UNIVERSITY OF CAPE COAST

VIEWS OF CLIENTS ON POST ABORTION CARE IN THE VOLTA REGIONAL HOSPITAL

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BY

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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 SetorwuAdde

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:.....

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

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ABSTRACT

The danger of dying from an unsafe abortion in Africa was almost three times higher than that in the Asia, and more than 15 times higher than that in the Latin America. However, reporting complications resulting from abortion remains difficult for some women. This study therefore examined post abortion care at the Volta Regional Hospital. Specifically, the study reviewed reported abortion complications, assessed the post abortion care services rendered to clients, examined the abortion experiences of clients, as well as clients' views on post abortion services at the Volta Regional Hospital. A conceptual framework was developed based on Health Belief Model and Health System Responsiveness Model to guide the study. An in-depth interview guide was used to collect data from 20 post abortion care clients at the Hospital. Data was analysed manually using qualitative content analysis technique. The study found that medical abortion was the major method of abortion among the women. It was also observed that women reported at the hospital due to incomplete abortion and haemorrhage. The study also revealed that, the post abortion care services provided at the hospital rarely included, family planning, and counseling. On the attitude of service providers and satisfaction with post abortion care services at the hospital, it was observed that clients were generally satisfied with the services rendered to them. Ghana Health Service and the Ministry of Health should intensify campaign programs on post abortion complications and the need to seek early treatment and in formal health facilities.

KEYWORDS

Post Abortion Care

Volta Region

Volta Regional Hospital

Responsiveness

Abortion Complications

Ghana Health Service

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DEDICATION

To my family

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LIST OF ABBREVIATIONS

AVSC	Association for Voluntary Surgical Contraception
D&C	Dilation and Curettage
D&E	Dilation and Evacuation
EVA	Electric Vacuum Aspiration
GHS	Ghana Health Service
GMHS	Ghana Maternal Health Survey
GSS	Ghana Statistical Services
HBM	Health Belief Model
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MVA	Manual Vacuum Aspiration
PAC	Post Abortion Care
VRH	Volta Regional Hospital
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

Globally, 56 million abortions occur each year (WHO, 2016). Out of this figure, 22 million are unsafe (WHO, 2016). Unsafe abortions account for 70,000 maternal deaths annually (WHO, 2011) and is also responsible for about 5 million women who are suffering from temporary or permanent disability(WHO, 2011; Iqbal & Elisabeth, 2009).About 5 million women are admitted to health facilities due to unsafe abortion every year in developing countries (WHO, 2015). It is also estimated that about 192 women die as a result of complications arising from unsafe abortions and almost all of these occur in developing countries (Iqbal & Elisabeth, 2009).

Jeanelle and Margaret (2012) posit that unsafe abortion accounts for 12% to 30% or even more of direct maternal deaths. Globally, unsafe abortion is the third major cause of maternal mortality after haemorrhage and sepsis in childbirth (Ahman & Shah, 2011). Severe infections and or bleeding are the major causes of death resulting from unsafe abortion procedure and in other cases, organ damage (Grimes, et al., 2006). Other complications that result from unsafe abortion include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs (Grimes, et al., 2006).

The majority of these abortions are as a result of unintended pregnancies as a result of lack of access to contraceptives or failure of contraceptives. Some other reasons mentioned in the literature are abusive relationships, lack of asupportive partner, financial difficulty, maternal health

concerns and medical conditions (Iqbal & Elisabeth, 2009; Finer & Kost, 2011).

About 20-50% of women who undergo unsafe abortion procedure are hospitalised for complications (Grimes, et al., 2006). The level of risk associated with unsafe abortion highly depends on the gestational age of the pregnancy. Later abortions are linked with an increased risk for the woman (Gebreselassie, Gallo, Monyo, & Johnson, 2005). WHO approximates that about 20–30% of unsafe abortions cause reproductive tract infections and about 20%–40% of these cause upper-genital-tract infection and infertility. An estimated 2% of women of reproductive age are infertile due to unsafe abortion, and 5% are having chronic infections (WHO, 2004). Unsafe abortion was also linked to a long-term risk of ectopic pregnancy, premature delivery and spontaneous abortion in subsequent pregnancies (Grimes, et al., 2006).

The danger of dying from an unsafe abortion in Africa is almost three times higher than that in Asia, and more than 15 times higher than that in the Latin America (WHO, 2011). However, reporting complications resulting from abortion remains very difficult for some women (Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013). Nonetheless, there are cases of reported post abortion complications at health facilities (Miller, 2015). The common post abortion complications reported by women at health facilities include incomplete abortion, bleeding and uterine perforation (Fetters, Vonthanak, Picardo&Rathavy, 2008).

Women, however, encounter different abortion experiences which include the variety of decisions they had to make, their emotions, physical

experiences, approaches they need to use including health care advice and in dealing with clandestine medical abortion(Silvina, Mariana, & Lila, 2014). There is, therefore, the need to provide post abortion care to women to help deal with their abortion experiences in a positive way since abortion in itself could constitute a traumatic experience (Coleman, Reardon, Strahan, &Cougle, 2005).The decision to access post abortion care is, however, highly influenced by a woman's perception about the services at a health facility. These include the value of care, conduct of service providers, and proximity to the health facility among many others (Melkamu, Betre, &Tesfaye, 2010). Thus these issues will positively or negatively affect post abortion care which in turn directly affect the rate of maternal mortality.

In Ghana, abortion remains a major contributor to maternal mortality accounting for 15-30% of maternal deaths (Asamoah, Moussa, Stafstrom, & Musinguzi, 2011). In an attempt to reduce the effects of unsafe abortion, a comprehensive reproductive health strategy was developed by the government of Ghana to address maternal morbidity and mortality associated with unsafe abortion (Taylor, Diop, Blum, Dolo, & Winkoff, 2011). However, social, religious, policy and legal restrictions on abortion continue to pose as barriers to having access to post abortion care(Maureen & Turner, 2003). This study, therefore, examined post abortion care at the Volta Regional Hospital.

Problem Statement

In Ghana, abortion is a criminal offense which is regulated by Act 29, section 58 of the PNDCL 102 of 1985 (Morhe & Morhe, 2006). Nonetheless, the law states that abortion may be performed by a registered medical practitioner when the pregnancy is as a result of rape or incest, to protect the

mental or physical health of the mother, or when there is a malformation of the fetus. The abortion laws in Ghana are comparatively liberal when compared to other countries in the region (Asamoah, Moussa, Stafstrom, & Musinguzi, 2011).However, maternal death is estimated at 350 per 100,000 live births in Ghana (Rominski & Lori, 2014).

Abortion complications are a large contributor to the maternal mortality in Ghana (Asamoah, Moussa, Stafstrom, & Musinguzi, 2011) with abortion accounting for about 15-30% of maternal deaths (Rominski & Lori, 2014; Asamoah, Moussa, Stafstrom, & Musinguzi, 2011). In view of this, the government of Ghana has taken steps to reduce the negative effects of unsafe abortion by developing a comprehensive reproductive health strategy since 2003 to address the maternal morbidity and mortality associated with unsafe abortion (Taylor, Diop, Blum, Dolo, & Winikoff, 2011).

Various issues with regards to abortion and post abortion complications have been studied in Ghana. For instance, studies have been done on the practice of abortion in Ghana. These studies have indicated that a large number of women in Ghana practice abortion with at least 47% of women having experienced an abortion at least once in their life (Morhe, Tagbor, Ankobea, & Danso, 2012; Sundaram, Juarez, Bankole, & Singh, 2012; Ghana Statistical Services [GSS], Ghana Health Service [GHS], & ICF International 2009; Agyei, Biritwum, Ashitey, & Hill, 2000). Ahiadeke (2002) also sugest that over a lifetime, 900 abortions per 1000 women will be performed. Studies have also been conducted on maternal mortality in Ghana which indicate that complications as a result of abortion is the leading cause of maternal mortality (Ohene, Tettey, & Kumoji, 2011; Mills, Williams, Wak, & Hodgson,2008;

Geelhoed, Nayembil, Asare, Schagen van Leeuwen, & van Roosmalen, 2002). Other abortion studies in Ghana focused on the knowledge of abortion laws in Ghana and the perception of Ghanaians on abortion (Konney, Danso, Odoi, Opare-Addo, & Morhe,2009; Hill, Tawiah-Agyemang, & Kirkwood, 2009; Clark, Mitchell, & Aboagye, 2010). Studies have also been conducted on the pre and post abortion experiences of young females (Esia-Donkor, Darteh, Blemoo, & Asare, 2015) however, this study only focused on young people (aged 12 to 24) and not women in general.

Billings, Ankrah, Baird, Taylor, Ababio and Ntow (1999) also conducted a study on midwives and comprehensive abortion care in Ghana. Their study focused on the stratergy for minimizing the three delays in relation to emergency treatment for incomplete abortion in Ghana. Sundaram, Juarez, Ahiadeke, Bankole, and Blades (2014) also examined the impact of Ghana's R3M programme on the provision of safe abortin and post abortion care. Their findings show that posta bortion care is not nearly as controversial as safe abortion and has long been part of essential emergency obstetric care in Ghana. According to the 2013 annual reproductive and child health report, complications of abortion have been identified as a major cause of maternal illnesses and deaths (GHS, 2014).However, it appears there is a literature gap on the experiences of women who seek post abortion care in a health facility. In view of this, this study was conducted to examine post abortion care in the Volta Regional Hospital. The Volta region has been noted for high incidence of induced abortion with 12.3% of women in their reproductive age group in the region ever had an abortion but a high percentage of 94.6% have not been able to gain access to post abortion care (GSS & GHS, 2009).

Objectives of the Study

The main objective of the study is to examine post abortion care services in the Volta Regional Hospital from the clients perspective. Specifically, the study was aimed to;

1. Gather information onabortion complications reported at the facility;
2. Document the experiences of clients seeking post abortion care;
3. Evaluate the post abortion care services rendered to clients at the facility;
4. Examine the clients satisfactionofpost abortion care at the Volta Regional Hospital

Research Question

1. What are the reported abortion complications?
2. What are the experiences of clients seeking post abortion care?
3. What are the services rendered to clients at the facility?
4. Are clients satisfied with post abortion services at the Volta Regional Hospital?

Rationale of the Study

The study will provide first-hand insight into the post abortion health care services in the Volta Regional Hospital. For instance, it will unveil the services rendered to the women, type of complications being treated and the experiences of the women in securing PAC in the Volta Regional Hospital. The results of the research, hopefully, would justify the need for the implementation of relevant policies by 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

The Volta Regional Hospital was also selected because a high percentage of women in the Volta Region do not get access to abortion services (GSS & GHS, 2009).According to the GMHS, 94.6% of women could not get access to abortion services.

Organisation of the Study

The study has been organized into five distinct chapters. The first chapter is introductory in nature and gives the background of the study, statement of the problem, research questions, the objectives, significance of the study, and organization of the study. The second chapter deals with the literature review, theoretical reviewand the conceptual framework.

Chapter three highlights the methods used in collecting data and the analysis of the data. It covers subtopics such as research design, population, sampling size and sampling procedures used, data collection, sampling techniques and data analysis. Chapter four is a presentation of data and analysis, which provides an overview of the variables that were studied. The final chapter, chapter five gives a summary of findings, conclusions and recommendations. This part of the project provides information on the outcome of the study (research findings), the conclusive statements that were made on the bases of the findingsobtained. Recommendations regarding future researches in the same or similar area have also been captured.

Limitations

This study is limited due to the small-scale of the study, making this study representative of a very specific population. Therefore, the results of the study cannot be generalized. Also, the respondents were not chosen randomly but were purposively selected from clients who received post abortion care at the facility at the time of the data collection, making the sample not completely or equally representative of all women who have undergone post abortion care. This study is specific for post abortion care at the Volta Regional Hospital and conclusions and recommendations should be read in light of this. The study also focused on just the views of clients but not service providers.

CHAPTER TWO
REVIEW OF RELEVANT LITERATURE

Introduction

This chapter reviews related literature on the topic under investigation in order to situate the study in the appropriate empirical and conceptual framework. The chapter looked at areas including post abortion care,reported abortion complications, services rendered to PAC clients at the hospital, experiences of clients seeking post abortion care, clients' perception about services received at the facility, essential elements of post abortion care, theoretical issues and conceptual framework.

Concept of Post Abortion Care

Post abortion care was first highlighted inInternational Pregnancy Advisory Services (1991) strategic planning document which promoted "the integration of postabortion care and family planning services in health care systems" (Maureen, Corbett; Turner, Katherine, 2003) in an attempt to bring to an end the continuous cycle of unwanted pregnancies and improving the overall health status of women. Association for Voluntary Surgical Contraception(AVSC) International (now EngenderHealth), Ipas, the International Planned Parenthood Federation (IPPF), the JHPIEGO Corp. and Pathfinder International came together in 1993 to form the Postabortion Care Consortium to help educate and promote postabortion care as a public health strategy(PAC-consortium, 2014). The original postabortion care model was published by Ipas in 1994. It encompassed three elements: emergency treatment services for complications of spontaneous or unsafely induced abortion, postabortion family planning counseling and services, and links

between emergency abortion treatment services and comprehensive reproductive health care (Maureen & Katherine, 2003). The model emphasised postabortion care as an important emergency obstetric service and the need for post abortion family planning services. The model also connected emergency abortion treatment to comprehensive reproductive health services. The International Confederation of Midwives in 1996 agreed on a resolution promoting the participation of midwives in the provision of postabortion care services (IPPF, 2001).

During the late 1990s, with the help of funding from the United States Agency for International Development (USAID) and aids from cooperating agencies, governments in Ghana, Kenya and Uganda validated that midwives in primary level facilities have the ability to provide high-quality postabortion care services and also improve postabortion family planning counseling and method provision (Maureen & Katherine, 2003).

Reported Abortion Complications

Reporting post abortion complications for immediate healthcare seem very difficult for some people (Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013). In spite of this, studies have indicated that varied post abortion complications are reported to health facilities. In Nebraska, reported abortion complications to the Nebraska Department of Health and Human Services increased by 4.3 percent (from 2,177 to 2,270) between 2013 to 2014 (Miller, 2015). Cervical laceration, haemorrhage, infection, perforation as well as retained products were the specific complications reported by the clients.

Similarly, reported post abortion complications rose over aten-year period in Pakistan (2002 to 2012) (Sathar, Singh, Shah, Rashida, Kamran

&Eshai, 2013). As such, they opined that the apparent rise depicts an increased access to varied post abortion services.Particularly, in the private health facilities whilst also reflecting high utilisation of misoprostol for performing abortions. This is because most women using this method incorrectly may lack the requisite knowledge and might, therefore, necessitate the need for seeking medical assistance for complications such as incomplete abortions and prolonged bleeding (Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013).

Analysis of post abortion complications at Ebonyi State University Teaching Hospital in Nigeria revealed that reported post abortion complications amounted to 41.4 percent of all gynecological cases over a five-year period.The dominant cases reported were induced abortion, missed abortion together with spontaneous abortion. Other reported complications were haemorrhage, gastrointestinal tract injuries, pelvic sepsis, renal failure as well as genital tract injuries (Kalu, UmeoraJ& Sunday-Adeoye, 2012). However, in Afghanistan, commonly reported post abortion complications comprised unsafe or incomplete abortion leading to sepsis, genital injuries, bleeding and shocks (Ansari, Zainullah, Mi Kim, Tappis, Kols et al., 2015).

In Cambodia, Fetters, Vonthanak, Picardo andRathavy (2008) observed that clients presenting serious infections such as organ failure were few whilst the common ones were septic shock/sepsis or disseminated intravascular coagulopathy. Other complications reported to the health facilities included bowel injury and uterine perforation(Fetters, Vonthanak, Picardo&Rathavy, 2008).

A study by Stanley, Henshaw, Adewole, Singh, Bankole, Oye-Adeniran andRubina, (2008) recruiting clients and their providers from thirty-three hospitals in eight states found pain (52%) and bleeding (44%) as the most serious post abortion complications. However, fever and injuries were reported by some of them. Although the complication results originating from the physicians' examination were almost the same as women's reports of complications, slight variations were noted and wherever differences occurred, the prevalence of complication reported by physicians was higher(Stanley, Henshaw, Adewole, Singh, Bankole, Oye-Adeniran&Rubina, 2008). It was again realised that most women performing D&C or an MVA encountered bleeding and pain with some of them having afever or genital/cervical trauma (Stanley, Henshaw, Adewole, Singh, Bankole, Oye-Adeniran&Rubina, 2008).

From a WHO sponsored case-study in North-East Brazil, local hospitals reported a significant rise in the cases of incomplete abortions whilst in one large public maternity health facility, incomplete abortion cases alone stood at 23 percent of all obstetric admissions (Mundigo&Indriso, 1999 cited in Warriner& Shah, 2006). This increase was associated with the sharp increase in the use of Cytotec, which was usually purchased over the counter from local pharmacists.

A couple of studies have however reported sepsis and haemorrhage as the leading complications resulting from induced abortion (Adinma, 2011; Delvaux, Soeur, Rathavy, Crabbé&Buvé, 2008; Fawole&Aboyeji, 2002). However, in Cambodia, reported complications were retention of products of conception as well as anexhibition of signs of infection (Fetters, Vonthanak, Picardo&Rathavy, 2008). Among women treated for abortion complications at

the three types of health facilities in Cambodia, the intensity of complications resulting from miscarriages and terminations varied. It was observed that relatively higher proportion of low severity cases were reported at hospitals, whilst the various health centres received higher rates of women presenting high severity complications (Fetters, Vonthanak, Picardo&Rathavy, 2008).In a case-control study, compared to one in the control group 12.3 percent of cases experienced organ failure (such as hypovolemic shock, cardiac failure, coagulation defects and renal failure) while two deaths were recorded following complications resulting from abortion(Arambepola, Rajapaksa&Galwaduge, 2014).

Prevalence of Unsafe Abortion

An estimated 21.6 million unsafe abortions took place worldwide in 2008, almost all in developing countries (WHO, 2007).Access to safe abortion can be restricted by laws, and this may compel women to turn to illegal or often unsafe abortion, or make them hesitant to seek care when urgently needed because of complications of an unsafe abortion and this phenomenon reflects in the high incidence of reported complications. This is because most of these abortions end in serious complications and even death; globally, an estimated 47,000 women die every year as a result of unsafe abortions, while many more experience severe health consequences. The vast majority of these deaths occur in sub-Saharan African countries where the legislation on abortion is inherited from colonial powers and is still severely restrictive (WHO, 2007).

An Ethiopian study utilising both quantitative and qualitative methods noted that only 17 percent of the research participants had a history of

previous abortion whilst some indicated that they actually wanted to end their pregnancies (24.5%) (Tesfaye&Oljira, 2013). However, those who did not want the current pregnancy far exceeded those who needed it (75.5%).At the same time, review of medical records among 569 public hospitals in Egypt revealed that virtually 20 percent out of the 22,656 admissions to obstetrics and gynaecology units demanded treatment of abortion complications(Huntington, Nawar, Hassan, Youssed& Abdel-Tawab, 1998, cited in Grimes, Benson, Singh et al., 2006).

According to the Ghana Maternal Health Survey (2007), 7 percent of all pregnancies end in abortions and 15 percent of women aged 15- 49 have ever had an abortion while 43 percent of women who admitted having had an abortion went to a pharmacist, friend or traditional midwives to have induced abortion, with 13 percent experiencing a health problem after the procedure while 41 percent received no medical care (GSS et al, 2009). A study conducted in Southern Ghana revealed that 17 abortions were observed for every 1,000 women of reproductive age (Ahiadeke, 2005). Also, a study on contraception and induced abortion in rural Ghana (Geelhoed et al., 2002) found that 22.6 percent reported having induced abortion.

Although unsafe abortions are preventable; they continue to pose undue risks to a woman's health and may endanger her life. The stigma associated with induced abortion in developing countries coupled with laws that render abortion legal under certain conditions (Morhee&Morhee, 2006) result in the practice of clandestine, unsafe abortions even when legal and safe services are available thereby leading to diverse complications reported to various health facilities. Consequently, Gillam, Yates and Badranath (2007)

argued that fertility in developing countries is mostly influenced by theuniversality of marriage, lower age at marriage, low level of literacy, poor standard of living, limited use of contraceptives and traditional ways of life.

Through vaginal examination, Fetters, Vonthanak, Picardo andRathavy, (2008) realised that women utilised multiple approaches in terminating their pregnancies such as misoprostol and other methods which caused injury to the vaginal or intra-abdominal area. A study by Mundigo andIndriso, (1999) cited in (Warriner& Shah, 2006) indicated that 121 out of 190 visits to pharmacy shops by women seeking assistance to terminate an unwanted pregnancy were provided an abortifacient of which as far as among 82 percent of the cases, the abortifacient offered was Cytotec(Mundigo&Indriso, 1999 cited in Warriner& Shah, 2006).

A study on pregnancy termination in Nepal showed that the procedures of termination of pregnancy were dangerous and accounted for high PAC cases reported in various health facilities. In most cases, such unsafe means of terminating pregnancy were noted to result in materna1 mortality and morbidity affecting the overall reproductive health of women (Olukoya, 2001). One of the major causes of deaths due to unsafe abortions was the length of time that elapses between the abortion and the time spent in seeking care. Lack of knowledge about the complication, failure to recognize the seriousness of the symptoms, lack of confidence in the medical system, traditional beliefs, and low socio-economic condition contributed to the delay in seeking care (Finer &Henshaw, 2006). In many parts of Nepal, deaths during pregnancy are taken as thenatural destiny of women and both antenatal

and post-natal care is not considered an essential part of the pregnancy and does not require medical attention (Finer &Henshaw, 2006).

Studies have also revealed that a sizable percentage of women in Ghana have, at some time, resorted to voluntary termination of unwanted pregnancy (Sedgh, 2010; GSS et al., 2009), leading to large numbers of maternal morbidity and mortality cases arising from unsafe abortion. This high post -abortion complications might be due to the presence of the abortion law which restricts women from seeking abortion from accredited health facilities where qualified practitioners operate. In Ghana, abortion is illegal unless performed by a medical practitioner in a medical facility under circumstances such as rape or defilement of a female idiot, incest, foetal impairments, or when physical or mental risk could occur to harm the life of the woman. Meanwhile, it is illegal if performed on request or for social or financial purposes (United Nations Department of Economic and Social Affairs (UNDESA), 2007 and Criminal Code of Conduct 1960).

Similar situations exist in other parts of the world where induced abortion services are not publicly available due to the laws, misinformation about the legal status of abortion, or safe abortion services are either non-existent or not publicized despite the legal status of the procedure (Schwandt, Creanga, Danso, Adanu, Agbenyega&Hindin, 2011; WHO, 2007; Alan Guttmacher Institute, 1991).

Post Abortion Care Services

Provision of better post-abortion-care (PAC) is crucial to preventing prolonged complications and untimely deaths especially in countries with restraining abortion laws (Arambepola, Rajapaksa&Galwaduge, 2014). Due to

the varied nature of post abortion cases reported at hospitals, studies have revealed that numerous services are warranted and are context specific as well (Population Reference Bureau, 2011; Center for Reproductive Rights, 2010). Among the services rendered to clients seeking post abortion care include but not limited to emergency treatment, counselling, contraceptive and family planning as well as reproductive and other health inclined services provided on-site through referrals to other health facilities (Population Reference Bureau, 2011).

Additionally, women in need of medical care for post abortion complications may need prolonged stay in hospitals, varying from several days through several weeks depending on the specific condition(Population Reference Bureau, 2008). Studies have revealed that in some developing countries, about 50 percent of budgets are directed towards treatment of post abortion complications (Population Reference Bureau, 2008). Essential post-abortion care rendered by health facilities comprise timely and appropriate treatment which must be accessible at each-district level hospital having well-established protocols for delivery of service and comprehensive training for securing high standard care (WHO, 2007).

Post abortion family planning counselling constitutes one of the essential post abortion services rendered by health facilities (Tesfaye&Oljira, 2013). This service provides anavenue for clients to receive emotional and psychological support from qualified counsellors located in various health facilities. However, in the case of Pakistan, it has been noted to be inadequate (Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013). This was evident in a national survey on post abortion care in the country where the study revealed

that no improvement has been witnessed in Post-Abortion Counselling (PAC) services over a decade in terms of the counselling reported(Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013). At the same time, only half of health facilities offering such service provided women seeking PAC with contraceptives (Sathar, Singh, Shah, Rashida, Kamran &Eshai, 2013).

However, in Ethiopia, post abortion clients were offered information on their current illness as well as family planning counselling (Tesfaye&Oljira, 2013). At the same time, some of them complained that they were not informed about dangers that may demand to revisit the health facilities as observed by Tesfaye andOljira (2013). About 57 percent of the clients admitted that they had at least one method of family planning. However, none of them complained about thedifficulty in securing contraceptive from the health facility.Meanwhile, some lamented that the contraceptives they wished to use were not available in the facility (Tesfaye&Oljira, 2013).

In Afghanistan, Ansari, Zainullah, Mi Kim, et al., (2015) found that generally, 78 percent of the health facilities had vacuum aspirators for rendering PAC services whilst some (75%) had flexible cannulas.Meanwhile, 70 percent in all had both equipment required for PAC services. Also in the case of Nigeria, it was unravelled that Manual Vacuum Aspiration (MVA) was the most prevalent intervention offered to clients as it was used to treat 95.8 percent of all PAC cases reported over a five-year period. Additionally, antibiotics were provided by the hospital to the clients whilst blood transfusion and laparotomy (surgical incision into the abdominal cavity, for diagnosis or in preparation for major surgery) were carried out for some of them due to

pelvic abscess gut and uterine perforation (Kalu, Umeora& Sunday-Adeoye, 2012).

The World Health Organization (WHO) reported that between 10 and 50 percent of women who engaged in unsafe abortions demand medical attention (WHO, 2007). Post Abortion Care is an all-inclusive strategy comprising medical and preventive care based on thetimely treatment of complications due to unsafe procedures. Notably, provision of post-abortion counselling, education together with family planning services and incorporation of thereproductivehealth care system are some of the essential services rendered by health facilities during post abortion care visits (Ngoc, Shochet, Blum, Hai, Dung, Nhan&Winikof, 2013). Additionally, Adinma (2011) observed that complete, appropriate and prompt post abortion care are offered in countries where abortion is legally outlawed.

In an unmatched case–control study involving nine hospitals in eight of the 24 districts in Sri Lanka, Arambepola, Rajapaksa andGalwaduge (2014) observed that doctors offered the best care throughout the hospital stay of clients. It was also realised that ward midwives only offered care to postpartum mothers, but not those seeking post abortion care whilst at the same time providing limited chances for clients to offset their doubts pertaining to care (Arambepola, Rajapaksa&Galwaduge, 2014). Moreover, removal of retained products of conception was carried out by either surgical or medical approach. The surgical methods employed among cases encompassed Dilation and Evacuation (D & E), Manual Vacuum Aspiration (MVA), manual removal of products as well as abdominal hysterectomy (Arambepola, Rajapaksa&Galwaduge, 2014).

It appears medical and surgical procedures dominate in literature and this portrays that they are the safest approaches. Systematic review of sixteen studies offered evidence to augment the dominant use of such procedures arguing that they are associated with lesser complications (Kapp, Whyte, Tang, Jackson &Brahmi, 2012), for instance, when removing retained products after fourteen weeks of gestation through medical procedure or surgical means at early stages of gestation (Gallo, Gebreselassie, Victorino, Dgedge, Jamisse&Bique, 2004). Also, MVA with local anesthesia is perceived as safer, faster and very effective and associated with shorter hospital stay as compared to sharp curettage with general anaesthesia which dominates in developing countries (Kinaro, Mohamed, Schlangen& Mack, 2009; Gómez-Sánchez, Escandón&Gaitán-Duarte, 2007;Thapa, Poudel, &Padhye, 2004).

The Sri Lanka case-control study indicated that most of the cases went through these procedures under anesthesia in the course of 24 hours of their admission. Additionally, virtually all cases (91.2%) were treated with some intravenous antibiotics including Cephalosporin and Metronidazole whilst some obtained intravenous fluids. With regard to postponement in thecommencement of treatment, preference for evacuation of retained products as well as pain relief administration, not much difference was noted among cases and controls (Arambepola, Rajapaksa&Galwaduge, 2014). They further realised that according to theassessment of clients, among all categories, clients reported that doctors provided the best care both prior to and in thecourse of treatment. A greater proportion of clients obtained anexplanation from doctors about their surgical/medical procedures as well as their health status (Arambepola, Rajapaksa&Galwaduge, 2014).

Windy, Ali, Mori, Wantania, Kuroiwa and Shibuya (2015)realised that in Indonesia, patients attending public hospitals for post abortion complication care did not receive adequate PAC services and this was due to the fact that government facilities were not well developed with the same level of service quality as compared to private hospitals. This reflected in long waiting times from arrival to treatment and poor treatment in terms of inadequate provider-patient relations (Windy, Ali, Mori, Wantania, Kuroiwa& Shibuya, 2015).

Experiences of Abortion Clients

The World Health Organisation has outlined some acceptable methods for conducting abortion namely Manual/Electric Vacuum Aspiration (MVA/EVA), Dilation and Curettage (D&C) and medical abortion which involves pharmacological agents (World Health Organization, 2003).Depending on the frequency, method and locations for seeking anabortion, people tend to have vast experiences motivated by diverse factors (Gaye, Diop, Shochet&Winikoff, 2014). This is because the specific method adopted will inform the experience both during and after the abortion procedures.

It is argued that abortion uniquely constitutes traumatic experience since it encompasses human death. Specifically, issues such as deliberate destruction of an unborn and innocent child together with witnessing violent death and destruction of parental predisposition and responsibility. Additionally, the separating of maternal attachments to the expectant child, and unappreciated grief are the basis for the claim that abortion in itself constitutes a traumatic experience (Coleman, Reardon, Strahan, &Cougle, 2005; MacNair, 2005).

The thought of abortion as intrinsically traumatic is demonstrated by the statement "once a young woman is pregnant, it is a choice between having a baby or having a traumatic experience" (Warriner& Shah, 2006). The conviction that women who terminate pregnancies will naturally sense grief, blame, remorse, damage, and despair also is reported by studies focusing on the psychological consequences of abortion, most of which were induced by psychoanalytic theory (Major, Appelbaum, Beckman, Dutton, Russo & West, 2009;Warriner& Shah, 2006).Abortion experiences among women might also differ based on their life cycle phase. Typically, it is more probable for a teenager terminatinga first pregnancy to experience post abortion psychological trauma than an adult who aborts a pregnancy after already having more children (Major, Appelbaum, Beckman, Dutton, Russo & West, 2009). They further noted that abortion experiences may vary as a result of women's religious, spiritual and moral beliefs as well as that of other people within their immediate social environment.

Access to Abortion Services among Women

Access to safe abortion and post abortion services in countries where abortion is prohibited by law is principally dependent on one's ability to pay and being able to access reliable networks of safe, clandestine abortion providers within one's vicinity (Warriner& Shah, 2006). As a result, poor women and rural residents are more probable to obtain poor quality abortion care as compared to urban and wealthier women. This variation in access to safe abortion care results in a disproportionate burden on poor women seeking anabortion and also on the public health services who out of pity might avert

scarce health care resources to care for them (Finer, Frowirth, Dauphinee, Singh, & Moore, 2005).

Wealth status, therefore, exposes women to various experiences in the quest to access safe post abortion services. Social inequalities are significant determinants of access to safe abortion care, irrespective of the legal context in which the procedure will be carried out (Warriner& Shah, 2006). Studies have indicated that most abortions are unintentional and may be mistimed pregnancies that might have been expected at an earlier or later date or possibly unwanted pregnancies that were not needed at that particular time or at any period and all these have their associated experiences (Warriner& Shah, 2006; Finer, Frowirth, Dauphinee, Singh, & Moore, 2005).

However, in certain instances, particularly among teenagers, a woman may not be aware she is pregnant until possibly during the second trimester which exposes them to diverse experiences after such abortions (Boonstra et al., 2006). The study further indicated that latertrimester abortions were performed after detection of fetal irregularities or dangers to the mother's health status and with this, the abortion procedures varied based on the specific circumstances surrounding each condition (Boonstra et al., 2006). However, Jones, Zolna, Henshaw, and Finer (2008) also realised that in the United States, most first-trimester abortions were conducted with electric vacuum aspiration and nonsurgical methods including utilisation of drug or mixture of drugs to abort pregnancy (such as mifepristone) (Jones, Zolna, Henshaw, & Finer, 2008).

Abortion may also vary based on a woman's ethnicity and culture. This is because according to the 2005 abortion surveillance carried out by the

Center for Disease Control, theabortion rate for Black women was 3.1 times higher than White women. At the same time, theabortion rate for women from other races such as Pacific Islanders, American Indians, and Alaska Native women had 2.0 times the rate for White women (Gamble, Strauss, Parker, Cook, Zane &Hamdan, 2008). It was also observed that ethnicity-specific variations in legal inducedabortion rates might mirror transformations among populations in various socioeconomic status, access to and utilisation of family planning as well as contraceptive usage and occurrence of unintended pregnancies. This same observation was made in another study in Cambodia where most of the clients seeking post abortion services reported contraceptive usage (Fetters, Vonthanak, Picardo&Rathavy, 2008).

Studies further indicate that various methods and oral medications, including laundry bleach, turpentine, as well as ingesting massive doses of quinine are mostly utilised by some women (Grimes, Benson, Singh, Romero, Ganatra, Okonofua, & Shah, 2006). Again, injecting toxic solutions to the uterus with douche bags or turkey basters is also noted to be common as well as absorption of soap solutions into a woman's circulation. However, the latter can lead to renal toxicity and untimely death. Using of potassium permanganate tablets in the vagina has also been observed (Grimes, Benson, Singh, Romero, Ganatra, Okonofua, & Shah, 2006). Utilisation of pharmaceutical products for termination was found to be prevalent among women and as a result, accounted for thedelay in seeking timely post abortion care (Fetters, Vonthanak, Picardo&Rathavy, 2008).

Factors Influencing the Abortion Decision Process

Among those who did not want their pregnancies, pressure from partners together with thelack of knowledge to use contraceptives regularly were the principal factors accounting for their pregnancies. The study further noted that the explanations for resorting to unsafe abortion among the post abortion clients comprised having too close or multiple pregnancies, pressure from partner, economic reasons, health-related factors and desire to complete their education. The study unravelled that seven out of ten respondents had knowledge about at least one contraceptive method whilst history of contraceptive use stood at 61 percent (Tesfaye&Oljira, 2013). Some also complained that they were not offered pain killers to offset medication even though they were experiencing pain in thecourse of their stay in the health facilities. Tesfaye andOljira (2013) opined that post-abortion patients in need of treatment are usually under immense emotional stress in addition to the physical illness they may encounter. As such Rawlins, et al., (2001) purported that establishing a timely and positive relationship can reduce the stress and concerns that may be felt by clients.

It has been noted that treatment of abortion complications has financial implications on individuals and countries alike. Grimes, Benson, Singh et al., (2006) reported that such financial burden is intense among public health systems in developing countries. They further noted that ability to ensure that women obtain easy access to safe abortion services reduces medical costs incurred by health systems whilst in some developing countries, as much as 50 percent of hospital budgets allocated for obstetrics and gynaecology are disbursed on the treatment of complications of unsafe abortion (Huntington,

Nawar, Hassan, Youssed& Abdel-Tawab,1998, cited in Grimes, Benson, Singh et al., 2006).

The direct costs comprise supplies, services of health personnel, blood, equipment, medications and overnight stays. In Tanzania, it was observed that cost per woman for the treatment of abortion complications from health systems was over seven times higher than the overall Ministry of Health budget per head of the population (Grimes, Benson, Singh et al., 2006). Meanwhile in Uganda, post-abortion care offered in tertiary hospitals by physicians was projected to cost health systems ten times higher than core abortion services rendered by midlevel physicians in primary care. Also in Nigeria, a 2005 study projected the gross national cost of direct medical care for treatment of abortion complication as $19 million (Grimes, Benson, Singh et al., 2006). Evidence on the costs and consequences of unsafe abortion is critical for policymakers, providers, and advocates seeking to mobilise resources to improve the situation. Reducing the public health problem of unsafe abortion is one of the most important goals of the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in September 1994.

Methods of Abortion among Women

Even safe abortion in developing nations carries risks that depend on the health facility, the skill of the provider, and the gestational age of the fetus. With unsafe abortion, the additional risks of maternal morbidity and mortality depend on what method of abortion is used, as well as on women's readiness to seek post-abortion care, the quality of the facility they reach, and the qualifications and often times of tolerance by the health provider. A woman

who seeks a clandestine abortion, or the provider she consults, may try a number of traditional techniques of varying efficacy and harmfulness and this has its own experiences. Methods of unsafe abortion include drinking toxic fluids such as turpentine, bleach, or drinkable concoctions mixed with livestock manure such as cow dung (Mpangile, Leshabari&Kihwele, 1999).

Others are forceful manipulation of the abdomen, the insertion of sticks and other objects into the vagina, cervix or uterus. Many of these techniques pose serious threats to a woman's health, and sometimes even her life. If these methods fail to bring about a complete pregnancy termination, she may then go to pharmacists, nurses or doctors known to provide abortion services. Unskilled providers also improperly perform dilation and curettage in unhygienic settings, causing uterine perforations and infections. Methods of external injury are also used such as jumping from the top of stairs or a roof, or inflicting blunt trauma to the abdomen such as massaging the abdomen (WHO, 2007).

There is limited data on the abortion methods and providers that women turn to for abortion services. However, the few studies available have produced conflicting evidence regarding the types of providers women turn to and the procedures they undergo to terminate a pregnancy. According to data from the GMHS (2008), many women who seek abortions do so with the help of a doctor and in a hospital setting, although significant proportions do not undergo the safest procedures available (Sedgh, 2010; GSS et al., 2009). The GMHS (2008) reported most women (57%) sought a doctor to perform an abortion, 16 percent went to a pharmacist or chemical seller, and 19 percent turned to a friend or relative or induced the abortion themselves (Sedgh, 2010;

GSS et al., 2009). The remaining women sought the help of a traditional practitioner (4%) or a nurse, midwife or auxiliary midwife (3%) but this study did not record traditional practitioners as sources or providers of abortion.

Among women reporting on their most recent abortion in the five years before the survey, 40 percent underwent dilation and curettage (D&C) (Sedgh, 2010; GSS et al., 2009). In contrast to the GMHS (2008), a 1997–1998 study in Southern Ghana found that only about 12 percent of women who obtained an abortion did so with the help of a physician (Sedgh, 2010; Ahiadeke, 2001). According to Ahiadeke (2001), more than two-thirds of women who sought abortion turned to an untrained provider or induced the abortion on their own (Sedgh, 2010). Findings from other studies suggest that misoprostol (Cytotec) is widely used for abortion including findings from a pilot study on medical abortion conducted in two hospitals in Ghana that found an overwhelming uptake of both Mifepristone and Misoprostol (Blum et al., 2007). Data from the GMHS (2008) showed only 16 percent of women said they terminated their pregnancy by taking tablets and about 6 percent of women specified that they took misoprostol (Cytotec) tablets (Sedgh, 2010; GSS et al., 2009). Less common methods included inserting an object, herbs or other substances in the vagina; receiving an injection; and drinking a herbal concoction (Sedgh, 2010; GSS et al., 2009) which is similar to findings from this study.

Adequacy and Quality of Post AbortionCare Services

Sub-standard post abortion service provision was reported by clients seeking post abortion care in Ethiopia (Melkamu, Betre, &Tesfaye, 2010; Melkamu, Enquselassie, Ali, Hailemichael& Yusuf, 2005). Such

circumstances were displeasing to the clients and could deter them from seeking subsequent post abortion care in health facilities because it induces bad perception about the facilities (Kumbi, Melkamu&Yeeneh, 2016).

On the contrary,Melkamu, Betre, &Tesfaye (2010) opined that most women perceive post abortion services in health facilities to be better and are therefore motivated to assess post abortion services. The specific factors that prompted this positive perception include thevalue of care, good conduct of service providers together with theproximity of the health facilities (Melkamu, Betre, &Tesfaye, 2010). However, that same study further unearths that some women perceived the services as expensive whilst some claimed health facilities rendering such services were far from their residence. Additionally, issues such as poor treatment and absence of drugs were perceived factors among the clients (Melkamu, Betre, &Tesfaye, 2010).

Studies have revealed that some hospitals offering PAC services are not receptive to singles and adolescents as in the case in Nigeria's Ebonyi State University Teaching Hospital where some clients lamented that the services are not friendly to singles and adolescents assessing the facility for PAC services. This was, however, attributable to the fact that the MVA room was located in the antenatal clinic complex (Fawole&Aboyeji, 2002).

Clients seeking post abortion care in Sri Lanka were also displeased with services received from health facilities owing to verbal harassment of some health-care-providers on their abortion condition. They acknowledged that the harassment was principally perpetrated by minor staff and in some cases, to the degree of compromising confidentiality of the information offered about clients' abortion status to clients' family members, staff or other

patients. Again, some complained that they were not offered ample time to seek clarification to clear their doubts concerning their health status and this reinforces negative perceptions (Arambepola, Rajapaksa&Galwaduge, 2014).

Notwithstanding this, Bjertnaes, Sjetne, andIversen (2012) indicated that the most significant determinant of holistic patient satisfaction in health facilities constitute patient-reported experiences and accomplishment of expectations. In the works of TesfayeandOljira (2013), most of the respondents (93.5%) acknowledged they were accorded the required politeness and respect by healthcare providers and as a result, they were enthused with the services received. This additionally induces positive perceptions about these health facilities where such warm reception was received. Again, findings from service observations in that same study indicated that most respondents were greeted in a polite and friendly manner whilst some added that the service providers were very supportive to them in thecourse of all patient-provider interactions (Tesfaye&Oljira, 2013).

In Ethiopia, almost all respondents in a cross-sectional study complained that waiting time from arrival to treatment was very long. It was further noted that those who complained about long waiting time were less satisfied as compared those who did not complain. Generally, clients voiced that they were satisfied as far as the services received are concerned. Additionally, some had difficulties in locating where exactly to seek a specific service whilst some acknowledged unsupportive staff as their principal reason for their difficulty in obtaining the service. Unemployed women were more probable to be content and have apositive perception of the post abortion service delivered as compared to employed clients (Tesfaye&Oljira, 2013).

Unsafe abortion services are characterised by alack of equity in cost, safety, and quality of thecase. In some Bolivian hospitals, women who presented signs of inducing abortion were charged higher fees for treatment of complications than women who appeared to have amiscarriage, which contributes to delays in obtaining care (Arambepola, Rajapaksa&Galwaduge, 2014). In Egypt, the price for a clandestine abortion increases in proportion to the level of safety provided (Melkamu, Betre, &Tesfaye, 2010) and this registers negative perceptions in the memories of clients.

In the findings of Windy, Ali, Mori, Wantania, Kuroiwa and Shibuya (2015), patients seeking post abortion care were quite satisfied with the range of services rendered by private health facilities and as such, they were enthusiastic to return for follow-up and were also ready to recommend the services to others. Also, they realised that the level of satisfaction was not in any way linked with patient's age, socioeconomic status, or educational level. Their study may point to the fact that perception of poor quality of care and services in public hospitals was a major reason for most patients to prefer private hospitals if only they could afford it (Windy, Ali, Mori, Wantania, Kuroiwa& Shibuya, 2015).

Nurses' attitudes and behavior portrayed to post-abortion clients have implications on clients' assessment of service and decisions toseek care as noted in Zimbabwe (Settergren, Mhlanga,Mpofu, Ncube&Woodsong, 2000). They further noted that community members were dissatisfied with nurses' gossip to family membersand neighbours, cold treatment, and unfriendliness to the youth. On the other hand, nurses also expressed frustration with some

clients' reluctance in explaining the reason for their conditions and delayed in seeking treatmentuntil complications were severe.

Essential Elements of Post Abortion Care Services

Post abortion care services refer to a specific set of services for women experiencing problems from all types of spontaneous abortion (ACOG, 2009). International Health Organisationsrecognize post abortion care to generally include emergency treatment for complications as a result of abortion or miscarriage as well ascounselling services that aim to identify and respond to the emotional and physical health needs of women and other relevant concerns. They also help in providing contraceptive and family planning services to women to help them prevent the occurrence of unwanted pregnancy or unsafe abortion or to practice birth spacing. Post abortion care services also include management of sexually transmitted infections and reproductive and other health services that are provided on-site or through referrals to other accessible facilities (PRB, 2006).

ACOG (2009) observed that in treating complications as a result of abortion, misoprostol has proven to complete expulsion in approximately 66-99% of women who received it for incomplete abortion and missed abortion in the first trimester. Clark, Shannon, and Winikoff (2007) also found a median success for misoprostol to be 80% or more for missed abortion and 92% for incomplete abortion. However, misoprostol was found to be more successfulfor treating incomplete abortion than it was for missed abortion (Zhang, et al., 2005). The increase in access to misoprostol has been linked with the improvement in women's health in developing countries (Grimes, et al., 2006).

Vacuum aspiration is a method WHO recommends as the preferred method for uterine evacuation before 12 weeks of pregnancy (Grimes, et al., 2006). This method has shown to be faster, safer, more comfortable and linked with ashorter hospital stay for induced abortion than in the case of sharp curettage(Rogo, 2004). The vacuum aspiration is also easier to use and has aneed for less analgesia and anaesthesia and has a lower cost per procedure if done on an outpatient basis (Iyengar & Iyengar, 2002; Jowett, 2000). Due to the ease of using it, it can easily be used in countries with a small number of physicians safely and effectively by mid-level health providers like midwives (Sibuye, 2004). The study by Mandira, Kristina, Kiggundu, Namugenyi, and Marie (2014) revealed that midwives who received training in manual vacuum aspiration found it efficient with satisfactory outcomes.

Dilation and curettage (D&C) are a standard medical care for treatment of incomplete abortion. D&C is a simple and a commonly performed procedure for first-trimestermiscarriage surgical abortion. It is a minor surgical procedure done to remove tissues from the uterus of a woman as a result of incomplete abortion, remaining pregnancy tissue from a miscarriage or placental tissue remains in a womb (Population Reference Bureau, 2008). Although it is a simple procedure, immediate complications can arise (Sherigar, Dalal, & Patel, 2005). These complications include uterine perforation, scar tissue formation, tears in the cervix, uterine bleeding and reactions to anesthesia (Patient Fact Sheet, 2008). Mansour (2013) also observed in his study that 4.3% of women had immediate complications after undergoing D&C but he explained this high rate could be as aresult of the small sample size used in his study. Sherigar, Dalal, and Patel (2005) observed

that the main determinants of the complications with D&C are the skills of the physician. However, Mansour (2013) concluded his study on the findings that complications as a result of the use of D&C for first trimester abortions are uncommon. He further stated that management of uncomplicated miscarriage can be more effectively and safely managed using the D&C procedure.

As part of the post abortion care services is counselling services that aim to identify and respond to the emotional and physical health needs of women and other relevant concerns. The American Psychological Association's Task Force on Mental Health and Abortion (TFMHA) in 2008 analyzed all empirical studies on the emotional effects of abortion published since 1989. Their findings indicated that aborting a wanted pregnancy can be associated with negative psychological experiences as compared to stillbirth or death of a newborn. However, it is less severe than the negative psychological experiences by women who deliver a child with a severe abnormality (PPFA, 2014). The counseling component of the PAC services enables the woman to discover other reproductive health concerns while talking to the service provider and receive counselling services to address those issues (Adinma, Ikeako, Adinma, Ezeama, & Ugboaja, 2010). The counselling component also includes providing information regarding contraception, potential post-abortion complications and other sexual and reproductive health needs such as HIV and sexually transmitted infection (STI) services (Evens, et al., 2013).

World Health Organisation's Standard of Post Abortion Care

The concept of post abortion care voiced out by Ipas in 1991and published by the PAC consortium in 1994, originally included three elements namely: emergency treatment for complications of spontaneous or induced

abortion;postabortion family planning counseling and services; andlinkages between emergency care and other reproductive health services. In 2002, the original PAC model was modified and expanded to five elements with the addition of counseling and community involvement (USAID, 2003). In order to ensure that the service provided isstandardised, WHO developed a teaching material for midwifery schools (WHO, 2006).

For the management of incomplete abortion, the WHO includes misoprostol on the Essential Medicines List for its management. However, the staff at all healthcare facilities should have undergone training and be equipped with the equipment to treat incomplete abortion through re-evacuation of the uterus with vacuum aspiration (WHO, 2010). The treatment, however, must be provided with the focus being placed on the possibility of infection or hemorrhage. Healthcare facilities must also be provided with anesthesia for completion of abortion using vacuum aspiration in the first trimester and for dilation and evacuation in the second trimester (WHO, 2003).

With failed abortion, the health care facilities must have the ability to terminate a pregnancy through MVA or D&E for second-trimester pregnancies to treat such cases (WHO, 2010). In treating hemorrhage, the delivery site must have the capacity to stabilize hemorrhage as soon as possible, this includes evacuation of the uterus and the administration of drugs to put a stop to the bleeding. The service providers must also be equipped and trained to be able to manage the treatment for infections that may result from unsafe abortion (WHO, 2003).

The WHO standard also requires post abortion family planning as an essential element of post abortion care. This states that women who have experienced abortion be it safe or unsafe abortion are in need of family planning services (WHO, 1997).

Theoretical Models

This section of the study reviewed theories related to the study. The theories reviewed include the expectation fulfilment model, the health belief model and the health system responsiveness model.

Expectation Fulfilment Model

The expectation fulfilment model of satisfaction by Linder-Pelz (1982) was developed based on the attitude and job satisfaction research carried out by Fishbein and Azjen (1975). Linder-Pelz (1982)defined patient satisfaction "as positive evaluations of distinct dimensions of the health care. This theory suggests that any experience that is in line with what is expected results in satisfaction but any that contradict will result in dissatisfaction. Embedded in this definition of satisfaction is the acknowledgement that satisfaction data like any other subjective data are limited by its subjective nature.

Hence, satisfaction is relative. This implies that satisfaction can change even when the object of evaluation may remain the same. This may be as a result of a change in the standard of evaluation or expectation (Linder-Pelz, 1982).

The model also suggests that satisfaction is a concept that can be studied in two distinct ways. Thus, satisfaction can be examined as a dependent variable which is determined by the characteristics of patients and

the service or satisfaction can be examined as an independent variable which is predictive of subsequent behaviour. However, Williams (1994), Schmidt (2003), and Wilde (1994) argued that it is more significant to relate a patient's experience of actual healthcare to his or herpreferences, rather than to his or her expectations. They argue that measuring patient's satisfaction with preferences will tell more about how the patients want the quality of care rather than the expectations that will show how the patients believe it should have been.

In view of these, Linder-Pelz (1982) proposed five antecedent perception and attitude variables as plausible determinants of satisfaction with health care.The perception variables include expectations, entitlement, occurrences and interpersonal comparisons while thevalue is the attitude variable.

This theory was used byBowling , et al. (2012) to measure patients' experiences, expectations, and satisfaction. They observed that most patients ideally expected cleanliness, information about where to go,convenient and punctual appointments and helpful reception staff, the doctor to beknowledgeable, clear and easy to understand, to be involved in treatment decisions and toexperience a reduction in symptoms/problems. Expectations least likely to be met includedbeing seen on time and choice of hospital/doctor, the doctor being respectful and treated with dignity (Bowling , et al., 2012).

In summary, satisfaction is an individual's relative evaluation of an aspect of health care encounter with an expectation. This notwithstanding, the model only deals with the social psychological determinants of satisfaction.

Leaving out socio-demographic or health variables or characteristics of the health care system or the provider of the care, in trying to evaluate health system satisfaction from a client's point of view. Though all these variables will affect a patient's evaluation of the health system.

Health Belief Model

The health belief model is considered the most frequently used theory in health education and health promotion (Glanz, Rimer, & Lewis, 2002). It is a psychological model which was developed in the 1950s. The model since then became popular among researchers and has either been adopted or adapted in several ways to explain various long-term and short-term health behaviours.

The theory attempts to explain and predict health behaviour of people based on various demographic and social variables. The fundamental concept of the original HBM is that, health behaviour is determined by personal beliefs or perceptions about a disease or condition and the strategies available to decrease its effect by the whole range of interpersonal factors affecting health behaviour (Sheeran& Abraham, 1995).

The health belief model has proven to be applicable to behaviours in different settings, from public health to internal medicine and surgery (Armstrong, Anderson, Le Et, & Nguyen, 2009; Perpina, et al., 2009; Carmel 1991). However, there are some reported shortcomings of the model. For instance, the health belief model like other models of rational choice fails to specify under what circumstances they will make a more rational decision. The model also does not take into consideration how emotions of the

individual such as anxiety or feat can affect rational thought and decision making (Berker, 1974).

Health System Responsiveness

This model was developed by the WHO with the goal of developing technical tools to assess, monitor and raise awareness of how people are treated and the environment in which people are treated when seeking health care. The underlining principle of the framework was, as a social system, the health system is expected to meet a core goal as well as a common social goal expected from all social systems in addition to their main aim (WHO, 2015).

The health system performance measurement is important because it helps identify the gaps of health systems, it also provides indicators for examining a health system over a period. Responsiveness under this framework has been defined to encompass the non-health enhancing and the non-financial aspects of the health system. According to Smith (1992), words that are commonly used in thediscussion of responsiveness are satisfaction and quality of care. Patient satisfaction in this context includes perceived need, expectations, and experience of care. The quality of care covers a wide dimension. These include structural quality, process quality, service quality and interpersonal quality (Donabedian, 1980; Kenagy, Berwick, & Shore, 1999).

Responsiveness as a measure of health system performance was developed by the World Health Organisation and covers a set of non-clinical and non-financial scopes of the quality of care that mirror the respect for human dignity and social aspects of the care process (Valentine, Prasad, Rice, Robone, & Chatterji, 2009). Concepts such as respecting patient autonomy

and dignity from the human rights aspect of health system responsiveness (WHO, 2008).Gradually, patients' views and opinions are being acknowledged as anappropriate source of information on non-technical aspects of health care delivery and themeasurement of health system responsiveness has largely been based on surveys of user views (Valentine, Prasad, Rice, Robone, & Chatterji, 2009).

Robone, Rice, and Smith(2010) used the health system responsiveness to determine the way health caresystems are organised and funded, the socio-demographic traits of the populations served and theeconomic, cultural and institutional characteristics of countries. Their findings indicated that the relevant determinants of responsiveness are health expenditure per capita, health care expenditure in the public sector and the population levels of education. Rice, Robone, and Smith(2009) used the health system responsiveness model to explore health system performance for differential reporting behaviour using data contained within the World Health Survey. Their results show large differences in the rankings of country performanceonce adjustment for systematic country-level reporting behaviour has been undertakencompared to a ranking based on raw unadjusted data.

Allthought the health system responsivenes model enables the study to examine the quality of care from the clients perspective, it does not have a method to examine responsiveness of non-personal interactions. For instance, the model does not enable the measurement of public health interventions delivered through the media. The model focuses on impatient and outpatient encounters (Valentine, de Silva, Kawabata, Darby, Murray,& Evans, 2003).

Conceptual Framework

The health system responsiveness framework developed by WHO as a component of the broader conceptual framework on health systems developed in the year 2000 (WHO, 2016) and the health belief model by Sheeran and Abraham (1995) were adapted for this study. Responsiveness was included to ensure that as a social system, the health system is expected to meet common social goals in addition to their main aim. This model has been selected because the WHO has proposed the health system responsiveness as a more desirable model as a measure by which health systems can be judged in the context of performance assessment from patients' views on the quality of care provided and satisfaction with health services (Valentine, et al., 2009).

Murray and Frenk (1999) proposed that responsiveness has two components which are respect of persons and client orientation. Respect of persons has to do with elements such as dignity, autonomy, and confidentiality. This aspect deals with the interaction of individuals with the health system that often have an ethical dimension. In relation to this study, respect for the dignity of the person measures how the health care providers treat the clients with courtesy and sensitivity to potentially embarrassing moments of clinical interrogation or physical exploration. Respect for autonomy with respect to this study enabled the study to know if patients are afforded the opportunity to choose the type of PAC service they want to receive.

The second aspect of responsiveness which is client orientation captures the other four elements which are main components of consumer satisfaction which are not a function of health improvement (Murray & Frenk,

1999). These four elements are prompt attention to health needs, basic amenities, access to social support and choice of institution and individual providing care.

Prompt attention to health needs under this study measures thegeographical accessibility of health care facilities taking into consideration distance, transport and terrain. The ability of patients getting prompt care in emergencies, reducing the time spent waiting for consultation and treatment and waiting times for appointments should be reasonable. Basic amenities also measure the health services such as clean environment and adequate beds at the facility for PAC clients.

The last element under this theory is the choice of institution and individual care. This under the current study will measure the freedom at which clients are allowed to have access to PAC. This looked at the experiences they go through to get access to the service they wanted.

The health system responsiveness was chosen as the theoretical framework because it best suits this study and helps answer the objectives of the study. For instance, after measuring the above seven elements, the study will be able to conduct a systematic review of reported abortion complications, assess the PAC services rendered to clients at the hospital, examine the abortion experiences of clients' seeking post abortion care and examine the clients view on post abortion care at the VRH.The framework will also enable us to determine if there are any inequalities in the distribution of responsiveness across individuals in differences related to social, economic, demographic and other factors. Thus, the health system responsiveness

framework will help this study to examine post abortion care in the Volta Regional Hospital.

Despite the power of health system's responsiveness to examine issues regarding post abortion care, it is limited in terms of experiences of clients. In order to make up for this limitation, the study further adopted health belief model to examine the abortion experiences of the clients.

According to the above version of HBM, action is guided by beliefs about the impact of illness and its consequences (threat perception) which depend on; perceived susceptibility or the beliefs about how vulnerable a person (abortion client in this case) considers herself in relation to a certain post abortion complication and its consequences.

Furthermore, the model considers beliefs about the consequences of health practice and about the possibilities and the effort to put them into practice. According to the model, behavioural evaluation depends on; perceived benefits of prevention or therapeutic health practices and perceived barriers, both material and psychological with regards to specific health problems. The model also considers cues to action, which includes different internal and external factors that influence action.

The study adopted the health belief model by Sheeran and Abraham (1995), which considers three main issues; individual's perception, health motivations and cues to action. This has helped in understanding better the abortion experiences of women

CHAPTER THREE

METHODOLOGY

Introduction

This chapter presents the methodsthat were followed in carrying out the study. It gives a description of the study area, research design, sources of data and target population. It further explains the study's sample size determination, sampling procedures/techniques, methods of data collection, research instruments and the procedures to be followed in data collection, processing, and analysis. Ethical considerations are also discussed.

Study Area

This study was carried out in Volta region, one of the ten regions in Ghana. This region is on the eastern side of the country and shares a border with Togo on the eastern side, with the Volta River and lake on the western side and the Atlantic Ocean on the southern border and the northern Region at the north. One of the unique features of the region is that it can boast of all the ecological zones and ethnic groups found in Ghana as indigenes.

The region has a total of 326 health institutions out of which 242 are administered by the Ghana Health Service (GHS), 18 are mission owned, one is quasi-government and 65 are privately owned. It is worth noting that many of the GHS-run health centres were community initiated. With the exception of Krachi East, Nkwanta North and AdakluAnyigbe, every district now has a hospital, either government- or mission-owned (GSS, 2013). The Volta Regional Hospital was selected because it appears the incidence of induced abortion is high in Volta Region

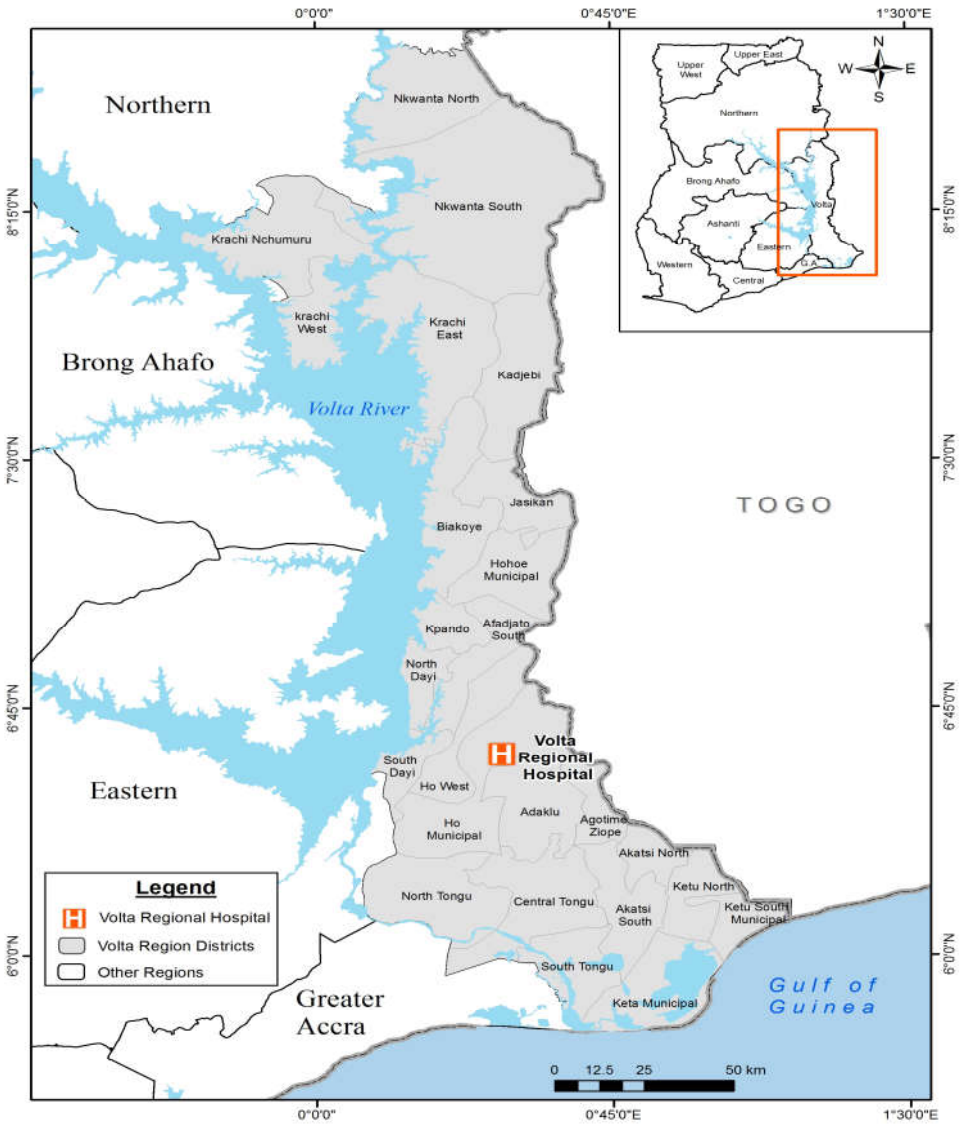

Figure 1: Map of Study Area Showing Volta Regional Hospital

Source: GIS unit of Department of Geography and Regional Planning, UCC

because according to the Ghana Maternal Health Survey 2007 (GSS & GHS, 2009), 12.3% of women in their reproductive age group in the Volta Region ever had an abortion but a high percentage of 94.6% have not been able to get access to abortion. Female students in the capital town of Volta Region, Ho do not have knowledge on contraception as much as they have in depth knowledge on local and herbal abortion methods and also admitted to relying

on abortion rather than contraception (Domhnaill, Huthinson, Milev, & Milev, 2011).

Specifically, the study was carried out in the Volta Regional Hospital of Ghana. This hospital is a government owned ultra-modern state of the art regional referral hospital situated in Ho, the capital town of the Volta Region. The Volta Regional Hospital is strategically located to provide specialized health service to the people of the Volta Region and beyond. Currently, the hospital is patronized by clients from the Republic of Togo, Benin, and the Federal Republic of Nigeria. The hospital adopted the vision statement "to become a regional center of excellence in health care delivery" with a mission statement "to provide standard and efficient health care services to clients by a punctual and dedicated health staff guided by the principles of integrity, confidentiality, and respect for others". Punctuality, respect, dedication, confidentiality, and integrity are the core values and policies adopted by the hospital to guide its staff in the performance of their duties.

The hospital has a five-member management team which is headed by the medical superintendent. The medical superintendent is also the Regional Deputy Director of Health Service in charge of clinical care in the Volta Region. The others are the Deputy Chief Health Services Administrator who is the head of administration, the deputy director of nursing services in charge of nursing services, the senior accountant who is the head of the finance and the principal pharmacist who heads the pharmacy department.

As at 30thSeptember 2014, the staff strength of the Volta Regional Hospital stood at 546. The hospital has a 240-bed capacity but currently, 150

beds are in use due to the inadequate number of health personnel especially, nurses and doctors at thepost at the hospital.

The hospital offers the following services; OPD services in-patient services, surgical services including orthopaedics, obstetrics and gynaecology, internal medicine, child health, dental care, ear, nose and throat, eye care, mental health, accident and emergency, pharmacy, radiology and imaging, physiotherapy services, public health services, administration, catering and cafeteria services, laundry services, social welfare, environmental health, stores and supplies, health information (medical records) and mortuary.

The hospital also has the following departments; psychiatric unit, surgical ward, medical ward, accident and emergency unit, Administration, pharmacy, public health unit, theatre, maternity unit, child welfare clinic, ART clinic, mortuary, herbal clinic, OPD, records unit, laboratory and obstetrics and gynecology unit.

The obstetrics and gynecology unit is responsible for the provision of post abortion care services at the Volta Regional Hospital. On the average, about 5 people access post abortion care services in a week and about 15 people in a moth.

Research Design

The study adopted the descriptive cross-sectional study design. With the aid of this design, the study was able to elicit data from research participants on reported abortion complications, post abortion care services rendered to clients and explore the experiences of the women in securing post abortion care and clients satisfaction with post abortion care (Creswell, 2003) within a short period at a one-time point. Data were collected on individual

characteristics and their exposure to the relevant issues under post abortion care. The descriptive cross-sectional design hence helped the study to give an overview of post abortion care at the Volta Regional Hospital.

Sources of data

The study usedprimary data which was collected with the aid of an in-depth interview guide. The interview was conducted with post abortion care clients.To throw more light on the abortion experiences of women, reported complications, the services rendered to the women and the view of women on post abortion care at the Volta Regional Hospital.

Target Population

The target population for the studycomprised all women who have accessed post abortion care in the Volta Regional hospital. This enabled the study to interview women who have already received post abortion care from the hospital to better understand the abortion experiences of women, reported complications, post abortion services rendered to clients and the views of clients on post abortion care at the Volta Regional Hospital.

Sample size for the Study

The choice of a sample size for the in-depth interview was guided by the need to obtain rich data. Thus, thirty patients were purposively selected for the study with the concept of saturation in mind. An interview is of theessence in getting diverse information from individuals. Bryan, Peter, Amit, and Renee (2013) found no evidence that studies with over 30 interviews yielded significantly more impact. Hence, 30 samples were selected for the study. In spite of this, the sample size was adjusted in the course of the data collection

bearing in mind the concept of saturation and adequacy in qualitative data collection (DiCicco-Bloom & Crabtree, 2006). The sample size that was employed in this study provided the grounds to engage in a critical data analysis. It has been suggested that qualitative study can obtain detail understanding of issues from comparatively fewer respondents using the right methods(DiCicco-Bloom & Crabtree, 2006). Unlike quantitative studies that require that samples are large enough for statistical inferences that will result in the generalization of the findings, qualitative studies are not concerned about generalization. At the 20th respondent, new ideas and themes stop emerging from the data. As such, this study considered views from a total of 20 respondents, drawing from the principles of saturation.

Sampling Procedure/Techniques

Purposive sampling technique was adopted to select respondents for the study.Purposive sampling allows an initial understanding of the situation, and to identify relevant groups with experiences relating to the topic under study (Palinkas, et al., 2014). This technique was used because the study selected patients who came for PAC services at the VRH during the period of data collection. The purposive sampling technique was used in an attempt to get respondents who have in-depth experience on the subject under discussion and have received post abortion care.

Since the study was not allowed to use the confidential records of patients to identify them for the interview, informant consent was sought from the health care providers to inform them about the study. The health providers then purposively selected clients who received post abortion care and informed them about the study. The PAC clients who were willing to partake

in the study were then provided all the information about the study and provided with informed consent forms to be filled. The patients who took part in the interview were allowed to select their own time and place of convenience for the interview to take place.

Research Instrument

The primary research instrument that was used for the interview is the in-depth interview guide. The in-depth interview guide was divided into sections. The first section required the respondents to give their background characteristics (age, sex, level of education among others). The subsequent sections required respondents to give responses that will answer questions relating to the objectives. The IDI was used to acquire in-depth information from respondents within the milieu of personal experiences with post abortion care (Ritchie & Lewis, 2003; Gravetter & Forzano, 2009). The study also made use of an audio recorder to help record the interview which was later transcribed for analysis.

Data Analysis

Twenty interviews with women who had accessed post abortion care in the Volta Regional Hospital were transcribed during the field work. The data was analysed using qualitative content analysis technique. A systematic qualitative orientated text analysis was carried out. Issues were summarised, explained and organised to demonstrate the paramount issues that were identified from the data.

In qualitative oriented research, theoretical arguments are expected to be used as a reference to the current study in comparable fields. However, in

the qualitative content analysis, content-related arguments should always be given preference over practical arguments (Mayring, 2014).This is because in qualitative research validity is regarded more highly than reliability hence this study focused on the content related arguments from the data(Mayring, 2014). The transcripts were read through several times while taking note of emerging issues. Later, these issues were put under various themes. Comparisms were made across themes and some related themes were merged. The final themes were presented and subsequently discussed in relation to empirical literature.

Ethical Issues

The topic for this study was first approved by the Department of Population and Health of the Universityof Cape Coast. Permission was also sought from the University of Cape Coast Ethical Review Board. Ethical clearance from the Ghana Health Service (GHS) and the VRH was also sought.

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. In view of this, participants were provided with information on counselling servicesorappropriatesupportbodies that will help them deal with these issues. Such materials were distributed to all respondents with the information sheet so that those who need 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. The audio recordings of the interview sections were also destroyed immediately after transcription. The transcribed documents were also protected with *"mylockbox"* app on the

computer to prevent unauthorised persons from getting access to the data. Participants were also allowed to withdraw from the interview at any time without reason or penalty. Participants were given participant information sheet and informed consent form that was filled before they were interviewed. This included the necessary information to ensure potential participants fully understood what they were being asked to do and any potential risk associated.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents results from the study of post abortion care at the Volta Regional Hospital. It provides an overview of the socio-demographic background characteristics of the respondents, comprising; age, level of education, religion, marital status, occupation, and place of residence. The chapter also presents information on the abortion experiences of respondents, reported abortion complications, post abortion care services rendered to clients at the hospitaland clients view on post abortion services at the Volta Regional Hospital.

Socio-Demographic Background Characteristics

Table 1 shows that80 percent of clients were aged 20-29 with the rest aged 30-39years. Among the respondents, 15 percent had attained basic education and 30 percent had tertiary education. Ninety-five percent of the respondents were Christians and 5 percent Muslims. Fifty five percent of respondents were never married and 45 percent of the respondents were married.

The main occupations of the respondents were seamstresses (5), civil serviceworkers (5), and traders (4). Four out of every ten respondents interviewed resided at Ho with the rest being residents of Sokode, Kpetoe, Tema, Akroful, Dzemeni, Tarkwa, DaveandLome. The table below shows the socio-demographic characteristics of the respondents.

Table 1-*Socio-demographic background characteristics*

Variable	Frequency (n=20)	Percentage (%)
Age		
< 20	1	5.0
20-29	16	80.0
30-39	3	15.0
Level of education		
No education	2	10.0
Primary	3	15.0
JHS	7	35.0
SHS	2	10.0
Tertiary	6	30.0
Religion		
Christian	19	95.0
Muslim	1	5.0
Marital status		
Never married	11	55.0
Married	9	45.0
Occupation		
Seamstress	5	25.0
Trader	4	20.0
Farmer	2	10.0
Civil servant	5	25.0
Student	2	10.0
Hairdresser	2	10.0

Table 1: continued

Place of residence		
Ho	8	40.0
Kpetoe	2	10.0
Sokode	4	20.0
Tema	1	5.0
Akrofu	1	5.0
Dzemeni	1	5.0
Tarkwa	1	5.0
Dave	1	5.0
Lome	1	5.0

Source: Fieldwork, Adde (2016)

Thematic Framework

A systematic qualitative orientated text analysis was carried out. Issues were summarised, explained and organised to demonstrate the paramount issues that were identified from the data. Based on the analysis, the themes that emerged are presented under thematic framework as follow.

Table 2-*Thematic Framework*

ISSUES	THEMES
Abortion experiences of respondents	1. Abortion strategies 2. Spontaneous abortion experiences 3. Factors that influence decision to seek post abortion care 4. Support received from family and friends
Reported abortion complications	1. Bleeding 2. Incomplete abortion
Post abortion care services rendered to clients at the hospital	1. Operative treatment 2. Counselling services 3. Family planning services
Views of clients on post abortion care services	1. Prompt attention 2. Attitude of service providers 3. Challenges 4. Clients satisfaction with post abortion care 5. What influenced respondents choice of institution

Abortion Experiences of Respondents

Abortion experiences among women include the range of decisions they had to make, their emotions, physical experiences, strategies they need to use including health care advices and in dealing with clandestine medical abortion(Silvina, Mariana, & Lila, 2014)**.** The study reveals a wide range of experiences regarding abortion among the respondents. These experiences include; abortion strategies, spontaneous abortion experiences, decision making process to seek care for abortion complications and support received from family and friends during theabortion process.

Abortion Strategies

Medical abortion is widely used by women in an attempt to terminate pregnancy which is normally done with the use of both Mifepristone and Misoprostol (Blum et al., 2007). With regard to the study, it was revealed that the respondents usually induced abortion at home using the medical abortion method which involves swallowing of pills. However, only one acquired the pills herself whereas the other two had to rely on others to acquire the pills for them. A 23 year old seamstress shared her experience as follows:

> *"I took some medicine. I was discussing the pregnancy with a friend and she told me she knows some medicine, so she will bring it to me. She brought me the medicine and I used it"* –Seamstress, 23 years

To corroborate this, a caterer, 29 years had this to day:

> *"I just bought some medicine and took it. The medicine is called Cytotec. After taking it, I stayed indoors for a while I think for about 8 hours and I started feeling cramps and not long after that the blood started flowing out"* –Caterer, 29years

The findings show that women prefer to abort their pregnancy on their own instead of seeking professional help. With about two thirds of the women who induced their abortion having to rely on other people to acquire the necessary drugs for the procedure. This is in line with a study conducted by Sedgh (2010) which revealed that most women who sought abortion induced the abortionon their own. The findings also indicate that women also induce abortion based on advice from significant others which is considered under the health belief model as cues to action (Sheeran& Abraham, 1995) which aids women in the decision making process. The common method of terminating pregnancy among women is the medical abortion by the use of pills more preferably the misoprostol (Cytotec) which was expressed in this study and others (GSS et al., 2009; GMHS, 2008; Blum et al., 2007).

Spontaneous Abortion Experiences

The study, however, found that not all the women deliberately induced the abortion. One respondent indicated she unknowingly took medications that resulted in an abortion. For instance, a 19 year old student indicated:

> *"It was at school that we were given some medicine "domekplevi tike". It was after we took the medicine that our headmaster told us that the medicine aborts pregnancy. We were writing exams when they brought the medicine to us. We were told the previous day that we were all going to take medicine when we come to school so we should all eat before coming to school"* –Student, 19years

One woman also indicated that her abortion was as a result of physical abuse by her husband. She had this to say;

> *"For this abortion, I will say it is my husband that gave me problems that resulted in the abortion. If not, I don't think the pregnancy would have ended in an abortion. Because of his problems, I started experiencing waist pain which resulted in this. We were struggling with each other and someone else came to hit me from behind on my waist. It was his girlfriend who did that"* –Seamstress, 29years

Taillieu and Brownridge (2010) in their study revealed, pregnancy serves as a protective period for most women against domestic violence and it also serves as a period of increased risk for a substantial minority. This corroborates the fact that there was only one incidence of domestic violence as the cause of abortion in the study

Also, spontaneous abortions occurred among the women as a result of carrying out activities that demand the use of excessive energy. This includes cooking meals that demand the use of excessive energy. Some issues relating to farming activities were also identified. A 28 year old student had this to say:

> "*hmmmm I don't know how to say it. I went to the farm to do some weeding. I was back from the farm and I realised I was bleeding so I came to the hospital and as soon as I got here and the baby itself came out"* –Student, 28years

Another respondent indicated:

> *"...But for this one, I was preparing 'banku'* [a local meal] *when the blood poured out of me. I couldn't even continue cooking the 'banku'. I had to leave it on the fire..."* –Hairdresser, 28years

Travelling long distances was also indicated as a cause of spontaneous abortion among the respondents. For instance, a respondent had this to say:

> *"For this particular one I can't exactly tell what happened but I did some rounds travelling around to my dad's place and other places with a motorbike so when I came back I was at health insurance* [office] *when I started bleeding so I don't know what caused it"* – Fashion designer, 26years

To buttress this quotation, another respondent had this to say:

> *"...For this one that I just came to the hospital, I took a ride on a motorbike and it bumped into a pot hole and I started feeling pains in my stomach. Only to come to the hospital and be told it has also gone waste"* –Trader, 25years

It was, also, observed that some of the abortions occurred as a result of accidents at home.

> *"I slipped on the floor. Where we were staying at first had a cemented floor so when it rained the floor was slippery and I slipped and fell. I started bleeding so I went to the hospital"* –Fashion designer, 26years.

Factors That Influence Decision to Seek Post Abortion Care

The study further observed that different situations informed women's decision to seek PAC services. Some of the women decided to seek PAC only at the point when they felt the pain was becoming unbearable and needed professional help in dealing with their situation. A respondent had this to say;

> *"My stomach was paining me severely and I went to the hospital. It started like some normal pains but was increasing in pain and when I couldn't bare it again, I went to the hospital"* –Student, 19years

Another respondent indicated:

> *"Well! When the thing* [abortion] *happened I didn't come to the hospital immediately. I stayed home for some time and I started feeling pains in my waist. I went to urinate and saw blood in my pant. When the pain was becoming too much, I pushed. After pushing, the blood started coming out of me like water. I almost died out of that. The blood was just coming out like water "tsruuuuuuuuuu" for a long time so I became weak and when I try to get up, I will fall" – Seamstress/trader, 29years*

Women delayed in seeking early post abortion care services at the hospital for various reasons. One of these reasons is the lack of or expired National Health Insurance Scheme cards. This prevented some women from seeking care at the hospital since they did not have money to pay for the services at the health center. One woman had this to say:

"…if not for the fact that my NHIS card had expired I would have come earlier and not wait for it to become this serious" – Hairdresser, 28years

The study also observed that women who experienced abortion were scared of stigma by the society. This to a large extent affect the decision making of some women to seek help at the health care facility. They would rather prefer to hide their situation and suffer in silence.

"The thing became unbearable for me before I decided to go to the hospital. I was feeling pain, I was feeling shy and didn't want anybody to know what was happening to me so I refused to go to the hospital but later on, I couldn't breathe again so they had to charter a taxi and take me to the hospital" –Seamstress, 23years

Nonetheless, multigravida women did not take long in seeking care at the hospital. They were quick to report at the hospital when they noticed a change or felt something was not in the right order.

"I know that during pregnancy you are not supposed to see blood. I have given birth before and I know the process so immediately I saw something came out of me I knew something was wrong and I had to go to the hospital" –Fashion designer, 26years

"When I was feeling cold and then all of a sudden I started feeling dizzy, I realized something was really wrong with me so I was rushed to the hospital" –Farmer, 33years

It was observed that whereas many factors influence the time a woman decides to seek professional health care for post abortion complications, the most influential factor was severity of the pain being felt from the

complication. Stigma and poverty nonetheless also played a vital role in influencing the decision making process. This corroborates the findings of Finer and Henshaw (2006). Finer and Henshaw (2006) argued that most women allow a lengthy time to elapse between the abortion and the time spent in seeking care. This could be attributed to the stigma associated with induced abortion in developing countries coupled with laws that render abortion legal under certain conditions (Morhee&Morhee, 2006). This affirms the health belief model's assertion that people's belief about the consequence of health practice, cues to action and health motivation are issues that influence the health seekingdecision making process (Sheeran& Abraham, 1995).

Support Received from Family and Friends

This section focuses on support women received from friends and family in seeking post abortion care.It appears more than three quarters of the women received support from their partners, family, and parents in seeking post abortion care at the hospital. This support mainly came in financial and emotional support. In most cases, those who received support from their partners and families acknowledged that the support was very critical in their decision to seek care as well as their general experience with the procedure. For instance, a 29 year old caterer had this to say:

> *"Yes, my husband. He has been very helpful right from the beginning till now. He was there for me by going to the hospital with me and when I was admitted, he comes to visit regularly and he buys food for me as well as being supportive in comforting and consoling me to get through the process"* –Caterer, 29years

Another respondent had this to say:

> *"Yes my father was a watchman and he is now on pension but takes some monthly pay of around GH$800 so he went for it and the boy who impregnated me also added some as well as my elder brother and they took me to the hospital. They also come to visit me from time to time"* –Student, 19years

On the other hand, it was revealed that about one quarter of the respondents did not have any support from their immediate families and partners. This resulted in their being left stranded at the hospital since they could not afford their bill. As such, they were kept at the hospital against their will although they had fully recovered from their conditions. This was what a respondent had to say:

> *"No one helped me even as I am here right now, I have been discharged but because of my bills, I can't go home. For my coming, my sister was the one who got me the taxi but even that there is a man in our house who is a driver so he decided to help me by bringing me. Aside that, I have not received any form of help from anybody again*" – Seamstress, 23years

To corroborate this, another respondent had this to say:

> *"Please no, there is no one even up to now I don't have anybody who will pay my bills for me"* –Hairdresser, 22years

Reported Abortion Complications

The common abortion complications that could occur include; offensive discharge per vaginum, injuries to the vagina, foreign bodies in the vagina, injuries to the cervix, incomplete abortion, bleeding, uterine

perforation among others (Ansari, Zainullah, Mi Kim, Tappis, Kols et al., 2015). From the study, the most common complications reported by women seeking post abortion care at the Volta Regional Hospital were bleeding and incomplete abortion.

Bleeding

The results show that about half of the women recorded heavy bleeding as a result of complication resulting from the abortion. For instance, some of the women indicated that:

> *"It was yesterday at dawn that I felt I needed to go to toilet but as I got to the toilet, I realised I was bleeding and I couldn't even ease myself again and before I realised I heard a sound "kpor" and it was the baby that has fallen off me"* –Farmer, 37years

A 28 year old student had this to say:

> *"Hmmmm, I don't know how to say it. I was back from the farm and I realised I was bleeding so I came to the hospital and as soon as I got here the baby itself came out*" –Student, 28years

This is further corroborated by a seamstress aged 29 years:

> *"I was feeling pains in my waist and when the pain was becoming too much, I pushed. After pushing, the blood started coming out of me like water. I almost died out of that. The blood was just coming out like water "tsruuuuuuuuuu" for a long time so I became weak and when I try to get up, I will fall"* –Seamstress/Trader, 29years

Stanley et al., (2008) observed that bleeding was one of the most serious post abortion complications reported at hospitals. This assertion was also corroborated by other studies which also found haemorrhage as the

leading complication resulting from induced abortion (Adinma, 2011; Delvaux, Soeur, Rathavy, Crabbé&Buvé, 2008; Fawole&Aboyeji, 2002).

Incomplete Abortion

The results also revealed incomplete abortion as a common abortion complication among women seeking post abortion care at the VRH. However, this complication was mostly observed among the respondents who induced their abortions at home. A 19 year old student who had an induced abortion indicated that:

> *"My stomach was paining me severely and I went to the hospital. It started like some normal pains but was increasing in pain and when I couldn't bare it again, I went to the hospital. It was at the hospital that I was told it is an incomplete abortion*" –Student, 19years

Another respondent who had induced abortion indicated:

> *"I was going to take my bath and it came out. The baby was coming out but it did not come out completely. Some parts of it remained in me although the baby itself came out completely, some of the things that are supposed to come out alongside the baby did not come out."* –Seamstress, 23years

These findings were corroborated by a 24 year old seamstress who indicated:

> *"Well for my situation I can't really tell what was wrong with me. It's like a clot of blood in my stomach but the doctor too is saying it is an incomplete abortion. So me, I really don't understand them but they washed my stomach for me"* –Seamstress, 24years

This finding supports the findings from a WHO study in North-East Brazil, local hospitals which reported rise in the cases of incomplete abortions (Mundigo&Indriso, 1999). This increase was associated with the sharp increase in the use of Cytotec, which was usually purchased over the counter from local pharmacists.

The common abortion complications that were reported by the women seeking PAC services at the Volta Regional Hospital were bleeding and incomplete abortion. The findings of this study are consistent with studies that have shown that incomplete abortion and haemorrhage are the leading complications resulting from induced abortion (Delvaux, Soeur, Rathavy, Adinma, 2011; Crabbé&Buvé, 2008; Fawole&Aboyeji, 2002).

Post Abortion Care Services Rendered to Clients at the Hospital

The post abortion care model emphasised post abortion care as an important emergency obstetric service and the need for post abortion family planning services and counselling(Maureen & Katherine, 2003). The post abortion services covered in this study include operative treatment, counselling services and reproductive and family planning services.

Operative Treatment

From the description of the PAC clients, it appears themajority of the women were treated with Dilation and Curettage (D&C) as an operative treatment. These women had some of the products of abortion which include placenta and blood left in their uterus which need to be removed from their system. For instance, a 23 year old housewife had this to say:

"They made me do ascan and they said the pregnancy is spoilt so they took me to a room and washed my stomach for me. When they were washing my stomach, I couldn't see what was going on but I saw that they inserted some things in my vagina and were scrapping the blood out and it was painful. But before that, the baby was removed first and it was a painful process. It took like an hour for the whole process to be completed" –Housewife, 23years

Another respondent indicated that:

"They took something, some metals and they injected me on my left thigh. Some plenty metals and they made me lay down so I actually didn't see what went on again. But it was not a machine that was using electricity, he just inserted the metals and scrap the things out. It was still painful though" –Student, 19years

It was also observed from the data that Electric Vacuum Aspirator (EVA) was also highly used by the health facility in the treatment of PAC. This was also mostly used in the cases of incomplete abortion to remove the products that were left in the uterus. A 26 year old fashion designer said this about the procedure:

"Well they used some machine but I don't know the machines name. They made me lay down and they brought the machine and some other tools like scissors and other things. They then spread my leg and inserted something which opened up my vagina up and down (laughs) *and they used the machine to bring the things out*" –Fashion designer, 26years

Another respondent had this to say:

> *"He injected me and took something like medicine and poured it on my lower abdomen and my vagina and then wiped the place to clean the whole area before switching on the machine and then inserting it in me. The machine then sucked the blood out of me. During the process, I was feeling pain and he was continuously telling me sorry and consoling me. He actually took his time in treating me"* – Farmer, 33years

This was further corroborated by a 28 year hairdresser who had this to say about the procedure:

> *"They inserted some machine in my vagina first and later took something that is plastic like and inserted that one too. The machine had one of the plastics in a bowl and the other one was in me and it was switched on and I saw the bad blood in my stomach coming out into the bowl. I was injected on my thigh before the procedure was started and two other injections were given to me in my vagina"* – Hairdresser, 28years

There were instances where the women were allowed to go through spontaneous vaginal delivery (SVD). This was normally the cases where the women reported with stillbirth at the hospital or in instances where the fetus was a bit matured. These women were taken through the natural process of delivery. A woman who went through SVD had this to say:

> *"She just gave me something like a chamber pot to sit on and she asked me to stamp my feet and she wore gloves. I then saw her take something like a small scissors to cut the baby from the umbilical cord*

and she then inserted hand in me and removed the rest of the things. They wanted to go and wash my stomach for me but I don't have money for that so I prevented them from doing it" –Seamstress, 23years

Another indicated that:

"It was a normal delivery just like when the woman is in labour. Because this one the pregnancy was a bit old so they had to administer the Cytotec so that I go through normal delivery and deliver the foetus" –Fire officer, 30years

The findings show that the common treatments that were offered to the PAC clients for the removal of retained products were D and C, electric vacuum aspirator and normal spontaneous vaginal delivery. This is consistent with Arambepola, Rajapaksa and Galwaduge (2014) who reported that most PAC services involved D and C and EVA which are non-surgical procedures.

Counselling Service

Counselling services are one of the major services required to be provided for PAC clients. But the study observed that about one quarter of the respondents received counselling, whilst others did not. The respondents who indicated that they were not offered counselling services, before, or after the procedure had these to say:

"No, I was not offered any form of counselling" –Fashion designer, 26years

"Oh! These people?[referring to the service providers],*they don't have time for me oo. All they know is to insult you and lie to you"* –Student, 28years

However, the women who were offered counselling services were made to understand their situation and the treatment they were about to receive. Others were also counselled about how to take care of their pregnancy in the future to avoid repeating the situation they just went through and ultimately losing their pregnancy again. A respondent who received counselling services had this to say:

"They advised me on how to take care of myself. They also spoke to me about how to take care of pregnancy. I was told not to be keeping myself away from the hospital when I am pregnant. Even if it is a headache I am experiencing during pregnancy, I should rush and come to the hospital and shouldn't sit in the house and say it is just headache. Because almost all of us in the ward are here because of spontaneous abortion. You will be in the house and by the time you realise then the pregnancy goes bad" –Seamstress, 29years

A 30 year old fire officer also indicated that:

"When I came on Sunday, they told me that this is the problem. That my cervix was open and my water surrounding the baby has finished and it is inevitable, anything can happen. So I should get ready. It is 50:50 for the good and the bad" –Fire officer, 30years

Another respondent who received counselling indicated:

"It was not really counseling. They just consoled my husband and I that it is well and I can still get pregnant so we should wait for

some time for the womb to heal before I try getting pregnant again" – Trader, 25years

Family Planning Services

Family planning services were also supposed to be offered to all women that sought post abortion care. However, only six women indicated they received these services. The women who were offered family planning services expressed satisfaction with the service process and quality of the service. For instance, a 29 year old seamstress who received family planning service had indicated that:

"They thought us about the pills, injectable, and condoms. They also told us about when someone has given birth to a lot of children and wants to stop given birth, they can do the permanent one for them and they won't get pregnant again. They said they also have some that can take you for five years. It will be inserted in your arm and when you think you want to start having children you will come and they will remove it. They said they also have the three months and some other things but when they were talking, I didn't really pay attention because of what I went through with my pregnancy" –Seamstress, 29years

Another respondent also indicated that:

"They did family planning for me. They said the children I am having are many so they want to do family planning for me so that I won't get pregnant again. They said they want to close my womb so that when we have sex again, I won't get pregnant" –Farmer, 37years

Post abortion family planning and counselling services are one of the essential post abortion services offered to women to address their emotional and psychological support (Tesfaye&Oljira, 2013). This notwithstanding, these services were not offered to most of the PAC clients who visited the facility. This conforms to the findings of Sathar, Singh, Shah, Rashida, Kamran and Eshai (2013) who also found that family planning and counselling services were inadequate in Pakistan. However, in Ethiopia, Tesfaye and Oljira (2013) observed that PAC clients were offered information on their current illness as well as family planning and counselling services. This notwithstanding, the few women who received counselling and family planning services were satisfied with the quality of the service rendered to them. This meets the demands of the conceptual framework to measure process quality and service quality (Kenagy, Berwick & Shore, 1999).

Client'ssatisfaction with Post Abortion Care Services

Most women perceive post abortion service at the hospital to be of a high quality and as such are motivated to seek post abortion care services at a health facility (Melkamu, Betre, &Tesfaye, 2010).Issues discussed under the views of clients on post abortioncare in this study include prompt attention, theattitude of service providers, client's satisfaction and choice of care provider.

Prompt Attention

According to the findings of the study, the hospital places a priority on giving early care to its clients. There were instances where clients were offered treatment upon arrival although they had not gone through the required

procedures to get the necessary documentation for the service. There were occasions where service providers took it on themselves to process the documents on behalf of the clients while they were being treated. A 25 year old trader who was treated while a hospital staff was processing her card had this to say:

> *"Oh, they were quick in attending to me. As soon as I got here, I was sent to the ward for treatment to begin but I can't really tell like how many minutes it took them to attend to me because I was in pain and I was really not thinking about that. I was actually in pain from the house so when I got here the door was not opened by then so I approached a young male nurse and as soon as I told him what was happening to me, he took a wheelchair and wheeled me to the ward and they started treatment on me while he went on ahead to process my card"* –Trader, 25years

Another respondent who received prompt attention indicated that:

> *"Yes when I got here, they didn't even make me stay at the OPD, I was moved to the gynaecological ward and my husband processed the folder at the OPD while I was being treated"* – Housewife, 23years

Nevertheless, a young girls was overlooked for older women to receive early care regardless of how long she had been in the ward waiting for her turn.A 19 year old student indicated that:

> *"When I got there they didn't clean my stomach for me early. I went on a Monday and I was given medicine and the doctor keep coming every day and will just tell me that he would come and do it for*

me and that was what kept happening till a white doctor came around and told them they had to do it for me so I can go home on Saturday. So I went on Monday and it was Friday before I was given my service. I was there before some people came and they did for them and they left and I was still there" –Student, 19years

Waiting time for treatment at the Volta Regional Hospital was relatively short. The respondents were to a large extent happy about the prompt attention they received at the Volta Regional Hospital. This according to the conceptual framework is part of client orientation which offers prompt attention to clients (Murray & Frank, 1999). Thus, clients were offered early treatment at the health facility. This was however not the case from the findings of Tesfaye and Oljira (2013). Tesfaye and Oljira (2013) observed that the waiting time from arrival to treatment was very long. Nonetheless, this study and other studies revealed that there is a bias in the delivery of early treatment to clients, with adolescents often not given early attention (Fawole&Aboyeji, 2002).

Attitude of Service Providers

The attitude of service providers towards clients is an integral part of post abortion care. Clients expressed happiness when service providers were nice to them (Melkamu, Betre, &Tesfaye, 2010). The study assessed the attitude of service providers by asking the clients about the attitude of service providers towards them. This study revealed thatthe respondents were generally happy about the attitude of service providers at the hospital. The service providers were generally praised for being caring and knowing how to

talk and interact with their clients politely. The clients expressed satisfaction in the attitude of the service providers. A 33 year old farmer who expressed being satisfied with the attitude of the service providers had this to say:

> *"Oh, they are good, caring and are free with us. For some other hospitals, the nurses are not friendly at all and will fight and argue with you at the list thing. But at this hospital, they are very kind and free. Ever since I came all those who came to speak with me talk with some kind of respect for me and if they say something or do something and realized you are not happy, they are quick to apologize"* –Farmer, 33years

Another respondent also indicated that:

> *"Their attitude, in general, is fine. They know how to talk to us and are not abusive in their choice of words and they take very good care of us like coming to check up on us regularly to see if everything is going on well"* –Housewife, 23years

About one fourth of the respondents, however, felt the service providers have a bad attitude. They expressed dissatisfaction with the treatment they received at the hospital. One client complained bitterly that they like to insult too much. Another client on the other hand felt not all of the service providers had a bad attitude. While some were good, others were provocative. A 28 years old hairdresser had this to say:

> *"I will not say everyone is having a good character. When I was here the other time, they really worried me. Is it insult they did not insult me? But I was in pain so I couldn't talk but those who treated me yesterday are very good"* –Hairdresser, 28years

Another respondent who complained bitterly indicated:

> *"Is this a good hospital? This is just a place for insulting hmmm the people are wicked and they don't take care of me. I have not been to a hospital that they have treated me like that before. The people are wicked, they are very wicked papa. Even if you are dying they won't mind you"* –Student, 28years

The need for service providers to be caring and polite to clients is not only critical but imperative. It is therefore not surprising that the clients were generally satisfied with the attitude of service providers. In line with the health system responsiveness, clients are expected to be treated with respect which has to do with elements such as dignity, autonomy, and confidentiality(Murray & Frenk, 1999). Clients were generally satisfied with post abortion care at the Volta Regional Hospital mainly because of the attitude of service providers. In a study by Melkamu and his colleagues, it was reported that service providers were found to be caring and polite to the clients who sought PAC (Melkamu, Betre, &Tesfaye, 2010). The finding from this study was consistent with that of Melkamu and his colleagues. However, some expressed dissatisfaction with PAC services at the VRH due to negligence and provocative nature of some service providers. This affirms the findings of Arambepola, Rajapaksa and Galwaduge (2014) study conducted in Sri Lanka which argues that post abortion clients were displeased with services received from health facilities owing to verbal harassment of some health-care-providers on their abortion condition.

Challenges

Generally, the respondents did not indicate that they had faced many challenges in terms of care and services received. However, it was revealed that the main challenge that the clients faced at the hospital wasfrequent water shortage.For instance, a 25 year trader indicated that:

> *"The only thing I will like to say is the water problem. I am not saying it is the fault of the hospital but the fault of those in charge of water in the town. The tap stops flowing regularly and causing water shortage at the hospital and because of that the washroom becomes nasty and other things that we need water to do becomes a problem"* – Trader, 25years

Another major challenge that was observed was the issue of health insurance. Most of the women reported to the hospital with little or no money with the intention that their health insurance will cover their bills only to be disappointed. A respondent who was disappointed had this to say:

> *"The only thing that is bothering me is that I had only GH 30 when I was coming knowing very well the health insurance will also cover some costs but they are telling me I have to pay GH 130 and that the insurance card does not cover everything. She said if not for the card, I would have paid about GH 400"* –Hairdresser, 28years

Another disappointed respondent also indicated that:

> *"Well, just as the government said health insurance will help us when we come to the hospital but when you come to the hospital then they expect you to pay for the medicine again and when you are done and about to leave they give you bill again and I don't*

understand why it should be like that. For example, when they wanted to clean my stomach for me, I was asked to pay for it as well as other things like water and medicines. Which I think should be covered by the NHIS" –Housewife, 23years

All respondents were asked whether they were satisfied with the post abortion care service at the facility and, if so, why. Overall, the women expressed much satisfaction mainly because of the attitude of the service providers towards them, how they were catered for even when they had no money to pay for the service. The respondents had this to say about the attitudes of the service providers:

"The reason I am very satisfied is that I have been to different hospitals and I have come here too and I have seen the difference. Surprisingly enough, this happens to be the hospital that I was rather afraid of coming to but I am really glad I did come here. The service providers here are very nice to us and caring" –Trader, 29years

Another respondent had this to say:

"…they are quick to attend to patients. Unlike other places that when you go and you are in pain, they will just stand and be watching you and how to even attend to patients or give them treatment becomes a problem. But for the three days, I spent at the regional hospital, I was amazed at the way everyone who comes is dedicated to their work. Everyone was serious about their work and did it to satisfaction at the same time smiling at us" –Farmer, 33years

Others also expressed satisfaction with the treatment they received mainly because after the treatment they did not suffer any complications again. For instance, a satisfied respondent indicated that:

> *"Yes because the day they cleaned my stomach, the following day and I was okay and I did not feel any pain again but some other sister came and she really suffered after the process. I think she even got a swollen thigh"* –Student, 19years

The findings show that if clients are treated with care and respect at a health facility, it gives them satisfaction with the health care services. The service providers at the Volta Regional Hospital were therefore commended by the respondents for their attitude towards them. Melkamu, Betre, andTesfaye (2010) opined that most women perceive post abortion services in health facilities to be better and are therefore motivated to access post abortion services in hospitals. The specific factors that prompted this positive perception include thevalue of care, good conduct of service providers together with theproximity of the health facilities (Melkamu, Betre, &Tesfaye, 2010). This corroborates with the current findings as well as the health system responsiveness model which requires health systems to provide structural quality, service quality, and interpersonal quality to attain patient satisfaction (Kenagy, Berwick, & Shore, 1999).

What influenced Respondents Choice of Institution

The decision on the choice of institution to receive post abortion care to a large extent was not made by the clients. Most of them were referred from the first health facility they sought to seek PAC service at. For instance, a respondent who was referred from the first health facility had this to say:

"...I was then sent to ahospital in Togo. When we got there, they pressed my stomach for long before it came out and I was in severe pain. But they said they were not having the machine that they will use to clean my stomach so they referred me to the VRH" – Hairdresser, 28years

To corroborate this finding, another respondent had indicated that:

"I was sent to the hospital in Sokode. They managed to stabilise my conditions there and then transferred me to the Volta Regional Hospital. It was at the regional hospital that they carried out some tests on me and detected that I was pregnant but had gone through spontaneous abortion so went ahead to clean my stomach for me" –Farmer, 33years

Some of the women also indicated their choice of theinstitution was based on their past experiences at the hospital. Experiences which include how they were treated at the hospital and the care they received while at the hospital. A respondent with past experience at the Volta Regional Hospital indicated that:

"Well this is the hospital that I had my first child and I liked how I was treated here so I don't see any reason to go anywhere else. Even my first child, I decided to come here because I like here because they treat people well even if you come alone and have no one to aid yuo, they themselves will take up that responsibility and take care of you for you to be comfortable. For example, when you come to this hospital and you need to purchase some things that you don't have

money, they give it to you and you pay for it later" –Housewife, 23 year

Another respondent had this to say:

"Because I don't have anyone who will take care of me at the hospital so I decided to come to the regional hospital. Unlike other hospitals that you need a relative or someone to be coming to wash for you, take care of you among other things, this place, the nurses do all that for you and make sure you are always comfortable" –Farmer, 37years

The inability of some hospitals to perform post abortion care services resulted in the referral of some respondents to the Volta Regional Hospital. However, some respondents take full responsibility of choosing the facility for their service which was mainly based on their past experiences at the hospital which was pleasant to them. This affirms the health systems' responsiveness model's proposal that the ability to exercise preferences could be as a result of treatment by persons of a particular gender, age group as well as emotional bonding to a particular facility (WHO, 2015). This also agrees with the findings of Windy, Ali, Mori, Wantania, Kuroiwa and Shibuya (2015) who argued that clients seek post abortion care at particular hospitals as a result of their satisfaction with the services at the facility. Hence, they were enthusiastic to return for follow-up and were also ready to recommend the services to others.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter outlines the summary of the major findings of the study. Conclusions are then drawn based on the major findings made. Based on the major findings made, recommendations are also made for policy and practice. Suggestions are then made for further research on post abortion care.

Notwithstanding the numerous studies conducted in Ghana on abortion, there is a paucity of the literature with regards to clients' view of post abortion care services. This study examined post abortion care in the Volta Regional Hospital. The study was guided by the health system responsiveness model and the health belief model to identify variables which affect the delivery of PAC services.

The study employed the interpretivist approach with a descriptive cross-sectional research design to conduct a review of reported abortion complications, abortion experiences of women, PAC services rendered to clients at the hospital and clients views on PAC services at the VRH. The sample size used for the study was twenty (20) PAC clients who were selected using the purposive sampling technique.

Summary of Key Findings

The main findings of the study relate to post abortino care including abortion experiences of respondents, post abortion care services rendered to clients, attitude of service providers and clients satisfaction with post abortion care.

The study observed that women who induced abortion at home mainly used medical abortion. The study also revealed that women did not seek early care for post abortion complications.

Among the reported complications for post abortion care at the Volta Regional Hospital, haemorrhage and incomplete abortion were the most commonly reported complications of clients for post abortion care. The study further revealed that the Volta Regional Hospital (VRH) offered treatment, counselling services and family planning services to post abortion clients but the hosital's emphasis was more on operating treatment.

The study also showed that early care was given to PAC clients at the VRH. On the attitudes of service providers and clients satisfaction with PAC at the VRH, it was revealed that clients were generally satisfied. The study indicated that the service providers have good interpersonal relationships with their clients to a large extent. However, there were some few challenges that clients faced in their quest to seek PAC. Financial constraints and frequent water shortage at the ward were the two main challenges faced by clients at VRH.

As a referral hospital, most of the clients were there as a result of a referral from other hospitals. However, those who came on their own accord came mainly because of their past experience at the Volta Regional Hospital.

Conclusions

The following conclusions are drawn based on the key findings of the study. Women prefer to induce abortion at home rather than seek professional service at a health center. The common method of inducing an abortion among women was the medical abortion preferably, the use of misoprostol (Cytotec).

The common post abortion complications reported by women at the Volta Regional Hospital were haemorrhage and retained products of abortion. However, women do not seek early post abortion care services at a health care center.

Post abortion family planning and counselling services are not offered to women who seek post abortion care at the Volta Regional Hospital. Although, these services are some of the essential post abortion services expected to be offered to women to address their emotional and psychological needs. The common treatment offered to the PAC clients were D and C, electric vacuum aspirator and SVD.

Post abortion care clients at the Volta Regional Hospital are offered early treatment at the hospital. PAC clients were also found to be generally satisfied with post abortion care services at the facility.

Women sought post abortion care at the facility generally as a result of a referral from another health facility or based on satisfaction derived from previous visits to the Volta Regional Hospital for health care services.

The conceptual model was relevant in the data analysis and discussion of the result. As such, the two models shape the understanding of the issues that emerged from the study.

Recommendations

Following on from the key findings and conclusions of the study, the following recommendations are made;

1. Ghana Health Service and the Ministry of Health should put in measures to make abortion services affordable at the hospitals. This

will encourage women to seek professionalabortion services at the hospital.

2. The Volta Regional Hospital should intensify the provision of pre and post counselling services as well as family planning services to their PAC clients.
3. Ghana Health Service and the Ministry of Health should intensify campaign programmes on post abortion complications and the need to seek early treatment at the hospital.

Suggestions for Further Research

A study should be conducted on post abortion care hospital records to investigate quantitatively, the association between diagnosed post abortion complication, as independent variable and the post abortion care services received, as the dependent variables. This would make it possible to examine the quantitative aspect of diagnosed post abortion complications and the treatment received by the women.

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APPENDICES

APPENDIX A

IN-DEPTH INTERVIEW GUIDE

University of Cape Coast

College of Humanities and Legal Studies

Faculty of Social Sciences

Department of Population and Health

In-Depth Interview Guide for Post Abortion Care (PAC) Clients

Background Information

1. Age …….
2. Educational level ……..
3. Religion ……
4. What is your current marital status?

   …….
5. What is your occupation? …….
6. Place of residence …….

Abortion experiences

7. How many abortions have you ever done?
8. How was the last abortion done?
9. Can you please tell me about how easy the method you used was?
10. Can you please tell me the cost of the last method and who paid for it?

Sequence of service

11. Who delivered the PAC service to you?
12. How was the treatment given to you?
13. After treatment did you receive counselling? –

    If "YES" can you tell me about the counselling process?
14. Were you offered reproductive and family planning services? –

    If "YES" can you tell me about the reproductive and family planning services received?

    - **Probe** for whether options were provided in order to make a choice!

Experiences before seeking post abortion care

15. What made you decide to come for the service?

    - When was the decision made to seek care?
16. Can you please tell me if you had any support from anybody to seek post abortion care?

    -**Probe** for the type of support and from which people

Experiences at the hospital

17. Can you please tell me about the attitude of service providers towards you?
18. Are you satisfied with the service delivery?

    - Why? .....
19. What are the challenges you faced in your quest to seeking post abortion care?

APPENDIX B

CONSENT FORM

UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

CONSENT FORM

I am Kenneth SetorwuAdde an M.Phil student at the department of Population and Health, University of Cape Coast. As part of my academic work, I am conducting an exploratory study on **"Post Abortion Care in the Volta Regional Hospital".** In line with the study, I would like to interview you for some information concerning your experiences regarding Post Abortion Care. Your participation in this interview is vital to the success of the study. The information you will provide in this interview will 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 will not be included. The results of the study will be shared with participating health facility. There is, however, no direct financial benefit for you for participating in the study. The study has no external or internal funding. You reserve the right not to respond to any question that you consider confidential and you are at liberty to back out of the interview at any point without any penalty. The interview process will take approximately 20 – 35 minutes. I, therefore, crave for your indulgence and co-operation in this interview by signing below if you agree to participate in this interview.

Thank you in advance.

.....		……..	.....
Respondent		Witness	Facilitator

Date: .....

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

Prof. AkwasiKumi-Kyereme	Dr. Eugene Darteh
Department of Population and Health, UCC	Dept. of Pop. and Health, UCC
Mobile: 0244255234	Mobile: 0243717014
E-mail: kumikyereme@yahoo.com	E-mail: edarteh@ucc.edu.gh

APPENDIX C

INFORMATION SHEET

UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

INFORMATION SHEET

Title of the study: Post Abortion Care in the Volta Regional Hospital

Introduction: I am Kenneth SetorwuAdde, an MPhil 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: kensadde@gmail.com

Nature of research: As part of my academic work, I am conducting a descriptive cross-sectional research on "Post Abortion Care in the Volta Regional Hospital". This study is entirely an academic work and seeks to examine issues surrounding Post Abortion Care towards effective management Post Abortion Complications in Ghana. Specifically, the study would seek to conduct a systematic review of reported abortion complications; assess the sequence of services rendered to clients at the hospital; examine the experiences of clients before seeking post abortion care, and examine the experiences of clients in seeking post abortion care at the hospital. In line with the methods for the study, I would like to interview you for some information concerning your views and experiences regarding Post Abortion Care.

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 Volta Regional Hospital. 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 aparticipant 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 Volta Regional Hospital. 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: 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.

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

Hannah Frimpong	Dr. Eugene Darteh
GHS-ERC Administrator	Department of Pop. and Health, UCC
Office Tel: +233 302681109	Mobile: 0243717014
Mobile: 0243235225	E-mail: edarteh@ucc.edu.gh

APPENDIX D

GHS- ETHICAL APPROVAL

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah. Frimpong@ghsmail.org

23rd December, 2015

Adde Setorwu Kenneth
University of Cape Coast
Department of Population Health
Cape Coast

ETHICS APPROVAL - ID NO: GHS-ERC: 14/10/15

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

"Post Abortion Care in the Volta Regional Hospital"

This approval requires that you submit yearly review of the protocol to the Committee and a final full review to the Ethics Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please note that this approval is given for a period of 12 months, beginning December 23rd, 2015 to December 22nd, 2016.

However, you are required to request for renewal of your study if it lasts for more than 12 months.

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

SIGNED.....

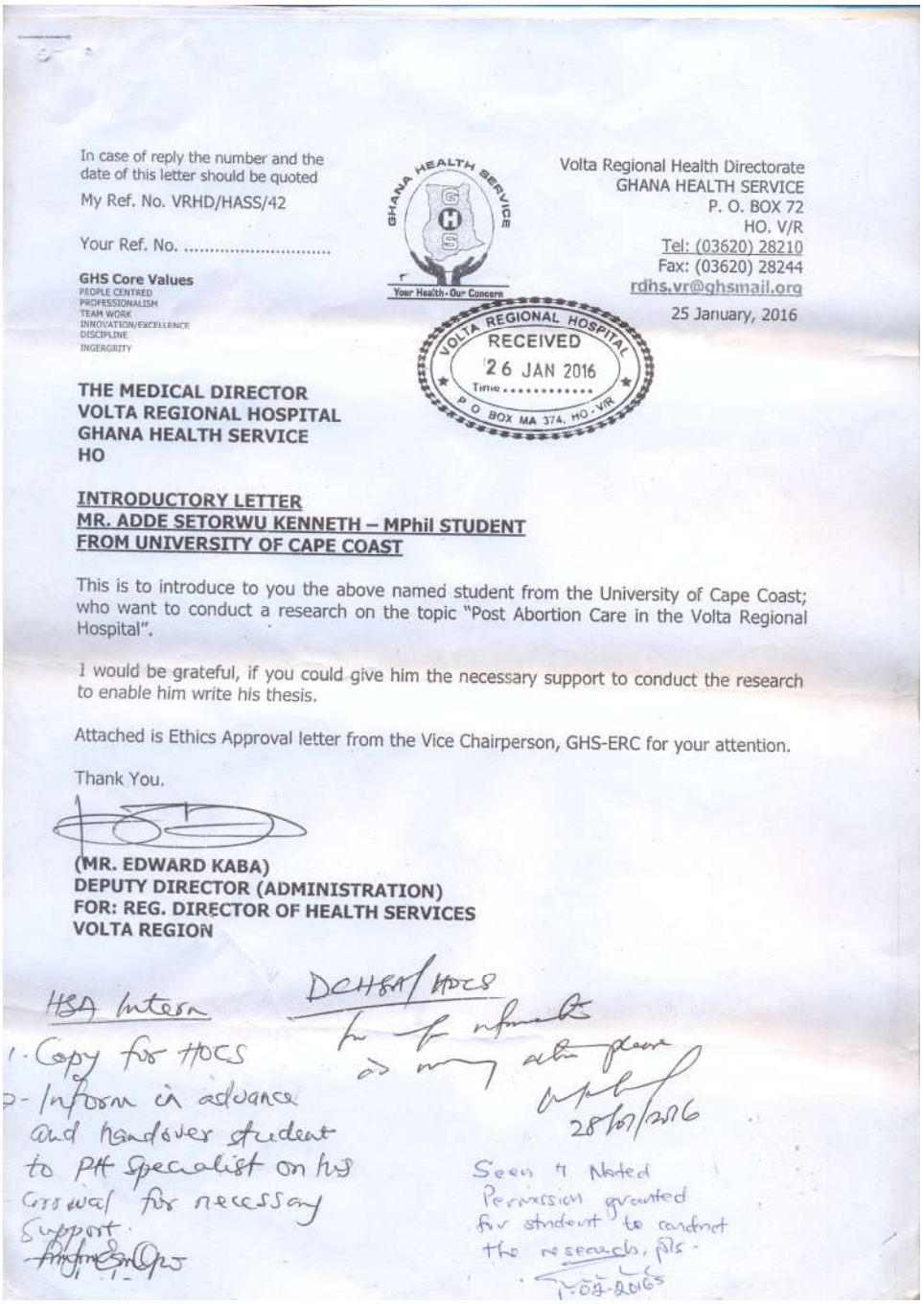
PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

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

1

APPENDIX E

VOLTA REGIONAL HOSPITAL INTRODUCTORY LETTER



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

My Ref. No. VRHD/HASS/42

Your Ref. No. .....

GHS Core Values
PEOPLE CENTRED
PROFESSIONALISM
TEAM WORK
INNOVATION/EXCELLENCE
DISCIPLINE
INGERGRITY

GHANA HEALTH SERVICE
Your Health - Our Concern

Volta Regional Health Directorate
GHANA HEALTH SERVICE
P. O. BOX 72
HO. V/R
Tel: (03620) 28210
Fax: (03620) 28244
rdhs.vr@ghsmail.org

25 January, 2016

VOLTA REGIONAL HOSPITAL
RECEIVED
26 JAN 2016
Time .....
P. O. BOX MA 374, HO - V/R

THE MEDICAL DIRECTOR
VOLTA REGIONAL HOSPITAL
GHANA HEALTH SERVICE
HO

INTRODUCTORY LETTER
MR. ADDE SETORWU KENNETH – MPhil STUDENT
FROM UNIVERSITY OF CAPE COAST

This is to introduce to you the above named student from the University of Cape Coast; who want to conduct a research on the topic "Post Abortion Care in the Volta Regional Hospital".

I would be grateful, if you could give him the necessary support to conduct the research to enable him write his thesis.

Attached is Ethics Approval letter from the Vice Chairperson, GHS-ERC for your attention.

Thank You.

(MR. EDWARD KABA)
DEPUTY DIRECTOR (ADMINISTRATION)
FOR: REG. DIRECTOR OF HEALTH SERVICES
VOLTA REGION

HSA Intern
1. Copy for HOCS
2- Inform in advance and handover student to PH Specialist on his Grrival for necessary Support.

DCHSA/HOCS
for the information & necessary action please
28/01/2016

Seen & Noted
Permission granted for student to conduct the research, pls.
1-02-2016

APPENDIX F

UCC IRB APPROVAL

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 03321-33172/3 / 0207355653/ 0244207814 C/O Directorate of Research, Innovation and Consultancy

E-MAIL: irb@ucc.edu.gh

OUR REF: UCC/IRB/3/108

YOUR REF:

18TH APRIL, 2016

Mr. Emmanuel Mensah Ampratwum
Department of Population and Health
University of Cape Coast

Dear Mr. Ampratwum,

ETHICAL CLEARANCE –ID NO: (UCCIRB/CHLS/2015/07)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for implementation of your research protocol titled: **"Health Seeking Behaviour among Women in their reproductive age in the Ningo-Prampram District."**

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol

Yours faithfully,

f.o.t (Samuel Asiedu Owusu)
ADMINISTRATOR

cc: The Chairman, UCCIRB

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date: 18-04-16