribution, accessibility, and provision of PAC services, the most important issue is the quality of care provided (Bell, Shankar, Ahmed, OlaOlorun, Omoluabi, Guiella & Moreau, 2021). Thus, understanding the quality of PAC services is crucial in coordinating efforts to reduce maternal mortality. The quality of PAC services could be viewed from three main perspectives – the "structural (facility infrastructure, management and staffing), process (technical quality and patient experience) and outcome (patient satisfaction, return visits and clinical outcomes) indicators" (Juma et al., 2022, p. 3).

From the structural perspective, the quality of PAC services is viewed from a set of signal functions which are mainly categorised as basic and comprehensive, basic only, and comprehensive only. The basic and comprehensive signal functions relate to remove retained products of conception, administer parenteral antibiotics, administer parenteral uterotonics, administer intravenous fluids, offer family planning 7 days each week, provide at least one modern, short-acting family planning method, and have staff trained in PAC on duty or on call 24 hours, 7 days a week (Owolabi

et al., 2021). The basic only signal functions include communicating with referral facilities and having vehicle with fuel to transport women needing referral elsewhere, and the comprehensive only signal functions include the ability to give blood transfusions, maintain a working PAC operating room, and provide at least one long-acting reversible contraceptive or a permanent approach (Owolabi et al., 2021).

As a process, quality of PAC services emphasises that patients must have good experience throughout the service provision. This implies that the attitudes of health care providers coupled with existing structural factors are necessary to predict the experience of patients who seek PAC services. This indicator includes providing patients with sufficient information to make informed choices and extends to providers who have the right to be trained and provided with supplies and respect they require to carry out their duty (Darney et al., 2018). At the end, quality of PAC service becomes an outcome that is measured clinically by effective management of abortion complications, or qualitatively by assessing the satisfaction of clients (Juma et al., 2022). By improving the quality of PAC services, abortion complications such as severe haemorrhage, sepsis and infections would be significantly averted. In the long run, this could be instrumental in facilitating the attainment of SDG Target 3.1, that is, to reduce maternal mortality to 70 per 100,000 live births (WHO, 2019).

Statement of the Problem

Given the high rates of maternal mortality worldwide, the ended Millennium Development Goals (MDG) Target 5A stipulated that by 2015, countries across the globe should reduce their maternal mortality rate (MMR)

by 75% (Kyei-Nimakoh, Carolan-Olah & McCann, 2016). Yet, available evidence indicates that this target was not reached as only a reduction of 45% in the global MMR was attained as of 2015. Countries in Southern Asia and SSA including Ghana were unable to attain this target as they recorded the highest MMR (Kyei-Nimakoh et al., 2016). In Ghana, MMR declined 760 per 100,000 live births in 1990 to 570 in 2000, and to 380 in 2013; thus, indicating a 50% reduction which was less than the expected 75% reduction target by the MDGs (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF, 2018).

It is believed that the inability of Ghana to meet Target 5A of the MDGs, and the reduced potential to achieve SDG 3.1 is partly due to gaps in the quality of PAC services (Izugbara et al., 2020; Kyei-Nimakoh et al., 2016). For instance, although abortion is legal under certain circumstances in Ghana, unsafe abortions contribute to about 15-30% of the maternal mortality cases in Ghana (Ganatra et al., 2017). This is mainly due to access to safe and quality abortion services which include limited access to legal abortion services, cost, infrastructure, sociocultural and social stigma (Boah, Bordotsiah, & Kuurdong, 2019). There are significant differences in the quality of PAC services, including the utilisation of suitable technology, between nations, urban and rural locations, and providers, patients, and facilities (Campbell et al., 2016; Izugbara et al., 2020). Compared to adolescent girls, older women of reproductive age have been found to receive quality PAC services (Mutua, Maina, Achia & Izugbara, 2015). A related study from South Africa showed that even while current PAC guidelines specified antibiotics and blood products, they were not always delivered to patients (Brown, Jewkes, Levin,

Dickson-Tetteh & Rees, 2003). Moreover, evidence suggests that blood, blood components, antibiotics, and analgesics administration during PAC are sub-optimal, owing primarily to cost-cutting measures in several SSA nations (Melese, Habte, Tsima, Mogobe & Nassali, 2018; Tsima, Melese, Mogobe, Chabaesele, Rankgoane, Nassali & Habte, 2016). These gaps in quality of PAC services as evidenced from the aforementioned studies conducted in SSA is a threat to the attainment of the SDG target 3.1 and a precursor to high MMR.

Of the previous studies that have assessed the quality of PAC services, there is limited evidence that the authors explored patient experience and satisfaction of the services they received (Baynes, Yegon, Lusiola, Kahando, Ngadaya & Kahwa, 2019; Eboigbe, Gadama, Filippi, Mehrtash, Adu-Bonsaffoh, Bello & Calvert, 2022; Obsie, 2020). For example, the study of Eboigbe et al. (2022) focused on the differences in adolescent and older women's satisfaction with abortion-related complications care in eleven sub-Saharan African countries while that of Baynes et al. (2019) looked at women's satisfaction and their perception about quality PAC in Tanzania.

However, in the context of Ghana, previous studies have not explored the connecting synthesis between clients' view of quality PAC and providers' view of quality PAC (Adde, Darteh & Kumi-Kyereme, 2021; Esia-Donkoh, Darteh, Blemano & Asare, 2015; Owolabi et al., 2021). Notwithstanding the fact that an estimated 69,846 PAC cases were treated in Ghana in 2017 (Polis et al., 2020). With district hospitals handling 36.6 percent, other hospitals handling 22.6 percent and health centres 20.7 percent (Polis et al., 2020). Polis et al. (2017) also observed that in Ghana, 63 percent of health facilities

provide post-abortion care services; 100% in teaching hospitals and regional hospitals, 86 percent to 93 percent among district or university hospitals as well as polyclinics. PAC provision among health centres, clinics and midwifery/maternity homes were between 41 percent and 61percent (Polis et al., 2020). However, the quality of PAC services has not been examined in Ghana. Specifically in the Greater Accra region which recorded the highest rate of induced abortion (14.7%) and miscarriage (14.2%) in Ghana in the latest maternal health survey (GSS, GHS, ICF, 2018; GSS, GHS, ICF International, 2015). The region also recorded the highest rate of women who ever had an induced abortion (26.4%) GSS, GHS, ICF, 2018; GSS, GHS, ICF International, 2015).

While Esia-Donkoh et al. (2015) explored the experiences of young women and girls seeking PAC, Owolabi et al. (2021) examined Ghana's healthcare facilities' capacity to provide PAC. It is important to note that identifying the divergence and convergences in the notion of quality PAC from the provider and client perspective, patient experience and satisfaction are cardinal indicators of quality of PAC services (Juma et al., 2022; Owolabi et al., 2021). This presents a significant gap in the current scholarship and discourse of the quality of PAC services in selected facilities in the Greater Accra Region of Ghana. This gap raises critical questions that this thesis seeks to answer. Against this backdrop, the present study sought to assess the quality of PAC services in Greater Accra.

Research Questions

1. How do women seeking PAC services in Greater Accra view the quality from their experiences?

2. How do service providers perceive the quality of PAC services in Greater Accra?
3. What are the connecting synthesis of the views of service providers and clients experiences of the quality of PAC services in Greater Accra?

Objectives

The study assessed the quality of post-abortion care services in Greater Accra.

Specifically, it sought to:

1. Explore the experiences of quality of PAC services of women presenting with induced abortion and spontaneous abortion;
2. Examine the views of health professionals on quality of post-abortion care services; and
3. Synthesize clients' experiences and health professionals' notions with the delivery of post-abortion care services.

Significance of the Study

One of the important stakeholders in the provision of PAC services is the healthcare providers. Hence, to improve the quality of PAC services, there is the need to understand service providers' construction of quality of PAC services. This will help policy and decision makers in determining the knowledge and gaps of service providers on quality PAC services. The study addresses a critical gap in the existing literature by assessing the quality of post-abortion care services, a crucial aspect of women's reproductive health. Through its specific objectives, the study delves into the complex dynamics surrounding quality of care, examining the perceptions of women seeking care

for induced and spontaneous abortions. Furthermore, it considers the perspectives of healthcare professionals, who play a vital role in delivering these services. By synthesizing the experiences of both clients and healthcare professionals, this study offers a comprehensive understanding of the challenges and opportunities in the delivery of post-abortion care services.

The results of the research, hopefully, would justify the need for the implementation of relevant policies by the government and other stakeholders to regulate activities to help improve the awareness and provision of PAC services. It is also expected that the current study will help fill the knowledge gap on the subject of post-abortion care in Ghana and further serve as reference material for students, scholars, and other researchers who may want to go into similar studies.

Contextual Definition of Terms and Concepts

This section presents some contextual definition of key terms and concepts in the study. It covers the operationalization of PAC, health professional, patient/client, social and supportive care, structure, process, and outcome.

Post-abortion care (PAC)

Post-abortion care is the treatment that is provided for women at a health facility for incurring complications such as bleeding or infection as a result of an incomplete abortion or miscarriage. This includes medical care such as medication or surgery given to women to evacuate the uterus to save her life (Corbett & Turner, 2003).

Health professional

A health professional is an individual associated with a specialty or discipline and is qualified by regulatory bodies to provide a health care service to a patient (Farlex, 2019). They provide essential services that prevent diseases, promote health, and provide health care services to individuals, families, and communities with the guide of the primary health care approach (WHO, 2019). In reference to this study, health professionals were service providers who worked directly with the provision of PAC services.

Patient/client

A patient refers to a person who is the recipient of health care (WHO, 2011). With reference to this study, a client is a woman who received PAC services.

Social support and supportive care

This refers to the family or friend that accompanies a client to the health facility to seek healthcare.

Structure

The setting under which care is provided. This includes the physical structure, the human resource and the organisational structure of the facility (Donabedian, 2003).

Process

Process in this study refers to the activities/procedures that take place in the provision of PAC services to a client. This encompasses the communication, diagnosis and treatment (Donabedian, 2003).

Outcome

Outcome in this study is conceptualised as the effects of the care/treatment on the clients. This also covers improvement in the client's knowledge on PAC services (Donabedian, 2003).

Quality Post-Abortion Care: quality of PAC service becomes is an outcome that is measured clinically by effective management of abortion complications, or qualitatively by assessing the satisfaction of clients (Juma et al., 2022)

Organisation of the Study

This thesis is divided into eight chapters, with the present chapter providing the introduction to the research topic. This entails the background to the study, problem statement, objectives of the study, significance of the study, contextual definitions of terms and concepts, and the organisation of the study. The second chapter reviews literature on conceptual and theoretical issues such as abortion, PAC, and quality of care. The chapter also discussed literature on the following elements of quality: availability of equipment and supplies, technical competence, responsiveness of providers, client-provider interaction, among many others.

In the third chapter, relevant empirical literature was reviewed based on the objectives of the study. Some of the issues captured in the empirical literature review include patients' views and attitudes about the quality of PAC services, health service providers' views and attitudes about PAC services, and the barriers to the provision and utilisation of PAC services. Chapter Four entails the research methods that would be followed to conduct the study. This includes the research and study designs, study area, population,

sampling procedure, data collection instruments, data collection procedure, data processing and analysis, and ethical considerations.

Chapter Five covers the results and discussion of the notions of quality of care between women who presented with induced abortion and those who presented with spontaneous abortion. Chapter Six discusses the views of health professionals on the quality of post-abortion care services provided at health facilities.

The health professional's views on the meaning of quality of post-abortion care services is discussed in Chapter Six. Chapter Seven covers the link between clients and providers notion of quality PAC services. It discusses the divergence and the convergences in the views of service providers and clients on the quality of PAC services.

Chapter Eight summarises the entire study, outlines the key findings, based on the key findings, and draws the conclusions and recommendations based on the findings and discussions.

CHAPTER TWO

CONCEPTUAL AND THEORETICAL PERSPECTIVES ON POST-ABORTION CARE SERVICES

Introduction

This chapter provides an overview of previous literature regarding post-abortion care services. Primarily, it is divided into two main sections. The first section covers the conceptual issues comprising abortion, PAC and quality of care. The second section of this chapter explores and discusses various theoretical perspectives that have a bearing on PAC. This section introduces also the conceptual framework that guides and describes the main focus of the thesis.

Conceptual Issues

This section reviewed concepts and models which are relevant to quality of PAC services to help explain and give meaning to the conceptual framework that has been adopted for the study. The concepts are abortion and post-abortion care, and quality abortion care.

Abortion

To ensure standardisation of care, the WHO postulated a definition for abortion as the termination of pregnancy prior to 20 weeks of gestation, either through medical intervention such as medications or surgical procedures or it occurs on its own (WHO, 2021). In the situation where pregnancy is terminated by itself due to some genetics, health or hazardous reasons, it is referred to as spontaneous abortion or miscarriage (Kharbanda, Haapala, DeSilva, Vazquez-Benitez, Vesco, Naleway & Lipkind, 2021). However,

pregnancy termination that is facilitated by medical interventions is known as induced abortion.

Induced abortions are further categorised as safe and unsafe (i.e., less safe and least safe) depending on some criteria. The WHO indicates that when induced abortion occurs in areas with low medical standards and/or performed by inexperienced health professionals, then it is categorised as unsafe; however, when it occurs within facilities with high medical standards and performed by experienced trained professionals, it is classified as safe abortion (WHO, 2019).

The discourse on abortion has for years been influenced by the pro-life and pro-choice debate. To those who ascribe to the pro-life perspective, it is logical to concur that if an unborn child is a human, then the child has a claim to such rights (Brysk & Yang, 2023). Therefore, it is not the right of the pregnant woman to decide to terminate the pregnancy. Essentially, pro-lifers are anti-abortion.

In the perspective of pro-choice, it is all about the rights and decisions of the pregnant woman. According to this perspective, every woman should have the rights to her own life and body (Clinton, 2018). Therefore, denying a woman an abortion is denying her the rights to bodily autonomy. This perspective further explains that when children are born to parents who lack interest or time for parenting, it increases the risk of the child not having the best quality of life. Hence, it becomes important for women to be given the freedom to exercise the right to decide whether or not they want to keep their pregnancies. This ideology postulates that the factors that make abortion permissible include the following:

> "(a) the mother does not want the child; (b) the father does not want the child; (c) the mother will possibly die from giving birth; (d) the pregnancy is the result of rape. The fact that the mother does not want the child could embrace several reasons: (a) the mother knows the child will be born with physical or mental abnormalities; (b) the mother is a drug or alcohol abuser; (c) the mother knows she is not financially fit to take care of the child; (d) the mother knows her relationship with the father of the child will not last, and she feels insecure; or (e) for no specific reason, she does not want the child." (Lopez, 2012, p. 515).

Notwithstanding the variance in the ideologies concerning abortion, it is undisputable that restrictions underlined by pro-life ideologies exacerbates the incidence and risk of unsafe abortions and related complications. For instance, Barot (2018) reports that in moderately restrictive countries, safe abortion is 42% while in most restrictive countries, only 25% of abortions are safe. Therefore, promoting the rights of women to decide freely and access abortion services is critical to improve utilisation of safe abortion services. Within the continuum of abortion services, there is comprehensive abortion care (CAC). According to the WHO, CAC comprises providing abortion information, managing abortions and providing post-abortion care (WHO, 2021). A key element of the CAC is the provision of PAC services.

Post-Abortion Care

Post-abortion care (PAC) is a strategy and an approach aimed at averting maternal mortality and morbidity aggravated from complications of

spontaneous, incomplete and unsafe abortions to improve the overall health and well-being of women (Ansari, Zainullah, Kim, Tappis, Kols, Currie & Stekelenburg, 2015). The term was first used in 1991 when family planning services were combined with PAC to end the cycle of unintended pregnancies, and to enhance the general result of unsafe abortions.

The WHO identifies five essential components of PAC. These are "a) community and service provider partnerships for prevention of unwanted pregnancies and unsafe abortion; b) counselling to identify and address the emotional and physical health needs of women; c) treatment of incomplete abortion using manual vacuum aspiration (MVA) or misoprostol to remove retained products of conception; d) post-procedure family planning counselling and services; and e) links with other reproductive health care" (WHO, 2022).

Quality Abortion Care

To understand the concept of quality abortion care, it is imperative to appreciate what quality of care encompasses. Quality pertains to the extent to which healthcare services for individuals and populations enhance the probability of achieving desired health outcomes while aligning with contemporary professional knowledge (Darney, Kapp, Andersen, Baum, Blanchard, Gerdts, & Powell, 2019). Hence, quality revolves around the domains of patient safety, effectiveness, patient centeredness, timeliness, efficiency, and equity (Darney et al., 2019; WHO, 2006). In reproductive health, the quality of care is defined to reflect the domains of choice of method, competent providers, privacy, information exchange, interpersonal interactions and ancillary services (Jain & Hardee, 2018). This means that

quality abortion care describes the process where abortion services are rendered by competent healthcare professionals; there is ample respect for privacy, detailed information and interpersonal interactions to ensure the safety and desired outcomes of the client (Baum, Wilkins, Wachira, Gupta, Dupte, Ngugi & Makleff, 2021).

Perspectives of Quality of Care

Theoretical Perspectives and Models on Quality of Post-Abortion Care

This section reviews models and theories which are relevant to quality of PAC services to help explain and give meaning to the conceptual framework that has been adopted for the study. Models such as A four level model of the health care system, Service availability and readiness assessment model and Donabedian model of quality care and theories such as crossing the quality chasm, the positioning theory, Optimizing performance and quality theory, are discussed in this section.

Crossing the Quality Chasm Theory

The focus of the crossing the quality chasm theory is on how the health system can be reinvented to foster innovation and improve the delivery of care. Developed by the Institute of Medicine in 2001 in the United States of America, the perspective responded to the quality gaps that were identified in the application of medical sciences and technology (Baker, 2001). The Institute identified six dimensions that they deemed needed some modification to apply to low-resource settings and modern times (Institute of Medicine, 2018). The introduction of the theory was to help the health system to apply new technology safely and appropriately to enhance quality of care (Institute of Medicine, 2001). The Institute recommended the rephrasing of some

wordings such as ‘patient-centred’ to ‘person-centred’ to reflect better the goal of health care around the needs and circumstances of each person; safety; effectiveness; accessibility, timeliness; efficiency; and equity are the other dimensions identified as essentials for quality care (Institute of Medicine, 2018).

Institute of Medicine (2001) stipulated that quality care should be person-centred. Thus, health care provided should be respectful and responsive to individual patient preferences, needs, and values. This dimension seeks to encourage collaboration between patients and care providers to manage a health condition or in the provision of healthcare services (Institute of Medicine, 2001). With this, health care should focus on the patient’s problem rather than the provider's diagnosis (Bokhour, et al., 2018).

By being safe, the patients should not incur any injury from the care being received at the health facility. The care being provided is supposed to help clients and not the other way around. Vries, Ramratthan, Smorenburg, Gouma, and Boremeester (2008) observed that one out of ten patients suffer an adverse effect from being hospitalised and about half of all these could have been prevented. This affects the safety of patients and the quality of care being provided to patients. This also has financial implications for the health care system as well (Vincent, Neale, & Woloshynowych, 2001). Given this, hospitals are being advised to put in pragmatic steps to manage the risks to patients safety at their facilities (Sujan, et al., 2015).

For care to be effective, it must be based on scientific knowledge and directed to all who could benefit from the care. Effectiveness in healthcare is

when the healthcare needs have been met and have brought about a positive outcome (Wilkin, Hallam, & Doggett, 1992). Mpinga and Chastonay (2011), on their part, argue that effective healthcare is determined by its availability and accessibility. As such, effective healthcare should be viewed as a right to health. Hence, the effectiveness of healthcare is based on its impact and satisfaction derived from the service (Regmi, 2012).

Care should also be timely, and measures should be put in place to reduce the waiting time before a patient gets access to health care. This includes removing access barriers and financial risks for people seeking health care. As such, the Institute of Medicine (2018) modified the domain of timeliness to include accessibility and affordability to acknowledge the importance of financial protection for quality care. Time spent waiting for healthcare to be provided to a patient affects the satisfaction they derive from care (Prakash, 2010).

The health care provided should also be efficient. Efficiency in this context refers to providing healthcare in a way that optimizes resource utilization and minimizes waste (Machta, Maurer, Jones, Furukawa & Rich, 2019). In so doing, measures should be put in place to avoid waste which includes the waste of equipment, suppliers, ideas, and energy. Improving efficiency in the provision of healthcare will ultimately result in the saving of resources in the health sector (Grigoli & Kapsoli, 2013). Nonvignon and Nonvignon (2017) argued that efficient healthcare provision has the potential to create additional fiscal space for the health sector.

The last point noted by the Institute of Medicine (2001) was equitable. To them, quality of care should not be dependent on personal characteristics

such as ethnicity, gender, socio-economic status, or the geographical location of the patient. As such, healthcare should be provided for all with clinical need as the sole condition and not influenced by factors such as social, economic, geographical or financial (Raine, Or, Prady, & Bevan, 2016). Equitable healthcare is about fairness, and everyone should have an equal opportunity to access healthcare.

Positioning Theory

The position theory, propounded by Bronwyn Davies and Rom Harre (1990), emerged out of a discussion on the problem inherent in the use of the concept of role in developing a social psychology of selfhood (Benwell & Stokoe, 2006; Morgan, 2007). The theory defines positioning as "the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced storylines" (Chiweshe & Macleod, 2017, pp2). This theory seeks to explain how people perceive others and themselves and this reflects in their speech.

The positioning theory takes conversations as a form of social interaction which results in interpersonal relations (Davies & Harre, 1990). The theory, therefore, suggests that one selects analytical concepts that serve to unveil conversations as a structure of speech-acts, thus, the social intentions of the speaker. The positioning theory emphasises how the discursive practices constitute the speakers and hearers in certain ways and yet, at the same time, it serves as a medium through which the speaker and the hearer can negotiate new positions (Davies & Harre, 1990).

The positioning theory draws from discursive psychology which permits for a multi-level analysis that interlaces how people position

themselves and each other within social and discursive power relations (Davies & Harre, 1990).

Chiweshe and Macleod (2017) used this theory to explore how health service providers interactively position women who had an abortion and how they made a reflexive position of the role they play in abortion services. Chiweshe and Macleod (2017) observed that service providers position women who induce abortion as agents of the devil. On the contrary, Chiweshe, Mavuso, and Macleod (2017) applied the position theory to analyse the narratives of women of their abortion decision and found that women who induced abortion position themselves as making responsible decisions. This emphasises the fact that positioning being reflexive or interactive is discursive and people are likely to accept or reject the way someone else positions them.

Optimizing Performance and Quality (OPQ) Theory

The optimising performance and quality (OPQ) theory suggests that performance and quality are intertwined concepts. While performance is the activities or tasks that individuals, organisations or teams do to achieve the desired results, quality is the extent to which the desired result, process or service conforms to standards or requirements (IntraHealth International, 2013).

The OPQ helps in assessing and addressing the performance of individuals, teams, organisations, and systems. It also helps in assessing the quality of health care provided to patients as defined by World Health Organisation as “proper performance of interventions that meet standards, that are known to be safe, that are affordable by the society in question, and that can improve the health outcomes” (IntraHealth International, 2013, pp4).

OPQ is a seven stage process that can be used independently or in conjunction with other tools to improve the quality of health services. The stage one is the describe context. At this stage, the OPQ team must profile the aspect of the health system or care they want to improve. This will help them grasp a better understanding of the issues at stake. This includes the organization's goals, priorities, structure, and culture; the external environment surrounding the organization; the perspectives of employees/health workers; and the clients and community served by the organisation. Understanding these issues could help in the implementation of the other stages of the OPQ process (WHO, 2006).

The stage two is known as the support stakeholder engagement, ownership, and leadership. At this stage, all the key stakeholders who would be involved in the process must be identified. These can include the service providers, clients/patients, managers, community representatives, policymakers, religious and community leaders, among many others depending on the location of the facility. For an OPQ to be successful, it is vital for the active involvement of stakeholders to feel ownership over the process and outcomes (Mungore, Kassouta, Sebikali, Lundstrom, & Saad, 2016).

Stage three deals with the identification of strengths and gaps. The OPQ team and the stakeholders define the expected quality standard and actual performance and quality. After this, they compare the two levels to have a better understanding of the gaps and strengths in performance and quality. Stage four, on the other hand, deals with finding the root causes, that is

undergoing a root cause analysis to determine the causal factors of the gaps and strengths (WHO, 2006).

In the fifth stage, interventions are selected and designed, as recommended by the OPQ, involving stakeholder discussions to identify measures that address the identified gaps' root causes and capitalize on recognized strengths (WHO, 2006). Stage six is focused on implementing the chosen interventions according to the intervention plans. The final stage, monitoring and evaluation, is a continuous process, with monitoring occurring at each step of the OPQ to allow for necessary adjustments. A comprehensive evaluation is conducted at the end to assess the interventions' overall performance.

Mungore, Kassouta, Sebikali, Lundstrom, and Saad (2016) applied the OPQ theory to five health facilities in Togo and documented that it has improved access to high quality PAC services which has led to an improvement in contraceptive counselling and uptake at the selected health facilities. The OPQ theory helped to identify the gaps that needed to be addressed and these were shared with the service providers. This helped in improving the PAC service quality in the facilities.

Four-level Model of the Health Care System

Ferlie and Shortell (2001) developed the four-level model of the health care system. They classified the health care system into four; the individual patient, the care team, the organisation, and the political and economic environment.

According to Ferlie and Shortell (2001), quality care begins with individual patients whose preferences, values, and needs should be the underlining factors in a patient-centred health care system. Patients are no longer passive recipients of care but are now active participants in the care they receive at a health facility. As such, clinicians are encouraged to see the patients as partners in the provision of health care and also to incorporate their values and preferences into the care process. Thus, the needs and preferences of individual patients should be the underlining factors in a patient-centred healthcare system (Fanjiang, Grossman, Compton, & Reid, 2005). This level encourages patients to voice their informed needs, preferences and participate effectively in decision making concerning the healthcare they are receiving.

The second level, according to Ferlie and Shortell (2001), is the care team. This comprises the health professionals, the patient's family, and others whose efforts in one way or the other contribute to the delivery of care to the patient or the population of patients. The role of the care team is to standardise care where possible, based on the best current evidence; to stratify patients based on medical need and provide the best evidence-based care within each stratum, and to customize care to meet individual needs for patients with complex health problems (Ferlie & Shortell, 2001). The primary aim of the second level is to standardise care based on the best available evidence, as well as customise healthcare to meet the individual needs of patients with peculiar health issues (Fanjiang, Grossman, Compton, & Reid, 2005). This suggests that health workers are to learn to deliver healthcare as a care team rather than the autonomy of individual physicians. This can be carried out at a single institution level or across institutional settings.

Ferlie and Shortell (2001) identified the organisation as the third level of quality health care system. By the organisation, they refer to the infrastructure and resources to support the work and development of the care team to be able to provide health care to the patients. The organisation also encompasses the information systems, decision making system, processes, and operating systems (Ferlie & Shortell, 2001) which helps in coordinating activities of the care team to be able to provide health care services. The organisation is thus the hospital, clinic, or the health facility and how the facilities are run.

Lastly is the political and economic environment. This level includes the financial, payment, and regulatory regimes and entities that determine the structure and performance of health care delivery systems (Ferlie & Shortell, 2001). The political and economic environment influences how the organisation operates. This is determined by the policies and political environment of the government. These regulations also influence the transparency of the health care system by setting rules and regulations pertaining to patient safety and other aspects of the quality of care. The economic and political environment also influences the level, structure and nature of competition that exist among healthcare providers and insurers. It also affects the efficiency and effectiveness as well as other aspects of quality healthcare services (Fanjiang, Grossman, Compton, & Reid, 2005).

Service Availability and Readiness Assessment (SARA) Model

One of the main functions of a health system is to ensure access to quality health services. Ensuring access to quality health services includes components such as availability, affordability, and acceptability. Availability

refers to the physical presence of the facility, while affordability refers to clients being able to pay for the service and acceptability refers to the socio-cultural dimension (WHO, 2013).

Another requirement for service quality is service readiness, thus, the capacity of the health service to deliver the service offered. This is measured by the presence of trained staff, infrastructure, guidelines, equipment, and other necessary supplies for the provision of a service (WHO, 2013). It is, however, worth noting that service availability and service readiness are requirements for the provision of quality services but do not necessarily guarantee delivery of quality service (WHO, 2013). Nonetheless, SARA is one of the tools used to collect data on service delivery. SARA considers the best practices and materials that were used for survey methods such as Service Provision Assessment (SPA) and the WHO/Health Action International (HAI) methodology used for assessing prices of medicines, affordability, availability, and price components (WHO, 2013).

The SARA was designed to assess the availability and readiness of qualified service providers and infrastructure/resources to provide services such as family planning, basic and comprehensive obstetric care, child health services, tuberculosis, HIV and AIDS, non-communicable diseases, and malaria, with three main focus areas, namely, service availability, general service readiness, and service-specific readiness. The number of facilities that are involved in SARA surveys is the maximum the available fund can support. However, the facilities are sampled using the multi-stage stratified sampling by facility level and public-private ownership (WHO, 2018).

Bell, Zimmerman, Choi, and Hindin (2018) adopted the SARA framework to assess abortion service provision in Nepal using a nationally representative health facility data. Using this framework enabled Bell, Zimmerman, Choi, and Hindin (2018) to have a more detailed readiness of abortion service assessment than in prior studies (Bell, Zimmerman, Choi, & Hindin, 2018).

Donabedian Model of Quality of Care

To Donabedian (1988), in measuring the quality of care, one has to define if the quality depends on one assessing the performance of service providers or also the contribution of the patients themselves and the health care system; the broad definition of health and responsibility for health, as to whether maximally effective or optimally effective care is sought; and whether the optimum quality is defined by social or individual preferences of care and the outcomes of care.

With regards to the measurement of quality-of-service providers, their technical performance and interpersonal performance are measured. The technical performance is measured by the knowledge and judgement used by the provider in providing the care. To determine the quality of technical quality, one has to compare it with the best in practice. The best practice, according to Donabedian (1988), is the one that has produced distinction or shown to produce the greatest improvement in the provision of health. Hence, the quality of technical quality is measured by the expected quality that could be achieved per the status of the current science and technology available in health care and its effectiveness.

The interpersonal quality, according to Donabedian (1988), deals with the communication between the health care provider and the client. Here, the client provides information with regards to their condition and preferred treatment and the service provider also provides information to the client on the treatment and how to manage the condition as well as provide words of encouragement to the client. The quality of technical care largely depends on the interpersonal process. Interpersonal quality must also meet individual and social standards. This is measured by the elements of privacy, confidentiality, informed choice, concern, empathy, honesty among many other virtues.

Encompassing the technical quality is the amenities of care. There is an environment in which health care is provided. The environment here refers to the structure of the facility. If it is user friendly in the sense that it provides convenience, comfort, quiet, privacy, and others that make it easy and attractive for patients to seek health care at the facility.

Donabedian (1988) also asserted that the quality of care should also be measured from the contribution of the patient and the family of the patient. This could be seen in the interpersonal quality where the communication is between the client and the service provider. Quality of care implemented by the patient also looks at how the patient heeds to directives from the service provider.

The model also argues that quality of care should be measured at the community level by looking at the community as a whole (Donabedian, 1988), and by looking at who has greater or lesser access to care and who after gaining access receives the greater or lesser quality of care. Based on the foregoing, Donabedian (1988) proposed three approaches to measure the

quality of care. He classified them as structure, process, and outcome. These have been referred to as the triad of structure, process and outcome (SPO) constructs which Donabedian argues that they interrelate against the backdrop that good structure will influence good process which will result in a good outcome (Donabedian, 2003).

The structure measures the setting under which care is provided. It is also the physical structure or building being used as the health care facility, and how suitable it is to provide the care being sought at the facility. The structure also connotes the human resources of the facility and the number and qualification of the service providers. It further looks at the organisational structure of the facility. This includes how the medical staff is structured and the policies guiding the facility, for example, policies in place for peer review. Thus, the structure encompasses the professional and organisational resources that are required for the provision of healthcare (Donabedian, 2003).

Ameh, Gomez-Olive, Kahn, Tollman, and Klipstein-Grobusch (2017) in their study used structure to measure availability of equipment, supply of critical medicenes and accessibility of care. By this study, Ameh et al. (2017) focused the structure component of quality care on the orgnaisational resources.

According to Donabedian (1988), the process encompasses what is done in the provision of care to the client, as well as the procedure the service providers use in providing quality care to the patients. This includes the interaction with the client, diagnosis, and recommending or implementing treatment. Thus, the things that are done for and to the patient in the quest to provide them with healthcare (Donabedian, 2003) is the process. In adapting

this model to measure quality of integrated chronic disease management, Ameh, Gomez-Olive, Kahn, Tollman, and Klipstein-Grobusch (2017) adapted process to encompass attendance, appointment, communication, pre-packing, examination, professional, referral, time with nurse, defaulter and friendliness. Ameh et al. (2017) measured these variables to determine the process quality of intergrated chronic disease management as priotity areas for enhacing quality of care.

The outcome, on the other hand, measures the effects of the care received by the client on his health status. This also looks at the improvement in the patient's knowledge with regards to the illness he/she was treated for and the salutary changes in the behaviour of the client. The outcome also measures the client's satisfaction with the care received (Donabedian, 1988). Hence, outcome is the desired result provided to a client by the health practitioner (Donabedian, 2003). The outcome is, however, categorised into technical outcomes which deal with the physical and functional aspects of care (reduction in disease and abscenec of complications, among others) and the interpersonal outcome which deals with the satisfaction the patient derives from the care received and the effect it has on the quality of life of the patients from the patients perspective (Donabedian, 2003). This was adapted by Ameh et al. (2017) as the satisfaction a patient derives from the waiting time, coherence, competence and the confidence the patient derived from the care received.

It is, however, important to know the relationship between the structure, process, and outcome before it can be measured because they are interconnected. Good structure relays into the likelihood of a good process and a good process increases the chances of a good outcome (Donabedian, 1988).

Flowing from the above, the Optimizing Performance and Quality theory (IntraHealth International, 2013), four level model of health care system (Ferlie & Shortell, 2001) and Donabedian model of quality care (Donabedian, 1988) were adopted for the study.

CHAPTER THREE

EMPIRICAL ISSUES ON POST-ABORTION CARE

Introduction

The chapter focuses mainly on conferences and policies on post-abortion care, post-abortion care, reported abortion complications, treatment and management of post-abortion complications, availability and accessibility of post-abortion care services, post-abortion care contraceptive, and family planning services, characteristics of post-abortion care users, client's views and attitudes towards post-abortion care, quality of post-abortion care and barriers to the provision and utilization of post-abortion care services. These help to guide the study by providing direction for construction of instruments for data collection and also help maintain a sense of the topic's position.

Frameworks, Conventions and Policies on Post-Abortion Care

The Addis Ababa Declaration on Population and Development in Africa beyond 2014 acknowledges that health is the prerequisite for the socio-economic development of Africa and that sexual and reproductive health and rights are not just vital for achieving social justice but also play a vital role in the realisation of the global, regional and national commitments to sustainable development (UNFPA, 2013). It further acknowledges that women's health plays a key role in the development of Africa.

The Addis Ababa Declaration suggests a commitment to strengthen health systems from the level of primary health care to provide equitable and universal access to comprehensive health care, and to also achieve universal access to sexual and reproductive health services which is devoid of any form of discrimination. Countries are also expected to enforce laws and policies that

will respect and protect the sexual and reproductive health rights of people, support the integration of sexual and reproductive health services and family planning, access to safe abortion services within the national laws and policies and also provide humane and compassionate treatment of abortion complications (UNFPA, 2013).

The maternal mortality ratio in Africa excluding North Africa remains high at 510 per 100000 live births (The African Union Commission, 2017). This among other factors necessitated the need for a revised Maputo Plan of Action 2016-2030 which followed the review of the Maputo Plan of Action 2007-2015 with the aim of the continent achieving universal access to comprehensive sexual and reproductive health services in Africa beyond 2015 (The African Union Commission, 2017).

The Maputo Plan of Action 2016-2030, therefore, suggests optimising the functioning of health systems for reproductive, sexual, maternal, neonatal, child, and adolescent health. This could be achieved by providing comprehensive and quality RMNCAH and strengthening referral systems and also ensuring available wide range of drugs and commodities for the provision of RMNCAH (The African Union Commission, 2017).

In Ghana, abortion is permitted by the Criminal Code Amendment, PNDC Law 102, 1985, now incorporated into the consolidated Criminal Code, 1960, Act 29, section 58. This law permits abortion if the pregnancy is as a result of rape, defilement, incest, when the pregnancy may affect the health of the pregnant woman or there is a substantial risk that the child, when born, may suffer from physical abnormality or disease (GHS, 2012). The provision in the law as such makes abortion laws in Ghana liberal.

The National Reproductive Health Service Policy and standards revised in 2003 address issues on post-abortion care which includes the creation of public awareness on prevention of unintended pregnancies, abortion and the associated complications associated with unsafe abortion, and equipping doctors and midwives with the necessary skills and decentralising MVA services to the district levels (DAWN, 2006).

Ghana's Reproductive Health and Strategic Plan: 2007-2011 has its Objective One as reducing maternal morbidity and mortality. The strategic plan admits that complications of pregnancy and childbirth are the leading causes of death for women in their reproductive age (GHS, 2007). Its goal for reproductive health is to improve the health and quality of life of persons of reproductive age and new born children by providing high-quality reproductive health services. This would be achieved with an emphasis on accessibility, efficiency, financing, partnerships, and quality (GHS, 2007).

Post-Abortion Care

Globally, countries have put in measures to reduce abortion-related morbidity and mortality through the provision of quality health care services for the management of abortion complications. Post-abortion care refers to a group of essential interventions that are provided to women who present with complications from abortion (UN, 1994; Owolabi, Biddlecom, & Whitehead, 2019).

Post-abortion care services consist of both curative and preventive care. Curative care covers the treatment of incomplete abortion and complications while preventive care has to do with contraceptive counselling and family planning services (WHO, 2012; PAC-consortium, 2015). Both

components are needed for the provision of high-quality post-abortion care services (Owolabi, Biddlecom, & Whitehead, 2019).

In May 2002, the PAC Consortium endorsed the Essential Elements of PAC model which is a reflection of both the perspectives of service providers and clients. The model aimed at providing the framework for the provision of high-quality and sustainable services (Corbett & Turner, 2003). The essential elements include community and service provider partnerships, counselling, treatment, family planning and contraceptive services, and reproductive and other health services (Corbett & Turner, 2003).

Community and service provider partnerships acknowledge the importance of the community in the efforts towards prevention, treatment, and advocacy. This element recognises that to increase access and the quality of post-abortion care services, a key strategy is community health education and mobilisation (PAC-Consortium, 2015). This, therefore, calls for a partnership between communities and service providers. This partnership includes but not limited to education to increase awareness on contraceptives, advocacy for holistic human rights-based reproductive health policies, education with regards to obstetric emergencies, and appropriate health-seeking behaviours, among many others (Corbett & Turner, 2003).

For the effectiveness of post-abortion, there is a need for family planning counselling to increase the confidence of women to have autonomy over their bodies (Che, Dusabe-Richards, Wu, Jiang, Dong, Li & Tolhurst, 2017). This improves a woman's understanding of her psychological conditions concerning her reproductive past and future. This also enables

women to make informed choices about their treatment and contraceptive options (PAC-Consortium, 2015).

Counselling services also help women with their coping abilities and management of anxiety (Corbett & Turner, 2003). Studies have shown that effective contraceptive counselling increases the use and adoption of post-abortion contraceptives (Rominski, Morhe, & Lori, 2015; Samuel , Fetters, & Desta, 2016). For instance, in Ethiopia, this has led to an increase from 58percent to 83percent in post-abortion contraception uptake (Samuel, Fetters, & Desta, 2016). This also helps in preventing repeat unwanted pregnancies and abortions. According to Corbett and Turner (2003), counselling aims to provide emotional support, ensure PAC clients receive accurate information, help women clarify their choices regarding pregnancy, abortion, and treatment, and also enable providers to understand women's experiences with abortion.

Another element of PAC is treatment. This aspect is essential within the framework of PAC as it ensures that women can access uterine evacuation and any other required medical treatments (Corbett & Turner, 2003). Treatment encompasses the use of abortifacients such as misoprostol and MVA techniques to complete incomplete abortions and also stop bleeding (Barot, 2014).

Last but not least is the linkage with reproductive and other health services. This is to encourage women to receive other health services that would be required at the time the woman reports for PAC services (Corbett & Turner, 2003). These services include STI prevention, diagnosis and treatment, gender-based violence screenings, nutrition education, infertility

counselling, hygiene education, and cancer screenings. In situations that the facility would not be able to provide other services that the woman needs, the facility should be able to have mechanisms in place for making referrals (Barot, 2014).

Reported Abortion Complications

A significant proportion of gynaecological admissions in SSA are from complications from unsafe abortion (Singh, 2010; Ishoso, Tshefu, & Coppieters, 2018; Izugbara, et al., 2019). Post-abortion complications have been categorised into low morbidity, moderate and severe (Gebreselassie, Gallo, Monyo, & Johnson, 2005; Gebreselassie, et al., 2010; Ziraba, et al., 2015). The low morbidity is usually characterised by a normal body temperature of less than 37 degrees Celsius, no clear signs of infections, system failure, or organ failure (Gebreselassie, Gallo, Monyo, & Johnson, 2005; Gebreselassie et al., 2010). The moderate post-abortion complications, on the other hand, manifests itself in offensive products of conception, temperature 37.3-37.9 degrees Celsius, and localised peritonitis, while the severe complications comprise death, sepsis, high temperature (>37.^{0}C), evidence of mechanical injury/foreign body as well as shock, pulse less than 119 beats/minute, organ or system failure, generalised peritonitis and tetanus (Ziraba et al., 2015).

Evidence from Kenya suggests that more than three-quarters of post-abortion clients presented with moderate or severe complications (Ziraba et al., 2015). Ziraba et al. (2015) further found in their study that clients with unplanned pregnancies were more likely (43% higher odds) to have moderate or severe complications as compared to those who had planned pregnancies.

Women who wanted more children and women who reported with spontaneous abortion were less likely to report moderate or severe complications as compared to their counterparts who did not want more children as well as those who had induced abortion. Again, Ziraba et al. (2015) also found that women who delayed in seeking early post-abortion care are more likely to have moderate or severe complications compared to those who seek early treatment. This is probably because delaying PAC, particularly more than 12 weeks' gestational age, exacerbates complications and therefore leads to more severe complications (Ushie, 2018).

Conversely, in a Zimbabwean study, the majority of post-abortion complications were mild (Madziyire et al., 2018) as opposed to that of Kenya where a higher proportion of complications were moderate or severe (Ziraba, et al., 2015). Contextually, both Zimbabwe and Kenya have restrictive abortion laws which limit the likelihood to report abortions (Mohamed et al., 2015). For that matter, it is expected that both countries would have a similar experience of post-abortion complications. However, this is not the case; Zimbabwe reports a higher incidence of mild post-abortion complications juxtaposed to Kenya. A plausible explanation for this observation is that, in as much as both countries have restrictive laws on abortion, the Zimbabwe law provides a detailed premise on which abortion can be accessed (Sully et al., 2018).

The Zimbabwean law on abortion states categorically that legal abortion is limited to circumstances of rape, incest, foetal impairment, or to save the woman's life (Sully et al., 2018),. thus, reducing the stigma and prejudice attached to abortion and encouraging timely access to abortion

services. However, Kenya's law on abortion is shrouded in ambiguity. Abortion is permitted in Kenya when there is the need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law (Government of Kenya, 2010). This ambiguity in the premise for abortion in Kenya puts women in a state of dilemma and subsequently delays their access to abortion, which translates into moderate-severe post abortion complications (Hussain, 2012; Marlow et al., 2014).

Extant evidence also suggests that reported post-abortion complications variates with some socio-demographic characteristics (Madziyire et al., 2018; Sully et al., 2018). For instance, Madziyire et al. (2018) postulate that women who reside in rural areas, are younger, not married, and of high parity were more likely to present with severe post-abortion complications. This finding is corroborated by other studies that have found rural-residing women to have a higher likelihood of presenting severe post-abortion complications (Mulat et al., 2015; Ushie et al., 2018). This is probably because rural settlers may have poor or no access to good health facilities and timely health services (Sibley & Weiner, 2011), hence their inability to seek timely post-abortion care which translates to severe post-abortion complications.

The study of Adde et al. (2018), Mutua et al. (2018) and Netshinombelo et al. (2022) explored clients' experience with prompt attention when they seek PAC services in Ghana, Kenya and South Africa respectively. Whereas Adde et al. (2018) found that women experienced prompt attention in Ghana, the same cannot be said for women in Kenya (Mutua et al. 2018) and South Africa (Netshinombelo et al., 2022). In Kenya, a major contributor to

women experiencing a delay in receiving treatment is the limited capacity of health facilities (Mutua et al., 2018). For instance, Mutua et al. (2018) observed that lower-level health facilities do not have ultrasound equipment as well as not having specialised gynaecologists who could perform specialised surgical interventions.

In the same vein, Ushie et al. (2018) postulate that highly educated women are more likely to seek timely abortion care which reduces the likelihood of experiencing severe post-abortion complications. This finding is consistent with Madziyire et al. (2018) which found a statistically significant association between level of education and timely health seeking practice. A plausible explanation for this observation is that education provides the individual with the right information in order to assist these individuals to make informed decisions concerning their sexuality and fertility (Ushie, 2018). Therefore, it implies that women who possess low levels of education are more likely to present severe post-abortion complications.

Evidence also suggests that women that report at a late gestational age are more likely to report severe post-abortion complications (Madziyire et al., 2018; Ushie et al., 2018). For instance, in a study by Ushie et al. (2018), it was revealed that a significant proportion of women (38%) presented for PAC at a >12 weeks of gestation. In Kenya, about 39% of all PAC patients sought care after 12 weeks of gestation (Ziraba et al., 2015). Delaying in seeking PAC will result in moderate to severe post-abortion complications. The fear of stigmatization from society is primarily what causes women to delay seeking PAC until the 12th week of gestation (Rehnström Loi et al., 2018; Ushie et al., 2018).

Treatment and Management of Post-Abortion Complications

Treatment and management of post-abortion complications can operate at three major levels: the community level, facility level, and higher-facility level (Mutua, 2019). Mutua (2019) asserts that at the community level, care providers are concerned primarily with the identification of complications and subsequent referral to nearby health facilities for continuity of care. However, at the facility level, PAC services are tilted towards the recognition of complications assessment of the stage of abortion; vacuum aspiration; treatment of infections, shock, tetanus, and anaemia; and evacuation of the uterus (Klingberg-Allvin et al., 2007; Mutua, Maina, Achia & Izugbara, 2015; Mutua, 2019). In situations where these services cannot be attained, a referral is quickly done (Mutua, 2019). Given the resource and facilities available at the referral facility, laparotomy or any indicated surgery may be recommended (Klingberg-Allvin et al., 2007).

For the management of complications of unsafe abortion, there are a number of procedures and technologies used. These include the use of medication abortion (MA) drugs, dilatation and curettage (D&C), manual/electrical vacuum aspiration (M/EVA), and digital evacuation (Izugbara et al., 2019). The reason for the vast array of management techniques is dependent on the facility type and the severity of complications (Bankole et al., 2018; Tsima et al., 2016). The choice of management technique is dependent on the availability of the technique as well as the human capital of the facility to use a technique (Bankole et al., 2018). Literature also holds that the choice to use a management technique is also

dependent on the severity of the complication (Clark et al., 2010; Blandine et al., 2012; Tsima et al., 2016; Bankole et al., 2018).

There is compelling evidence that medication abortion drugs and MVAs are more effective and safer compared to D&C (Gebreselassie et al., 2010; Tavrow, Withers, & McMullen, 2012; Osur et al., 2013; Suh, 2015; Makenzius et al., 2017). As such, in Uganda for instance, misoprostol was approved in 2013 to be used for the treatment and management of post-partum haemorrhage and incomplete abortion (Paul et al., 2014). Other studies also posit that misoprostol was effective 99.9% of the time in treating incomplete first trimester abortions (Adisso et al., 2014; Gaye et al., 2014). Again, extant literature postulates that misoprostol is tolerable, safe, and acceptable to the majority of women in SSA (Klingberg-Allvin et al., 2015; Maxwell et al., 2015; Makenzius et al., 2017). However, on its own, misoprostol is more likely to cause incomplete abortion, even when used correctly (Sedgh et al., 2016).

Despite the overwhelming health benefits and safety of misoprostol, it appears that health facilities in SSA predominantly provide D&C (Izugbara et al., 2019). For instance, Bankole et al. (2018) observed that D&C was commonly used for the treatment of 49% of post-abortion patients. Similarly, Paul et al. (2014) also found in their study that in Uganda, there were some barriers to the use of misoprostol. They identified restrictive drug policies as a significant barrier to the use of misoprostol in the treatment and management of post-abortion complications. Other factors identified for the low patronage of misoprostol included the poor accessibility and affordability of this drug (Nabudere, Asiimwe & Mijumbi, 2011; Nath, 2007). This finding is

inconsistent with Sedgh et al. (2016) which posits that juxtaposed to mifepristone, misoprostol costs much less and is far more widely available and accessible.

In the same vein, studies have shown that MVAs are less invasive, cost-effective, reduced the risk of maternal death and yielded more patient satisfaction compared to the use curettage (Adisso, Hounkpatin, Komongui, Sambieni, & Perrin, 2014; Mutua, 2019; Jacques, Edgard-Marius & Bruno, 2006; Shochet et al., 2012).

Availability and Accessibility to Post-Abortion Care Services

Accessibility to PAC services has been defined by Billings et al. (1999 cited in Rominski & Lori, 2015) as encapsulating issues pertaining to the cost of service/payment options; distance from the woman's home; social proximity to a provider; and, waiting time for services. On the other hand, availability to PAC services concerns the facility's capacity such as space, personnel, logistics, among others to render PAC services to patients (Maxwell, Voetagbe, Paul, & Mark, 2015; Mohamed et al., 2015). Improving availability and accessibility to PAC services is essential to the prevention of moderate to severe post-abortion complications and maternal mortality (Awoyemi & Novignon, 2014; Mutua et al., 2015; Bankole et al., 2018).

Currently, post-abortion care services are provided by both the private and public health service providers including clinical officers, nurses, physicians, and specialists such as obstetricians/gynaecologists and internists (Izugbara et al., 2019). This diverse cadre of care providers operates in a different facility including maternity homes, public health facilities, primary health care centres, teaching hospitals, etc. (Jaldesa, 2014; Namugenyi, &

Klingberg-Allvin, 2014; Ziraba et al., 2015). Results from a study by Bankole et al. (2018) to explore the severity and management of complications among post-abortion patients treated in Kinshasa health facilities suggest that 46% of PAC was provided by mid-level personnel such as nurses and midwives. However, 54% of the clients in this study received PAC services from physicians (Bankole et al., 2018). This situation of nearly half of women having received PAC services from mid-level care providers is significantly attributable to task shifting activities at health facilities or centres where PAC services are provided (Paul et al., 2014).

Task shifting is the process or system of delegating tasks to less specialized health providers (Paul et al., 2014). This system is used primarily as a result of the low supply of specialized human resources (Gessessew et al., 2011; Pereira et al., 2011; Chen et al., 2004). The practice of task shifting, also known as task sharing, is an effective way of optimizing the roles of available human resources by redistributing tasks among health workforce teams (Dawson et al., 2014). The strategic utilization of task shifting is agreed to enhance productivity and improve efficiency in the health care delivery process (Nabudere et al., 2011; Dawson et al., 2013).

In many contexts in sub-Saharan Africa (SSA), lower cadre providers have been cited to diagnose and treat incomplete abortions effectually as physicians (Bacon et al., 2014; Paul et al., 2014). For instance, a study by Berer (2009) on the provision of abortion by mid-level providers postulates that the utilization of task shifting officers in providing treatment for incomplete abortion will increase women's access to PAC. In the same vein, results from a qualitative study by Paul et al. (2014) indicate that task shifting

was present in the delivery of PAC services in Uganda, with midwives being the primary task-shifting officers. Paul et al. (2014) continue by asserting that as a result of the absence of adequate doctors, midwives are compelled to provide PAC services outside their defined task area.

The availability of PAC services, technologies, and providers is unevenly distributed across geospatial regions (Izugbara et al., 2019). Existing evidence from the literature suggests that PAC technologies, services, and the needed providers are predominantly situated in the urban areas, government-owned, NGO-owned facilities, big private, and referral hospitals (Okonofua et al., 2011; Ziraba et al., 2015; Campbell, Aquino, Vwalika, & Gabrysch, 2016). This is evident in the incidence of post-abortion complications recorded by place of residence. For instance, Barot (2014) posits that, in Rwanda, rural poor women are more likely to suffer severe complications of abortion due to the unavailability of PAC services, technologies, and providers. Likewise, Banerjee, Kumar, Warvadekar, Manning, and Andersen (2017) showed that abortion care services are free in India at public health facilities. However, it is mostly the poor women that seek abortion services at public health facilities, and the only cost incurred is the money spent on transportation and food. As such, poor women end up spending more on accessing abortion services at urban hospitals (Banerjee, Kumar, Warvadekar, Manning, & Andersen, 2017). These findings underscore the health inequalities in rural and urban areas.

Despite the seeming unavailability of PAC services to rural dwellers, Gebreselassie et al. (2010) emphasize that unlike another context as in the case of Uganda, Ethiopia is experiencing an increase in the number of state facilities in the rural areas, hence, contributing to the reduction in the

incidence of abortion-related complications. This growing number in state-owned facilities in rural Ethiopia to provide PAC services has been attributed to the fairly flexible abortion law in Ethiopia (Dibaba et al., 2017). However, in settings that the rural health bureaucrats have a double-blind approach to handling the abortion policy, it leaves the service providers with uncertainties as to whether to provide the service or not (Haaland, Haukanes, Zulu, Moland, & Blystad, 2020) and that can have ripple effects on the availability of PAC services to patients who need it.

In the quest to enhance availability and accessibility to PAC services, particularly within the sub-region, some measures have been identified to be quintessential to this effect. Studies have identified male involvement programmes, systematic contraceptive counselling, provider-training sessions, recognition of the patients' autonomy to privacy and confidentiality, and, supportive supervision for providers to be critical for ensuring the availability and accessibility of PAC services to patients (Rasch et al., 2005; Rasch & Lyaruu, 2005; Clark et al., 2010; Paul et al., 2014). For instance, in a qualitative work by Paul et al. (2014), it was found that the lack of training for midwives limited their capacity to effectively perform task shifting PAC services; therefore, they recommended the training of all task shifting officers to enable effective provision of PAC services even in the absence of physicians.

Such training for mid-level providers is essential to boosts their volition and capacity to provide PAC services, reduce delaying in managing patients, as well as expanding access to PAC services (Akiode, Fetters, Daroda, Okeke, & Oji, 2010; Clark et al., 2010; Mayi-Tsonga et al., 2012).

Evidence from Tanzania also suggests that community mobilization and targetted outreaches, as well as the involvement of males in PAC programmes, constituted some of the measures that have been rolled out to enhance accessibility and availability of PAC services (Rasch & Lyaruu, 2005; Fetters, Samandari, Djemo, Vwallika, & Mupeta, 2017).

Post-Abortion Contraception and Family Planning Services

Post-abortion care comprises both curative care (treating incomplete abortion and its complications) and preventive care (contraceptive counselling and services) (Huber et al., 2016; Owolabi, Biddlecom & Whitehead, 2018). To avoid repeat unwanted pregnancies, post-abortion contraceptive counselling, and family planning services offer education to PAC clients (Paul et al., 2014; Samuel, Fetters, & Desta, 2016). Other studies have also suggested that contraceptive counselling and family planning offered to post-abortion patients is important for preventing unwanted pregnancy and STI/HIV infections (Izugbara et al., 2019; Rasch et al., 2006; Johnson et al., 2002). According to Sullivan et al. (2018), post-abortion family planning enables patients to become knowledgeable about the various alternatives at their disposal. This knowledge gained is essential to the prevention of unwanted pregnancies and the need for repeated abortions (Owolabi, Biddlecom & Whitehead, 2018; Izugbara et al., 2019).

Despite the benefits and acceptability of post-abortion family planning and contraceptive counselling, many facilities refrain from providing such services (Rasch et al., 2005; Kinaro et al., 2009; Tesfaye & Oljira, 2013; Evens et al., 2014). A plausible explanation for this observation may include the restrictive nature of abortion laws in the majority of the countries in SSA

(Dibaba et al., 2017; Sully et al., 2018). Such restrictive laws render health providers confused as to whether providing post-abortion family planning and contraceptive counselling will be against the law (Marlow et al., 2014).

In SSA, the most pervasive contraceptive methods provided to post-abortion patients include oral contraceptive pills (Benson, Andersen, Healy, & Brahmi, 2017); injectables (Kalu et al., 2012); and, condoms as well as intrauterine devices (IUDs) (Ogu et al., 2012; Rominski et al., 2015; Makenzius et al., 2018). In a multi-country study (Ghana, South Africa, Ethiopia, and Zambia), it was found that implants were received by 24%, 15%, and 8% of women in Ethiopia, Ghana, and Zambia respectively (Benson, Andersen, Healy, & Brahmi, 2017). In that same study, it was also found that injectables were received by 37% and 88% of women treated for abortion complications in Ghana and South Africa; however, IUD was the least method accepted in South, Ethiopia, Ghana, and Zambia (Benson, Andersen, Healy, & Brahmi, 2017).

It is worth noting that in areas where abortion is legal, PAC services and programs are tailored towards the provision of stand-alone post-abortion family planning whereas in states where abortion is illegal, post-abortion family planning is a single service (Curtis, Huber, & Moss-Knight, 2010). This is done to ensure that everyone who needs post-abortion family planning or contraceptive counselling gets access to it. Although this position is theoretically sound, some studies posit that post-abortion family planning and contraceptive counselling must be integrated into PAC as one service instead of standalone interventions (Ferreira et al., 2010; Prata et al., 2011; Paul et al., 2014; Owolabi et al., 2018). For instance, Owolabi et al. (2018) postulate that

post-abortion family planning is provided at the same time and location as a clinical treatment for complications. This is supported with the rationale that it has greater chances of increasing accessibility to contraceptives and family planning services, thereby, facilitating the uptake of contraceptive methods and preventing unwanted pregnancies (Johnson et al., 2002; Okonofua et al., 2011; Huber et al., 2016).

Studies have shown that the combination of post-abortion contraceptive counselling with the actual provision of the contraceptives significantly enhances the utilization of modern contraceptive methods including IUD, oral contraceptives, implants, Depo Provera, and bilateral tubal ligation (Rasch et al., 2005; Okonofua et al., 2011; Rominski et al., 2015; Huber et al., 2016; Samuel et al., 2016). For instance, evidence from Zambia indicates that following the receipt of contraceptive counselling, more women reported using high effective contraceptives; this translated into a lower incidence of unplanned pregnancies (15%) and fewer repeated abortions (Johnson et al., 2002). Similarly, Rasch et al. (2004) found that 86 percent of patients who received contraceptive counselling kept using contraception 1-6 months after their discharge.

The uptake of contraceptives and family planning among PAC patients has been noted to be associated with several determinants including parity, health facility type, age, prior contraceptive use, as well as partner's attitudes towards contraceptives (Prata et al., 2011; Benson, Andersen, et al., 2017; Asrat et al., 2018; Hagos et al., 2018; Makenzius et al., 2018). For instance, Rasch and Lyaruu (2005) found that, in Tanzania, the involvement of men in contraceptive counselling yielded an increase in women's uptake for FP and

contraceptives. This observation is attributable to the elevated status ascribed to men as the main decision makers for households (Morrell, Jewkes & Lindegger, 2012); therefore, involving men in FP and contraceptive counselling provides the platform to demystify their perceptions about FP and propel them towards a better appreciation of post-abortion FP and contraceptive counselling.

In the same vein, Prata et al. (2011) found that education was positively associated with the uptake of post-abortion FP and contraceptives. Thus, the higher the educational status of a woman, the more likely they are to take up post-abortion FP and contraceptives. This observation may be explained in the perspective that education empowers women to be autonomous to take critical decisions including decisions that concern their health and wellbeing, hence, resulting in an increased uptake of post-abortion FP and contraceptives (Larsson & Stanfors, 2014). Misinformation and misperceptions about FP and contraceptives are very influential in limiting PAC patients from receiving FP and contraceptives (Penfold, Wendot, Nafula, & Footman, 2018). For instance, Penfold et al. (2018) posit that fear of adverse events of FP and contraceptives warded off PAC patients from taking up modern contraceptives. Therefore, education becomes imperative for eliminating such perceptions and fears.

Characteristics of Post-Abortion Care Users

Post-abortion care clients vary in age, parity, marital status, place of residence and experience with family planning (Ziraba, et al., 2015; Ishoso, Tshefu, & Coppieters, 2018; Bankole, et al., 2018; Gebreselassie, Gallo, Monyo, & Johnson, 2005; Mutua, Achia, Manderson, & Musenge, 2019).

Evidence shows that in Kinshasa, DR Congo, adolescents (aged 19 years and below) constitute a quarter (25%) of those admitted for treatment for complications of unsafe abortion (Ishoso et al., 2018). This is probably because adolescents are more likely to delay health care or they will be unable to seek health care due to stigmatization (Kumar et al., 2009); poor or no knowledge as to where to find help; lack of financial capacity to seek early post-abortion care; attitudes of health workers (Bruyn & Packer, 2004). Hence, they report with moderate to severe abortion complications and constitute a significant proportion of PAC patients (Onwudiegwu, 2012; Kalilani-Phiri et al., 2015; Maxwell et al., 2015; Ishoso et al., 2018).

Extant studies postulate that in DR Congo and Nigeria, single women and women with higher incomes presented more for PAC compared to married, older, and poorer women (Awoyemi & Novignon, 2014; Bankole et al., 2018; Ishoso et al., 2018; Ushie et al., 2018). This finding is probably attributable to the fact that single women do not have partners for whom they would have to discuss the issue before deciding to seek PAC services; likewise, women with higher incomes are usually empowered to be autonomous and capable of taking critical decisions concerning their health and wellbeing (Larsson & Stanfor, 2014). Hence, they can decide to seek PAC services on their own accord compared to their counterparts who are married and/or poor (Larsson & Stanfor, 2014; Bankole et al., 2018; Zafer et al., 2018).

Besides the personal characteristics of PAC patients, they also possess diverse clinical symptoms (Izugbara et al., 2019). Clinical symptoms ranging from instrumental injury, system or organ failure, gangrenous uterus, low

blood pressure, weak pulse, pelvic infection, presence of a foreign body in the genital tract, sepsis, uterine perforation, and gut injury, are presented by PAC patients (Gebreselassie et al., 2005; Henshaw et al., 2008; Ziraba et al., 2015; Bankole et al., 2018; Ishoso et al., 2018). Other PAC patients may include women who experienced either spontaneous or self-induced abortions as well as induced abortions performed by quacks, boyfriends, husbands, family members, friends or traditional birth attendants (TBAs) (Gebreselassie et al., 2005; Izugbara, Egesa, & Okelo, 2015; Mohamed et al., 2015; Ziraba et al., 2015; Bankole et al., 2018). All of these form the basic characteristics of PAC patients.

Client's Views on Post-Abortion Care

Depending on the frequency, method, and location for seeking abortion services, people tend to have different experiences motivated by diverse factors that influence their views (Gaye, Diop, Shochet, & Winikoff, 2014; Adde, Darteh, Kumi-Kyereme, & Amu, 2018). Clients' perceptions or views on PAC services are formed and reinforced by the attitudes of providers (Everns et al., 2013). For instance, a study by Arambepola, Rajapaksa, and Galwaduge (2014) indicates that women who presented with induced abortion were less satisfied as compared to their counterparts who presented with spontaneous abortion. Their dissatisfaction was mainly as a result of verbal harassment for their abortion status and breaching of confidentiality of their health status to family members and other health workers at the facility (Everns et al., 2013; Arambepola, Rajapaksa, & Galwaduge, 2014). On the other hand, a facility-based study in Ghana observed that PAC clients were generally satisfied with post-abortion care services received, primarily because

of the swift response by service providers in providing early treatment and having a positive attitude towards the PAC clients (Adde, Darteh, Kumi-Kyereme, & Amu, 2018).

Available evidence suggests that PAC patients develop their views on PAC services based on the ease of accessing PAC services (Penfold et al., 2018). For instance, Smith, Ly, Uk, Warnock, and Free (2017) assessed women's view on receiving post-abortion contraception intervention via mobile-phone. Their findings revealed that women had a positive view of PAC services because the mobile phone service made the entire process convenient and cost-effective. Penfold, Wendot, Nafula, and Footman (2018) also posit that these facilities guaranteed being cost-effective and discrete in their dealings. Thus, women are very concerned with issues relating to trust, privacy, and confidentiality from their service providers (Cotter et al., 2020). Hence, convenience is a significant predictor of the clients' views about PAC services.

It is worth noting that most clients perceive PAC services as a last resort. This is evident in a study by Oyeniran et al. (2019) which revealed that in Southwestern Nigeria, women did not envisage seeking post-abortion care services while inducing an abortion because they expected favourable results from the abortion. Hence, when they experienced complications, the first call for them is to seek help from home; and if all help fails, then they resort to PAC services from health facilities (Oyeniran, et al., 2019). This delay in seeking PAC services may be attributed to the stigma and other associated negative social ascriptions (Casey, et al., 2019). Hence, PAC patients would rather opt to suffer complications and eventually seek PAC services than to

bear the shame from society (Everns et al., 2013; Rogers, Sapkota, Paudel, & Dantas, 2019).

Trust, privacy and confidentiality were also found to be overlapping in the narratives of women's experience of PAC services (Cotter et al., 2020). The client's narratives show that they experienced trust, privacy and confidentiality at the health facilities and this helped in establishing trust and rapport with the service providers. To the clients, PAC services should always be direct, accurate and private (Cotter et al., 2020). Tagoe-Darko (2013), Netshinombelo et al. (2022) and Ourdrago and Juma, (2020), on the other hand, observed that PAC clients did not experience privacy and confidentiality and as such do not have trust in the service providers. This the women attributed to the stigma of seeking PAC services. Women seeking PAC services were labelled as killers, sinners and bad influences. As such, some service providers disclose their information to the police.

Providers Views and Attitude towards Post-Abortion Care Services

The attitude of health professionals to PAC patients plays a major role in their experiences at the health facility. To the clients, a positive attitude of health professionals encourages them to seek timely PAC services (Mutua et al., 2018). In most resource-constrained settings, as it is in SSA, abortion-stigma transcends beyond the patient to include the providers (Harries, Cooper, Stebel & Colvin, 2014). This stigmatization suffered by PAC providers goes a long way to influence their attitudes towards PAC services and PAC patients (Botes, 2000). This situation causes moral distress as well as dampens the providers' volition and commitment to deliver timely, thoughtful, and supportive abortion care and thus, indirectly contribute to an increase in

maternal mortality due to unsafe abortions (Rehnström Loi et al., 2015). For instance, Rehnström Loi et al. (2015) in a systematic review found that nurses and midwives had a negative attitude towards PAC services and PAC patients. This observation was made primarily due to the fact that both the nurses and midwives induced abortion was 'terminating motherhood' and therefore viewed women who opt for abortion as having denied their role as mothers (Mayers et al., 2005; Harries et al., 2014).

The attitude of providers towards PAC patients has also been noted to be shaped by the disclosure of information from patients (Paul et al., 2014). Paul, Gemzell-Danielsson, Kiggundu, Namugenyi, and Klingberg-Allvin (2014) found that in Uganda, providers had a positive attitude towards PAC services; however, they expressed frustration in dealing with PAC clients since these patients refuse to divulge what happened, thereby increasing assessment time and complicating the service provision. Hence, out of frustration, service providers spew harsh treatment towards PAC patients (Paul et al., 2014).

Besides the stigma and non-divulgence of information that frustrates PAC providers to exert negative attitudes towards PAC patients, it has been recognized that PAC service providers may have conflicting moral values to the provision of abortion service (Rehnström Loi et al., 2015; Cleeve et al., 2019). For instance, evidence from Uganda postulates that service providers are torn between the conflict of morality and duty which appears to be negatively influencing the attitude of service providers as well as the quality of care provided, particularly for women presenting for complications from induced abortion (Cleeve et al., 2019).

It is important to note that the attitude of a PAC service provider is said to be negative when that service provider perceived PAC services as sinful and as nothing they could support (Paul et al., 2014). Essentially, service providers with negative attitudes towards PAC services or PAC patients are most probable to have less experience and training (Warenius et al., 2006; Abdi & Gebremariam, 2011; Paul et al., 2014). For instance, Abdi and Gebremariam (2011) found that in Ethiopia, PAC providers with experience and training were 2.5 times more likely to exert positive attitudes towards PAC services. Therefore, training and education need to be effectual to facilitate the formation of positive provider attitudes towards PAC services. In Ghana, it was revealed that the clients were generally happy with the attitudes of the service providers (Adde et al, 2018), citing reasons such as the service providers being friendly, and nice and regularly checking up on them to see their general welfare.

Studies also show that some clients experienced negative attitudes from service providers. These negative attitudes exhibited by the service providers include insulting and provocative behaviour of health professionals (Adde et al., 2018; Mutua et al., 2018; Netshinombelo et al., 2022). The study by Mutua et al. (2018) also reported that the negative attitude of service providers could be attributed to the uncertainty surrounding the legality of abortion. As such, service providers discriminate against women seeking abortion-related care services, and are unresponsive and unsupportive to them (Mutua et al., 2018).

Quality of Post-Abortion Care Services

Quality of PAC services is geared towards the provision of timely interventions that minimize the risk of maternal mortality emanating from unsafe abortions, irrespective of it being induced or spontaneous (Mutua, 2019). In the perspective of Corbett and Turner (2003), the quality of PAC services is quintessential to the promotion of the safety and wellbeing of women who have had an abortion. Broadly, quality of PAC services can be viewed from the perspective of five levels: the patient, service provider, facility of care, policy, and legal environment for care delivery (Barua & Apte, 2007).

Essentially, women have the right to receive quality emergency treatment for complications arising from abortions, irrespective of the personal characteristics including age, political beliefs, marital status, among others (Rawlins, 2001). Quality of PAC services has been thought of as a significant step towards the advancement of the rights of women (León et al., 2006). Quality of PAC services has also been known to be essential to the prevention of future unintended pregnancies (Riley et al., 2020). Despite the importance of the quality of PAC services, it appears to be an under researched theme in SSA (Izugbara et al., 2019). Therefore, it is worth exploring the quality of PAC services.

In the discussion or evaluation of the quality of PAC services, the Donabedian quality of care framework is usually used (Riley et al., 2020). This framework encapsulates both process indicators (the standards of care delivered from provider to patient) and structure indicators (the environment where care is delivered) (Donabedian, 1988 cited in Riley et al., 2020).

Specifically, the structure indicators are measured by signal functions; that is, a shortlist of significant life-saving interventions that treat abortion complications and measure the capacity and structural quality of PAC (WHO, UNFPA, UNICEF & AMDD, 2009). The process indicator, on the other hand, encompasses the measure of the quality of PAC services through the provision of evidence-based standards of care (Huber et al., 2016).

There is compelling evidence which suggests that there are variations in the quality of PAC services between countries, the urban-rural dichotomy as well as between patients, providers and the facilities (Graff & Amoyaw, 2009; Izugbara et al., 2015; Maxwell et al., 2015; Campbell et al., 2016; Mutua et al., 2017; Riley et al., 2020). For instance, in a study conducted by Riley et al. (2020) to evaluate the quality and coverage of PAC in Zimbabwe, it was found that at the population level, the health system had only 41% of the recommended basic PAC facilities and 55% of the recommended comprehensive PAC facilities. Thus, the capacity of health facilities to provide quality PAC services was fairly poor. This finding is consistent with other studies conducted in other contexts including Zambia (Campbell, Aquino, Vwalika & Gabrysch, 2016), Kenya (Mutua et al., 2017), and Nepal (Bell, Zimmerman, Choi & Hindin, 2018).

Other studies have postulated that there is a growing use of medication abortion and MVA in the treatment of incomplete abortions (Prata et al., 2013; Jaldesa, 2014; Suh, 2015). Yet, the use of forceps evacuation, D&C as well as the use of bare-finger (digital) continue to be more pervasive in the treatment of incomplete abortions in several contexts (Basinga et al., 2012; Cook, de Kok, & Odland, 2017; Bankole et al., 2018; Madziyire et al., 2018). This may

be attributable to the restrictive drug policies surrounding the use of medication abortions in some contexts such as Uganda (Paul et al., 2014). Cook, de Kok, and Odland (2017) also identified a number of factors that accounted for the low uptake of MA and MVAs: the familiarity with the use of curettage, lack of training on how to use MVA, health workers' attitudes towards PAC, and low supervision of PAC service rendered. All of these come together to influence the low uptake of MA and MVA and the wider spectrum of quality of PAC services.

Age and parity have also been identified as being associated with the quality of PAC services received in Kenya (Mutua et al., 2015; Izugbara et al., 2019). For instance, Mutua et al. (2015) found that, in Kenya, older women were more likely to receive better quality of PAC (measured in terms of timely treatment at presentation, contraceptive counselling upon discharge, treatment by qualified personnel, use of appropriate technology) juxtaposed to younger women.

Currently, interventions to improve the quality of PAC services may include addressing human resource shortages at facilities (Riley et al., 2020) as well as the provision of regular in-service training and revamping the supervision of PAC services rendered (RamaRao, Townsend, Diop & Raifman, 2011). It is also posited that enhancing teamwork between various cadre of health providers and task-shifting officers can be significant in improving the quality of PAC services provided to PAC patients (Firth-Cozens, 2001; Riley et al., 2020). In the same vein, Izugbara et al. (2019) postulate in their systematic review that upgrading facilities, providing capacity building for health providers, and task-shifting to nurses and other

mid-level cadres of care providers will be essential to improving the quality of PAC services. For instance, in Senegal, Gaye et al. (2014) observed that the training of mid-level providers increased the availability of skilled providers as well as improved the use of quality PAC methods and treatment satisfaction. Likewise, following the training of mid-level providers, the proportion of uterine evacuation procedures performed with MVA increased from 14% to 50% of procedures in intervention facilities in Ethiopia (Fetters et al., 2008; Prata et al., 2013).

Other studies have also suggested that the adoption of harm reduction mechanisms coupled with community mobilization and proper care of PAC equipment are imperative to improving the quality of PAC services (Prata et al., 2013; Tumasang, Leke, & Aguh, 2014; Paul et al., 2014; Klingberg-Allvin et al., 2015; Chukwumalu, Gallagher, Baunach, & Cannon, 2017; Fetters et al., 2017; Kiemtore et al., 2017; Bain & Kongnyuy, 2018; Benson et al., 2018).

Communication was also a key component of quality of post-abortion care services. Communication and supportive care were conceptualised as how service providers interacted with the clients by using appropriate language and being respectful to clients. From the study of Cotter et al. (2020), clients perceive service providers to be supportive when they provided accurate information about potential side effects and pain the procedure might come with. Clients were of the notion that a key component of communication and supportive care was when service providers were transparent and personalised communication (Cotter et al., 2020; Ourdrago & Juma, 2020). Ourdrago and Juma (2020) showed similar results where clients would have preferred

service providers to communicate to them the reason for a particular PAC method.

Clients were happy with their PAC experience when service providers personalised the care to the client's needs by asking questions to know the needs of the individual. The clients' experience from Cotter et al. (2020) showed that service providers were usually not transparent with post-abortion family planning. Clients were usually given incomplete information about the process. Hence, clients experience side effects without prior knowledge, which affects their tendency to use family planning negatively.

Studies showed that clients generally would prefer to be involved in treatment decision-making (Penfold et al., 2018; Ourdrago & Juma, 2020). Clients experienced disappointment when their preferred method of treatment was not used. The clients, however, obliged with the choice of service providers with reference to the statement they are professionals and know what is best (Penfold et al., 2018; Ourdrago & Juma, 2020).

Barriers to the Provision and Utilization of Post-Abortion Care Services

Available evidence suggests that several factors act as barriers to the provision and utilization of PAC services (Izugbara et al., 2019). These factors can be categorized as individual, community, provider, and health system-level barriers (Kinaro, Mohamed Ali, Schlangen, & Mack, 2009; Clark et al., 2010; Mutua, Maina, Achia, & Izugbara, 2015; Campbell, Aquino, Vwalika, & Gabrysch, 2016). These barriers may lead to delays in seeking prompt PAC services, thereby exacerbating the tendency for severe complications and death (Izugbara et al., 2019).

The individual-level barriers are the personal characteristics of the client that challenge their quest to access and utilize PAC services. These barriers may include the place of residence of the woman, gender, educational level, marital status and wealth index (Gebreselassie, Gallo, Monyo, & Johnson, 2005; Ziraba, et al., 2015; Bankole, et al., 2018; Ishoso, Tshefu, & Coppieters, 2018; Mutua, Achia, Manderson, & Musenge, 2019; Riley et al., 2020).

For instance, Coast and Murray (2016) found in their study that in Zambia, adolescents possessed lower levels of awareness on the legality of abortion and was thus, the main barrier to seeking abortion services. Although the cost of the service was low, adolescents could not afford it since they were not financially independent (Coast & Murray, 2016). Women who were not able to afford their bills at private hospitals were denied certain procedures until they could afford them or transferred to public facilities (Mutua et al., 2018). In public facilities where all services are supposedly free, women are not able to pay for their indirect costs such as toiletries and bathing accessories (Mutua et al., 2018). A similar experience was shown among PAC clients in Ghana even though Ghana has a National Health Insurance Policy. The narratives of the women showed that even for the health insurance, they had to pay some bills which were not covered and this left the women disappointed (Adde et al., 2018), being detained at the health facilities (Adde et al., 2021).

Mutua et al. (2018) also observed that in Kenya, the mode of payment was also a challenge as well as the payment before every service policy. Women who reported at the health facilities with cash and not mobile money (M-Pesa) were required to walk long distances in search of mobile money

services. This was because M-Pesa was the only accepted mode of payment at the health facilities. This, therefore, restricted PAC services to even women who could afford to pay for the service.

Even when these adolescent PAC patients can afford PAC services, they are exposed to high risk of provider-stigmatization and mistreatment, which prevents them from seeking PAC services (Evens et al., 2014; Izugbara et al., 2015). Similarly, Mutua, Maina, Achia, and Izugbara (2015) also observed that in Kenya younger women and women without education are more likely to delay in seeking and utilizing PAC services. This is primarily because such women lack greater autonomy in decision making concerning their health and wellbeing; for that matter, they would have to discuss with their partners before they could take up PAC services (Rehnström Loi et al., 2018).

With respect to the community-level barriers, studies have shown that cultural factors and lack of community support are some of the barriers to post-abortion care services (Cleeve, Faxelid, Nalwadda, & Klinberg-Allvin, 2017; Mohamed, Diamond-Smith, & Njunguru, 2018). Most communities within the SSA context have restrictive laws on abortion (Mutua et al., 2015). For that matter, there is intense stigmatization that is attached to abortion and PAC (Aniteye, O'Brien & Mayhew, 2016). This is probably because communities in SSA predominantly ascribe to the pro-life ideology; hence, seeking PAC services is perceived as morally wrong and culturally unacceptable (Levandowski et al., 2012; Cockrill & Nack, 2013; Payne et al., 2013). As such, as a way to avoid shame from the ridicule of the society for

seeking PAC services, its utilization is likely to be low (Aniteye, O'Brien & Mayhew, 2016).

The provider-level barriers significantly have to do with the attitudes of PAC service providers (Riley et al., 2020) as well as the capacity of the providers to efficiently and effectively provide PAC services (Paul et al., 2014). For instance, in a qualitative study by Paul et al. (2014), it was found that PAC service providers in Uganda lacked the requisite training and competencies to provide PAC services effectively. Other studies have also asserted that in SSA, poor provider attitude, conscientious and religious objections by some providers also act as barriers to the provision of PAC services (Rasch et al., 2005; Onah, Ogbuokiri, Obi, & Oguanuo, 2009; Voetagbe et al., 2010; Bacon et al., 2014; Chiweshe & Macleod, 2017; Faundes & Miranda, 2017; Izugbara, Egesa, Kabiru, & Sidze, 2017; Mutua, Manderson, Musenge, & Achia, 2018; Håkansson, Oguttu, Gemzell Danielsson, & Makenzius, 2018).

In the study of Mutua et al., (2018), clients were not happy with the technical performance they experienced from service providers. To them, the poor surgical and medical care could be attributed to the lack of clarity on abortion law and the lack of care guidelines. Clients, thus, expressed having experienced repeat procedures due to inadequate provider skills. Clients also felt they experienced "revacuations" because the service providers were unable to make the right diagnosis (Mutua et al., 2018). In South Africa, clients' experience showed that service providers do not provide clients with any medication for pain management (Netshinombelo et al., 2022). Contrary to the above findings, Adde et al. (2018) found that in Ghana, PAC clients

experienced service providers with which they rated to have good technical performance. This was against the backdrop that the women were happy with the outcome of their treatment since they did not experience any further complications.

Facility-level barriers including lack of space and privacy, as well as the shortage of supplies, equipment, and contraceptives, limited the provision of PAC services to PAC patients (Paul et al., 2014). Other critical facility-level barriers that impede the provision of PAC services in SSA include non-availability of medications, stock-outs, lack of basic supplies, obsolete and deteriorating equipment, and lack of adequate facility space (Osur, Baird, Levandowski, Jackson, & Murokora, 2013; Sully et al., 2018). For instance, Reiss et al. (2017) found a low level of knowledge among pharmacy workers in Senegal regarding misoprostol uses, registration status, treatment regimes, and side effects. Hence, pharmacy workers are reluctant to stock and have a low provision of misoprostol, especially selling it for reproductive health purposes (Reiss, et al., 2017). This reluctance to use misoprostol may be attributed to restrictive policies and fears that one would be answerable if complications developed following the use of misoprostol (Tagoe-Darko, 2013; Paul et al., 2014).

Another facility level barrier to the utilisation of PAC services is the clients' experinece with diginity and respect at the health facilities. Cotter et al. (2020) showed that in Kenya, clients' experiences depict that they were not treated with dignity and respect at the government health facilities. Clients expressed the feeling of being dignified and respected when treatment was received at a private health facility as compared to government facilities.

Hence, women contextualised their positive experiences based on the negative experiences they received at government hospitals. The clients' experiences also depict that service providers at private facilities follow up on their clients with phone calls to check up on them. Similarly, Netshinombelo et al. (2022) also observed that in South Africa, women seeking PAC services experience being treated without dignity and respect at health facilities. This mistreatment includes clients' narratives that showed they were discharged from the facility even while they were in pain.

This mistreatment was, however, not the case for women who presented with complications from spontaneous abortion. Women who reported complications from spontaneous abortion narrated that they experience a treatment that was with dignity and respect. On the other hand, women who presented with complications from induced abortion reported that service providers did not have the patience to provide them with painkillers or explain to them why they should take their medications and the side effects; those who presented with spontaneous abortion were given preferential treatment (Netshinombelo et al., 2022).

Conceptual Framework for the Study

Based on the above models discussed, the current study adapted the Donabedian (1988) quality of care as the conceptual framework. The study measured the quality of post-abortion care services using the three approaches; namely, structure, process, and outcome in relation to the elements of post-abortion care services.

The structure measures the quality of amenities which has to do with infrastructure as well as suppliers and equipment. The structure also measures

the pre and post-procedure waiting and recovery time, and the PAC procedure room. This was done to examine if the amenities in the various facilities meet the requirement for the provision of quality post-abortion care.

The process measures the technical and interpersonal qualities of the service providers. This looked at issues relating to the knowledge of the service providers regarding post-abortion care and workshops, seminars and capacity building programs attended to increase their knowledge and practices in the provision of post-abortion care services. The process also enabled the study to measure the interpersonal skills of the service providers, thus, how they are able to interact with the clients in providing them with treatment and counselling.

Regarding the outcome, this measured the effect of the care provided to the post-abortion clients, and the satisfaction the client derived from the service that was provided to her at the facility. The outcome also measured the link between post-abortion care and other reproductive health services provided at the facilities. The outcome was also measured by looking at the community and the patient, and by examining who has greater or lesser access to PAC services and who derives greater or lesser quality of post-abortion care services.

The Donabedian (1988) quality of care framework, however, has some weakness and hence needed adaptation for this study. The progression from structure to process to outcome was too linear (Kajonius & Kazemi, 2016) and consequently would not permit to measure how these domains interact with each other to enable the provision of quality PAC services. The model also did not factor in antecedent characteristics such as the environment (physical

characteristics, service providers, cultural beliefs, etc) and patient characteristics (age, type of abortion, etc) which are important in measuring the quality of PAC services (Kajonius & Kazemi, 2016). The Donabedian (1988) quality of care framework was therefore complemented with the four-level model of the health care system by Ferlie and Shortell (2001) and the optimising performance and quality theory (IntraHealth International, 2013). The four-level model of the health care system will enable the study to be able to measure the three domains of the Donabedian quality of care by incorporating the characteristics of the individual patient, the service providers, the organisation and the political and economic environment for which PAC is being provided.

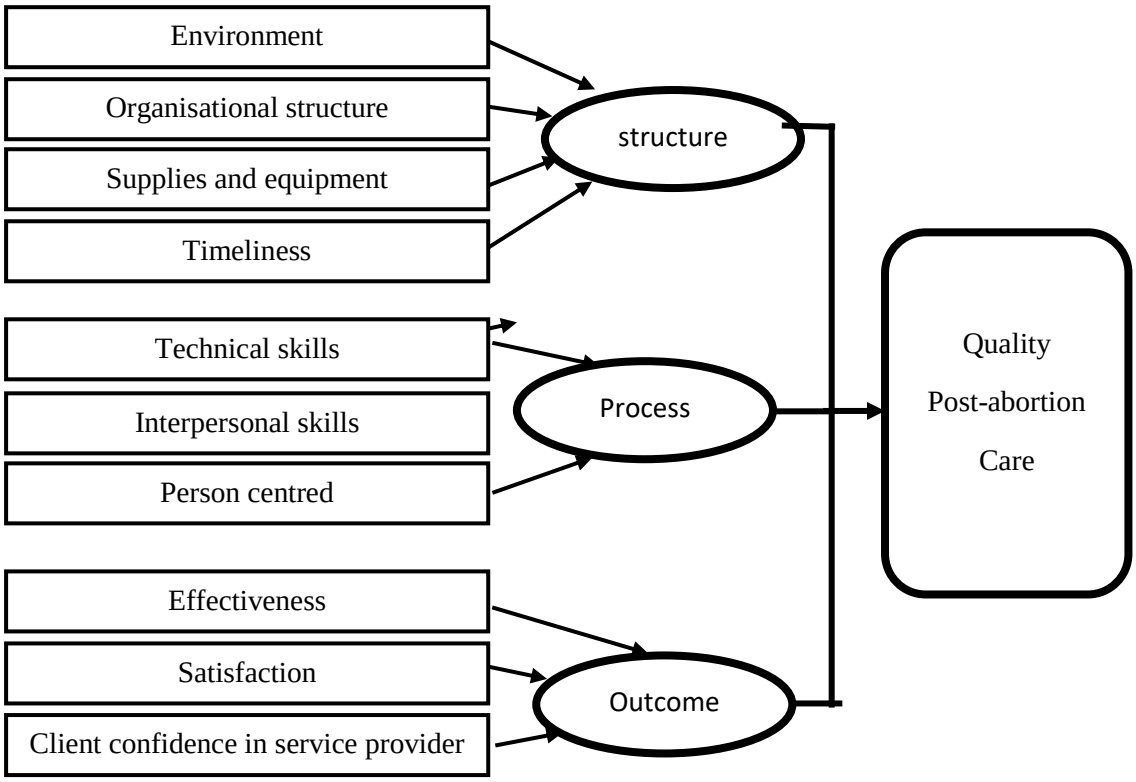

Figure 1: Conceptual Framework
Source: adapted from the Donabedian model of quality care (Donabedian, 1988)

Optimising performance and quality theory (IntraHealth International, 2013) also enabled the study to measure how the three domains (structure, process and outcome) influence and interact with each other to provide quality PAC services.

The Donabedian (1988) quality of care was adapted as the framework for the study because among all the models and theories reviewed, this best fits the health care system than the others. It is easy to measure, helps to avoid the need for multiple processes and outcomes required for complex settings, measures the care patients receive, detects problems without having to wait for poor outcomes to become apparent and directly suggests targets for quality improvement. The framework is also useful when evidence-based processes of care is not available or technical skill involved in accessing quality of PAC procedures (Mountford & Shojania, 2012). Although the other models are also for measuring the quality of care, they are more suited for measuring the quality of businesses (Seth & Deshmukh, 2005; Ghotbabadi, Feiz, & Baharun, 2015).

CHAPTER FOUR

METHODS OF DATA COLLECTION AND ANALYSIS

Introduction

This chapter introduces the methods for data collection and analysis for the study. Specifically, it covers the study area, philosophy of the study, study design, sources of data, target population, inclusion and exclusion criteria, selected number of participants, selected number of facilities, selection of participants, research instrument, pre- testing, data collection procedure, and data management. Also critical among the issues discussed in this chapter are data analysis and ethical considerations.

Study Area

The study area for this study is the Greater Accra region. Greater Accra region has the smallest area among Ghana's 16 administrative regions, with a total land surface of 3,245 square kilometres. This represents 1.4 percent of the total land area of Ghana. However, it is the most populated region in Ghana, according to the 2021 Population and Housing Census (GSS, 2021). The region is also the most urbanised region in Ghana with about 87 percent of its populace living in urban centres (Songsore, 2016). The capital city of the Greater Accra region, Accra is at the same time the capital city of Ghana (GHS, 2020).

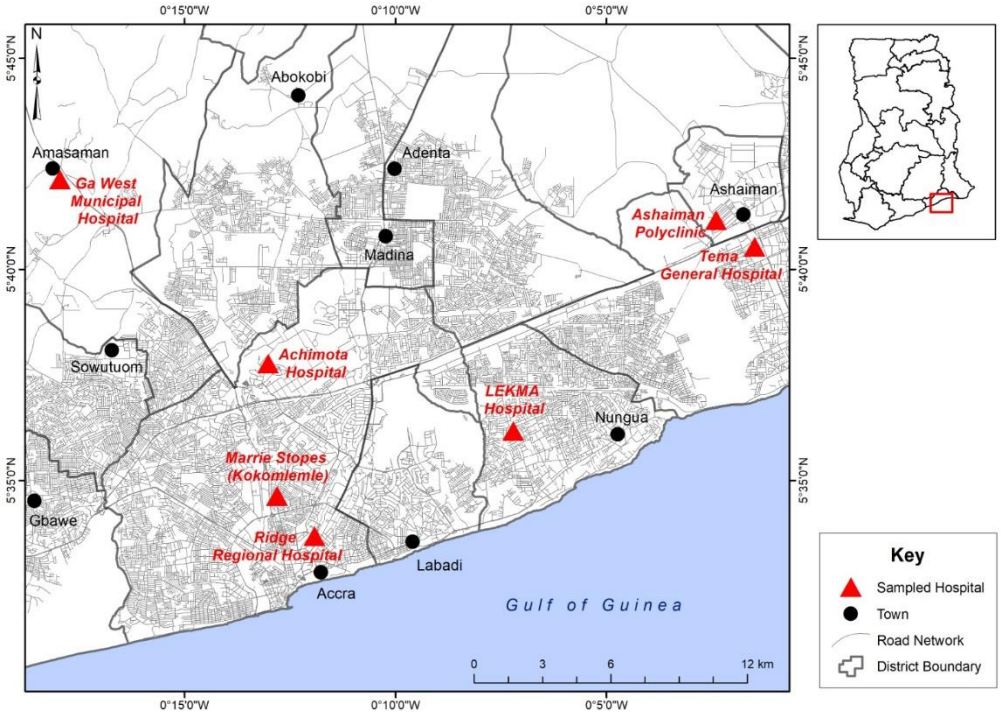

Figure 2: Map of study area

Sexual and Reproductive Health Characteristics

The region has the highest unmet reproductive health needs (contraceptive service use, obstetric care, and antenatal care) (29.3%). Greater Accra recorded the highest rate of induced abortion (14.7%) and miscarriage (14.2%) in Ghana in the latest maternal health survey (GSS, GHS, ICF, 2018; GSS, GHS, ICF International, 2015). The region also recorded the highest rate of women who ever had an induced abortion (26.4%) GSS, GHS, ICF, 2018; GSS, GHS, ICF International, 2015).

Health Facilities in the Region

The region has a regional hospital, eight district hospitals, 99 private hospitals, 14 polyclinics, and 362 health centres/clinics (GHS, 2018). Specifically, the study was conducted in seven health facilities selected exclusively from the Greater Accra region; namely, Ashaiman Polyclinic, Marrie Stopes (Kokomlemle), Ga West Municipal Hospital, Ridge Regional

Hospital, Lekma Hospital, Achimota Hospital and Tema General Hospital. These facilities were selected on the bases of recording a minimum of 200 abortion cases in 2019 (GHS, 2020).

Philosophy of the Study

The study was guided by the interpretivist philosophy in social sciences. While positivism guides the conduct of quantitative research, interpretivism forms the basis of qualitative research (Merriam, 2009; Khan, 2012; Pervin & Mokhtar, 2022).

The research questions were answered with the interpretivism paradigm since these research questions do not have an objective reality (Khan, 2012). The first objective, for instance, revealed the multiple realities of the notions of quality of care between women presenting with induced abortion and those with spontaneous abortion. The second objective, on the other hand, revealed the multiple realities of how health professionals evaluate the quality of post-abortion care services. The interpretivist paradigm also enabled the third research question to reveal multiple realities of health professionals' construct of the challenges women face in seeking post abortion care services. This philosophy enabled me to generate a deeper understanding and evaluation of the process component of quality of PAC services with different interpretations and complications in its unique setting rather than trying to generalise the understanding for a whole population (Creswell, 2007).

Owing to the fact that interpretivism philosophy guided the study, a qualitative research method was used. The qualitative research was adopted to explore the health professionals' view on the quality of post abortion care

services and their perceived challenges women face in seeking post abortion care services. This enabled the study to explore, understand, and explain the perceptions, views, attitudes, and experiences of clients seeking post-abortion care at the various health facilities.

Study Design

To gain an in-depth understanding of the quality of post-abortion care services in Greater Accra, the study was carried out using the phenomenological study design. This design was used because it seeks to describe the essence of a phenomenon by exploring it from the persons' who experience it (Creswell, 2012; Yin, 2016). This approach, thus, provided the basis to explore the notion of quality PAC services from the provider and client's perspectives, and how this quality was experienced (Teherani, Martimianakis, Stenfors-Hayes, Wadhwa, & Varpio, 2015).

Sources of Data

Primary data was collected from selected health facilities, PAC clients, and health professionals who provided post-abortion care services at the selected health facilities. With regard to the PAC clients, the data collected covered their notions of quality based on the service they received. The data from the service providers, on the other hand, also related to their views on quality PAC services, the challenges they faced with delivery of PAC services, and capacity of health facilities to provide quality PAC services.

Target Population

The target population for the study was health professionals who provided post-abortion care services at the selected health facilities in Greater

Accra region as well as women who have received PAC services from the selected health facilities in the region.

Inclusion and Exclusion Criteria

All health facilities that provided PAC service during the period of study, and recorded a minimum of 200 abortion cases in the period of 2019 were included in the research. The minimum of 200 abortion cases was chosen to help zone out the abortion hotspots in the Greater Accra region in the year preceeding the period of data collection.

For the participants, all women presenting with incomplete, inevitable, missed, complete or septic abortion during the period of data collection were eligible for inclusion for this study. With regard to the service providers, those who worked directly with the provision of PAC services were included in the study (Dibaba, et al., 2017). They comprised obstetrician/gynaecologists, general practitioners, midwives, nurses, and other health workers in charge of providing PAC counselling, treatment, family planning counselling and methods, follow up of patients in the recovery room and after discharge, and educational talks in waiting room.

Selected Number of Participants

The number of participants was not determined a priori but evolved during the data collection, bearing in mind the adequacy of information obtained (Sim, Saunders, Waterfield, & Kingstone, 2018). As such, the adequacy of the participants was assessed during the data collection period. At the end of the first month of fieldwork, fifteen (15) interviews were conducted. These comprised nine (9) clients and six (6) service providers. The interviews were transcribed and read through several times to take note of the key issues

that are emerging from the data. This informed the areas that needed probing and further understanding during the second month of fieldwork. At the end of the second month of the fieldwork, eleven (11) interviews were conducted comprising six (6) clients and five (5) service providers. The old and newly emergent issues were compared and assessed to determine whether the data hold enough information to adequately develop the themes based on the adopted theoretical framework. In the last month of fieldwork, eight interviews were conducted comprising five (5) clients and three (3) service providers. This was used to consolidate the data and ensure that all pertinent issues regarding the quality of PAC are adequately explored (see Sim et al., 2018). In total, thirty-four (34) interviews were conducted, which was made up of twenty (20) clients and fourteen (14) service providers. The final sample of thirty-four (34) allowed for a thematic analysis to be carried out in order to enhance the trustworthiness of the study results. This adaptive approach to determining the selection of participants allows for the adequacy of the sample to be determined during the data collection.

Based on evidence from previous studies, it is envisaged that data adequacy for each category of the study participants will be achieved by interviewing between 15 to 20 participants (Bryan, Peter, Amit, & Renee, 2013; DiCicco-Bloom & Crabtree, 2006). Notwithstanding, the rule of thumb in determining the total number of participants was to allow the sample to evolve during the data collection.

Selected Number of Facilities

Eleven facilities made up of three polyclinics, five government hospitals, two private hospitals and one teaching hospital were eligible for the

study. These comprised all the health facilities that provide PAC services in the study area. However, seven provided ethical clearance for the study to be conducted.

Selection of Participants

The selection of the participants was conducted at twol levels. The first level was the selection of the participants who have accessed PAC services services (induced abortion and spontaneous abortion). A homogeneous purposive sampling was used to select them. This sampling technique was employed to select six women that presented with complications from induced abortion and 12 with complications from spontaneous abortion. In all, 18 participants were selected.

Thus, I interviewed a homogeneous group of women who presented with induced abortion and a second homogeneous group of women who presented with spontaneous abortion to understand the notion of quality from their perspectives (Palinkas, et al., 2014; Ashley, 2020). These homogeneous groups of women were sampled at various facilities. The sampling was done in such a way that clients from all the selected facilities were adequately represented using the client exit interviews which was conducted at a point where the PAC clients are ready to be discharged.

The service providers, on the other hand, were selected using the expert purposive sampling approach. In view of this, service providers who worked directly with the provision of PAC services during the period of the data collection were selected. A total of thirteen participants comprising seven midwives, one nurse, one health assistant and four medical officers were

selected. From Table 1, a total of thirty-one (31) interviews were conducted comprising 13 service providers and 18 clients.

Table 1: Facility, number of clients and providers interviewed

Name of facility	Number of Clients	Number of Providers
Ashaiman Polyclinic	3	3
Marrie Stopes	2	1
Ga West Municipal Hospital	1	-
Ridge Regional Hospital	2	1
Lekma Hospital	4	3
Achimota Hospital	2	4
Tema General Hospital	4	1
Total	**18**	**13**

Source: Fieldwork, Adde (2020)

Research Instruments

The in-depth interview (IDI) guide is the instrument that was used to collect the data. It was divided into two main parts. The first part, which comprised questions for the client-participants, had two sections. The first section was made up of questions that focused on the background characteristics (age, marital status, occupation, etc.) and warmup questions. The second section comprised questions that required participants to give responses to issues relating to patients experience with PAC services. This was further divided into sub-themes such as dignity and respect, autonomy, privacy and confidentiality, communication and social support, and supportive care. The final section was the closing courtesies.

The second part which comprised questions for the provider-participants was structured into two sections. The first section was made up of

questions that covered the background characteristics (age, designations, religion, years of employment, etc.) of the service providers and warm up questions. The second section focused on the service providers notions of quality PAC services.

Pretesting

The interview guides that were used for the data collection were pretested at the Tema General Hospital, after ethical clearance was issued by the Ghana Health Service Ethical Review Board (GHS-ERC) with reference number GHS/RDD/ ERC/Admin/App/21/ 348. In the pretested of the instruments, three service providers and three PAC clients were recruited. The facility for the pretesting was selected from the seven health facilities from which ethical clearance was received for this study. This was done against the premise that it is advantageous for pretesting to recruit participants from the study population that will be used for the main study (Moore et al., 2011). Participants that were recruited for the pretesting of the instruments were, however, not included in the main study. The pre-testing was undertaken to correct errors and shortcomings that were inherent in the instruments.

Pretesting was critical in this investigation since it gave a picture of the conceptual framework's adequacy and application for the study. It also gave me the opportunity to evaluate if the questions were clear and the language used was adequate for a quality discourse (Adams, Khan, Raeside, & White, 2007). The interviews done during the pretesting were transcribed. The transcripts were analysed, which resulted in the creation of themes and categories. The suitability of the instruments (interview guides) was determined based on the pre-test findings. In collaboration with the study's

supervisors, minor changes were made to the instruments to ensure that they had the best potential to continue a quality discourse, which is critical to attaining the research objectives.

Data Collection Procedure

Upon arrival at the selected health facilities, I was directed to the administrations where I presented my ethical clearance letters and other neccesary documents. I was then introduced to the in-charge of the PAC units in the various hospitals. The in-charges in turn introduced me to service providers in the units and encouraged them to provide me all the necessary support to enable me carry out my data collection. The various health facilities all provided me with chairs and a table at a designated area for my interviews to be carried out.

Clients who were at the selected facilities for PAC services were selected with the help of the health professionals. The attending PAC service provider at the time will have to approve the psychological and physical readiness of the client before the interview will commence (Kumbi, Melkamu, & Yeneneh, 2008; Adde, Darteh, Kumi-Kyereme, & Amu, 2018; Adde, Darteh, & Kumi-Kyereme, 2021).

Clients who were willing to participate in the study were provided with a participant information sheet and a consent form to sign/thumbprint and then allowed to select a place and time of convenience for the interview to be conducted. The clients who were ready to be interviewed at the designated area at the health facility were interviewed there. Others opted to have their interviews over the telephone since they wanted to get home and rest before

taking part in the interview process. With such clients, date and time were scheduled for the interviews to be conducted.

Regarding the service providers, they were asked to indicate a time and venue that were favourable for them to be interviewed. This is to avoid interfering with or interrupting their work during working hours. Since I was stationed in the health facility to meet clients who come for PAC services, as and when some of the service providers were free, they invited me to their consulting room and I interviewed them. In relation to facilities that were very busy, I scheduled with the service providers and met them early in the morning for the interview before their office hours. Others also scheduled for over the phone interviews after working hours.

Data Management

The audio recordings of the interviews were transcribed into Microsoft word document. The audio recordings of the interview sections were destroyed immediately after transcription. The transcribed documents were protected with the *"mylockbox"* app on the computer to prevent unauthorised persons from getting access to the data. Only the researcher and the supervisors had access to the transcripts for the purposes of data analysis.

Data Analysis

The qualitative data collected was transcribed, proofread, and prepared for analysis by combining all transcripts into a Microsoft word document. Before the audio files were transcribed, I played them and listened to them all over again to be familiar with the audio. I also made brief notes to develop a structure of how the transcription process will look like. After this, the first draft of the audio files was then transcribed (Allsop et al., 2022). The audio

was then played again while editing the first draft to correct mistakes and omissions that occurred during the first draft. Once the edited document was ready, I formatted it to look like an interview transcript. This included adding paragraphs, titles, headers and adjusting the font size. Each interview was formatted with a unique heading for easy navigation during reading for analysis. Transcribed interviews were proofread by comparing with notes taken during the interview process while listening to the audio recordings (Moser & Korstjens, 2018). The transcripts were further proofread using the grammarly application to correct all misspellings, missed punctuation and inconsistencies. This helped improved clarity and readability of the transcripts.

The data was then managed and analysed using NVivo 12 for thematic analysis. With this, the transcripts were read and re-read to ensure familiarity with the data. First, a codebook was created. With this, preliminary codes were identified with corresponding frequencies from the responses of the participants. Codes were then collated and sorted based on their shared pattern to form sub-themes and subsequently, main themes (Allsop et al., 2022). This second-level of coding consisted of extracting common codes from individual documents and creating a new document of all commonly coded items, to create a composite collection of distinct conceptual categories. This moved the coding process into the narrowing segment of the funnel by refining the individual document level to the level of group data. Where needed, themes were combined, separated, or discarded to define a pattern of shared meaning projected by a central idea. After this, the themes were refined and defined by providing names and clear working definitions capturing the essence of each theme (Allsop et al., 2022).

The characteristics of each respondent was also used for comparative analysis. Finally, a descriptive narrative of the themes together with analytic narrative and data extracts was used to contextualise the analysis based on existing literature (Clarke & Braun, 2017). By this, I synthesised and integrated the recurrent patterns and linkages between and among codes, emergent across all the data, into distinct themes. Codes were linked in a tentatively meaningful way. Statements of the participants were presented as quotes to substantiate responses given to questions posed during the interview process. Tables were also used to compare the quantitative data with the qualitative data.

Ethical Issues

I received ethical clearance from the Ghana Health Service Ethics Review Committee with reference number GHS/RDD/ ERC/Admin/App/21/ 348. Permission was also received from the Greater Accra Regional Health Directorate of the Ghana Health Service with reference number GARHD/ 001/2021.

Before the commencement of the data collection, participants were made to sign an informed consent form. For those who could not read and write, it was read and explained to them before they signed. Those who could not sign were given the opportunity to thumbprint. Due to the sensitive nature of the topic under study, there is a potential risk of participants being exposed to psychological harm, emotional harm, and/or embarrassment. Given this, participants were provided with information on counselling services or appropriate support bodies that will help them deal with these issues. Such materials were distributed to all respondents with the information sheet so that

those who needed assistance can seek it. To ensure confidentiality, participants were not asked to give any information that could reveal their identity. The identity of participants was also not included in the resulting report from the study under no circumstance.

Participants were allowed to withdraw from the interview at any time without reason or penalty. Participants were provided with a participant information sheet (PIS) and informed consent form (ICF) that was filled before they are interviewed. The consent form was endorsed by the respondents by either signing or thumbprinting. This included the necessary information to ensure potential participants fully understood what they were being asked to do and any potential risk. The PIS and ICF was administered to the participants at the initial contact with them at the health facilities. They were then allowed to take their time to go through the documents and those who wished to take part in the study called the investigator for the consenting process and interview to take place.

Also, due to the coronavirus pandemic, all the necessary safety protocols were observed to ensure the safety of respondents and the researchers. For instance, all respondents and researchers were provided with face masks and face shields before the interview. Social distancing was also observed throughout data collection. The participants were also provided with nose masks and hand sanitisers before the interview took place.

CHAPTER FIVE

NOTIONS OF QUALITY OF POST-ABORTION CARE AMONG CLIENTS

Introduction

Chapter Five provides results on the notions of quality of care among the participants who presented with induced abortion and those with spontaneous abortion at the study facilities. This chapter comprises two main sections. The first sections consist of the socio-demographic characteristics of the client-participants, comprising age, marital status, occupation and type of abortion presented at the facility. The second section focuses on notions of quality of care by the client-participants. These notions of care relate to two main dimensions - the structure and the process of PAC services.

Socio-demographic Characteristics of Participants

The ages of the clients ranged from 19 years to 37 years. Nine out of the clients were single, eight were married and one was co-habiting. Three of the clients were students, three were unemployed and the remaining 12 were self-employed (see Table 2).

Table 2: Socio-demographic characteristics of clients

Code	Age	Marital Status	Occupation	Type of abortion	Facility
Client 1	37	Married	Seamstress	Spontaneous	District Level
Client 2	32	Married	Trader	Induced	Poly Clinic
Client 3	31	Married	Trader	Spontaneous	District Level
Client 4	32	Married	Hairdresser	Spontaneous	District Level
Client 5	19	Single	Student	Induced	District Level
Client 6	33	Married	Marketing	Induced	Health Centre
Client 7	33	Cohabiting	Trader	Spontaneous	Regional Level
Client 8	34	Single	Unemployed	Spontaneous	District Level

Table 2 continued

Client 9	19	Married	Unemployed	Induced	Poly Clinic
Client 10	23	Single	Student	Spontaneous	District Level
Client 11	21	Single	Student	Induced	Health Centre
Client 12	32	Single	Hairdresser	Spontaneous	Regional Level
Client 13	32	Married	Hairdresser	Spontaneous	District Level
Client 14	31	Single	Trader	Spontaneous	Poly Clinic
Client 15	31	Married	Trader	Spontaneous	District Level
Client 16	28	Single	Trader	Spontaneous	District Level
Client 17	24	Single	Unemployed	Induced	District Level
Client 18	23	Married	Fashion designer	Spontaneous	District Level

Source: Fieldwork, Adde (2020)

Perspectives of Participants on Quality Structure

The perspectives of clients regarding structure as a component of quality of care encompassed three domains. These are infrastructure, organisational characteristics, and pre- and post-procedure waiting time.

Infrastructure

The data showed infrastructure connotes a physical environment that can provide privacy. To ensure privacy, the infrastructure should provide an environment of care that is appropriately organised.

Enabling environment for the promotion of privacy

The environment in this context deals with the structure of the facility as well as the service organization. This was to ascertain how the environment of care was helpful or not with regards to ensuring privacy of clients, and also, how clients were treated with an assurance that no one could easily hear what was being discussed between the client and the service provider. From the data, the clients generally described positively the environment of the various facilities in relation to privacy. Although the waiting area was at the obstetrics

and gynaecology wards/units with women seeking other obstetric and gynaecological health conditions, most of the participants expressed the view that they were attended to alone with no other clients in the treatment/consulting room. Given that the waiting room was in the Obstetrics and Gynaecology wards of the facilities, it was easier to ensure privacy of clients seeking PAC services. Most of the study participants also expressed the view that the rooms were such that no one, including those at the waiting room, could easily hear their conversation. A client who expressed satisfaction with the environment had this to say:

> *The room I think is okay because I was the only one in the room with the service providers and the place was covered so that no one else can see what was going on in there. there was privacy, no one was there except for the workers...* (37 years seamstress, Spontaneous abortion)

To buttress this, another participant shared the following opinion:

> *I am very much satisfied, even with my treatment at the theatre. Yes, from the room I was treated, I am much convinced that not even a word said inside could be heard outside by a passer-by...* (23 years student, Spontaneous abortion)

It is important to note that the assurance of privacy in PAC services was not consistent across the study facilities. Whereas most of the participants were of the view that the environment guaranteed privacy, in two facilities, participants recounted that the environment made room for other patients to easily hear what was being discussed. In these facilities, the consulting rooms have more than one service provider at a time and all were attending to

different clients. This made it possible for other clients to overhear each other, thus making them uncomfortable. Some clients shared the following:

> *There are three doctors in the consulting room, so other patients also join [at the time of consultation], so when you say something, the other person can hear it* (33 years trader, Spontaneous abortion)

Even though most of the study participants regarded the environment as an important aspect of the overall service experience, a few of them were indifferent about the care environment. The participants with indifferent attitudes contended that they presented at the facility for treatment and whether someone could hear their discussion with the service providers or not was of little importance to them. They were of the view that once the discussion meant to facilitate their treatment experience, it was acceptable. It is, however, worth noting that all the participants who were indifferent about the care environment presented with spontaneous abortion. One participant had this to say:

> *They didn't take me to the consulting room, I was sent to the emergency ward, and two doctors came and asked me questions about my health, they stood by where I was sitting and asked me, but they didn't take me to the consulting room. But I was okay there, the place was comfortable. I wasn't bothered if someone will hear us, because anybody at the hospital is sick so if you hear of my sickness is nothing.* (32 years hairdresser, Spontaneous abortion)

Another participant intimated:

> *My mind was not on whether somebody will hear or not, I think they asked the questions so they can treat me* (32 years hairdresser, Spontaneous abortion)

In the light of the above, clients were typically treated in an environment that provided them with privacy. Nevertheless, privacy was not assured in few of the facilities as highlighted by the study participants. The narratives suggest that whereas privacy is at the core of quality PAC services, not all clients were concerned about privacy. This could be as a result of the anxiety that comes with seeking PAC services, especially for women seeking PAC for spontaneous abortion.

Organisational Structure

The organisational structure in this study outlines how the activities of the health facilities are directed to ensure clients receive quality PAC services. This also describes the systems put in place to ensure client satisfaction.

Privacy during the procedure

The participants generally viewed privacy as being properly covered during the procedure to avoid exposing the clients to other people other than the primary provider(s). These are activities and protocols deliberately designed to offer the client privacy during treatment (Donabedian, 2003). Almost all the clients asserted that they were covered during treatment. The procedure rooms were covered so did the providers make effort to fully cover their bodies. While not all facilities had separate treatment rooms, service providers put in measures to ensure they protected their privacy. A participant remarked:

> *...I was well covered. Aside from that, anytime the Doctors needed to expose my body for any form of exercise [care and services], they apologized [sought my consent] to me.* (23 years student, Spontaneous abortion)

To support this, another participant had this to say:

> *...The room was properly covered as well as my body* (32 years trader, Induced abortion)

A participant, however, noted that, although there was a curtain to cover the treatment area, the laxity of other clients sometimes left the place opened, which could compromise the privacy of other clients. She remarked:

> *There is a curtain there so it will depend on the other client, some of them when they go in and come out, they don't close the space they just leave it open but then there is an instruction that when you enter pull the curtain down so the instruction was given just that some people were not following the instructions.* (29 years student, Induced abortion)

Confidentiality of clients

The clients share the view that the facilities placed measures in place to provide confidentiality for them. The clients asserted that the service providers tried as much as possible to ensure that their information was well protected even as they discuss their conditions, even in situations that the consulting rooms were shared and there were other doctors attending to other patients. Some clients shared the following:

> *…Yes, they were only two service providers in the room with me at the time. I was the only one in the room and I don't think anyone outside can hear us* (37 years seamstress, Spontaneous abortion)
>
> *… Even with patients in the same room, the Doctor tries their best not to be loud in order not to be heard by the others.* (23 years student, Spontaneous abortion).

This was, however, not the case with all the units of the facilities. Clients lamented that at the Out-Patient Department where their information is taken before the clients meet with the doctors, measures are not taken to provide confidentiality. Clients were of the view that others could easily hear their details as their information was being taken. A client had this to say:

> *…except for the fact that when they were taking our details, people could hear whatever information I was giving out. Where they take our details is different from where we go for the consultation.* (33 years trader, Induced abortion)

Waiting Time before Treatment

Waiting time was contextualised as the time spent by a client from arrival at the health facility to the time the client received treatment. When asked about the waiting time before treatment, three main issues emerged from the data. These are severity of presenting cases, provider availability - related waiting time, and client – related waiting time.

Severity of Presenting Cases

Most of the participants shared the view that the waiting time for treatment (i.e., the time between arrival and being attended to by a service provider) was short. However, this short waiting time was rather in relation to

the severity of presenting cases. Thus, the short waiting time is not a conscious institutional effort but often a reactionary measure by the service providers based on the severity of the woman's condition. This was, however, a structural issue with the availability of few service providers at the health facilities as opposed to service providers negligence. It was evident that PAC clients associated short waiting time with the critical conditions they arrive in at the facilities. Clients were of the view that complications from abortion issues are very delicate and hence service providers offer them prompt attention to avoid complicating issues further which could result in maternal mortality. A 23-year-old client who received prompt attention had this to say:

> *I was attended to immediately I got to the hospital. I think it is because my condition was an emergency as I was still bleeding upon arrival.* (23 years student, Spontaneous abortion)

> *The time was okay, the condition wasn't critical so I can't say they kept long.* (32 years reader, Spontaneous abortion)

Another participant who reported long waiting time due to the condition in which she presented had this to say:

> *There was a doctor but they said where the thing is, I have to wait for a while. I came around 8 pm and they gave me an injection and told me to go and lie down, so it was around 3 am that they did the D&C for me.* (23 years trader, Spontaneous abortion)

Provider Availability Related Waiting Time

The study also observed that some PAC participants were of the view that waiting time before treatment was long. Even though service providers are expected to give prompt attention to clients in accordance with good practice

(quality of care), provider availability could necessitate delays. Several reasons were put forward by the study participants as accounting for the long waiting time including the condition of the complication, the volume of clients, and unavailability of service provider. For instance, a client who presented with a spontaneous abortion expressed having a long waiting time and indicated that she was made to wait because the service providers were engaged elsewhere; hence, the PAC clients had to wait for their turn. A participant had this to say:

> *… They told me the doctor is at the theatre, so it was later that the doctor came to perform the DNC. Yes, they did, if it was not the doctor who was not around like I would have left there earlier than this…* (34 years trader, Spontaneous abortion)

Client Related Waiting Time

Some of the study participants attributed their long waiting time to financial difficulties. In many of the study facilities (both private and public), clients seeking PAC services are required to make advance payments before the service is provided. Clients who could not promptly pay for the services therefore spent longer time organising/mobilising resources to pay for the services. In most instances, the service providers were ready to attend to them but they had not raised the required funds. One participant recalled:

> *I got here around 2 pm and left around 4 pm because I was waiting for my husband for the money. They were ready to attend to me but because my husband was not in with the money, we had to wait a little longer* (37 years trader, Spontaneous abortion)

Whereas some participants considered the waiting either as short or long, few participants were indifferent about the waiting time. For those indifferent, they argued that they did not know the procedural and operational arrangements at the facilities. For others, it was simply an issue about large number of PAC clients. In this sub-population, some indicated that they did not take note of the time of arrival and were therefore fine. A client who expressed being indifferent because there were many clients had this to say:

> *The time was okay, the way the people were many and they did everything fast I was even not expecting that.* (31 years trader, Spontaneous abortion)

Another participant who was indifferent about the waiting time also had this to say:

> *For that, I can't say anything about it because I don't know how they work. We reached there around 6:50 am and the doctor who was supposed to be in the theatre room told me she have closed so I had to wait for the next doctor, at that time I was suffering so I was just begging her to help me else I may lose my life and she did it for me* (26 years trader, Spontaneous abortion)

The findings of the study suggest that short or long waiting time is a function of presenting condition by the client. Critical conditions are attended to promptly, thereby shortening the waiting time. On the other hand, waiting time becomes long when clients do not present with critical conditions. This, however, cannot be blamed on the service providers since it is a medical condition and they needed the right condition to administer treatment. Besides, several clients present at the facility at the same time, necessitating providers

operating by the "first-come, first-serve" principle. This notwithstanding, short waiting time could be linked to dignity and respect because when a client is attended to early, she gets the feeling of worthy of respect and dignity.

The findings also revealed that service providers were perceived to be inadequate; hence, participants had to wait for long periods before it gets to their time for PAC services. This is mainly because only doctors are allowed to provide PAC services to the clients. However, the facilities get overwhelmed with the number of patients they receive. In reference to this, some clients were indifferent to the time spent taking into consideration the number of other clients around.

Notwithstanding the fact that prompt attention is a mandatory component of quality of care, the evidence from this study revealed that such critical elements are largely relational as well as institutional. This could raise some fundamental ethical issues. However, the narratives show that facilities are left with no choice than to provide services based on the prevailing circumstances.

Perspectives of Clients on Quality Process

Interpersonal and technical qualities of service providers are important in clients' notion of care (Chichirez & Purcarea, 2018). In this study, the participants constructed quality of care to also comprise the process of care which measures the interpersonal quality element of quality care. They identified four main characteristics; namely, dignity and respect, autonomy, and communication.

Dignity

Patient-centred care embraces respect and responsiveness to individual patient preferences, needs, and values (Institute of Medicine, 2001). In this study, the participants viewed dignity and respect in terms of perceived positive attitude of service providers during the care process and responsiveness to concerns of patients.

For most of the participants, they were happy with the type of interactions they had with the providers. According to participants, service providers were friendly, interactive, jovial and respectful to them throughout the process of providing care. For instance, a client shared the following:

> *Perfect, especially the doctors, and along the line they were advising me and stuff, I really loved it. You see doctors are there to help patients, but compared to other hospitals I have gone to, here, they don't just treat you like a patient, they treat you like a human. I was going through pains but they were doing everything to make me laugh.* (23 years trader, Spontaneous abortion)

To buttress the above, another participant also had this to say:

> *They are good and they have time for anybody who comes to the hospital, there were very friendly too because I came there for the D&C on October 3rd and the doctor who did it was very friendly, as she was doing the thing [referring to the procedure] she was still discussing with me, though I was feeling pains it wasn't as when I came.* (26 years trader, Spontaneous abortion)

To many participants, the friendly attitudes of the providers was beyond their imagination/expectation due to the nature of the complications they presented. Specifically, participants in this group felt they did not "deserve" the standard of interactions they had with the providers because their complications were due to self-initiated induced abortion. The anticipation from such participants was that the service providers would be within their right to speak rudely to them in such a situation. So, participants shared a feeling of satisfaction because the providers were not rude to them even though the situation they presented in could have justified providers being rude towards them. A client who presented with complications from an induced abortion had this to say:

> *It was normal, I was not of myself when I came so I was just going through the process, nobody spoke rudely to me and even if they did, I think it's normal* (29 years student, Induced abortion).

Respect

The providers were considered generally as respectful. To the client participants, respect from the service providers was evident in how responsive the providers were to them [clients]. For instance, where there was a need for further explanations, the providers took their time to explain to the clients. To the participants, service providers were aware that they were at post for the sake of the clients and as such needed to treat patients with respect. A client narrated:

> *Yes, I was. They were always available at the time I needed them to help me out with anything… I think it is because they are aware of the fact that they are here because of patients and the patients are there*

because of them as well, hence they have to be good to them for the patients to also accord them the needed respect. (23 years student, Spontaneous abortion)

Another client who expressed that the providers had time to listen to her and address her concern had this to say:

...I had wanted to go home so that it will come naturally but she advised that it will be best if I see the other doctors for their examination before I go home. So, I went to the emergency ward and they told me if it stays there for long it can give me an infection so they have to bring it out, they interacted with me for quite a long time before what had to be done was done (32 years trader, Spontaneous abortion)

However, for the adolescent participants, the service providers were not respectful to them. They explained that this negative attitude of the service providers towards them could be because of their age with the condition in which they presented to the facility. A few also complained about similar disrespectful attitude of some of the nurses at the district level health facility. It was also observed that, at the same district level facility, two kinds of services provider attitudes were experienced by the adolescent participants. While some were disrespectful, others were not. They complained about how some providers spoke rudely to them and threatened to inform their parents about the service they came for at the facility. One had this to say:

Initially, I met very rude and mean ones [service providers], but those who later attended to me were very kind-hearted and patient towards me. I had a very great time with them but unfortunately, I was referred

to the female ward and met another rude nurse who kept shouting at me and threatened to tell my mother I was having sexual intercourse secretly even though she was aware my mother was both asthmatic and a BP patient who was also pregnant and could be affected by the news. I did not even understand what she was trying to imply (19 years student, Induced abortion).

Autonomy

Client autonomy is one of the components of quality health care services. It focuses on the involvement of patients in the treatment decision-making process. Based on this, clients were asked about who decided on the treatment received. Generally, the clients expressed that their consent was sought in the decision-making process regarding the kind of care to be provided. From the accounts of the participants, service providers usually explained to them their condition and the medical interventions available. The clients subsequently gave consent to the kind of treatment before they were administered. This was regardless of the type of abortion the clients presented with at the facility. To many of the PAC participants, service providers prioritised seeking client consent before providing any treatment. For instance, a client who presented with complications from an induced abortion had this to say:

It was my husband and I who came to tell them, and the nurse said unless they give us medicine, the medicine will be better for me. They said because of the previous C.S I had, if they use any machine to do it, I can lose my life. So, they gave me the medicine. I accepted before they gave me the medicine. (19 years unemployed, Induced abortion)

Another client had this to say:

> *Yes, I was informed by the Doctors. Aside from that, anytime they wanted to conduct any treatment on me, they informed me of it and told me of the reason to which it needed to be done.* (23 years student, Spontaneous abortion)

Two clients, however, expressed the view that their consents were not sought before the treatment was given to them. To them, the doctors did what they thought was the best option for them. They were not told what type of treatment they will be given and if they consent to it or not. A 32-year hairdresser participant who presented a spontaneous abortion indicated that she was interrogated about her condition and based on that the doctor decided on her treatment and said that "they asked me questions and I answered so they based on that to give me treatment". Another remarked as follows:

> *No, that is what I noticed, they just gave me a paper to write my name somewhere and then sign somewhere, she didn't ask me anything, it was when the doctor went out that I tried to read through the thing myself as fast as possible. Then I got to know some things, but nobody told me anything, they didn't ask me any questions.* (29 years student, Induced abortion)

Communication

Communication refers to the way in which the service providers interacted with the clients, addressed their concerns and how service providers managed their conditions with words of encouragement (Donabedian, 1988). Almost all the clients, irrespective of their background, and the facility they sought for care indicated that the service providers had good communication skills. To some of the participants, this communication skills helped them to

overcome their fears and anxiety they had prior to accessing care at the facility. For instance, some of them made these remarks:

> *To me, their behaviour is good because of the way they talk and laugh just to make me happy. When I came, I was afraid and feeling anxious, but how they acted towards me helped me to overcome all the fear and anxiety which made me feel relieved to discuss issues with them.* (31 years trader, Spontaneous abortion)

Regardless of the type of abortion that led to the complications, most of the client participants also expressed satisfaction with the way the service providers talked to them. They offered various remarks using words such as they were nice, polite, and friendly to depict that the service providers were sociable. To the participants, this enabled them to feel at ease and able to easily communicate with the service providers. The clients were also able to ask service providers questions to have a better understanding of their situation. Some of the clients who were happy with the way the service providers communicated with them had this to say:

> *It was normal, they all talked with me with some kind of respect. They were somehow friendly, especially with my doctor, they often check up on you to check your BP and other kinds of stuff, and they ask you how you are.* (32 years hairdresser, Spontaneous abortion)
>
> *They were all saying sorry throughout the process, when I react to the pain, they will say that 'oh sorry'. So, for me I will say that they are just kind.* (26 years trader, Spontaneous abortion)

When probed further to find out if the participants asked the service providers questions and had the required answered, they unanimously indicated that they

always received the needed responses from the service providers anytime they asked them questions. To support this is the following quote:

> *Yes. For instance, I was able to ask the doctor the difference between the treatment he was giving me and CS…He told me for CS I wouldn't be able to go to the house today [same day] but for this [PAC], I can go to the house after treatment, so there is a difference.* (37 years seamstress, Spontaneous abortion)

Whereas most of the participants who presented with complications from spontaneous abortion were happy with the communication of the service providers, a few who presented with complications of induced abortion expressed their unhappiness with the communication of the service providers. For instance, one expressed meeting some rude service providers at the initial stage but later met 'nice' ones (service providers who were polite, patient, and engaging), and another expected more from them.

> *Initially, I met very rude and mean ones, but those who later attended to me were very kind-hearted and patience towards me.* (19 years student, Induced abortion)

> *Professional enough, well they told me what they were doing but sometimes some of us want more of the explanation. For instance, when I came and they took my scan they didn't give me the scan, I didn't really see it, and I am such a person that I want somebody to explain things to me like this, this is what we have seen. I was almost 12 weeks [into my gestational period] so I was expecting some more explanations.* (33 years trader, Induced abortion)

However, a few of the participants could not ask questions because they were constrained by the volume of clients at the facility at the time of stay. They simply did not get the chance as the providers had to attend to many other PAC patients. One participant recalled:

> *Yes, I wanted to ask them questions but I did not get the chance to ask them. They were attending to other patients so I didn't get the chance to ask them any questions. A lot of people came there that night.* (23 years trader, Spontaneous abortion)

Social Support and Supportive Care

According to Donabedian (1988), quality of care encompasses the process of treatment. This process involves the procedure service providers use in providing care to the patient, not forgetting how the service providers interact with the client and their family or whoever accompanied them to the facility. Supportive care relates to how the service providers helped the clients to overcome their fears and anxiety. Two main perspectives were derived from social support and supportive care: responsiveness to treatment supporters and dealing with PAC seekers fear and anxiety.

Responsiveness to treatment supporters

Responsiveness to treatment supporters was how service providers responded to the people that accompanied the PAC clients to the facilities. This theme highlights how treatment supporters were treated at the facilities. From the data, the client participants unanimously were of the view that the service providers were responsive to their treatment supporters. The views reflect that service providers interacted with treatment supporters in a friendly manner. This helped them to feel welcome and continue to support the clients.

For instance, a client who presented with complications from induced abortion remarked *they treated them well* (24 years unemployed, Induced abortion). To buttress this, another participant remarked:

> *They [service providers] were nice to my husband, even some of my medications it was one of the nurses who went and bought them for me because they told my husband he is tired so he should sit down she will go and buy it for him.* (26 years trader, Spontaneous abortion)
>
> *It was good, one of the nurses helped her to carry her baby since she couldn't take the baby to the laboratory, so they treated her well.* (28 years trader, Spontaneous abortion)

It was evident from the narratives that the service providers were courteous and considerate of the needs of the treatment supporters. This was highlighted in the friendly manner in which service providers attended to the treatment supporters. This, according to the views of the participants, helped in reducing their fear and anxiety the treatment supporters had as a result of their (clients) post-abortion complications. The views further revealed that service providers assisted treatment supporters with their errands when they noticed that they were fatigued. The clients expressed happiness and satisfaction with how their treatment supporters were treated.

Dealing with PAC seekers fears and anxieties

The study also examined how the service providers interacted with the clients to help them deal with fear, anxiety and pain prior to being treated. The views of the client participants showed that PAC clients were given assurance and reassurance during the procedure that they are in good hands to help them deal with their fear and anxiety. To manage the pain, clients were given

medications to relieve them of the pain. One client who expressed she got scared after hearing the shout of another client during her treatment had this to say about how her fear was handled:

> *...like the first girl they did the D&C for the way she was shouting, I was a little bit scared. The doctor told me I shouldn't be afraid and that it is not that painful. How he spoke to me before they started the thing [PAC] and that made me calm down.* (23 years trader, Spontaneous abortion)

Another had this to say:

> *Not until I was told I will be sent to the theatre, but they tried their best to calm me down after explaining certain things to me. I was very much scared about the process but they tried to explain things to me and assured me that nothing was going to happen to me so I calmed down* (23 years student, Spontaneous abortion)

A client who presented with an induced abortion also had this to say:

> *I was a bit afraid, but when I came and how the nurses spoke to me, I overcame the fear. (19 years unemployed, Induced abortion)*

Based on the views of the clients, it was evident that the service providers ensured that the clients were relaxed before treatment. They managed the fears and anxiety of the clients before treatment was given to them. This was regardless of whether the woman presented with complications from an induced or spontaneous abortion. Thus, clients who presented with spontaneous abortion as well as those that presented with induced abortion were all helped to overcome their fears and anxiety prior to the procedure.

Discussion

This chapter explored the notion of quality of care among women seeking PAC services in an urban setting in Ghana. It was evident that clients' notion of quality-of-care hinges on quality structure and quality process.

Concerning quality structure, four key tenets were identified. These were infrastructure, organisational characteristics, supplies and equipment and waiting time. Participants regard the infrastructure as an enabling environment for the promotion of privacy and confidentiality as critical in ensuring quality PAC services. Evidence suggests that enabling environment in terms of the structure is important to ensuring quality PAC service (Ameh et al., 2017).

An enabling environment is a prerequisite for the provision of quality PAC services since this will help promote the provision of privacy and confidentiality (Donabedian, 1998). My findings show that some facilities have a consulting room that provided clients with privacy while other facilities do not have a consulting room that provided privacy to the PAC clients. Notwithstanding the unavailability of private consulting rooms in all the facilities, all the facilities put in measures to ensure they protect the privacy of their clients during treatment. Previous studies have shown that the availability of PAC services at the facility is one element of quality PAC; however, there is a need for the facilities to have the capacity such as space, personnel, and logistics, among others to provide PAC services to clients (Maxwell, Voetagbe, Paul, & Mark, 2015; Mohamed et al., 2015). Improvement in the accessibility to PAC services is essential to the prevention of moderate to severe post-abortion complications and maternal mortality (Awoyemi & Novignon, 2014; Mutua et al., 2015; Bankole et al., 2018).

The present study also revealed that participants viewed waiting time before treatment as an element of quality PAC services that was influenced by both relational and institutional factors. The findings from the current study observed that PAC patients were generally satisfied with the waiting time, consistent with some previous studies. For instance, Adde et al. (2018) in a facility-based study in Ghana found that PAC clients were largely satisfied with the PAC services because of the short waiting time. The relatively shorter waiting time at the health facilities recorded in this study could provide grounds for optimism as it could go a long way to help in addressing pregnancy-related complications and maternal mortality or morbidity (WHO, 2015; Singh et al., 2019).

Although clients largely reported short waiting times, there were instances where clients reported long waiting times. These long waiting times were attributed largely to inadequacy of service providers for PAC services at the health facilities. A plausible explanation for this is the reservation of PAC services to only medical officers. Evidence shows that improving the quality of PAC services must include addressing human resource shortages at facilities (Riley et al., 2020). Izugbara et al. (2019) argue that task-sharing at the health facilities to redistribute health tasks with the other cadre of care providers could help deal with human resource shortages. Indeed, task-sharing has been rolled out in several health facilities in Ghana. The evidence from the present study reinforces the need for task-sharing to be accelerated and strengthened to ensure smooth health delivery, including PAC services (Aborigo, et al., 2020).

To enhance health outcomes and to attain Universal Health Coverage, Ghana has undertaken a number of health system reforms over the years to help improve organisational characteristics of health facilities. The current National Health Policy (2019) places a strong emphasis on system strengthening, expanding public health initiatives, and increasing the population's access to services through community health services. A social health insurance scheme was also established to reduce devastating costs, especially for the weak and vulnerable (Ministry of Health, 2019). The sustainable development goals (SGDs) are anchored on the principle of "leaving no one behind" (UNSDG, 2023). This is consistent with the foundation of universal health coverage which stipulates that "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship", anchored on the principle of "health for all" (WHO, 2023). However, the current study revealed that the ability to afford treatment was a barrier to receiving prompt attention for some women seeking PAC services. Women who could not pay for their services on time were delayed treatment untill they could pay their bills. Although there is a policy intervention of free maternal health care in Ghana, just like in other LMICs, it does not cover PAC services (Valssoff, Singh, & Onda, 2016). Hence, although there is the availability of PAC services in Ghana, financial accessibility serves as a barrier (Rominski & Lori, 2015).

The present study also found that regardless of whether the client presented with complications from a spontaneous or induced abortion, clients perceived service providers to have a positive attitude. The positive attitude alluded to the fact that service providers made the clients feel comfortable in a

friendly environment. The implication is that such experiences may encourage women to seek early PAC which could be a positive influence on health seeking.

With regards to quality process, it was further observed that PAC seekers who presented with complications from induced abortion were surprised about the friendly attitude of the service providers. This group of women felt they did not qualify for a positive attitude from service providers since their condition was self-inflicted and justified providers being rude towards them. This shows that PAC clients could self-stigmatise which is associated with psychological distress years after the abortion (Biggs, Brown, & Foster, 2020). The distress may not be associated with termination experience but due to the social risks of ever having an abortion. These can worsen when judged against anxieties about future fertility prospects, which is one of the pervasive public/community narratives about abortion being a cause of infertility in some women in Ghana. In a context where public polemics on some SRHR issues are moralised, abortion clients seeing the services they received is not too surprising.

The findings further show that there is an issue of clients understanding and knowing their rights and entitlements. This confirms the argument of Reiger et al. (2019) that although abortion is legal in Ghana, most Ghanaian women were ignorant of the law and assume abortion was illegal. The 2017 Ghana Maternal Health Survey report also showed that out of the women who have heard about abortion or experienced abortion, only 11% knew it was legal (GSS, 2018). This shows there is a gap in the community and service provider partnership, which is one of the elements of the PAC

model. The CAC framework also recognises the need for community support and advocacy which is intended to empower prospective service users (Chavkin, Baffoe, & Awoonor-Williams, 2018).

Community and service provider partnership emphasises community health education and mobilisation which increases awareness and encourages women to seek early PAC services (Corbett & Turner, 2003). The positive attitude of service providers observed in this current study affirms the findings of Paul et al. (2014), Assefa (2019) and Pyne and Ravindran (2020) who also observed that healthcare providers show positive attitude towards abortion and its related issues. This is, however, contrary to the findings of Rehnström Loi et al. (2015) who found that nurses and midwives have a negative attitude towards PAC services and PAC clients. A plausible explanation for the positive attitude of the PAC service providers could be attributed to in-service training of service providers, as argued by Abubakari, Gmayinaam, and Osei (2023) who observed poor abortion law knowledge among nursing students was associated with negative attitude towards abortion. Hence, to enhance the quality of PAC services, providers could benefit from regular in-service training which could help in changing perceptions and attitude towards PAC clients. The positive attitude observed could serve as motivation that will encourage women to seek early healthcare in the future. Positive feedback from the clients will also encourage other women to seek PAC services when they encounter complications (Zaroui et al., 2015; Dapaah, 2016). I also found that patients were by and large satisfied with the service providers' responsiveness to their needs and concerns. Service providers exercised patience in dealing with the concerns of the PAC clients. The positive attitude

of service providers coupled with the responsiveness of service providers to the needs of clients will help dissuade the stigma and other associated negative social ascriptions that cause a delay in women seeking PAC services (Casey et al., 2019). In some resource-constrained areas such as SSA countries, abortion stigma transcends beyond the patient to include the providers (Harries et al., 2014).

The quality-of-care model by Donabedian (1998) postulates that process quality encompasses all that is done in the provision of care to the client which includes involving clients in decision-making regarding treatment. The findings from the current study showed that clients were involved in the decision-making process and this encouraged clients to adhere to treatment. The current findings affirm the argument of Wancata and Hinshaw (2016) that service providers need to counsel and listen to patients so that they can make informed decisions that correspond with their personal goals and values. The quality-of-care model (Donabedian, 1998) also argues that communication is a key factor in the provision of quality care to patients. Altogether, the PAC clients were satisfied with the quality of communication at the health facilities. I also found that PAC patients were confident they could ask questions of the service providers and be answered. Service providers with strong interpersonal skills can assist PAC clients manage their fear and anxiety. Botes (2000), however, found that due to stigmatisation suffered by service providers, it affects negatively their attitude and interpersonal skills with their clients (Harries, Cooper, Stebel & Colvin, 2014; Rehnström Loi et al., 2015).

CHAPTER SIX

VIEWS OF HEALTH PROVIDERS ON THE MEANING OF QUALITY OF POST-ABORTION CARE SERVICES

Introduction

This chapter presents the results of the views of health professionals on the meaning of quality of post-abortion care services in the Greater Accra region. The results are based on interviews conducted with service providers in the selected health facilities that provide post-abortion care services. Using a deductive approach, the main codes that were deduced from the data were providers view on quality structure and process with the main themes: the relationship between service providers and clients, treatment decision making, ensuring privacy and confidentiality, communication about available PAC services, service providers' ability to provide post-abortion care, and other services provided as components of PAC, providers perception about women seeking to terminate a pregnancy and description of quality post-abortion care. Table 3 presents the demographic characteristics of the providers who participated in the study. The ages of the service providers ranged from 26 years to 45 years with years of experience ranging from 1 year to 20 years. Eleven out of the thirteen service providers were Christians.

Table 3: Socio-demographic characteristics of service providers

Code	Age	Designation	Years of employment	Religion	Marital Status	Facility
Provider 1	26	Obstetrics and Gynaecologist	2	Christian	Single	District level
Provider 2	31	Midwife	6	Christian	Married	District level
Provider 3	32	Senior Staff Midwife	7	Christian	Single	District level
Provider 4	49	Senior Health Assistant	17	Christian	Single	Regional level
Provider 5	28	Registered nursing assistant clinical at O&G	1	Moslem	Married	District level
Provider 6	43	Midwife	20	Christian	Single	Health Centre
Provider 7	29	Medical Officer	1	Christian	Single	District level
Provider 8	40	Midwife	8	Christian	Married	Poly Clinic
Provider 9	28	Midwife	2	Christian	Single	District level
Provider 10	36	Midwife	13	Moslem	Married	District level
Provider 11	45	Obstetrician	19	Christian	Single	Poly Clinic
Provider 12	37	Midwife	5	Christian	Married	District level
Provider 13	32	Medical Officer	2	Christian	Single	District level

Source: Fieldwork, Adde (2020)

Service Providers' View on Process Quality

Perception of quality of the care process is an integral part of the service delivery. The views of service providers on process quality were sought to understand the providers perception of all that went into providing treatment to the PAC clients. To the provider participants, this measures the interpersonal quality of the service providers, with main characteristics; namely, cordial relationship, patience for clients, autonomy, communication and the service providers perception of women seeking abortion.

Cordial Relationship

The provider participants expressed the view that service providers need to have a cordial relationship with their clients. To the service providers, PAC services are sensitive issues and as such providers need to have empathy for their clients. This, they believe, will promote a cordial relationship that will encourage the clients to open up to them for an honest discussion that will result in quality treatment. By this, the service providers remarked that they are friendly to the women who presented to their facility with complications from abortion. To the service providers, the cordial relationship between them and the clients was not relational to the type of abortion that resulted in the complications. Based on that, the service providers also offer their numbers to the clients to call in case they have any discomfort at home. A midwife had this say:

> *The relationship of providers to the client is very cordial and humility because the way the job is, it is a sensitive area so far as reproductive health is concerned so if you don't have that kind of cordial relationship, the client will not be ready to have that confidence and open up to you* (Health Centre Midwife, 43 years)

Another also had this to say:

> *…The staffs are very friendly with the patient and we have a cordial relationship. It is your patient and their health is our concern so we are closer to them especially when the person comes in pain, we need not do anything bad so we console them very well. Most of them will call you 'saaa'* (Tertiary Facility Senior Health Assistant, 49 years)

It is worth noting that a service provider also indicated that aside from being cordial to them, they sometimes do offer free service to clients who cannot afford the fees for treatment out of empathy. To them, what matters most is saving the life of the woman first before any other matters. She remarked:

> *I think the providers are welcoming and they give them all the options they have. I think the only problem is the finances of the client, the majority of them come in and they cannot afford it, that will be a challenge but we are welcoming and even something we go the extra mile and give them free care when they are bleeding so badly that it's life-threatening because some will come septic because they induced and they did it in unhygienic conditions so we try to save the life first before you can think of any other thing, so we are very welcoming* (District Facility Medical Doctor, 32 years)

The providers interviewed further argued that building cordial relationships with PAC patients was mutually beneficial. For instance, in situations where there is an emergency case, service providers would be able to explain to waiting clients the urgency of the situation and attend to patients in crisis. The cordial relationship allows for decisions to be taken quickly without offending patients/clients on waiting list. This is how one of the study participants put it:

> *...but sometimes if the cases should come, you know some cases are emergency and others are not so sometimes we would talk to the person who is next to do it and beg her so we can attend to the emergency. Because if maybe you are stable, somebody who is not stable must be attended to first so we plead with them so we attend to emergency cases* (District Facility Nurse, 28 years)

Patience for Clients

For most of the provider participants, they were of the view that service providers must have time and patience for their clients in order to understand their concerns. Clients must not be rushed through the process or ignored. To them, it was the right of the patient to understand their situation and treatment options in order to make an informed decision. However, while this was the ideal, the provider participants also acknowledge that, on days that the client volume was high, providers are not able to spend adequate time with clients. For instance, a participant made this remark:

> *... generally, I think the system favours patient's satisfaction. We have time for them as well but for the time it is relative because looking at the situation that we have today, about the [large] number of people [that we have to attend to], but then generally we will have time for them and then communicate to them* (District Facility Medical Doctor, 29 years)

Another had this to say:

> *...Time to attend to clients varies depending on the pace at which the client takes to understand what the Doctor is trying to communicate.* (District Facility Midwife, 32 years)

The service provider participants also highlighted that clients are not to be rushed to decide nor should a decision be forced on them when they are indecisive. In such situations, clients are to be accorded the time they need to think about their situation and make an informed decision. The data also showed that in circumstances that the patients are taking long to decide, they

should be offered time or the option to be admitted at the hospital to afford them the time to think about their decision. A midwife remarked:

> *…There is a discussion between the clients and the doctor so when an agreement is reached, then the care is given. But when there is no agreement, we give the patient some space if they wish to be admitted for them to have enough time to think about it* (District Facility Midwife, 32 years)

Another also had this to say:

> *…sometimes we even give them time to go and think about it and still come back. So, we relate with them very well…* (District Facility Midwife, 37 years)

Autonomy

According to Donabedian (1988), the quality of technical care largely depends on the interpersonal relationship between the service provider and the client. The service providers will have to demonstrate that they are genuinely committed in helping the clients while the clients in turn have to trust the service providers and share valuable information about their condition. In this regard, the service provider involves the client in decision making regarding treatment by giving the clients autonomy. Regarding the clients' autonomy, two main perspectives were deduced from the data: client involvement in health decision making and providers understanding of patient autonomy.

Client involvement in PAC decision making

With respect to client involvement in PAC decision making, the analysis showed that service provider participants generally agreed that they sought the views of their patients in the treatment decision making process.

The service providers narrated that this was to avoid getting into trouble with the law should there be complications after the treatment. These complications, they indicated, could result from allergies to certain medications which the service provider might not have been aware of, hence the need to seek the views and consents of clients in treatment decision making. Below are the views of some participants to support this.

> *Their age is considered and their decision, everything we do here is based on what the client says. Most of the time you will get clients even wanting to be discharged against medical advice, so we tell them that, 'write a letter and you can go.' We do all this to educate you [client] that you [client] need to be on admission if the client says she wants to leave, they have the right. We do not do things without telling you [client], before every procedure has to be done, you [client] consent to it before it can be done. So their [clients] decision is the number one thing we consider when doing things. And when they are minors too, we talk to their parents or guardian that brought them. A client will consent to what you are saying when she has fully understood what you mean so if you come and it is induced and you are bleeding, bleeding can bring down your Hb, so if I explain everything to you, I believe you [client] will consent to it for your health* (District Facility Midwife, 28 years)
>
> *Oh yes, we involve them because there are some people who have allergies. Before you give the medicine, the doctor will check before they will do the procedure so the doctor will ask so many questions so*

you will know the patient before even the procedure starts… (Tertiary Facility Senior Health Assistant, 49 years)

In situations where the clients arrived at the facility unconscious, the service providers indicated that it was important to seek the consent of the treatment supporter. In the case of minors, consent was taken from their guardians or parents. A service provider remarked:

We explain things to them if even you are unconscious and you are here with someone like your husband or someone closer to you, we tell the person that this is what we are going to do, we cannot do something and later be in trouble. So, we explain to the client, if she is okay with it, we don't force them but we will tell her it will help her. For example, if you are pregnant and it has raptured, you are bleeding, even that, you will sign a consent form before we will start everything (District Facility Nurse, 28 years)

Another also had this to say:

…If the girl is underage, they mostly come with their parents so it is the parent involved because is the parent who is even going to supervise for them to take the drug so age is considered. If it is an induced abortion, you can't give medication again so you have to explain to the client… (District Facility Midwife, 37 years)

The provider participants also discussed that service providers must not discriminate based on age, type of abortion or marital status to involve clients in decision making. Every client, regardless of their background characteristics, has to be involved in the care decision-making process. To the service providers, saving the life of a client was the most important

consideration in the continuum of care and not their age or type of abortion that resulted in the complication. A midwife remarked:

> *...In post-abortion care if you are going to talk about age or marital status it will lead to maternal death and that is what we are preventing. So irrespective of your age, you have come with a problem and that is what we are going to handle as it is. Then after we have to stabilise you and solve the problem, we will then liaise you with the necessary people to come in and do further counselling for you* (Polyclinic Midwife, 40 years)

Another also remarked:

> *...It is expected that the older a client, the more experienced they are, hence little time is devoted to clients in this criterion, but in the case of minors, we devote much time to engage with them because we assume, they have little or no knowledge on the process...* (District Facility Midwife, 32 years)

Providers understanding of patient autonomy

Respect for clients' autonomy is an important issue in health care delivery. The service provider participants recounted acknowledging the autonomy of clients seeking PAC services. According to them, clients ought to be presented with treatment options that are available and assisted to make an informed decision. To the provider participants, healthcare cannot be provided to a client without their knowledge, hence the need to provide a client with all the services the facility can provide and allow the client to make a decision. The accounts provided by the study participants also revealed that they are aware of the importance of clients' autonomy and endeavour to respect the

same in their engagement with the clients. The service providers also highlighted that they usually seek the consent of PAC clients before delivering services. For instance, a participant had this to say:

> *My understanding is that, though we have to provide the service to the client at all costs to save their life, we still need the patient consent to do it so I believe that it is how you the health worker will explain the thing to the client that will let her consent to it* (District Facility Midwife, 28 years)

Another participant had this to say:

> *Definitely patients should be involved in treatment, you can't do something to someone without the person's knowledge, how it is being done and all that so I do believe patients have a role to play in what is done to them. It always balls down to what the facility can provide, so we lay down to them these are the things we can do, what do you want? If they want ours, we go down with it, if they want another method, we cannot provide we always refer to a facility that can provide that service* (District facility Medical Doctor, 26 years)

The service provider participants asserted that it is important to involve clients of PAC service in decision making regarding the services to be provided. This is especially important when it comes to delicate medical issues like abortion, with its potential complications. The views also showed that service providers need to involve their clients in treatment decision making regardless of their age, marital status or type of abortion. This is mainly because they are of the view that their first and foremost priority as health care providers is to save a life. The service providers also involved their clients in

treatment decision making in order to determine the best treatment possible to give to their clients. This will help mitigate the negative consequences of treatment such as allergic reactions. Seeking the consent of the clients also helps insulate the service providers from possible litigations that might arise from complications in treatment.

The evidence also shows that service providers are well aware of patient autonomy and perceive it as an important component of service delivery. They explained that regardless of the need for treatment to be given to a patient, you must seek the consent of the patient before treatment can be given. However, the choice of the patient must be considered in light of the services the facility can provide.

Communication

Communication is one of the key attributes of interpersonal quality when measuring quality health care services (Donabedian, 1988). This is because if there is quality communication between the service provider and the client, there is a higher likelihood of the client making an informed decision and also adhering to medical advices (Ameh et al., 2017). From the data, three perspectives were deduced: providing clients with treatment information, allowing clients to ask questions and be answered, and perception of client-provider interaction.

Providing clients with treatment information

One of the key themes that emerged from the data was that providing clients with adequate treatment information is critical for medical compliance. The data showed that PAC seekers need to be educated on the side effects of the medications and all these ought to be done before treatment for the clients

to clearly understand before they are sedated. This helps the effects of the sedation not to influence how the clients understand the information given to them. The provider participants pointed out that this approach enables the clients to make an informed decision. The data showed that service providers educated their clients on their condition and the services available for that condition. A medical doctor had this to say:

> *I have actually seen some clients before where you prescribe antibiotics for them, they go home and don't take it so that I am actually always courteous to make sure that I tell you, use this for that, use this for that. Sometimes they feel once they are done with the MVA they don't need the medication again, but I actually have to sit them down and explain things to them. Usually, I do it before the procedure to make sure that they understand because sometimes during the procedure we sedate them and I mean talking to such a client afterwards they might sometimes forget* (District Facility Medical Doctor, 26 years)

Another participant had this to say:

> *Okay, for instance, there was one case the woman came bleeding and I met her case when I arrived in the morning. I told them its not all bleeding cases that you even lose the baby, some it might be threatened, so the baby is still there. But initially, the man wanted us to do a CAC for the woman so that the woman will lose her twin gestation but the woman also wanted the baby. So I educated them that it's between the two of them so they have to make a decision now…* (Polyclinic Midwife, 31 years)

The above views also showed that the interaction with the client also gives the service provider a clear understanding of the situation and whether to start with the process or not. Sharing treatment information with the clients and allowing them to make an informed choice helps in promoting clients' compliance with treatment and medications.

Allowing clients to ask questions and receive feed-backs

Patients are no longer passive recipients of care but are now active participants in the care they receive at a health facility. As such, clinicians are encouraged to see the patients as partners in the provision of health care and also to incorporate their values and preferences into the care process (Ferlie & Shortell, 2001). In so doing, patients should be allowed to ask questions and be answered. This allows patients to have patient-centred health care. Analysis of the data showed service provider participants unanimously agreed that there is a need to allow clients to ask questions and be answered. This, they agreed, enhances cooperation from the clients. Allowing clients to ask questions also helps to ensure that the clients duly understand the education they have been given before the treatment process. For instance, a midwife remarked:

> *…you allow them to ask questions before you start everything, she has to understand whatever is going to happen to her so we allow her to ask any question that she has to before the procedure starts. After the procedure, too the post counselling you are doing you let the client tell you what you said just to make sure information is well passed* (District Facility Midwife, 28 years)

Another participant had this to say:

> *Oh yes, we [service provider and PAC client] sit and converse like what we are doing now, we talk a lot. Even those who will come and have already started the process by using medicines, we ask them the reason they did that and ask them if there is any problem that made them do that. Some people you know it might be a financial problem, others will say they are schooling and some also say their babies are too young and other kinds of stuff, so we talk a lot* (Tertiary Facility Senior Health Assistant, 49 years)

The views show that service providers allow women to ask questions and obtain clarifications of issues. This, in accordance with the opinions, is done to make sure that clients fully comprehended their condition and their preferred course of treatment. From the above views, it was also evident that this helps to ensure clients cooperate with the treatment process and also increases their adherence to medication after treatment, since they understand the importance of taking the medication given them after treatment.

Service providers perception of client-provider interaction

I further tried to examine the service provider's perception of client-provider interaction. From the data, the service provider participants were of the view that client-provider interaction is the discussion that goes on between the service provider and the client. They also elaborated that it is important since it is needed for the client to understand their condition and the treatment being given to them. It also helps the service providers to understand the clients' condition better and to be able to give them adequate treatment. Thus, client-provider interaction is an important part of the PAC service quality and

how service providers view it could influence their approach to service provision for women seeking PAC. One participant remarked:

> *Client provider interaction is when both the client and we the health service providers understand what we are doing and we are able to provide good health care. There must be an agreement between both parties, and if the patient really understands what is being talked about, the work becomes easier, but if on the other hand, the patient doesn't understand, we try as much as possible to make them understand the benefits, side effects and everything relating to the entire process so that they know what they are going in for by explaining clearly in a language the patient is conversant with* (District Facility Midwife, 32 years)

Another participant had this to say:

> *My understanding is, the discussion with the client whatever he or she is feeling it is important to help the nurses or the doctor for the treatment given to the patient* (District Facility Nurse, 28 years)

A medical doctor, however, remarked that despite the participants' understanding of client-provider interaction, factors like the patient-to-doctor ratio prevent the service providers from providing client-provider interaction to every client. This is captured in the quote below:

> *… sometimes you can get time for a client, you explain things to them, they ask questions and all that but you always don't get that time and freedom all the time. In the case where you are alone here, the place is overwhelming, a lot of emergencies in, you want to sort them out, you don't really get the time to talk for long but then there is yet still a time*

of interaction where you explain some things to them, but it's not as long or as probably as the patient will want (District Facility Medical Doctor, 26 years)

The views show that the service providers generally have knowledge about client-provider interaction and its importance. It was, however, revealed from the views that although the service providers were knowledgeable on client-provider interaction, they are not always able to interact with their clients. This is mainly due to the overwhelming number of clients that they attend to on a daily basis at the facilities – an indication of low doctor to patient ratio in the health facilities.

Providers' Perception of Women Seeking to Terminate Pregnancy

It is important to note that the attitude of a PAC service provider is said to be negative when that service provider perceived comprehensive abortion care (CAC) services as sinful and as nothing they could support (Paul et al., 2014). Essentially, service providers with negative attitudes toward CAC services or PAC patients are most probable to have less experience and training on abortion and related care/services (Abdi & Gebremariam, 2011; Paul et al., 2014; Warenius et al., 2006). In view of this, I explored the perception of service providers on women seeking to terminate a pregnancy.

Open-minded approach to abortion and PAC services

From the data, it was evident that most of the service provider participants do not judge women who present themselves to terminate a pregnancy. To them, everyone has a reason for their actions and inactions. Hence, they provide a counselling section for the women to know the reason for their decision and provide them with alternatives. If the woman still

decides to go ahead with the termination of the pregnancy, the service is then provided. According to the views of the provider participants, women are not denied the service of pregnancy termination since it is legal in Ghana to a large extent. The views also showed that service providers honour the decision of the women to prevent them from attempting illegal methods that could endanger their lives. One of the participants remarked:

> *I actually don't really have much in mind, I just usually ask them why they are doing it and depending on the reasons given, we sometimes try to encourage them to keep it and some do work actually. You realise their reasons are not that strong, they just probably want to terminate the pregnancy for a few reasons. And some you think it might harm baby and mother psychologically, I mean health is complete physical, mental and social wellbeing so once it affects social wellbeing and all that, I go ahead to do it* (District Facility Medical Doctor, 26 years)

Another participant had this to say:

> *I see it as a choice she has, it's a right too. I always say that nobody should be forced to carry an unwanted pregnancy so I think it's a choice she has and she has to come and exercise that right so I don't have any problems with that at all* (Polyclinic Obstetrician, 45 years)

A few of the service providers were, however, identified as pro-lifers and would not want to associate with the termination of pregnancy. These providers indicated that they try as much as possible to counsel the women against termination of the pregnancy. However, when the woman still insists

on going ahead with it, they refer them to colleagues who will be willing to provide them with the service. This is captured in the quote below:

> *What comes to mind is to talk to her and then find out, personally I am pro-life so I will just counsel her but then we have a number of Marie Stopes agents so in case we don't have anyone on duty who is willing to do it some of the other doctors will do it so if they are around, we just refer them to them but if they are not around, we will give them the number for Marie Stopes* (District Facility Medical Doctor, 29 years)

Some service providers would also not take part in providing pregnancy termination services because it is against their religion. These group of service providers try to talk their clients out of inducing the abortion. However, in instances that the women insist of terminating the pregnancy, they are referred to other colleagues or health facilities. One participant had this to say:

> *It's worrying because it is life you are carrying and you have no right to take somebody's life. Per me, my religious background doesn't permit me to allow someone to terminate a pregnancy so to me I will do all that I can to convince you…After all the counselling and the person still insist on terminating the pregnancy, that doesn't mean you should insist that the pregnancy should be there, probably she may go out and do a different thing that will complicate her life and she may die. So, you still refer her to the family planning unit and they will give her the options which could be a safe abortion which she will finish and have a healthy mother than going around to take something different then come back with complications* (Polyclinic Midwife, 40 years)

From the above views of the participants, most of the service providers perceive pregnancy termination as the choice of the women. They, therefore, do not hold any judgemental perception against these women. According to the views of the participants, service providers, however, provide these women with counselling services before the pregnancy termination. A few of the service providers, however, identify as pro-lifers and are against the termination of pregnancy. From the above views, these groups of service providers try as much as possible to convince women to change their minds about terminating their pregnancies. However, in situations where the women insist on going ahead with the termination, they refer them to other colleagues to provide them with the treatment. This, to them, is a case of finding a balance between their moral obligation and their legal obligations to their clients.

Service Providers' View on Quality Structure

Structure, in this context, relates to the available infrastructure at the health facilities for the provision of PAC. It also examines the availability of supplies and equipment necessary for the provision of PAC, as well as the administration and governing structure that enables or inhibits the provision of quality PAC services at the health facilities.

Infrastructure

Having an infrastructure that ensures privacy and confidentiality is a key component of service quality (Donabedian, 1988). This is to provide health care in an environment that is user-friendly and provides the client with comfort, privacy and confidentiality. These are attributes that make it easy and attractive for patients to seek health care at a health facility. The service

provider participants conceptualised infrastructure as the ability of the facility to have an environment that provides privacy and confidentiality. The infrastructure of the health facility should have a separate room for treatment, provide protection of patients' records and ensure no one hears doctor-patient interactions. Two key themes were derived from the data: separate treatment rooms and protection of clients' information.

Separate treatment room

In this study, a "separate treatment room" concerns the facility having a designated room for the provision of CAC services. This is a place where PAC clients could receive their treatment in privacy and confidentiality. According to the service provider participants, it is important to have a separate treatment room for CAC services. This, to them, will help promote the provision of privacy and confidentiality. However, most of the facilities do not have a separate treatment room for the provision of PAC services. PAC clients were usually treated at the obstetric and gynaecological unit where other services are also provided. Some service provider participants were of the view that their facilities did not have adequate infrastructure to have a separate room for the provision of PAC/CAC services. The unavailability of a separate treatment room also inconveniences the service providers in their quest to provide prompt treatment since they have to share treatment room with other healthcare services. A participant had this to say:

> *It is actually not separate, usually our clients who come for a vaginal delivery are sometimes examined in the same room, so it is not a separate treatment room for abortion. We use the same treatment room for SVDs (Spontaneous Vaginal Delivery) and all that so sometimes*

> *when the place is overwhelmed if you are having an MVA (Manual Vacuum Aspiration), someone is also examining a client there, so the facility is not that adequate to have a special room for abortion* (District Facility Medical Doctor, 26 years)

Another participant remarked:

> *The treatment room we use here is the same as the labour room, we don't have a separate room, I don't know if family planning, they have some. We don't have a specific room for EOUs (Evacuation of the Uterus) which I think we have to get. After the EOU here, we bring them back to the ward and the ward too there are other cases there but probably they don't know what we went to do there, they will not know* (Polyclinic Midwife, 31 years)

It is, however, important to note that the absence of a separate room does not entirely mean a compromise on quality. Service provider participants asserted that there is a need for service providers to put measures in place to ensure that the interest of the client is safeguarded. Some participants narrated that although they do not have a separate treatment room, they do not mix the clients during treatment:

> *As I said earlier, we do not have a room for that [PAC services], though we do conduct delivery there but we don't mix them with those who have to deliver so that we can provide adequate privacy for them because some of them even feel shy to come for that particular procedure. But in other facilities I know they have a setup for that procedure alone which is combined with the family planning unit so you as an individual going there, people might think you are going for*

> *a family planning service meanwhile you are going for an abortion service. So here it is just the doctor, client and one assistant that's all and nobody can see you from outside when you are in the room* (District Facility Midwife, 36 years)

Whereas most of the service provider participants indicated that they do not have a separate treatment room in their facilities for CAC and PAC services, a few of them indicated their facilities do have. These facilities have a separate treatment room that clients are sent to for treatment. In those rooms, it is only the service providers and the clients that are allowed. A service provider participant who indicated that their facility has a separate treatment room had this to say:

> *We have a separate room for the procedure that we take the client there so we don't allow any person to go there. It is the doctor and the health worker assisting the doctor that goes there together with the client. It is only three people that go there…* (District Facility Midwife, 28 years)

Another service provider participant remarked:

> *…we have a separate treatment room for them [PAC clients], when she says she wants to do family planning then we take them to where it is done; it is a different door they use to enter. Nobody can see you from outside* (District Facility Midwife, 37 years)

The above views show that service providers perceive separate treatment room for the provision of CAC and PAC services to be important. However, most of the facilities do not have a separate treatment room for PAC services. PAC clients had to be treated in the same treatment room that other

health care services are provided. This notwithstanding, it was evident that the service providers try not to mix the clients to ensure some privacy and confidentiality. In cases where there the facility is overwhelmed with patients, the treatment beds were separated with screens to cover the clients and provide some privacy. The unavailability of a separate treatment room in the facilities also serves as a barrier in the quest of the service providers to provide prompt treatment to their clients.

Protection of client's information

Non-disclosure of information in this context concerns the infrastructure in place for service providers to protect the information of their clients from being disclosed to unauthorised persons. The confidentiality afforded to clients at the facility makes them feel comfortable. Per the assertion of the participants, safeguarding patient identity promotes client confidence and they will be willing to seek health care at the facility again or encourage others to do so. Even when clients presented with their partners, there was a need for the consent of the clients to be sort before any information could be disclosed to their partners. To support this, a service provider had this to say:

> *A consent form is filled by the client before everything begins. Most often, we come across situations that the woman does not want her partner to be aware of it, so we do them for them…* (District Facility Midwife, 32 years)

Another service provider also remarked:

> *On the privacy, with PAC cases, it is just between you and the client, if there is a third person you ask the client if she is comfortable with it, if*

> *she tells you no then you stop, if she tells you to continue then we do it because it is a private thing. On the identity protection, they have a consent form they sign, that one their names don't come on it, it is client number that we use to identify them, like number 10, 20, and others but you have a book that you write their name in and that one the client is aware but, on the paper, it is number 10* (District Facility Midwife, 37 years)

It is, however, worth noting that the information of clients was only disclosed to a colleague service provider during shift changeover as part of debriefing. A participant remarked:

> *…Confidentiality is very important too so we don't disclose any information to anybody. Apart from the nurses who come to take over from us whom we explain things to before we leave, we don't disclose any information to anyone* (District facility Nurse, 28 years)

Other Services Provided as Components of PAC

Post-abortion care services have other components apart from the treatment. PAC services comprise both curative and preventive care. While treatment is part of curative care, other components such as counselling form the preventive care (WHO, 2012; PAC-consortium, 2015). It is against this background that I sought to explore other PAC services that the infrastructure support provided at the health facilities. In this study, the service provider participants viewed other services provided as component of PAC to be client follow-up services, referral services and post-abortion counselling services.

Client follow up services

The data shows that as part of PAC services, the facilities also provide follow up services. The follow-up service is offered to all PAC clients. The narrative of the service provider participants points to PAC clients typically having two weeks to return to the facility for review. To the participants, PAC service is only complete after a review has been conducted two weeks after treatment. However, turn-up is poor and hence service providers have to result to phone calls to follow up on PAC clients. The views of the service provider participants also showed service providers presented the PAC clients with their contacts to call in case the PAC clients notice anything out of the ordinary while at home. According to the service provider participants, client follow up is mostly done by the use of the phone since most of the clients do not come back for the review at the facilities. This is captured in the quotes below:

> *We tell them to come back in two weeks' time and then we will repeat the scan again to see if everything is fine with them and then we let them do another FBC test to see if their blood level is fine* (District Facility Midwife, 28 years)
>
> *We will review them in 2 weeks' time, then we repeat pelvic scan to see if the uterus is empty depending on whatever happens. A few of them may have gestational diseases or in one instance we actually had an ectopic pregnancy present with an intrauterine pregnancy and so the pelvic scan helps that* ... (District Facility Medical Doctor, 29 years)

From the foregoing, it is clear that client follow-up services are a part of the PAC services provided in Ghanaian healthcare institutions. A review

after two weeks of receiving PAC services is a requirement in the provision of PAC. The views of the participants, however, showed that clients more often than not do not adhere to that. Nonetheless, to ensure that all clients do not experience further complications after treatment, service providers do phone call follow-ups. The clients are also provided with the contact details of the service provider to enable them easily contact the service providers in case of any abnormality after treatment.

Referral services

The data also showed that the facilities have the infrastructure to offer referral services to their clients. The referral services need to be offered to clients who presented with a complication that is beyond the capacity of the facility. It is also to be offered when the client prefers a certain treatment that is not available at the facility. In these instances, the clients are referred to a facility that can provide treatment for such complications. This, according to the service provider participants, is done to ensure that clients are provided the treatment of their choice. This also helps in promoting a client centred approach in the provision of PAC services in health facilities in the Greater Accra region. Referral services were also to be offered when the service providers realised the complication was wrongly diagnosed and not a PAC case and had to be treated at a different unit. For instance, a service provider had this to say:

> *… mostly they refer them here, sometimes when they come here we tell them to go to the ANC or they refer you to another place, maybe the case that you brought here is not an emergency so you will not be*

> *directed here or what they thought was the problem is not the problem so we send them back* (District Facility Nurse, 28 years)

Another service provider had this to say:

> *So, with the referral sometimes I do refer especially when what they want is not provided here, we have other facilities somewhere I refer them to…* (Medical Doctor, 26 years)

A service provider also indicated that there were instances when the clients will want a second opinion before deciding on which treatment to opt for. In such situations, the clients are referred to another facility. She remarked:

> *On some occasions, you would realise the labs result or the scans clearly indicate that the client needs to undergo the procedure but clients will say they want a second opinion or a second scan to be taken, so we allow them to do so out of their own will. Even if they want to be referred to another hospital, we willingly do that for them but we make sure we call the referral side and inform them about what is going on so that when the patient gets there, they are treated with the needed care. In most cases, nurses are given them to accompany them wherever they go* (District Facility Midwife, 32 years)

Post-abortion counselling services

According to the service provider participants, post-abortion counselling is an important aspect of the PAC services which ensures clients are educated to avoid a reoccurrence of post-abortion complications. This also helps women to make post-abortion family planning decisions to avoid any further unwanted pregnancy or steps to take to ensure subsequent pregnancies do not result in miscarriage. The service provider participants also highlighted

that service providers provide post-abortion counselling services to PAC clients. Clients who wished to have a baby are counselled on the steps to take. Likewise, clients who wish to avoid pregnancy are also counselled and directed to the family planning unit for further counselling services. Clients are also counselled on the importance of adhering to the medications and advice given to them. For instance, a midwife had this to say:

> *…After the procedure, we counsel you on the importance of taking the medication. With the spontaneous abortion, we educate them that the next time you want to get pregnant, come for preconception care and when you are pregnant to come early so that if it is anything that keeps letting the pregnancy abort, we take care of it. we have a family planning unit so it is a midwife who provides the contraception services* (District Facility Midwife, 28 years)

Another had this to say:

> *…Yes, pre and post. And I think that when we say, maybe when she goes home and she is bleeding, there is temperature, she should come and report. That is the post so when she sees all these things, she is aware that she should call or come back to the hospital* (District Facility Midwife, 37 years)

The service provider participants, however, indicated that the post-abortion counselling service was usually provided at the family planning unit. Clients are, therefore, directed to the family planning unit to receive post-abortion counselling. One service provider participant remarked:

> *The family planning unit takes care of contraception because it is very important, you know they are sexually active so after the procedure,*

they put them on contraceptive to prevent any unwanted pregnancy. … Some will tell you they don't even know anything about family planning so that is when we send them to the family planning unit to do the total education over there on all the various methods so that they will have an informed choice (Polyclinic Midwife, 40 years)

Another service provider participant had this to say:

… After the procedure, aside from talking to them we send them to the family planning unit. All the clients are attended to, one after the other because there is data-keeping and we want to make sure that they are adhering to what is going on or they understand what is happening here so both before and after (Polyclinic Midwife, 32 years)

It is evident that service providers perceive post-abortion counselling as an important component of PAC services as it offers the service providers the opportunity to educate the clients to avoid a reoccurrence of post-abortion complications. The health facilities offer post-abortion counselling services. However, post-abortion counselling is usually carried out in the family planning unit. After treatment, the PAC clients are directed to visit the family planning unit and receive post-abortion counselling. The views of the participants showed that the counselling service is designed towards the needs of each PAC clients. Women who are in need of a baby are counselled on the necessary steps to take while those who want to prevent unplanned pregnancies are also educated on the family planning options. Clients are also counselled on the importance of adherence to the medication given to them.

Organisational Characteristics

The organisational characteristics were conceptualised as the component of infrastructure that enabled service providers to provide positive treatment outcomes. PAC treatment encompasses the use of abortifacients such as misoprostol and MVA techniques as a solution to incomplete abortions and also stop bleeding (Barot, 2014). Following from the above, I sought to explore the service providers' perception of their facilities infrastructure that will enable them to provide PAC treatment. The key themes that emerged from the data were satisfactory treatment outcomes, training and availability of consumables/equipment for PAC.

Satisfactory treatment outcomes

The service provider participants in the study shared their view on satisfactory treatment outcomes by rating themselves to be good and excellent based on the successful treatment outcomes. To the service provider participants, a satisfactory treatment outcome is one that does not record any complications after treatment. This assertion was, however, largely that of the doctors. In the government health facilities, the other cadre of service providers were not sure of their ability to provide quality PAC services. This, they said, was the result of them playing a passive role while the medical doctors play an active role in treatment. For instance, a medical doctor who said his treatment outcomes were good had this to say:

> *I think am well equipped to do so. So far, with treatment outcomes, I can say that 94% of my clients do not come back with retained product or infection, so those are the things I will say* (Polyclinic Medical Doctor, 32 years)

A midwife in a private health facility who plays an active role in the delivery of PAC also had this to say:

> *...If you say, I should access myself when it comes to this job; I will give myself 99.9%, for that one no two ways about it because I was once a quality accessor before coming to the field to work in the clinic. I was the quality accessor advisor for the organisation* (Health Centre Midwife, 43 years)

Some service provider participants were also of the view that the ability to provide quality PAC services was based on the ability to determine emergency cases early and provide timely treatment. This is seen in the quote below:

> *I think I will use good, good to very good is fine. The treatment outcomes are actually very good…I think I am very good; well, I think I am able to identify emergencies easily and then act fast to them with them. With emergencies, you just have to identify them fast and then act fast and make sure that the patient becomes stable. Once you are able to do that, I think the patient should be fine* (District Facility Medical Doctor, 26 years)

The other cadre of service providers in the government health facilities, however, were not so sure of their ability to provide quality PAC services. This was because the provision of PAC treatment was reserved for medical doctors. For instance, a midwife who used to work at a health centre where she was allowed to provide PAC had this to say:

> *It's been a while since I did some, it was when I was in Kumasi so there, I will say 9 out of 10 because there are certain complications you cannot manage you need to call the doctor. My treatment*

outcomes were very good and that depends on the client… (District Facility Midwife, 36 years).

Another service provider participant had this to say:

Oh, with the vacuum aspiration to me I need to be supervised because it's a long time after the training but we still have a few midwives who were practising it frequently so whenever the doctor is not there, we sometimes refer them there to do the treatment. Here because it is a polyclinic any of the cases that come here, we report to the doctor, so if the OBG specialist is not there, another doctor will be available to do it (Polyclinic Midwife, 40 years).

The above views show that the perception of service providers on their ability to provide quality PAC services is based on their cadre and their role in the provision of PAC services. While some cadre of service providers take an active part in the provision of treatment to the clients, others play a passive role. The views of the participants, however, showed that this was not the case in private health facilities. In the private health facility, task-sharing was being practised to help reduce the workload on the medical doctors. In the government health facilities, on the other hand, only medical doctors are allowed to provide treatment. The midwives at the government health facilities were only called into action when the service providers are overwhelmed by the workload or in the absence of a medical doctor. This, thus, affected the confidence of the midwives in the government health facilities in the provision of PAC treatment as compared to midwives in private health facilities.

Adequate training

Another key theme that emerged from the service providers' perspective on organisational characteristics for the provision of quality PAC services was adequate training. The service provider participants indicated that receiving adequate training will enable them to get better and record better treatment outcomes. The participants also highlighted that the training they received at school was adequate for the service. They were also of the view that the provision of PAC services is also an on-the-job training in which senior colleagues continue to teach you new developments on the job. One service provider participant remarked:

> *I think the training was adequate. …The work is actually on the job training too. Your senior colleagues come, this one tells you about new development, so this is how we do it here, this is how we do it there. So, I think we still share knowledge among ourselves too and the skills are upgraded too* (District Facility Medical Doctor, 26 years).

Another service provider participant also remarked:

> *When I joined the unit, I had training; I had senior colleagues so I had the opportunity to get training both hands on and the theoretical sections* (District Facility Medical Doctor, 29 years).

Whereas the medical doctors indicated that they had adequate training at school and on-the-job, the midwives noted that it will be prudent that they are also provided with training to provide quality PAC services. This, they said, will help reduce the workload of the medical doctors. This is captured in what one service provider participant said:

> *...it will be good if all midwives, not even just midwives even some nurses are trained on MVA because the MVA is not only for the CAC, sometimes it could be retained product so if we are trained it will help because here we have only one OBG specialist, so if he is not there and a woman has come bleeding, the scan is showing it is inevitable and maybe at that time you are not able to reach the specialist and there is no doctor available, if we have been given such training we could save that woman. Then afterwards doctor will come and review.* (Polyclinic Midwife, 40 years)

She further remarked that it has been a long time since she had her training and had not practised much since the medical doctors are the ones that provide PAC services:

> *That was a long time when I completed midwifery and I had the training. In fact, we were trained on CAC and not quite long that we came here but here we have doctors and others so I didn't practice it much* (Polyclinic Midwife, 40 years)

The opinions of the service provider participants on the study's findings demonstrate that adequate training is a prerequisite for the provision of quality PAC services. However, whereas all service providers receive sufficient training in school, organisational characteristics of the facilities is such that the medical doctors receive on-the-job training as well and are constantly practising by providing PAC services. The other cadre of service providers do not utilise the training they received at school, hence becoming rusty in their ability to provide quality PAC. The data also show that the other cadre of service providers are willing to help the medical doctors in the

provision of PAC treatment since they have also been trained in the provision of PAC services.

Availability of consumables/equipment for PAC

The provider participants expressed disagreements on the availability of consumables and equipment needed to provide quality PAC services. Whereas some were of the view that their facilities had adequate consumables and equipment, others were of the view they did not have adequate consumables. However, others were also of the view that they did not get their equipment restocked regularly and they had to clean and sterilise the old ones for reuse. The service provider participants reflected that the provision of consumables and equipment was the responsibility of the government; however, this was not being provided regularly. Therefore, the service providers had to take the responsibility to acquire their own equipment to be able to provide PAC services to their clients. For instance, a midwife remarked:

> *… There is a problem with space and then we don't also have the instruments to carry out the process. Even currently, what doctor is using is his own personal MVA set…* (Polyclinic Midwife, 40 years)

Another service provider participant remarked:

> *…Hmmm, sometimes they have to even buy themselves because it is not easy to get them … ideally you have to use let say I think 20 times but sometimes you are forced to go the extra mile because you are not getting it but then you will not say because you are not getting it if someone is in with an emergency and you have some you have used for*

> *more than 20 times you won't use. It all depends on how you clean and sterilise your equipment* (District Facility Midwife, 36 years)

On the other hand, a few of the service providers also indicated that their facilities have adequate consumables and equipment which are also restocked regularly. One participant remarked:

> *They are always available anytime and any day, they still come for monitoring because there may be an emergency at any time. There is nothing lacking, we have everything…* (District Facility Midwife, 32 years).

Another participant also had this to say:

> *We don't have a problem with it. Everything is constant here and everything is hygienic so we don't have any problem with that* (Tertiary Facility Senior Health Assistant, 49 years).

Discussion

This objective examined the views of health professionals on the quality of PAC services at health facilities. The study showed that the views of the service providers were based on the process and infrastructure quality of PAC services. With regards to the process quality, the key issues that emerged had to deal with interpersonal skills of the service providers, autonomy, communication and perceptions of service providers on abortion.

The perception of service providers towards abortion and PAC services greatly affects their attitude towards PAC (Paul et al., 2014). For instance, in Uganda, Cleeve et al. (2019) found that service providers were torn between the conflict of morality and duty and this affected their attitude and quality of PAC services negatively. This contradicts the findings of the current service

which found a positive attitude from service providers towards PAC clients. The current study showed that the service providers are of the opinion that saving the life of their clients is paramount. Hence, there is the need for a positive attitude to encourage the clients to seek treatment. Paul et al. (2014) found that although service providers in Uganda had a positive attitude toward PAC clients, they expressed frustration in dealing with PAC clients since PAC clients refuse to divulge what happened. The current study, however, showed that, in Ghana, service providers show positive attitude toward PAC clients to encourage them to open up during the discussion. This shows that service providers in Ghana have good interpersonal qualities which is an important component of the process of quality as highlighted in the conceptual framework.

It was also observed that the positive attitude by the service providers towards clients could be attributed to the fact that providers were of the view that the only reason they are at the facility is because of the clients, hence the need to treat them with utmost importance. This confirms the argument of Paul et al. (2014) that the perception of service providers greatly affects their attitude towards PAC clients. For instance, service providers who perceive PAC services to be sinful and morally wrong have a negative attitude toward clients (Bacon et al., 2014; Chiweshe & Macleod, 2017; Faundes & Miranda, 2017; Izugbara, Egesa, Kabiru, & Sidze, 2017; Mutua, Manderson, Musenge, & Achia, 2018). The negative attitude of service providers could, however, be changed with the provision of education and training for service providers (Warenius et al., 2006; Abdi & Gebremariam, 2011; Paul et al., 2014). With a positive perception of quality of care, clients are likely to revisit and also

encourage others to seek health care at the health facility (Manzoor et al., 2019)

I also found that in Ghana, service providers perceive client involvement in health care decision-making as a very important aspect of health care, especially in delicate health care situations such as abortion and PAC. Service providers were also involved in treatment decision-making regardless of their age, marital status, or type of abortion. This contradicts findings of a study conducted in Kenya which suggests that age, parity and other demographic characteristics of clients are associated with the quality of PAC services clients received (Mutua et al., 2015; Izugbara et al., 2019). Again, Mutua, Maina, Achia, and Izugbara (2015) observed that in Kenya, younger women and women without education are more likely to delay in seeking and utilising PAC services primarily because such women lack autonomy in decision-making concerning their health and well-being. This was, however, not the case in the current study which observed that service providers are knowledgeable of patients' autonomy and hence engage their clients in decision-making. This also helps to ensure clients cooperate with the treatment process and also increases their adherence to medication after treatment. Whereas this is a positive sign, this finding has to be taken with caution because of the study setting. The situation could be entirely different in rural settings and lower-level facilities.

This notwithstanding, the findings also showed that although service providers are aware of the importance of client-provider interaction and also engage their clients in decision-making, they are sometimes faced with an overwhelming number of clients and are not able to engage all the clients. This

could be linked to another finding of this study which showed that in government-owned health facilities, only medical doctors were allowed to provide essential PAC services like treatment, while the lower cadre of service providers were restricted to passive roles. This calls for strengthening task-sharing to reduce the workload on medical doctors. There is documented evidence that lower cadre providers and mid-level personnel such as nurses and midwives are able to provide PAC services (Bacon et al., 2014; Paul et al., 2014; Bankole et al., 2018). The practice of task shifting has proven to be an effective way of optimising the roles of available human resources by redistributing tasks among the health workforce team (Nabudere et al., 2011; Dawson et al., 2013). This affirms the argument of Riley et al. (2020) that interventions geared towards improving the quality of PAC services should include addressing human resource shortages at facilities.

The structure quality of care, according to Donabedian (1988), has to do with the quality of amenities such as infrastructure, equipment and consumables to provide quality PAC. Studies have shown that the lack of adequate facility space serves as a barrier to the provision of quality PAC services (Osur, Baird, Levandowski, Jackson, & Murokora, 2013; Sully et al., 2018). This affirms the findings of the current study which also observed that most of the study facilities do not have the required equipment and a separate treatment room for PAC services. This makes the provision of quality PAC as well as privacy and confidentiality for clients during PAC services difficult for the service providers. A possible explanation for the lack of adequate amenities could be attributed to the lack of financial support for infrastructure in the health sector in Ghana. For instance, in 2019, the government of

Ghana's budget for the Ghana Health service comprised 99.8% for the compensation of employees and only 0.2% for goods and services (UNICEF Ghana, 2019).

Regarding the other services provided as a component of PAC services, it was evident that client follow-up services, referral services and post-abortion contraceptive counselling were important services provided that ought to be provided. These other services are important for the provision of quality PAC services as indicated by WHO (2015) that both curative and preventive care are needed for the provision of high-quality PAC services (Owolabi, Biddlecom, & Whitehead, 2019). However, the current study showed that PAC clients in Ghana rarely utilise follow-up services. A plausible explanation is that once clients are relieved from the discomfort they faced before treatment, they see no reason to go for a follow-up check-up. This calls for the need for extensive counselling services for clients to understand the need for follow-up services.

CHAPTER SEVEN

SYNTHESIS OF CLIENTS' AND PROVIDERS' PERSPECTIVES ON THE QUALITY OF PAC SERVICE DELIVERY

Introduction

Post-abortion care services consist of both curative and preventive care services. Curative care covers the treatment of incomplete abortion and complications while preventive care has to do with contraceptive counselling and family planning services (WHO, 2012; PAC-consortium, 2015). Clients' experience has been acknowledged as an important component of quality of care, in addition to clinical effectiveness which largely depends on the service providers (Doyle, Lennox, & Bell, 2013). Thus, quality of care can be viewed through the lenses of both clients and services providers. As such, the chapter synthesises the perspectives of service providers and clients on the quality of PAC services, highlighting differences and similarities. This is particular important as conceptualisation of quality may differ between service providers and clients. This was conceptualised as outcome of PAC services which was further categorised into technical outcome and the interpersonal outcome. This conceptualisation (i.e., technical outcome and interpersonal outcome) falls under the broad theme of notion of quality outcome of PAC services.

Notions of Quality of Outcome of PAC Services

The outcome, in this context, is the subjective views of clients and service providers on the quality PAC services. It also measured the service providers satisfaction with the status of PAC services. This was categorised into technical outcome which deals with the physical and functional aspects of care (reduction in disease and absence of complications, among others) and

the interpersonal outcome which deals with the satisfaction the patient derives from the care received and the effect it has on the quality of life of the patients from the patients and service providers perspective (Donabedian, 2003).

In view of the above, participants were asked to comment on the quality of PAC services in the selected health facilities based on their experience. With regards to the interpersonal outcome, two main themes were deduced from the data (quality of communication, and prompt attention to clients reporting for PAC services). Four main themes were also deduced from the data for the technical outcome (quality of treatment, quality of environment, consumables and equipment for PAC, and privacy and confidentiality). Aside the interpersonal outcome and technical outcome, two key themes (training of nurses on PAC and task sharing and positive experience but room for improvement) also emerged inductively from the data.

Interpersonal Outcome

Quality of communication

Quality communication, in this context, relates to how the service providers interacted with the clients seeking PAC service with clients' satisfaction as the primary aim. The client participants identified three indicators that underpinned their perspective of quality communication. These indicators of quality communication are politeness, patience and respect from service providers during communication. This group of clients, irrespective of their background characteristics, were happy with the behaviour of the service providers and how they spoke to them. To these participants, the way service providers interact with clients greatly affect their health seeking experience.

For instance, a 29 years old student who presented with induced abortion remarked "they [service providers] were always polite when talking to me'. Another client had this to say:

> *They were very good and polite towards us. They accorded respect to us anytime they wanted to say something to us* (33 years trader, Induced abortion)

Another client remarked:

> *... they all talked with me with some kind of respect. They were somehow friendly, especially with my doctor, they often check up on you to check your BP and other stuffs, and they ask you how you are* (32 years hairdresser, Spontaneous abortion)

Whereas the clients' perspective of quality communication from their experiences was based on the behaviour and manner in which the service providers speak to them, the service providers, on the other hand, perceived quality communication as one that is patient-centred. This is different from the clients' perspectives on quality of PAC services. In the view of the service providers, quality PAC service is achieved if they are able to educate their clients on the process and treatment procedure before the commencement of treatment. To them, the client should be made aware of the options so that they make an informed choice. Again, the service providers reiterated that clients should be involved in the decision-making process. For instance, a participant indicated:

> *... For post abortion care to be quality means making sure patients understand what they are going to do, and after it is done, follow up to make sure they don't develop complications and when they are*

developed you will act quickly and then offer contraceptive care to those who will need them. I think basically if you are able to do them, then I think abortion care should be okay (District Facility Medical Doctor, 26 years).

… Usually, before we start everything, we tell them about what the abortion care is going to involve, both during and after. We don't wait and inform them after because when they don't know what is really going to happen and you start with the procedure, they start getting uncomfortable, hence it is best to educate them before undertaking the process and after that, the medication and everything follows. They need to be aware of what is going to be in their system and how it is going to be in their system for the next pregnancy especially those who really want to conceive after…. (District Facility Midwife, 32 years)

Prompt attention to clients reporting for PAC services

The data also showed that another experience that shaped clients' perception of quality PAC services was prompt attention from the service providers upon their arrival at the health facilities. Some clients expressed satisfaction with the quality of service based on the prompt attention they received from the service providers. Others were also happy with the way service providers were prompt to get the consumables needed to render PAC services to them. The narratives from the study participants highlighted that regardless of the time (whether day or night) clients presented at the facility with complications from abortion, they received prompt attention. This theme (prompt attention) was derived from both the service providers' and clients' accounts. A client who was happy with the prompt attention had this to say:

> *I will say they are perfect because how they treated me that night was nice, I even thought that when I get there that night, they won't even take care of me but they did their best. In most of the hospitals that I have gone to, if you go in the night, the nurses will never mind you and you will be there suffering*. (28 years trader, Spontaneous abortion)

Similarly, prompt attention also emerged from the side of the service providers as an important part of the quality of PAC services. For a health situation such as abortion which can be life-threatening, time is of the essence. Participants emphasised that prompt attention should be complimented by reassurance to the client. A service provider who also indicated that prompt attention is a reflection of quality PAC services had this to say:

> *The quality of post abortion care is given prompt and adequate treatment to a woman who needs post abortion care. Following with planning and making sure to let her know we have experts here who can give her that quality care that she needs.* (Polyclinic Midwife, 40 years)

The above narratives show both clients and service providers have a converging experience on prompt attention as a measure of the quality of PAC services. Participants are of the view that prompt attention reduces the waiting time at health facilities and this enables women to receive early treatment which could be the distinction between fatality and survival. The views also showed that delays in receiving treatment could worsen the condition of the client or result in maternal mortality. According to the narratives, there is a chance of delay in health-seeking decision making and delay in commuting to

the health facility; hence, there is a need for prompt attention to be provided at health facilities to prevent further delay.

Technical Outcome

Quality of treatment

Quality of treatment was one of the key themes that emerged from the data under technical outcome. From the narratives of the participants, what is meant by quality of treatment varied between service providers and the clients. Some clients were of the view that the PAC service they received at the facility was quality because of the treatment provided. These clients expressed satisfaction with the outcome of the treatment that they received. Some clients also expressed satisfaction with the treatment by comparing their condition before arriving at the facility and their condition after the treatment. One participant remarked:

> *I cannot say anything, but the way I was before I came here, I can only give thanks to God. When I came this was not how I was but now I am better so I thank God and the doctors because they treated me very well.* (32 years hairdresser, Spontaneous abortion)

The views of other client participants also showed that clients also judged the quality of treatment based on the process and outcome of the treatment process. Below is the remark of a participant to corroborate this.

> *It is very fine because when somebody does something good for you, you need to acknowledge him or her. At times it is not everywhere you go that they will take care of you like the way they did*. (35 years trader, Spontaneous abortion)

Service providers, on the other hand, described quality PAC services/treatment to be one that records a smaller number of complications after treatment. These providers were of the view that once clients receive treatment and do not return with complications after treatment, then the service provided is quality. Hence, the quality of PAC services is measured by the number of complications that are recorded after treatment. This perspective is different from that of the clients. This is what some of the service providers had to say:

> *I will describe it as quite good because as I said we have not recorded any direct maternal death as a result of abortion before [where services were sought from the facility]. It was just one occasion that I remember somebody came and did it and they come back with complaints and pains so we have to admit her and administer antibiotics and she became okay so the care is quite good.* (Polyclinic Obstetrician, 45 years)
>
> *We haven't had people coming back with complications so I think it is very good. Just a few that sometimes they come with pelvic inflammatory disease (PID) but it is being treated so I think it is good.* (District Facility Midwife, 28 years)

Quality of environment

Quality of environment as a technical outcome was derived from the clients' data. Some clients constructed their perceived quality of service based on the physical environment in which the treatment was provided to them. They were satisfied with the serene and peaceful nature of the environment in which they were treated. One participant remarked:

> *I think if I have to grade between 0 and 10, I will put them on 8. I have not had an experience with this before but generally I feel that I am comfortable here, the environment is quiet and peaceful* (33 years trader, Induced abortion)

Some also shared the view that they were happy about the hygienic environment in which they received treatment. For instance, a client who expressed she felt comfortable because of the environment had this to say:

> *The hospital seems to provide quality care as all the Doctors/Nurses I met were up to the task, the place was neatly kept and the patients seem to all be responding to treatment* (23 years student, Spontaneous abortion)

Positive experience but room for improvement

Although all the clients and service providers were generally happy about the quality of PAC services at the various health facilities, a few were of the view that there is room for improvement. For instance, a client was of the view that it will be prudent if the service providers could provide post-abortion counselling services. Remarks were also made for the various units responsible for the provision of PAC services to be in close proximity to each other. These, according to the clients, are some of the ways the quality of the service can be improved. The call for improvement was made based on their experience at the facility.

> *Everything is perfect, the only problem I had was where they asked me to go for the scan. The place is far, if they can bring it closer to the hospital, it will be nice.* (28 years trader, Spontaneous abortion)

> *If not for the phone that was stolen, like I am okay, so now I will give 7 out of 10 for the quality of care. Again, I know they are busy but after the process, they need to give counselling, and talk to us for us to feel relaxed because we have been through a lot*. (32 years hairdresser, Spontaneous abortion)

On the side of the service providers, they shared a similar view that even though they provide quality PAC services, there is a need for improvement due to the challenges of space and equipment that confront them. A service provider also indicated there is room for improvement and had this to say:

> *So, because of some of the challenges we face, I will say that we are doing well but there is a lot of room for improvement"* (District Facility Medical Doctor, 32 years)

Consumables and equipment for PAC

A key theme that emerged from the service provider participants data was inadequate consumables and equipment for PAC. Service providers lamented the inadequate consumables and equipment needed to provide treatment to their clients affected the technical outcome. This, they said, makes it uncomfortable to work. For instance, a nurse narrated:

> *… we don't also have the instruments to carry out the process. Even currently what doctor is using is his own personal MVA set…* (Poly Clinic Midwife, 40 years)

Another nurse remarked:

> *… and the equipment they need to treat the patient, some of them are not available so if they will get some for us. The nurses too must be*

appreciated when they do something good because they are really suffering here. (District Facility Nurse, 28 years)

Privacy and confidentiality

Privacy and confidentiality were derived from both the provider participants and the client participants data as part of the technical outcome. However, the data shows divergent views from the participants. Whereas some participants were of the view that the facilities provided privacy and confidentiality, others were of the view that privacy and confidentiality were not guaranteed. However, it is worth nothing that whereas the narratives from the service provider participants generally point to privacy and confidentiality not guaranteed, the narratives from the client participants, on the other hand, generally point to the facilities safeguarding privacy and confidentiality.

However, in-depth analysis of the clients' narratives revealed some nuances. In times where there is more than one client in the consulting room, the client participants pointed out the discreet nature in which service providers speak to them as a means to maintain privacy and confidentiality. To them, the service providers did their best to ensure they provided them (clients) with privacy and confidentiality. One client had this to say:

…from the room I was treated, I am much convinced that not even a word said inside could be heard outside by a passerby. Even with patients in the same room, the Doctor tries their best not to be loud in order not to be heard by the others (23 years student, Spontaneous abortion)

The client participants who received treatment in a separate treatment room also pointed out that they were satisfied with the privacy and confidentiality.

This, they said, was due to the fact that they were attended to in a room that had only service providers present. She narrated:

> *…there was privacy, no one was there except for the workers. Yes, they were only two service providers in the room with me at the time. I was the only one in the room and I don't think anyone outside can hear us* (37 years seamstress, Spontaneous abortion)

The service provider participants, on the other hand, shared the view that although they provide privacy and confidentiality to their clients, they sometimes have to compromise on privacy. This they attributed to the lack of separate treatment rooms; hence, in times of large number of clients, the room is shared for the clients. Two service provider participants remarked:

> *I mean in our setting it's quite difficult ensuring privacy, well where procedures like this are done it's definitely kept away from other client, so most clients don't know that you came here for this or you came here for that… It is actually not really separate, usually our clients who come for vaginal delivery are sometimes examined in the same room… We use the same treatment room for SVDs and all that so sometimes when the place is overwhelmed, if you are having an MVA and someone is examining a client there…* (District Facility Doctor, 26 years)
>
> *If they come here, we have screens so we put the screen around them. We know it is women to women anyway but still we keep privacy. We have separate rooms, it is only the doctor, and the assistant who will be inside and sometimes the doctors will be more than one.* (Regional Level Senior Health Assistant, 49 years)

Ways to Improve on PAC Services

Training of nurses on PAC and task sharing

The views of the service provider participants showed that service providers experience a high client to provider ratio at the health facilities. To the service provider participants, this puts pressure on the service providers and affects the quality of PAC service provided to the clients. The service provider participants, therefore, suggested a need for training of general nurses and midwives to provide PAC services, which will allow for task sharing. According to the participants, it will also reduce the patients to doctor ratio since the other cadre, for instance midwives, will be able to attend to some of the clients with minor complications while the medical doctors focus on emergencies and serious complications. One participant had this to say:

> *If numerous nurses and midwives are trained there will be a lot of hands-on board but if there are fewer people, then it means we have to wait. Sometimes there are emergencies so when a lot of people are trained it makes the work faster since more hands are on deck saving lives* (District Facility Midwife, 32 years)

Another participant also remarked:

> *At least every midwife has to be trained on comprehensive abortion care or MVA and others because for instance if a client comes bleeding and you notice that the bleeding will not stop unless the retained product is removed, then you go ahead to do it and save the person. People bleed through this and they die, so I think all midwives should be trained so that we will all know how to use the MVA set so*

that if a doctor is not around, we can also provide care to the clients (Polyclinic Midwife, 31 years)

Advocacy for comprehensive abortion care services

A few of the service provider participants were also of the view that there is a need for mass education and advocacy on comprehensive abortion care services. According to them, this will help reduce the prevalence of illegal abortion which will reflect in the number of women presenting with complications from induced abortion. Educating women on CAC will also enable women to use medication for abortion the right way and this will reduce the number of complications resulting from induced abortion. According to the service provider participants, advocacy for CAC services will also help reduce the stigma attached to abortion and encourage women to seek early PAC services. The service provider participants were also of the view that seeking early PAC services will help reduce the number of women who present at the facilities with emergency cases. For instance, a medical doctor remarked:

I think what will help me do the work easier is probably community education, educating the masses to seek quality abortion care because most of them feel, I don't know if its stigma and don't come to the hospital for care. I don't know if it is anxiety too, they just go and take anything then when complications arise, they now come to the hospital. Sometimes they don't have much money for blood, sometimes people come in so pale, and have lost a lot of blood, they don't have financial support for the blood and all that is needed and it makes treatment a

bit difficult so it is just better they come to the hospital to seek care… (District Facility Medical Doctor, 26 years)

Another service provider participant remarked:

"I am happy we have the medication abortion but then some people, it is like the education about that medication abortion is not well with them because some of them they abuse it. even though they know they can use this amount, they don't know it has a limit within certain weeks so they will take it and even how to take the medication they don't know, they just take it and then they rather come in bleeding, meanwhile, if you know the normal gestational week you are going to take, you will know how to take it and use it and you will know. I think giving them education will help limit the coming into the facility and also limit the spread of infection. I think the education has to go viral so that everybody will know about it" (District Facility Midwife, 36 years)

Discussion

I explored the points of divergence and convergence of clients and service providers on quality PAC services as well as possible was to improve on PAC services. The results showed that service providers and clients generally have a positive experience and perceive quality PAC as one with quality communication, quality of treatment and prompt attention. The findings further revealed that clients also judged the quality of PAC services on the quality of the environment.

Although both clients and service providers highlighted quality communication as a component of quality PAC services, there was a variation

in what quality communication meant to each group. Whereas quality communication was concerned with the behaviour and manner components of communication to the clients, the service providers were concerned with clients' involvement in treatment decision-making. The focus of clients on the behaviour and mannerism of the service providers affirms the findings of Brown, Alaszewski, Swift and Nordin (2011) that the behaviour and body language of service providers help to foster trust in the clients. Brown et al. (2011) also argued that whilst verbal communication is important to explain issues to the clients, it was the body language that was crucial in validating trust from the clients. Service providers, on the other hand, were focused on the user-centred perspective of communication to ensure that the clients understand them. Evidence supports a positive association between client centred approach by service providers and positive patient outcomes (King & Hoppe, 2013; Naughton, 2018; Kwame, & Petrucka, 2021).

A plausible explanation for the variation could be that while service providers are trained to adopt a user-centred approach in communicating with their clients, clients, on the other hand, could be lacking in such information. Hence, clients based their judgement of quality communication on the sociocultural dimension of communication which focused on behaviour and mannerisms (Uyanne & Oti, 2012). Notwithstanding the variation in what constitutes quality communication, quality communication helps increase the client's confidence and satisfaction with the treatment given to clients. The findings also show that clients are likely to adhere to the medications if they have confidence in the treatment given to them as well as actively participate in the decision-making process.

The study also showed that both the service providers and clients were of the notion that prompt attention is a measure of quality PAC services. This affirms Donabedian's (1988) argument of process quality which measures the technical and interpersonal qualities of the service providers. This encompasses all that is done in the provision of care to the client (Donabedian, 1988). The study further shows that denying PAC clients prompt attention could result in worsening conditions for the client. The findings show that there is a chance of delay in health-seeking decision making and delay in commuting to the health facility; hence, there is a need for prompt attention to be provided at health facilities to prevent any further delay. This supports the conclusions of Rominski, Morhe, and Lori (2015) and Izugbara et al. (2019) that delays in obtaining timely PAC services increase the risk of serious complications and death. Thus, it came as no surprise to us that we saw that PAC clients received fast treatment at the health facilities, as reported by both service providers and clients. We think this is an effort on the part of the medical facilities to avoid any more delays that would aggravate the complications of the clients.

With regard to quality treatment, whereas clients consider quality treatment on the immediate outcome of the relief they receive as compared to how they arrive at the facility, service providers measure quality treatment based on no adverse effects after treatment. The disparity in the notion of quality treatment can be attributed to the fact that service providers have been trained and educated on the WHO post-abortion care guidelines (WHO, 2022) to be aware that PAC service is only completed after the client receives a check-up two weeks post-treatment (Barot, 2014; WHO, 2015). Despite the

disparity in the understanding of quality treatment, both service providers and clients expressed satisfaction with the treatment outcomes. The above discussion shows that there is generally a positive outcome for PAC services in the selected health facilities studied, according to the Donabedian (1988) theory.

Donabedian (1988) argued that quality health care service should be provided in an environment that is user-friendly by providing convenience, comfort, quiet, and privacy among others that make it easy and attractive to a patient to seek healthcare at the facility. The Optimal Healing Environment framework also argues that serenity and lovely environment serves as a form of environmental therapy and contributes to healing (Sakallaris et al., 2015). The findings of the study showed that PAC clients were generally satisfied with the serene and peaceful nature of the environment in which they received PAC services.

Although both PAC clients and service providers were generally satisfied with the quality of PAC services provided in health facilities in the Greater Accra region, I found that there is still room for improvement. I found that the consumables for the provision of PAC were not always readily available. I also observed that there is a need for the provision of separate consulting and treatment rooms for PAC services to help promote privacy and confidentiality. Similar observations were made in Kenya and Uganda (Osur et al., 2013) and Zimbabwe (Sully et al., 2018). The findings further showed that PAC clients were of the view that there is a need for the provision of post-abortion counselling services. This affirms the WHO guidelines for the provision of PAC services which recommends the provision of post-abortion

counselling (WHO, 2022). This will help respond to the emotional needs of the clients. I also found that there is a need for the units responsible for the provision of PAC services to be in close proximity. This would help provide a more comprehensive and coordinated approach to the provision of quality PAC services.

The findings also showed that service providers associate complications from abortion with a lack of education on comprehensive abortion care services. Educating women on the CAC services will help reduce the rate of unsafe abortion which will cause a drop in the number of women who present at health facilities with complications from induced abortion. Evidence from Kenya (ZIraba et al., 2015) suggests that women who induced abortion were more likely to present with moderate or severe post-abortion complications. Oyeniran, et al. (2019) also observed that in Southwestern Nigeria, women who indulge in unsafe abortion delay seeking treatment at health facilities. A possible explanation for the above is the associated stigma of abortion and lack of education on CAC services. There is, therefore, a need to increase advocacy and education on CAC services at health facilities. This will help encourage women to seek safe abortion care services rather than risking their lives with unsafe abortion methods and also reduce the risk of women delaying seeking PAC services.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

Efforts to address maternal mortality, especially in resource-limited settings have gathered momentum in recent years. The provision of quality PAC services is essential in achieving reduction in maternal deaths as it is an important component in reducing abortion-related morbidity and mortality. This chapter presents an overview of the study, methods of the study, a summary of the main findings, conclusions and some recommendations. Also, contributions to knowledge, limitations and opportunities for further studies are highlighted in this chapter.

Summary of the Study

The focus of the thesis was to assess the quality of post-abortion services in the Greater Accra region by exploring the notion of quality of care of women presenting with induced abortion and spontaneous abortion, examine the views of health professionals on the quality of PAC services and explore the clients and health professionals' experiences with the delivery PAC services. The core argument is that connecting the synthesis between clients' view of quality PAC and providers' view of quality PAC are cardinal indicators of quality PAC services. However, there is a paucity of literature pertaining to this. This gap raised critical questions on the discourse of the quality of PAC services in Ghana and by extension in SSA.

I assessed the quality of post-abortion care services in the Greater Accra region; specifically, the study sought to: (1) explore the notions of quality of care of women presenting with induced abortion and spontaneous

abortion, (2) examine the views of health professionals on quality of post-abortion care services, and (3) explore clients and health professionals' notions with the delivery of quality post-abortion care services.

The study was guided by the interpretivist philosophical position to social sciences research since the research questions do not have an objective reality. Hence, a qualitative research method was adopted for the study. To gain an in-depth understanding of the quality of post-abortion care services in the Greater Accra region, the phenomenological research design was used.

I used primary data which was collected from selected health facilities in the region. The target population for the study were health professionals who provide PAC services as well as women who received PAC services at the selected health facilities. A total of 34 participants were interviewed for the study. This was made up of 18 clients and 13 service providers. The study participants were drawn from 7 health facilities that were purposefully selected with the main criteria for selection being the availability of PAC services during the period of data collection. The data was collected using two separately developed in-depth interview guides (one for service providers and one for the clients) as the instruments for data collection.

Data was managed and analysed using QSR NVivo 12 plus computer software. The analyses followed the thematic analytic procedures. With this, preliminary codes were identified with corresponding word frequencies from the responses of the participants. Codes were then collated and sorted based on their shared pattern to form sub-themes and subsequently, main themes. For comparative analysis, each participant's characteristics were also used. In order to contextualise the analysis based on the body of literature, a

descriptive narrative of the themes was combined with an analytical narrative and data extracts. This allowed for a comprehensive presentation of the issues to enhance trustworthiness of the results.

The findings from the study showed that clients' notion of quality PAC services pivots on structure and process quality for PAC services. Regarding structure quality, clients perceive an enabling environment that offers privacy and confidentiality as a key component of quality PAC services. It was, however, evident that while some facilities have consulting rooms that provided privacy and confidentiality, others do not. Notwithstanding, the clients also expressed that the facilities that do not have private consulting rooms try to put in measures to promote privacy and confidentiality.

Short waiting time was also observed as a key indicator of quality PAC services. The findings show that clients largely reported having experienced short waiting time which provides them with optimism of receiving early treatment that will prevent further complications. It is also worth noting that a few of the clients experienced long waiting time which they attributed to a high patient-to-doctor ratio at the health facilities. Another barrier to prompt attention that emerged from the findings was financial constraints. Women who could not afford their bills were delayed treatment until they could afford their treatment cost.

The study also showed that clients perceived service providers to have a positive attitude regardless of whether they presented with complications from induced or spontaneous abortion. PAC seekers who presented with induced abortion were surprised about the friendly nature of the service

providers. Service providers were also found to be responsive to the needs and concerns of their clients.

Concerning process quality, the findings show that clients were involved in the decision-making process regarding the available treatment options and this to a large extent encouraged clients to adhere to treatment. Regardless of the type of abortion leading to the post-abortion complication the clients presented with, clients expressed that the service providers sought their consent in treatment decision-making. This is particularly refreshing given that healthcare in general is gradually drifting towards client-centred approach. I also found that, to the clients, service providers have good interpersonal qualities and clients were generally satisfied with the quality of communication at the health facilities and they were confident they could ask the service providers questions and be answered adequately.

It was further evident from the client's data that service providers offer them social and supportive care to help them overcome their fear and anxiety. The clients were offered assurance and reassurance during their treatment to help deal with their fear and anxiety. Clients were also offered medications to help manage the pain they were in.

The findings of the study also showed that service providers also pivot their quality of PAC services around the structure and process of PAC services. Concerning the process quality, it was observed that in the provision of PAC services, providers show a positive attitude to their clients. This encouraged women to open up about their condition, which helps service providers to provide the right treatment. The service providers also perceived the involvement of clients in treatment decision-making as a very important

aspect of health care. Hence, irrespective of the type of abortion, age, or marital status of the clients, the service providers involved them in the treatment decision-making. Nonetheless, in instances where the service providers were overwhelmed with the number of clients, they are not able to actively engage all the clients in treatment decision-making.

Regarding the structure quality, the findings show most of the facilities do not have the required equipment and a separate treatment room for PAC services. Hence, the provision of quality PAC services become difficult. The absence of separate treatment rooms in some facilities made it difficult for service providers to ensure privacy and confidentiality. This notwithstanding, under the structure quality, it was observed that as part of the treatment of post-abortion complications, other services provided to PAC clients were follow-up services, referral services and post-abortion contraceptive counselling. These services help in the provision of both curative and preventive care.

The study also highlights the connecting experiences of service providers and clients on the outcome of PAC services. It was observed that both service providers and clients generally have a positive experience and perceive quality PAC as one with quality communication, treatment and prompt attention. However, there was a divergent view on what quality PAC services meant to service providers and clients. For instance, whereas clients perceive quality communication as behaviour and mannerism, service providers perceive it as one that involves clients in treatment decision-making. Regarding quality treatment, while clients consider treatment to be quality

based on the immediate outcome of relief they received, service providers measure treatment quality as having no adverse effects after treatment.

Conclusions

The study concludes that clients who presented with induced abortion and those who presented with spontaneous abortion experienced similar quality of PAC services. Both groups of clients were of the view that the PAC services provided at the health facilities were of quality. The study also concludes that to the clients, the quality of PAC services pivots on the structure quality and the process quality. Regarding structure quality, the study concludes that to clients, an enabling environment that offers privacy and confidentiality is key to the quality of PAC services. However, not all the facilities were able to provide clients with an enabling environment with privacy and confidentiality. Concerning waiting time/prompt attention, as a component of the quality structure, it was concluded that the health facilities try as much to provide prompt attention to clients but this is sometimes delayed when the clients to doctor ratio is high or the inability of clients to pay for the PAC services. The study further concluded that clients were generally satisfied with the process quality of PAC services at the health facilities. The study concluded that clients were treated with good interpersonal skills and a person-centred approach comprising dignity, respect and autonomy. However, this was not always the case when it comes to adolescents. The study also concludes that as part of process quality, clients were offered social and supportive care to help overcome their fears and anxiety.

The study also concludes that the views of service providers on the quality of Pac services pivot on the structure quality and the process quality. The

study concludes that concerning process quality, service providers provide PAC services with a positive attitude. It was also concluded that the positive attitude of service providers encouraged clients to open up to service providers with information about their conditions. Service providers also involved PAC clients in treatment decision-making. However, this was sometimes hampered when the number of clients was too many. Regarding structure quality, the study concludes that five of the seven facilities do not have adequate equipment and a separate treatment room for the provision of quality PAC services. This complicated the provision of privacy and confidentiality.

Synthesising the experiences of PAC clients and the views of service providers, the study concludes that both service providers and PAC clients have a positive experience with PAC services. Both service providers and PAC clients consider PAC services to be of quality. Nonetheless, service providers and clients have divergent views on what constitutes the quality of PAC services. Whereas clients consider immediate relief from pain as quality treatment, service providers consider quality treatment as one with no adverse effects. The study also concludes that while clients had a positive experience, service providers also have positive views on the quality of PAC services in the Greater Accra region. However, there is still room for improvement

Recommendations

1. It is recommended that the management of health facilities should take pragmatic steps to ensure that all health facilities have an enabling environment to be able to provide privacy and confidentiality to PAC clients.

2. It is also recommended that Ministry of Health should review their policy on the cadre of service providers that can provide PAC services. Reviewing the policy and allowing for task shifting to lower cadre of service providers will help reduce the client to doctor ratio. This will also lead to a reduction in waiting time for treatment.
3. Delays to treatment as a result of inability of clients to foot their treatment bills highlights a need for the government and the Ministry of Health to consider adding PAC services to the National Health Insurance Scheme. This will help save the lives of women who suffer from post-abortion complications and help reduce the maternal morbidity and mortality.
4. Lastly, it is recommended that policy makers and the service providers put in measures to increase education to the general public on quality PAC care services. This will go a long way in bridging the perspectives of clients and service providers on what constitutes quality PAC services.

Contribution to Knowledge

The Donabedian (1988) quality of care model provides a framework for measuring the quality of healthcare services. The model assumes a linear progression of care from structure to process and then outcome. The evidence from this study, however, shows that quality care may not necessarily follow a linear progression. The model also did not factor in antecedent characteristics like the environment and the patient characteristics which are important in the measure of quality health care services. As such, I suggest modification to the model to incorporate the characteristics of the individual patients, the service

providers, the organisation and the political and economic environment for which PAC services are provided. For instance, in measuring quality structure, the data from clients focused on environment, organisational structure and timeliness/prompt attention while that of the service providers focused on environment, organisational structure, and supplies and equipment. Concerning the process quality, the client data showed clients perspective focused on interpersonal skills and person-centred domains whereas that of the providers focused on interpersonal skills, person-centres and technical skills. On the outcome quality both clients and providers data focused on effectiveness, satisfaction and client confidence in providers.

This study has made some important empirical contributions to the field of abortion studies. From the client's perspective, quality PAC services are perceived through the lens of the layperson without comparing it to the protocols for the provision of PAC services. The clients focussed on aspects such as accessibility, responsiveness, effectiveness, and patient satisfaction. They valued factors such as the availability of services, short waiting times, clear communication, inclusion in treatment decision-making, and overall satisfaction with the PAC services received. These subjective elements reflect the client's experience and their expectations of receiving quality PAC services which are different from that of the providers, who consider quality of abortion care as factors such as clinical protocols, technical competence, availability of equipment and consumables, and no adverse outcome after treatment.

The approach used in this study, which combines the viewpoints of providers and clients, provides a thorough understanding of the various

elements of quality PAC services and identifies potential areas for improvement. It also allows for a comprehensive assessment that takes into consideration the subjective experiences of the clients and the objective measures of service provision from the service providers' perspectives.

Areas for Further Study

Despite the important contributions made from this study, it is worth mentioning that the current study used a purely qualitative approach to research and was limited to only the Greater Accra region. It may be worthwhile for quantitative research to be conducted in this regard.

Referral services are integral part of PAC services as evident in the present study. However, what was not clear is how these referrals are done. It will be imperative for future studies to follow the care seeking journey of women seeking PAC services for both spontaneous and induced abortions in addition to partnership with the community health services. Such studies will broaden our understanding of the dynamics of quality PAC services across contexts.

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APPENDICES

Appendix A: INFORMATION SHEET

Title of the study: Quality of Post-Abortion Care Services in Ghana
Introduction: I am Kenneth Setorwu Adde, an PhD student in the Department of Population and Health, University of Cape Coast.

Address: Department of Population and Health. Faculty of Social Sciences, University of Cape Coast. PMB. University Post Office. UCC – Cape Coast
Telephone: 0244136688
E-mail: Kenneth.adde@stu.ucc.edu.gh

Background and Purpose of research: As part of my academic work, I am conducting a convergent parallel mixed method research on "Quality of Post-Abortion Care Services in Ghana". This study is entirely an academic work and seeks to examine issues surrounding Post-Abortion Care towards quality management of Post-Abortion Complications in Ghana. Specifically, the study would seek assess the capacity of health facilities to provide quality post-abortion care services; explore notions of quality of care between women presenting with induced abortion and those with spontaneous abortion; evaluate the views of health professionals on the quality of postabortion care services and explore health professionals construction of the challenges associated with the delivery of quality post-abortion care services.

Data collection will be done using the English and Twi language.
Nature of research: In line with the methods for the study, I would like to interview post-abortion care clients and the post-abortion care service providers. The respondents are allowed to choose their desired venue and time for the interview to be conducted.

Participant involvement:
Duration: I would like to seek your views and experiences regarding issues surrounding Post-Abortion Care. The interview process will take approximately 20 – 35 minutes.
Potential Risk: Some of the questions may bring to mind emotions since you may be required to recall some experiences.

Benefits: The results of the study will be shared with the participating health facilities. However, there is no direct financial benefit for you for participating in the study.
Cost: The interview process will cost you approximately 20-35 minutes of your time.
Compensation: There is no financial or material compensation to be given to you as a participant in the study.
Confidentiality: Since the study adopts a qualitative approach to research and the interview process will follow "one-on-one" approach, your identity will be known to the interviewer who is also the Principal Investigator. The information you will provide in this interview would be tape-recorded and later transcribed to be used for the analysis but you are assured of total confidentiality and anonymity. In effect, your name would not be included and there would be no traceable link with the data to you.
Voluntary participation/withdrawal: Your participation in this interview is entirely voluntary and you can withdraw from the interview at any stage of the interviewing process without any penalty. You reserve the right not to respond to any question that you consider confidential. I, however, crave for your indulgence and co-operation in this interview.
Outcome and Feedback: The results of the study would be shared with the participating health facilities. The audio-recorded interviews, as well as the transcribed data, would be protected using *Mylockbox* computer software. The hard copies of the transcribed data would be hidden from sight and access to it will be restricted as much as possible. The transcribed data, as well as the entire data set, would be destroyed as soon as the study is completed.
Funding information: The study is entirely an academic work and has no internal or external funding. All expenses regarding the conduct of the study will be borne by the student who is the Principal Investigator.
Sharing of participants Information/Data: the data collected is solely own by the principal investigator and will not be shared with any other organization.
• Provision of Information and Consent for participants

A copy of the Information sheet and Consent form will be given to you after it has been signed or thumb-printed to keep.

For any further clarifications, you can please contact the following people

Nana Abena Apatu
GHS-ERC Administrator
Office Tel: +233 503539896
E-mail: ethics.research@ghsmail.org

Dr. Amo-Adjei Joshua
Department of Pop. and Health, UCC
Mobile: 0244092814
E-mail: joshua.amo-adjei@ucc.edu.gh

Appendix B: CONSENT FORM

STUDY TITLE: Quality of Post-Abortion Care Services in Ghana

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (……*name of language*). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form. The interview process would be tape recorded and later transcribed to be used for analysis but you are assured of confidentiality and anonymity. In effect, your name will not be included.

I voluntarily agree for the interview process to be tape recorded YES [ ] NO [ ]
I voluntarily agree to be part of this research.
Name of Participant……..
Participants' Signature ……... OR Thumb Print……
Date:…….

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (…….*name of language*) language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……
Signature of Interpreter …….. OR Thumb Print …….....
Date:……
Contact Details

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (……..*name of language*)

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:……
Signature…….... OR Thumb Print …….....
Date:……

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name…….
Signature …….
Date…….

Appendix C: In-Depth Interview Guide for PAC Providers

Interviewee: _____Date: _____

1. **BACKGROUND OF RESPONDENTS**

Participants No.	
Date of Interview	
Name of interviewer	
Study Site	
Setting (Urban/Rural)	
Age	
Designation	
Years of employment	
Religion	
Marital status	

Warm up questions:

1. Can you tell me a little about what you do in this hospital? (Probe:
    a. How long have you been in this role;
    b. What was your motivation to work in this unit?
    c. Tell me about your experience in offering PAC?

2. **Meanings of Quality in PAC**

What does post-abortion care quality mean to you?

- Thinking about the services you offer in this facility, what would you say about how you (provider) relate with PAC clients? (Probe for:
    - Time spent with clients;
    - Friendliness of staff to PAC patients;
    - Responsiveness of providers to PAC clients' needs;
    - Importance of client to the facility etc.)

- What is your experience in involving PAC care givers in treatment decision-making in this facility? [Probe for:
    - Only health workers;
    - Health workers together with clients;
    - Considers the age of patient;
    - Marital status;
    - Type of abortion – spontaneous or induced]
    - What is your understanding of patient autonomy in treatment?

- Reflecting on the general setting of this facility, how do you ensure the privacy/identity protection & confidentiality of women who come for PAC? [Probe for: separate treatment rooms; patient records/data disclosure of clients information to non-clinicians]

- How do you ensure that privacy and confidentiality are maintained when managing PAC clients?

- As you know, people have different ways of communicating to other people. Can you briefly tell me about how you talk to PAC clients on services available? (Probe:
  - Providing reasons for medications and procedures;
  - Allowing clients to ask questions and being answered).
  - What is your understanding of client-provider interaction?

- Tell me about other services that you provide as components of PAC. Probe:
  - Client follow-ups and referrals;
  - Post-abortion counselling

- I would like us to talk about post abortion contraception in this facility:
  - Who provides the service and why? (Probe: doctor, nurse, counsellor, other person).
  - Under what circumstances is post abortion contraception provided?
  - To whom is post abortion contraception provided (Probe: always provide FP to all PAC patients, probe young/unmarried people)
- Reflecting specifically on post-abortion contraception and family planning counselling, what are your thoughts about the quality of counselling provided in this facility? (Probe for:
  - Restrictions on the content of counseling provided
  - Availability of methods
  - Client's choice of method etc.)

- How would you describe your abilities in providing PAC? Probe for
    - Treatment outcomes
    - Training
    - Management of emergencies
    - Availability of consumables/equipment for PAC
- What usually comes to your mind when you see a woman seeking to terminate pregnancy?
- Overall, how would you describe quality of post-abortion care to a patient?

- Is there anything I did not ask and you'd want to discuss regarding quality of PAC?

Appendix D: In-Depth Interview Guide for Women

Interviewee: _____Date: _____

3. BACKGROUND OF RESPONDENTS

Participants No.	
Date of Interview	
Name of interviewer	
Study Site	
Setting (Urban/Rural)	
Age	
Marital Status	
Occupation	
Remarks/ context	

Getting to the facility:

Can you tell me a little about how you ended up in the hospital? (Probe

- What time of day did you present to the facility?
- Were you alone or was someone there with you?
- Who took you here or called the cab, ambulance?
- What was different about this trip from your other visits for health care to the hospital?
- Who made the decision for you to present to the hospital?

4. PATIENTS EXPERIENCES WITH SERVICES

1. **Dignity and respect**:
   - Please, reflecting on the time it took you before being treated, what can you say about it? Probe: short waiting time; long; reasonably okay? What is the reason that makes you think so about the time?

   - How would you describe the attitude of nurses, doctors and other health workers towards you during the care process? (Probe for: friendly; hostile; indifferent etc.)

   - Can you tell me about how the nurses, doctors, responded to your concerns? Probe for: insults, threats, spoke rudely, or physically abused you? What would you say could have caused such behaviour of health care providers? Probe for; type of abortion being treated (induced-spontaneous; your age, marital status; religion etc.)

2. **Autonomy:**
   - Can you tell me about who made decisions on how you were treated? Probe: only health workers, your caregivers; yourself;
   -

3. **Privacy and confidentiality:**
   - Thinking about the specific place in the facility where you were treated, what would you say about it, whether other people around could easily hear your conversations? Would you say you're satisfied with how your information was handled and why?

   - What are your views about the room where you were treated? Probe: properly covered from the view of people not involved in your treatment? Your body was adequately covered? How about privacy from persons accompanying the provider? Or care givers?

4. **Communication**:
   - How would you describe the way the nurses, doctors, and other staffs talked to you? Probe: reasons for medication; procedures performed; ability to ask questions and being answered?

   - What aspects of your communication with nurses, doctors and other staff did you like and which ones you did not like?

   - Did you feel that you could ask your providers any questions you had about the kind of treatment you received? Why do you think so?

   - How would you describe the way the nurses, doctors and other staffs behaved or treated you?

5. **Social Support and Supportive care**:
   - How would you describe the way nurses, doctors etc. behaved towards the person who accompanied you to this facility?

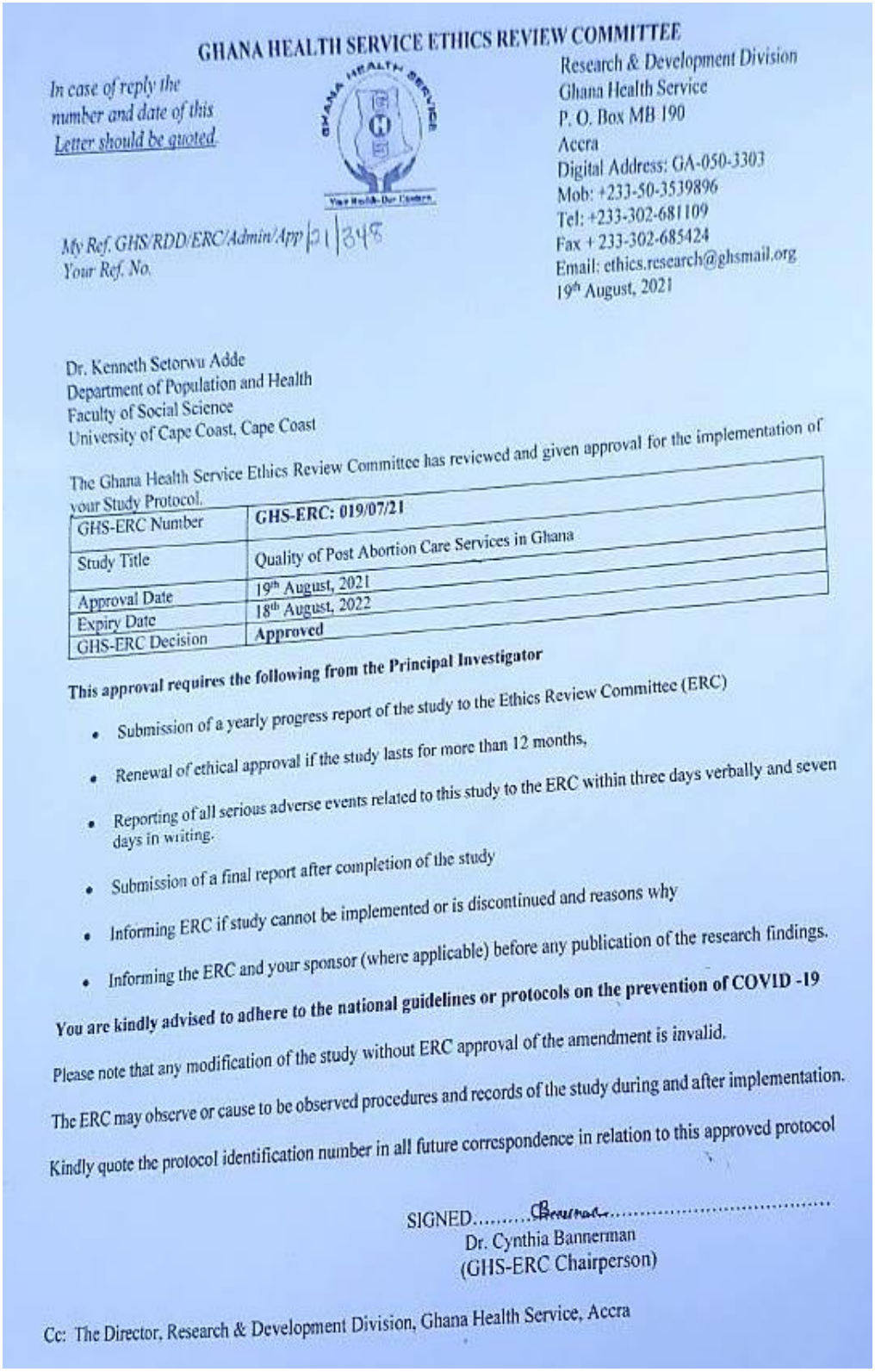
   - In your opinion, how did the nurses, doctors help you overcome any anxieties and fears you had prior to being treated? Probe: pain management drugs; referrals (e.g. STI and cervical cancer screening)

   - Now I want you to tell me about your notion of quality of care you received during this visit?

   - Is there anything else you would like to tell me?

     Thank you for your time and participation

Appendix E: Ghana Health Service Ethics Approval Letter



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org
19th August, 2021

My Ref. GHS/RDD/ERC/Admin/App/21/348
Your Ref. No.

Dr. Kenneth Setorwu Adde
Department of Population and Health
Faculty of Social Science
University of Cape Coast, Cape Coast

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC: 019/07/21**
Study Title	Quality of Post Abortion Care Services in Ghana
Approval Date	19th August, 2021
Expiry Date	18th August, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. Cynthia Bannerman
(GHS-ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra