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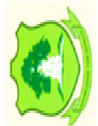

ATTITUDE AND UTILIZATION OF COMPREHENSIVE ABORTION CARE SERVICES BY YOUNG PEOPLE (10 - 24 YEARS) IN THE TAMALE METROPOLIS

BY

FREDERICK YENBAAR NUURI-TEG

(UDS/CHD/0152/13)

A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

FEBRUARY, 2017

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DECLARATION

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I, FREDERICK YENBAAR NUURI-TEG, do hereby declare to the University for Development Studies that this dissertation is my own original work, and has not been submitted or concurrently being submitted for any degree award in any other University.

....

Frederick Yenbaar Nuuri-Teg Date

(UDS/CHD/0152/13)

I hereby declare that the preparation and presentation of this thesis was supervised by me in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

....

Dr. Paul Armah Aryee Date

(Supervisor)

I hereby declare that, as the Head of Department (HOD) of the Community Health Department that this thesis passed through the requisite guidelines for thesis write-up.

....

Dr. Michael Wombeogo Date

(HOD)

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DEDICATION

This work is dedicated to my family; Gilbert Nuuri-Teg, Agnes Nuuri-Teg and Flora Nuuri-Teg

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ABSTRACT

Globally, unsafe abortion especially among young people has become a key public health concern compelling government and civil society organizations to institute legal policies and interventions such as Comprehensive Abortion Care (CAC) that provides safe abortion services. Despite these sorts of interventions, many female young people continue to practice unsafe abortion when unintended pregnancy occurs. This study was therefore aimed at assessing the attitude and utilization of CAC by young people, both males and females in the Tamale Metropolis. A cross sectional study was used to gather information from young people (10-24 years) in urban and rural areas as well as CAC service providers in the Tamale Metropolis. A structured questionnaire was used to gather data which was analyzed using Statistical Package for Social Science version 20.0. A mixed method of sampling was used to select a total of 340 respondents for the study. The study found out that 56.4% of the respondents were unaware of what CAC service was and 73.6% did not know where to seek CAC services. Majority,62.1% of the respondents had a negative attitude towards CAC services. The study further revealed that the highest ranked factor influencing the utilization of CAC service with a mean rank of 1.9 is physical access to CAC services. Respondents in the study also revealed that residing in the rural area (P=0.033), unavailability of CAC services (P=0.031), attitude of Health Workers (P=0.001), stigma (P=0.038) and cost of service (P=0.028) are significant barriers that prevent young people especially ladies from utilizing CAC services. The study showed that majority of the young people in the Tamale metropolis have low knowledge and awareness about CAC leading to a negative attitude and low utilization of CAC services. Stakeholders should promote access to safe and legal abortion services and also publicize the availability of these services whiles ensuring affordable especially for poor and rural women. The study recommends further research into assessing the quality of CAC services provided and also, complications arising from CAC services in the Tamale Metropolis.

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LIST OF ABBREVIATIONS

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CDC	Center for Disease Control and Prevention
WHO	World Health Organization
UN	United Nation
PNDC	Provisional National Defense Council
GHS	Ghana Health Service
CAC	Comprehensive Abortion Care
MHD	Municipal Health Directorate
UNFPA	United Nations Population Fun
GDHS	Ghana Demographic Health Survey
GMHS	Ghana Maternal Health Survey
SBM	Socio-Behavioral model
ICPD	International Conference on Population and Development
GNPC	Ghana National Population Council
PAC	Post Abortion Care
R3M	Reduce Maternal Mortality and Morbidity
FP	Family Planning
EVA/MVA	Electric or Manual Vacuum Aspiration
STD	Sexually Transmitted Disease
MTP	Medical Termination of Pregnancy

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PHC	Population Housing Census
GSS	Ghana Statistical Service
IDI	In-depth Interview
FGD	Focus Group Discussion
SPSS	Statistical Package for Social Science

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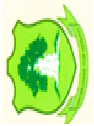

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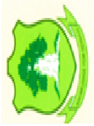

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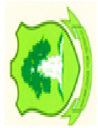

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Preventable pregnancy complication and child birth across the globe accounts for about 800 maternal deaths each passing day with developing countries accounting for over 99% of these deaths (WHO, 2014). Gorrette (2005) tied down the high global rates of maternal mortality to low rates of contraceptive usage, high number of unintended pregnancy and limited access to safe abortion and post abortion care. Sedgh et al., (2007) in their study indicated that there is a consistently high unsafe abortion in places with restrictive abortion laws which goes to suggest that women who experience unplanned pregnancies in these areas are most likely to resort to unsafe abortion. About, 48% of all induced abortions recorded globally are reported to be unsafe (WHO, 2007).

Abortion is the spontaneous or induced termination of pregnancy before fetal viability. Due to the popular usage of the word abortion to mean a deliberate pregnancy termination, some people prefer to describe the spontaneous fetal loss before viability as miscarriage. The National Center for Health Statistics, the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO) define abortion as pregnancy termination prior to 20 weeks' gestation or a fetus born weighing less than 500g (Schorge et al., 2008). However, the term abortion most commonly refers to the induced abortion of a human pregnancy. The similar procedure after the fetus may be able to survive on its own is medically known as a late termination of pregnancy (Grimes & Gretchen, 2010).

In developing countries 82% of unplanned pregnancies occur among an estimated 215 million women with unmet needs for modern contraceptives (Singh et al., 2009). It is most likely that women with unplanned pregnancies develop the intension of resorting to an induce abortion which most often are done clandestinely and are highly unsafe. The World Health Organization reported that most abortions that occur globally emanate from

developing countries with a record of 35 million annually whiles developed nations record an estimated 7 million abortions (WHO, 2007).

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In Africa, the annual induced abortion rate between the year 2003 and 2008 indicated an increase from 5.6 million to 6.4 million. Thirteen percent of all the pregnancies in Africa ended in abortion in 2008 (Sedgh et al., 2012; Singh et al., 2009). Of the 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions. Abortion rates estimated for West Africa are among the highest worldwide (Guttmacher Institute, 2009).

According to the World Health Organization (WHO, 2007), nearly 20 million women experience an unsafe abortion each year with more than 97% emanating from developing countries of which Africa is not exception (WHO, 2007). Studies have shown that unsafe abortions contribute significantly to the high rates of maternal mortality globally, accounting for 13% of these maternal mortalities and an estimated 66,500 women die every year with more women experiencing short and long term health complications as a result of unsafe abortion (Rasch, 2011; WHO, 2011). This implies that women in developing countries are confronted with challenges in accessing safe abortion, even in countries where abortion is legal under certain conditions.

Globally, 70,000 adolescents are reported to die annually through pregnancy and child birth, and 3.2 million unsafe abortions among adolescents ‘girls 15-19 years old occur in developing countries with young women below the ages of 25 years in African account for nearly two third of all unsafe abortion (UNFPA, 2014).

Ghana ‘s desire to institute road maps towards achieving Maternal Mortality Reduction and largely honor her international commitments to reproductive health under the MDGs four (4) and five (5), has made the law on abortion liberal unlike many other African countries, yet the Ghana Maternal Health Survey (2007) report had it that 15% of women in Ghana

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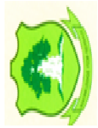

had had at least one induced abortion in their lifetime. This could be due to the fact that the law facilitates a broad range of legal indications as well as restrictions (Turkson, 1996; Morhee et al., 2006; UN 2001).

Abortion under the Ghana ‘s *Criminal Code Law: PNDC L 102. (1985)* has been permitted since 1985 provided it is carried out by registered medical practitioners in registered facilities and where a pregnancy is as a result of rape, incest, its continuation would result in injury to a woman ‘s physical or mental health, or the fetus has a substantial risk of a serious abnormality. Although most Ghanaians do not know the law, they have the notion that abortion is forbidden (Aniteye and Mayhew, 2013). Furthermore, Aniteye and Mayhew cited that the inclusion of this legal clause within the Criminal Code has contributed to the general perception of abortion as a crime when all the conditions indicated in the law are breached. Ghana Health Service on the other hand provides direction for the interpretation of the law on abortion through its standards and guidelines which is in sync with the World Health Organization ‘s guidelines and standards of best practice (WHO, 2003).

In 2000, Ghana developed the National Adolescent Reproductive Health Policy which was aimed at reducing abortion among adolescents by 50% by 2010. In light of this GHS focused on improving adolescent health by preventing early, coerced and/or unprotected sex and treating its consequences (Ghana National Population Council, 2000). This notwithstanding, studies indicate that among Ghanaian women and adolescents 18% of them had their first sexual encounters through force. Coker-Appiah et al., (1999) found that one in five Ghanaian women has been raped; however, less than 1% formally reports the crime.

Aboagye et al., (2007) explained that the concept of Comprehensive Abortion Care (CAC) is a global strategy developed from the integration of safe induced abortion, post abortion care and family planning services. It was modeled with the aim of reducing death and

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suffering as a result of unsafe induced and spontaneous abortion. CAC comprises safe-abortion services and post-abortion care that lies within the domain of midwives and obstetricians. Before 2006, midwives were only eligible to provide post-abortion care whilst the doctors performed both post-abortion care and safe-abortion services. Following the development of the GHS Standards and Guidelines for CAC (2006), training of midwives in the provision of safe-abortion services then commenced and currently midwives are reportedly providing CAC services.

In the Northern region, CAC was first launched in the Tamale Teaching Hospital by Pathfinder International in collaboration with the hospitals 'authorities. This was aimed at reducing maternal mortality due to unsafe abortions among a total of 910,403 women of reproductive age in the region. In the year 2007, CAC was extended to nine (9) district hospitals in the Northern region to promote the availability and expansion of quality CAC services and also to combat abortion related stigma (Pathfinder International, 2009). In the Tamale metropolis, three government hospitals; West Hospital, Central Hospital and the Tamale Teaching Hospital are accredited to provide CAC services (Tamale MHD Annual Report, 2014)

1.2 Statement of the Problem

In Ghana abortion is common among all religious, ethnic and socioeconomic groups and 7% of all pregnancies according to GMHS (2007) end up in abortion. Unsafe abortion coupled with relatively low use of modern contraception is estimated to cause 15% of maternal deaths in the country (Oliveras, 2006; GMDGA Framework 2010). Ghana has an induce abortion rate of 15 per 1,000 pregnant women, highest among young people between 15-24 year olds especially in the Urban setting (Aboagye et al., 2007). Experts find that up to 70% of Ghanaian urban adolescents 12 to 24 years of age self-report previous abortions (Glover, et al., 2003; Agyei et al., 2000).

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According to the Ghana Demographic Health Survey (2008), 13 per cent of women aged 15-19 in Ghana were already mothers, or pregnant with their first child. Available statistics from the GHS (2012) revealed an appalling 750,000 teenage pregnancies (15 - 19 years) across the country. Abortions among adolescents were also observed to be high as there were 603 adolescent abortions among 10 – 14 year olds in 2012 and 574 in 2013. Adolescents of 15 – 19 years gave a record of 8,424 abortions in 2012 and 8,675 in 2013(Ghana Health Service, 2013)

Available data indicates that teenage child-bearing is highest in the Northern and Central regions of Ghana with each recording 23% rate of teenage pregnancy in Ghana (GDHS**,** 2008). In the Northern region, 23% of young girls between ages 12-19 were reported to be mothers or pregnant already (Ziem and Gyebi, 2012).

In the Northern Region a total of 65 institutional maternal deaths were recorded in 2012 with 49.2% occurring in the Tamale metropolis whiles in 2010, the metropolis recorded a total death of 1,257 of which 2%of these deaths were pregnancy related (GSS, 2010). Gumanga and colleagues (2011) reported that abortion complications were the leading cause of death among the youngest women in a sample of maternal deaths at Tamale Teaching Hospital making unsafe abortion the fourth leading cause overall. Majority of the deaths occurred between the ages of 15-34 years 59 (90.8%) and out of these 65 institutional deaths, unsafe abortion accounted for 3 (4.6%) of the deaths (Ziem and Gyebi, 2012). The Northern Regional Health Directorate (2014) recorded 8 deaths among young women as a result of post unsafe abortion complications, 79 of these post unsafe abortion complications were as a result of hemorrhage, 31due to sepsis/infections and 1 from perforation.

Owing to the above, one would have expected that the introduction of the CAC in the Metropolitan area in 2006 would have been seen by the young people as an opportunity for

terminating unintended and untimely pregnancies safely, yet young people in the metropolis barely regarded these services. This study is aimed at investigating the poor attitude and utilization of CAC among young people in the Tamale Metropolis.

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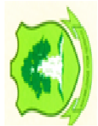

1.3 Research Questions

1. What is the awareness and knowledge of young people on CAC services in the Tamale Metropolis?
2. What is the attitude of young people towards CAC services in the Tamale Metropolis?
3. What is the utilization rate of CAC services among young people in the Tamale Metropolis?
4. What are the existing barriers that prevent young people from accessing CAC services in the Tamale Metropolis?
5. What factors enhance the utilization of CAC services among young people in the Tamale Metropolis?

1.4 Main objective of the Study

The study aimed at assessing the attitude and utilization of Comprehensive Abortion Care among young people (10- 24 years) in the Tamale Metropolis.

1.5 Specific objectives of the Study

The specific objective sought to;

6. To assess the awareness and knowledge of young people on CAC services in the Tamale Metropolis.
7. To determine the attitude of young people towards CAC services in the Tamale Metropolis.
8. To determine the utilization rate of CAC services among young people in the Tamale Metropolis.

9. To identify barriers that prevents young people from accessing CAC services in the Tamale Metropolis.
10. To identify factors that enhances the utilization of CAC services among young people in the Tamale Metropolis.

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1.6 Justification of the study

It is evident that unsafe abortion is a leading cause of maternal mortality globally and reducing this burden has been a significant global health priority for the past two (2) decades (Elisabeth and Iqbal, 2007). Several interventional measures have been adopted by countries to alleviate this menace of maternal mortality as a result of unsafe abortion. In this light, CAC approach which is believed to have the potential of increasing access to safe abortion and post-abortion care and hence, lead to a reduction in unsafe abortion and its related complications has been adopted in Ghana since 2006 (Kuffour et al., 2011). This study provides baseline information focused on the attitude and utilization of CAC services among young people in the Tamale metropolis. The outcome of the study describes factors that influence young people‘s utilization of CAC services and existing barriers that however prevents its utilization. This therefore serves as a reference point to GHS and related organizations who institute strategies aimed at increasing safe abortion and post abortion care service utilization and as well curtail the existing barriers faced by young people in accessing these services.

1.7 Significance of the study

The relevance of this study is to identify and explain the attitude and utilization of Comprehensive Abortion Care Services by young people, both males and females who are between the ages of 10 to 24 years and reside in the Tamale metropolis. The identification of this information would go a long way to help develop better strategy by stakeholders such as Ghana Health Service, Civil Society Organizations etc. that will improve the

attitude and utilisation of Comprehensive Abortion Service in the Tamale metropolis and Ghana at large. This will ultimately contribute significantly to reducing complications and maternal mortality as a result of unsafe abortion.

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1.8 Conceptual Framework

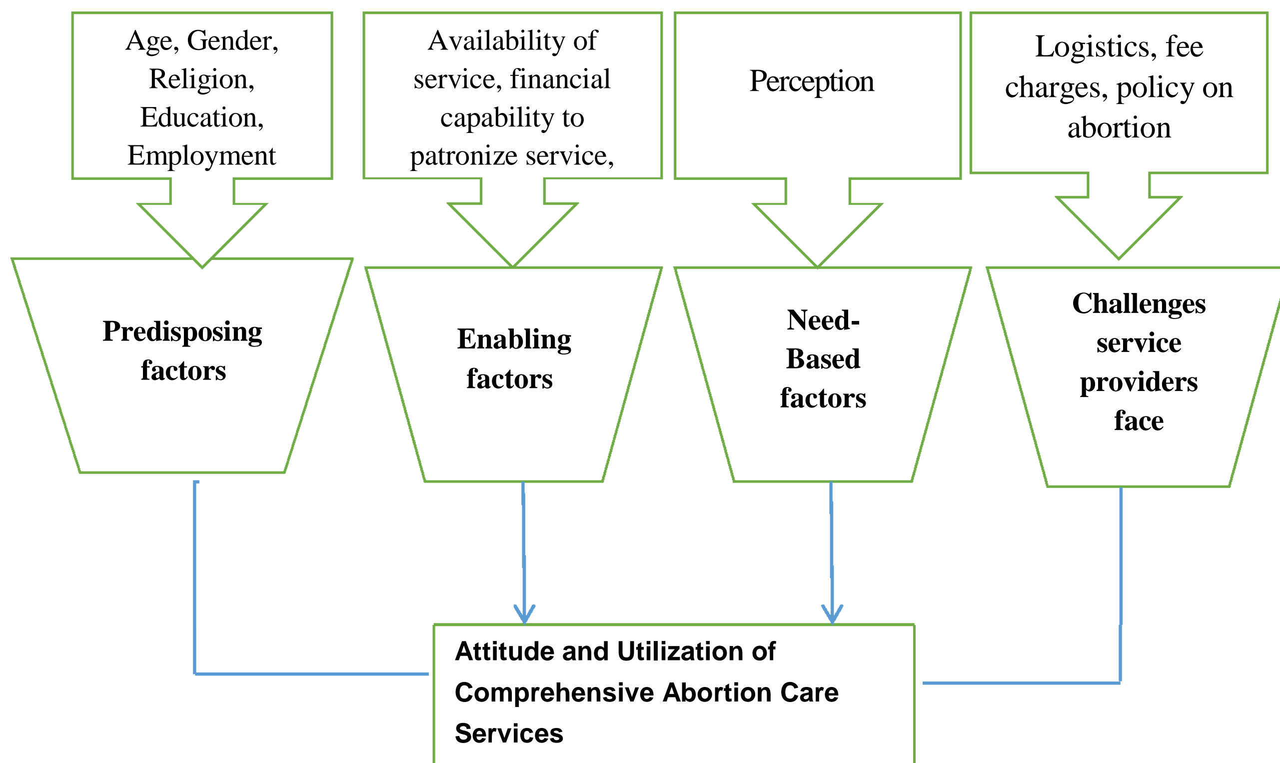

Figure 1: Social-Behavior factors and Attitude and Utilization of Comprehensive Abortion Care.

Source: Taylor and Todd 1997, Andersen 1995, Tonglet, Phillips, and Read 2004

1.8.1 Explanation of conceptual framework

The conceptual framework for this study was developed based on the Socio-Behavioral model (SBM) which was initially designed by Taylor and Todd (1997) and later revised by Read (2004) to study the determinants of acute health care services. The Socio-Behavioral model suggests that individual decisions which can be influenced or constrained by other societal factors which can directly result in the access to health services. In the original model, health care services and individual factors were the most influential on people‗s

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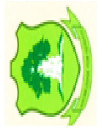

decision to access care. In the SBM, the individual factors which was discovered to be the most influential on people's decision to access health care services are grouped into three: need-based, enabling, and predisposing. According to Andersen (1995) these three influential factors can be described as;

- ***Need-based factors:*** This model explains that the Need-based factors include individuals' perceived and assessed functional capability, symptoms and state of health. Hence, the way a person views his or her own general health and ability to function, as well as experience regarding symptoms of illness, pain and worries put them in a position to determine the degree of their illness, as to whether it is serious or not.
- ***Enabling factors:*** factors that include family and community resources that patients have access to and therefor enable them make use of the services. These enabling resources such as health personnel, availability of facilities, income, travel and waiting time are some of the measures that must be available for the patient to use anytime needed.
- ***Predisposing factors:*** these factors referred to those that are present, preceding ill health and needs care such as demographic factors(e.g. age and gender which denotes biological factors that influence the likelihood to need health services),social structures (e.g. marital status, education, race, ethnicity, occupation which is measured by various factors and determines a person's status in society or a community) and health beliefs (e.g. attitudes, knowledge and values that people uphold toward health and health care services such as contraception, abortion , CAC services). These three factor influence particular health choices.

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1.9 Operational Definitions

Maternal mortality: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental cause (WHO, 2004).

Abortion: the spontaneous or induced (Safe or unsafe) termination of pregnancy before fetal viability or pregnancy termination prior to 20 weeks' gestation. (Schorge et al., 2008)

Unsafe abortion: Unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. (WHO, 16)

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Unintended abortion: is a pregnancy that is reported to have been either unplanned (that is, the pregnancy occurred when no children, or no more children, were desired) or mistimed (that is, the pregnancy occurred earlier than desired). (Centre for Disease Control and Prevention, CDC, 2015)

1.10 Organization of the Chapters

In accordance with study objectives outlined, this thesis was organized into six chapters. The first chapter presents the overview of the general introduction to Comprehensive Abortion Care service from a global and Ghana perspective. It also includes the problem statement, research question, conceptual model, research objectives and relevance of the study. This chapter thus presents a comprehensive background upon which the study was built.

Chapter Two presented a review of related literature including the theoretical perspective of the study. The approach of previous studies in relation to the awareness, knowledge, attitude, utilization and non-utilization, and barriers of CAC paying particular attention to their research methods, their findings and recommendations are also outlined.

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Chapter three focused on the methodology and instruments of the study and indicates the rational for the various choices made. It consists of sections such as study area, study type and design, study population, study unit, sample size, sampling method, variables and data sources, study instrument, data analysis and presentation methods, quality control, ethical considerations, study limitations and method of results presentation.

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Chapter four presents a detailed outcome of the study. The results were presented in themes.

Chapter five highlights discussions and interpretations of the study findings. The discussion was based on the objectives of the study.

Chapter six is the last chapter of the study and it presents the conclusion and recommendations of the study findings that can be adopted to promote a change in the attitude and utilization of CAC services among the young people in the Tamale metropolis.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section presents relevant related literature of this study. It reviewed the research topic as other researchers had studied. It observed the theoretical framework and empirical evidence in detail.

Burns & Grove (2009) explain that, literature review is an organized written presentation of what has been written and published about a topic by other scholars and includes a presentation of research conducted in the selected field of study. The further indicated that the general purpose of a literature review is to convey to the reader what is currently known about the topic of interest

Also, according to Polit and Hungler (1999), literature review refers to activities pertaining to identifying and searching for information on a topic and developing an understanding of the state of knowledge on that topic. It helps the researcher to generate ideas or focus on a research topic and helps bring the problem into sharper focus and aids in formulation of appropriate research questions. They also posited that literature review provides the foundation on which to base new knowledge.

The literature review is based on the specified objectives of the study and covers works of others in both developing and developed countries with a special interest on the findings and methodological issues in the former.

2.2 Global Context on Unsafe Abortion

Abortion has been cited a major human behaviour practiced in all cultural settings since time immemorial and despite the institution of several restrictive laws, controlling it has not been successful. Therefore, in the event of an unintended pregnancy, women will most

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likely resort to an abortion regardless of whether the procedure is safe or legal and also, as long as unintended pregnancies exist abortion will be a fat of life (Morhee and Morhee, 2006).

WHO (2011) reports that unsafe abortion accounts for at least 13% of global maternal mortality with Africa accounting for an extremely high proportion of these mortality. Hence, reducing the burden of unsafe abortion has been a significant global health priority especially for Ghana which apparently has a liberal law on abortion for the past two decades. According to Elisabeth and Iqbal (2007), WHO recognizes unsafe abortion as a serious public health problem in many countries. These countries have signed declarations and resolutions indicating an increasing agreement that unsafe abortion is an important cause of maternal death that can and should be prevented through interventional comprehensive measures such as sexuality education, family planning, safe abortion services and post-abortion care in all cases. Also, the issue of unsafe abortion globally carries both political and religious weight that has been subjected to strict regulation by law and heavy debates around it (Westley, 2005).

It is estimated that between 10% and 50% of women who under unsafe abortion suffer complications and death, thus, placing a substantial burden on the health care system especially in developing countries with limited resources (Namrata & Sumitra). Over 5 million complications are reported globally due to unsafe abortion. These complications emanate from incomplete abortion, haemorrhage, infection, uterine perforation, and damage to the genital tract and internal organs (Haddad, 2009).

The WHO Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets, which was adopted by the World Health Assembly in 2004 noted that ―As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goals on

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improving maternal health and other international development goals and targets" (WHO, 2004).The strategy is in sync with the international human rights agreements and global consensus declarations that require respect, protection and fulfillment of human rights (WHO, 2004). Towards realizing these rights, and to save women‘s lives, programmatic, legal and policy aspects of the provision of safe abortion need to be adequately addressed.

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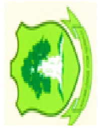

The 1994International Conference on Population and Development (ICPD) in Cairo established internationally agreed definitions of reproductive health and rights. In addition, governments specifically addressed the tragic consequences of unsafe abortion and agreed that "in circumstances where abortion is not against the law, such abortion should be safe" (UN, 2004). In 1999, at a special session of the United Nations General Assembly to review the ICPD, governments further agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible" (UN, 2009).

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2.2.1 Ghana Context on Unsafe Abortion

In Ghana, complications from unsafe abortion are a large contributor to maternal morbidity and mortality. Asamoah et al., (2011) reported that abortion according to the Ghana Medical Association is the leading cause of maternal mortality, accounting for 15-30% of maternal deaths. WHO (2007) revealed that abortion conducted by well-trained provider in an accredited health facility is one of the safest medical procedures of abortion with very minimum complications estimated at 1 in 100,000. Ghana has relatively liberal laws governing abortion compared to other countries in the region and the Reproductive Health Strategy developed in 2003 indicates that the performance of safe abortion must be done by a qualified healthcare provider (Sedge 2010, Morhee and Morhee 2006). Morhee and Morhee further cited that unsafe abortion in Ghana is a criminal offense regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985. The Act according to the Consolidation of Criminal Code of Ghana (1960) states that:

1. Subject to the provisions of subsection (2) of this section

a. any woman who with intent to cause abortion or miscarriage administers to herself or consent to be administered to her any poison, drug or other noxious thing or uses any instrument or other means what-so ever; or

b. any person who—

(i) administers to a woman any poison, drug or other noxious thing or uses any instrument or other means what-so ever with intent to cause abortion or miscarriage, whether or not the woman is pregnant or has given her consent

(ii) induces a woman to cause or consent to causing abortion or miscarriage;

(iii) aids and abets a woman to cause abortion or miscarriage;

(iv) attempts to cause abortion or miscarriage; or

(v) supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage; shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

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2. It is not an offence under section (1) if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner specializing in Gynaecology or any other registered medical practitioner in a government hospital or a private hospital or clinic registered under the Private Hospital and Maternity Home Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:

a. where pregnancy is the result of rape or defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;

b. where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis;

c. where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease.

According to Taylor et al., (2011), Ghana has taken steps to alleviate the negative effects of unsafe abortion that contributes to the hiking maternal morbidity and mortality case through the development a comprehensive reproductive health strategy that specifically addresses this challenge. Abortion in Ghana is generally considered a volatile issue that is less spoken off thus making the Ghanaian parliament to clearly deliberate or debate on the issue of access to abortion (Braam & Hessini, 2004).

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In Ghana, safe abortions are conducted in both private and public health facilities that have received accreditation. However, Aniteye and Mayhew (2013) discussed that abortion in public facilities are most often not openly available due fear of prosecution although doctors provide the service in a clandestine manner which most often are labeled as ‗incomplete' (spontaneous abortion) or curettage or diagnostic dilation. They further mentioned that some health workers and paramedical staff which include nurses (especially male nurse) and some doctors conduct clandestine abortions in private undesignated facilities or places with high fees charged. This practice is against the law of Ghana and makes them liable to be prosecuted if caught though such cases are rarely reported to the police. The study further revealed that private hospitals are known to conduct safe abortions at high fees compared to the public health facilities.

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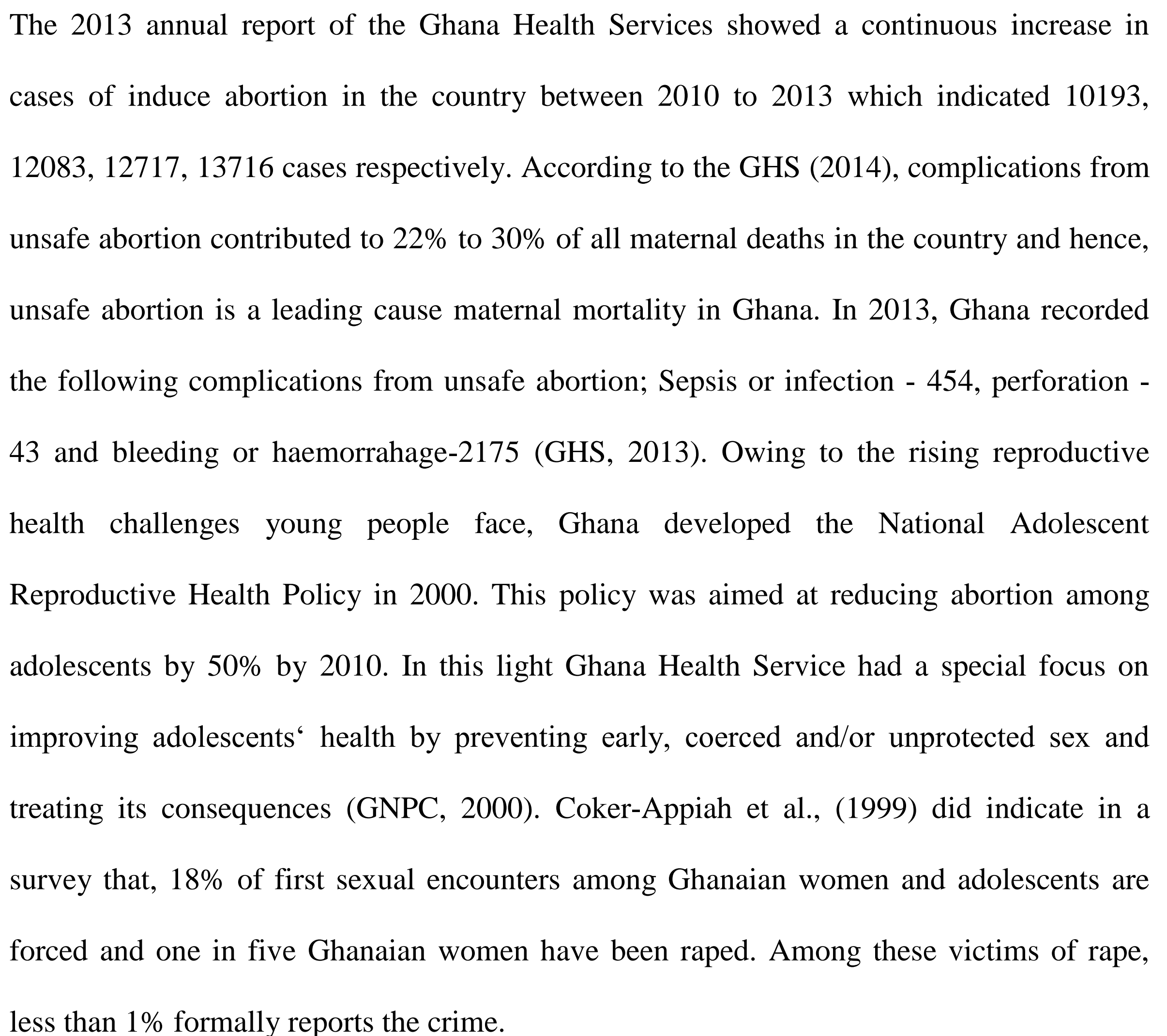

The 2013 annual report of the Ghana Health Services showed a continuous increase in cases of induce abortion in the country between 2010 to 2013 which indicated 10193, 12083, 12717, 13716 cases respectively. According to the GHS (2014), complications from unsafe abortion contributed to 22% to 30% of all maternal deaths in the country and hence, unsafe abortion is a leading cause maternal mortality in Ghana. In 2013, Ghana recorded the following complications from unsafe abortion; Sepsis or infection - 454, perforation - 43 and bleeding or haemorrahage-2175 (GHS, 2013). Owing to the rising reproductive health challenges young people face, Ghana developed the National Adolescent Reproductive Health Policy in 2000. This policy was aimed at reducing abortion among adolescents by 50% by 2010. In this light Ghana Health Service had a special focus on improving adolescents' health by preventing early, coerced and/or unprotected sex and treating its consequences (GNPC, 2000). Coker-Appiah et al., (1999) did indicate in a survey that, 18% of first sexual encounters among Ghanaian women and adolescents are forced and one in five Ghanaian women have been raped. Among these victims of rape, less than 1% formally reports the crime.

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In 2003 the rights of women to safe, elective abortion for a range of indications was adopted by the African Union as a protocol on the Rights of Women in Africa (Hessini et al., 2006). In this light, Ghana's reproductive health policy boosted through a systematic guideline for the provision of Comprehensive Abortion Care services (CAC), including safe abortion procedures within the limits of the law, as a drive to reduce the high toll of maternal deaths resulting from unsafe abortions (GHS, 2005).

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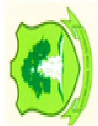

Evidence from the Ghana Statistical Service (2012) indicates that Ghana is a generally a religious country, with records from the 2010 census indicating that more than 95% of the population adhere to some religion. The census revealed that over 70% of Ghanaians were identified as Christian, while about 19% were Muslim and 5.2% practice traditional religion. Religious and cultural ideology and practices have been found to have a direct association with health outcome and behavior (Gyimah et al., 2006).Despite the frequency of abortion in Ghana, it is more often viewed with a morally lens and thus, condemned in the context of religiously conservative and cultural belief systems (Pellow, 1977).

2.3 The Concept of Comprehensive Abortion Care

Comprehensive Abortion Care (CAC) was built on the element of Post Abortion Care (PAC) as a global strategy developed from the integration of safe induce abortion, post abortion care and family planning services. It was modeled with the aim to reduce death and suffering as a result of unsafe induced and spontaneous abortion (Engender Health, 2009).

In Ghana, CAC falls under the umbrella of the Reduce Maternal Mortality and Morbidity (R3M) initiative introduced in September 2006 under the leadership of the Ministry of Health or Ghana Health Service with a consortium of six agencies; Engender Health, Ipas, Marie Stopes International, ORC Macro International, Population Council and Willows Foundation. Its services comprise safe-abortion services and post-abortion care and lies

within the domain of midwives and obstetricians (Aboagye et al., 2007). Before 2006, midwives in Ghana were only eligible to provide post-abortion care whilst the doctors performed both post-abortion care and safe-abortion services. Following the development of the Ghana Health Service Standards and Guidelines for Comprehensive Abortion Care in 2006, the training of midwives to provide safe-abortion services commenced. They are currently reported to have been providing CAC services to Ghanaian females.

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In 2006, Pathfinder International collaborated with authorities of the Tamale Teaching hospital to launch the Comprehensive Abortion Care project in the facility. This was further extended to three other facilities in the Upper East region in 2007. To achieve the project goal, Pathfinder adopted a three-prolonged approach which include;

- Comprehensive advocacy to communities that involves discussion and analysis of health problems that exist in the communities, creating an environment open to accept safe abortion.
- Building the capacity of health providers at all levels to deliver quality services with the use of modern techniques and equipment.
- Revamping and upgrading facilities to ensure the delivery of quality services and safe environment for health care.

According to Engender Health (2009) CAC is built on the following five elements;

i. Community and service provider partnerships for prevention (of unintended pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and assurance that health services reflect and meet community expectations and needs

ii. Counseling to identify and respond to women‘s emotional and physical health needs and other concerns

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iii. Treatment of incomplete and unsafe abortion and complications that are potentially life threatening

iv. Contraceptive and family planning services to help women prevent an unintended pregnancy or practice birth spacing

v. Reproductive and other health services, preferably provided on-site or via referrals to other accessible facilities in providers' networks

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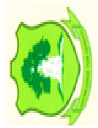

The objectives of comprehensive abortion care in Ghana for women are:

a. To ensure that the abortion care services provided to women, as permitted by law, are safe, affordable and accessible

b. To reduce morbidity and mortality due to unsafe abortion through public awareness on the availability of safe abortion care services and the dangers of unsafe abortion

c. To reduce deaths and disability from abortion complications through effective management and/or stabilization and referral

d. To improve women's broader reproductive health by integrating abortion care services into other sexual and reproductive health services

e. To help women make free and informed decisions regarding their pregnancy, be more informed about health services and follow up care needed, and feel more emotionally comfortable with their decisions through supportive, nondirective reproductive health counseling

f. To prevent unintended pregnancies through contraceptive services, including counseling and method provision

CAC adopts a woman-centered abortion care approach which is a comprehensive way to providing abortion care services to a woman taking into account the various factors that influence her individual needs (both physical and mental) as well as her ability to access services and her personal circumstances. Hence, for a woman to realize her sexual and

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reproductive rights, CAC provide a range of services to support them. This comprehensive model that is woman-focused should comprise the following key elements:

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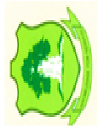

- Choice: this includes a woman‘s right to define the timing of pregnancies, whether to continue or terminate a pregnancy, and to choose from available abortion procedures, contraceptive methods, providers, and a facility. A woman‘s choice must be informed by complete and accurate information and the opportunity to ask questions, and express concerns to, knowledgeable health care personnel.
- Access: this refers to woman‘s access to affordable, barrier-free, and culturally appropriate services that are readily available for all legal indications within the law of her country.
- The fundamental aspects of quality: include the following (although high-quality abortion care varies, depending on local context and the availability of resources):
    - Tailoring each woman‘s care to her social circumstances and individual needs
    - Using internationally recommended abortion care technologies, particularly manual vacuum aspiration (MVA) and medical abortion, as well as appropriate clinical standards and protocols for infection prevention, pain management, management of complications, and other clinical components of care
    - Offering post abortion contraceptive services, including emergency contraception, to help women prevent unwanted pregnancies and avoid repeat abortions
    - Providing women with other reproductive health (RH) services or referring them to other appropriate providers for services such as sexually transmitted infection (STI) care, HIV and AIDS services, family planning, counseling on sexual violence, special services for adolescents, etc.

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2.4 Awareness and Knowledge of Young People on Comprehensive Abortion Care

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2.4.1 Awareness and Knowledge on Abortion

Globally, there is a high burden on sexual reproductive health issues due to lack of awareness and underutilization of health services especially among young women. As a result, there continue to be a high rate of maternal mortality and morbidity and other reproductive health complications (Stanton et al., 2013).

Otoide et al., (2001) established from a focus group discussion with adolescents in Nigeria that sexually active female youth are more knowledgeable on abortion as compared to less adolescents who are not sexually active. Otoide et al., (2001) indicated that sexually active female youth gave lengthy responses and more detailed information on abortion than those who were not. Also it was revealed that those who were more educated gave more correct explanations on abortion which indicate a correlation in level of education and knowledge on abortion. The study further indicated that there was often a diversity of opinions in the responses of respondents regarding their understanding of what "abortion" meant. Majority of the respondents in the study defined abortion as "an act or process of terminating an unintended pregnancy" whiles the minority of the respondents defined it as the "termination of pregnancy after 3-4 months with the use of a sharp metal instrument or a drip". Majority of the respondents also identified the reasons why young people choose not to go in for abortion as; the need not to interrupt schooling by the pregnancy; not being old enough to get married; fear of family members knowing; not planning to marry the partner; being jilted by a fiancé and also as a result of rape.

As a way of reducing the risk-taking behaviour and protecting adolescent regarding abortion, there is the need to better understand adolescents' information pathways (Hindin

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et al., 2013). Manju (2012) study disclosed that health workers were the major sources of information on reproductive health and rights and this was tied to the frequent interaction that ensue between the respondents and the health workers during health checkup and general health awareness programmes. The newspaper was the second major source of information followed by Radio, Friends and Family. According to Manju (2012), family being the least source of information is an indication that the family members are not aware or knowledgeable about reproductive health and rights and therefore cannot educate young people on it. Besides, society does not allow people to freely discuss about issues regarding sexual and reproductive health among family members.

With a low knowledge on save abortion among women, several studies in India have however confirmed that a great number of women in the country are previewed to information regarding abortion, dangers of unsafe abortion and the laws on abortion in the country. There is however a challenge of misinterpretation by women and other health workers regarding the need of spousal consent before abortion is conducted at the health facility (Council, 2008; Gupte, 1997).

A study by Syden (2011) that investigated the association between unmarried women and unsafe abortions with medical students discovered that, nine out of ten students (90.2 %) agreed with the statement that unmarried women prefer to have their abortion outside of public health facilities. Also, 91.2% of the students interviewed indicated that abortions conducted in unregistered clinics were more harmful than at registered clinics and also two thirds (69.8 %) of them were of the assessment that unmarried women turn to experience more complications from abortion than married.

In Jharkhand, Devgaria (2011) established that less than a quarter of the youth had comprehensive knowledge about abortion. It also indicated that the knowledge level was remarkably high among those young men with 10 or more years of schooling compared to

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less than six years of schooling. Again, a higher percentage of the young men engaged in business/service sector knew about it than those engaged in cultivation/labour. The possible explanation to back this finding was that young men were more educated and exposed to mass media besides their working environment, which contributed positively to their knowledge level. Data from the study further revealed that knowledge level was relatively better among those young men who had partial exposure to mass media than those with a full exposure. Also, the study suggested that, young men from households with high wealth index had comprehensive knowledge on abortion compared to those belonging to the general caste. On the other hand, analysis reveals that comprehensive knowledge about abortion was 9%, 28% and 21%, respectively among the young women aged 15-19 years, 20-22 years and 23-24 years.

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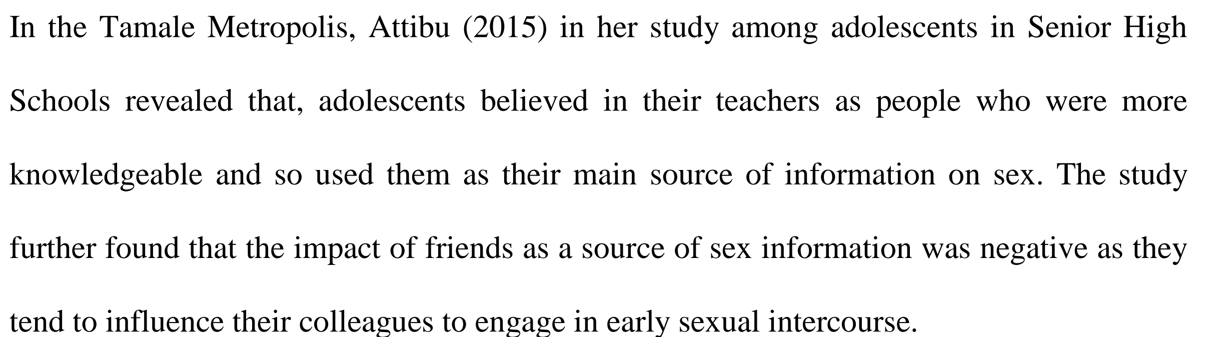

In the Tamale Metropolis, Attibu (2015) in her study among adolescents in Senior High Schools revealed that, adolescents believed in their teachers as people who were more knowledgeable and so used them as their main source of information on sex. The study further found that the impact of friends as a source of sex information was negative as they tend to influence their colleagues to engage in early sexual intercourse.

The Ghana Statistical Service (2007) contended that female adolescents have low knowledge on Comprehensive Abortion Services in Tamale as compared to other regions in Ghana. Social and economic characteristics also predict which women are likely to obtain an abortion include never having married, being in their 20s, having no children, coming from a wealthy household and living in an urban area. According to Hesse and Samba (2006), 20% of births are by Ghanaian adolescents, with most occurring out of ignorance, as sexual and reproductive health education is inadequate or often even not available. Sexually transmitted infections are common among this age group. Single women, especially adolescents, are not targets of family planning (FP) clinics and most clinics cater for married women.

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2.4.2 Knowledge on Abortion Techniques

Induced abortion can be performed in several ways which could either be safe or unsafe. However, safe abortion services provided at authorized health facilities consist of surgical, medical and Electric or Manual Vaccum Aspiration. According to Duggal et al., (2004) 98% of all abortions in India is done through sharp curettage (i.e. cervical dilation and curettage to scrape the uterus wall) which appears to be the most prominent technique. Using this technique, about 73% of the abortions were performed prior to gestational week 12. However, medical abortion (Misoprostol and Mifepristone) was legalized in India in the year 2002 with approval from the Drug Controller General and it is performed at gestational age of 9 weeks or 63 days (Drugs Controller General, India. 2006).

Meanwhile, electric or manual vacuum aspiration (EVA/MVA) can be used for pregnancy termination with gestation age of 12 weeks. This technique is a fast procedure that requires less dilation and no need for sedation or anesthesia because of its less pain.

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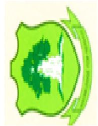

Mitchell et al., (2014) in their bit to discover adolescent knowledge and beliefs about abortion method in Kenya recognized that adolescents were aware of a host of contraindicated and ineffective abortion methods which suggest that there may be a large population of youth who experiment with wide range of ineffective methods including innocuous and harmful techniques. Results of the study also indicated that some students identified restricted substances such a marijuana, alcohol and hallucinogens as a means of pregnancy termination which raises a great deal of concern about how legal restriction on abortion may compound other risk-taking behaviours. The study also adds that certain techniques of abortion that WHO deemed as safe such as Aspiration and Medication abortion were misperceived by these adolescents which is largely blamed on misinformation that they receive or part of the broad societal critique of abortion as a practice.

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It is reported by Sedgh (2010) that studies have presented contradictory findings regarding the types of providers women turn to and the procedures employed in terminating a pregnancy. The study made reference to the 2007 GMHS which reported that many women who obtain abortions from a hospital by a doctor whiles a significant proportions do not go through available safety processes. According to WHO (2003) 40% of women who reported most recent abortion in the five years prior to the study indicated they underwent Dilation And Curettage (D&C), 16% reported terminating their pregnancy by taking tablets, and about 5–6% indicated the use of Cytotec (misoprostol) tablets. However, 12% of the women in the study underwent manual vacuum aspiration (MVA), a method considered to be safer for early termination of pregnancy as compared to Dilation And Curettage (D&C). GSS (2009) also revealed other methods which are less common to include; inserting an object such as herbs or other substances in the vagina; taking an injection; and drinking herbal concoction. The report further indicated that only 14% of women who underwent an abortion received local anesthesia while most received pain relievers and 25% received general anesthesia. According to the same survey, 57% of women sought a doctor to perform an abortion, 16% went to a pharmacist or chemical seller, and 19% turned to a friend or relative or induced the abortion themselves. The remaining women sought the help of a traditional practitioner (4%) or a nurse, midwife or auxiliary midwife (3%).

2.4.3 Knowledge on Abortion Law

According to WHO (2000), up until the second half of the 20th century, abortion was regarded illegal in most countries and was associated with high illegal and unsafe abortion rate and correspondingly high maternal morbidity and mortality. With this stringent regulation on abortion in most part of the world, the development and implementation of national laws and policies remain an essential tool towards guaranteeing the provision of

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quality health services, be it safe abortion, post abortion care or family planning. The liberalization of abortion laws in recent years in almost all countries of the European Union, the United States and Canada coupled with better and wide spread promotion and use of contraceptives has led to rapid decline in the rate of unsafe abortion and its associated mortality in the developed world. (Cook et al., 1998; Rahman et al., 1998)

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In most African countries, abortion remains both unauthorized and unsafe and hence, making African the highest contributor of global maternal mortality and morbidity. In the wake of this, the concept of Post Abortion Care (PAC) was developed as an approach to reducing mortality and morbidity from incomplete and unsafe abortions and resulting complications, and for improving women‘s sexual and reproductive health and lives (Post abortion Care Consortium Community Task Force, 2002).

In India, a great proportion of the female populations from the general population were discovered to be unaware of abortion law after decades of legalizing safe abortion services. In this regard, NGOs, women groups and volunteers are being employed to inform women of their rights to safe abortion service (Ojha et al., 2003; Anand et al., 2010). A similar study by Worku et al., (2014) in Ethiopia to assess the knowledge of tertiary and college girls on the countries liberalization of the abortion law after six years of existence, showed that two thirds of the respondents were unaware of the abortion induction law in the country.

In Ghana, regardless of the liberal nature of Ghana‘s law on abortion, many Ghanaians perceive abortion as illegal and thus, resort to unsafe abortion which continues to be the leading cause of maternal mortality. A report from the Ghana Maternal Health Survey (2007) found that only 4% of women thought that abortion was legal in Ghana. Quite interestingly, only 11% of women in the survey with at least a secondary school education were aware of this fact. However, among the medical professionals, knowledge of the country‘s moderately liberal abortion law seems to be substantially higher, but still not

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widespread. In the study, 54% of physicians were aware that abortion is legal if indicated to preserve the health of the woman.

In Ghana, despite the relatively liberal law governing abortion coupled with the integration of abortion service into the national reproductive health strategy women are still not accessing safe abortion services, though they exist (Konney et al., 2009; Henaku et al., 2007). Some health providers who were expected to be aware of the law on abortion in a study were rather found to be unsure of the law governing abortion services (Morhe et al., 2007; Voetagbe et al., 2010). Also, some women interviewed on the law of abortion were also unsure of the law (Konney et al., 2009; Hill et al., 2009). Hills et al., (2009) study in the Brong Ahafo region of Ghana, established that abortion was deemed illegal, dangerous and bringing public shame, but also being perceived as common, understandable, and necessary.

2.4.4 Knowledge and Usage of contraception

Abortion-related deaths and injuries are primarily prevented through the reduction of unplanned or unintended pregnancies. The world currently experiences about 75 million unintended pregnancies each year with 190 women confronted with an unintended or unplanned pregnancy every minute and in effect, over half of these unplanned pregnancies end in abortion (Westley, 2005). The cardinal reasons for these unintended pregnancies are contraceptive failure and non-use of contraception, basically due to lack of access or awareness. In CAC, the use of contraceptives is promoted as an integral part of the services to prevent unintended pregnancy. Under Family planning, the choice of contraceptives method by a client is given upon counseling on the benefits and side effects of each of the various methods. However, a difficulty in accessing contraceptive methods by young and unmarried women who also have limited control over their reproductive choices due to unequal gender roles that is construct by society. Despite wide spread knowledge on the

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benefits of contraception, young people are underserved and affected by barriers of cost, stigma and lack of information.

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According to Westoff (2005), high access to contraceptive as well as its utilization can drastically reduce safe and unsafe abortion by reducing unintended pregnancies. The case is made of Russian where the rate of abortion received a sharp decline due to the advent of modern contraceptives and its uptake.

The utilization of contraceptive by young people may be hindered by several factors which may include; insufficient counseling, difficulties understanding or using methods, unacceptable side effects, non-availability of methods, relationships and demands of family members, or difficulty obtaining or affording method refills. Unmet need for family planning according to the UN (2008) is the gap between women‘s stated desires to delay or avoid having children and their actual use of contraception. This is regarded as a problem as far as maternal health is concerned because once a woman has the number of children she desires, not being able to use contraception might result in an unintended pregnancy and birth thus, increasing the risk of maternal death due to unsafe abortion (Joyce et al., 2000).

Also, the Social Cognitive Theory (Bandura, 1986) provides a conceptual basis for considering the individual and contextual factors affecting contraceptive use and continuation. According to the theory, cognitive processes including knowledge, intentions, skills, and self-efficacy interact with emotion and the social environment to shape behaviors. The influence of gender norms, power, relationships, and broad social conditions are recognized to be important determinants of health behaviors according to the theory, and it has been widely used in research and interventions for improving contraceptive use (Lopez et al., 2009).

It is evident that there is high level of knowledge on contraception among literate woman and men in many countries which therefore calls for the need to conduct more education and hence expose illiterate women and men to contraception information through social and mass media campaign. Srivastava et al., (2005) therefore established from a study in India that in a society where the level of illiteracy is high, the approach to wide spread education and access to information should be employed. It also presented that, the media followed by health personnel and social circle have been the major sources of information on contraceptives. However, findings from a similar study in Ethiopia also indicated that, health professionals were the major sources of information regarding contraceptives.

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Devgaria (2011) observed in Jharkhand that nearly half of both young men and women had no knowledge about all modern methods of contraception. Factors believed to have significant effect on the knowledge of young men about these modern contraceptive methods include; education, inter-spousal communication on reproductive issues, caste and household wealth index. On the other hand, the significant factors that have significant effect on young females are; age, education, exposure to mass media, inter-spousal communication and caste. IFFP (2006) also indicated that the use of print and broadcast media in urban areas provide a greater range and supply of family planning services and distribution outlets compared to rural areas. According to Haile et al., (2000) most family planning services exclusively target women whiles excluding men who in most instances are responsible for making reproductive health decisions. Therefore, most men lack adequate knowledge on family planning services, and on the premise of many unfounded rumours, most rural African men are not in support of the utilization of family planning services. This suggests that the lack of knowledge and familiarity with contraceptives indeed remains a key barrier to its utilization.

Evidence from Akyeah (2007) study have presented culture and religion are key factors that influence the utilization and non-utilization of modern contraceptives especially in

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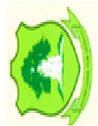

Africa thus, recommend the active engagement of cultural and religious leaders in family planning interventional programmes as key proponents in championing the acceptance and utilization of modern family planning services.

In Ghana, the use (contraceptive prevalence rate) of modern contraceptives among women of reproductive age is 17% which discloses a decline since 2003 and also the highest in West Africa. Research shows that, women getting family planning services from public facilities dropped from 31% to 24% between 2009 and 2010. It is also evident that only 40% of the current need for family planning commodities are met, hence, a high unmet need (defined as sexually active persons who do not want to get pregnant but are not using contraceptives) in Ghana (Macro International, 2009). Data also indicates that 13% of all births are unintended, 37% unplanned and 23% mistimed and leach into the challenge of limited access to family planning services such as modern contraceptives (GDHS, 2009).

The use of contraceptives leaves many Ghanaian women to be wary for fear of side effects that may impair their fertility in future and some women also reported that contraception was more harmful to their health than abortion (Aniteye & Mayhew 2011; Biney, 2011). Adanu et al., (2005) recounted that women seeking induced abortion care were more aware of modern contraception than women seeking spontaneous abortion care whiles this did not reflect into higher usage rates of contraception. A study by Domhnaill and colleagues (2011) discovered that schoolgirls sampled were much more aware of abortion methods compared to contraception. The study further revealed that many of the students explicitly mentioned that they do not use contraception because they knew how to abort a pregnancy in the event of an unplanned pregnancy.

2.5 Attitude of Young Peopletowards Comprehensive Abortion

According to Henshaw et al., (1999) there is the tendency for one to argue on the basis of morality that, the liberalization of abortion laws would lead to an increase in the rate of

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abortion especially among young women, on the other hand, data from developed countries with liberal access to safe and legal abortion and good contraceptive services have shown low rate of unsafe abortion which otherwise in developing countries where abortion is highly prohibited with clandestine or illegal abortion continues to pose a serious health challenge on women.

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In Brazil and in other setting a prominent disagreement between expressed abortion attitude and actual abortion behaviour have been shown (Leal, 2012; Faundes et al., 2004) and a study by Bailey et al., (2003) disclosed in a survey that half of pregnant Brazilian adolescent had friends and families who recommend abortion to manage an unintended pregnancy. This private advice reflects a well-documented acceptance of abortion as an option in the case of a specific unintended pregnancy despite a public discourse of moral censure (Peres *et al.,* 2006; Faundes et al., 2004).

Animaw et al., (2014) disclosed that among female university and college students in Ethiopia about half of the students believed safe abortion services should be legalized for everyone in need of the service to have access. However, majority of them did strongly agree that abortion is not accepted by their religion and community from which they come from. Also majority of the students in the survey had a negative attitude towards the law to liberalize induce abortion.

Syden (2011) was of the view that almost all medical students thought of unsafe abortion as a serious challenge in India and alluded that abortion conducted at an unregistered health facility is more harmful than at a registered health facility. The study also discovered that most of the respondents agreed to the statement that the number of abortions among unmarried women is rising and that unmarried women prefer to have abortion in unregistered health facilities than the registered ones and thus have more complications than married women. However, the acceptance of abortion among

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unmarried women in case of an unplanned pregnancy was disagreed by one fifth of the respondents in the study whiles one fourth of the students were also of the opinion that abortion is morally wrong.

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Abortion is widely stigmatized in the Ghanaian society, though many people consider it acceptable under certain conditions. An in-depth interview with adolescent females in Accra revealed a strong opposition to abortion among a higher number of females, but nearly all described situations, such as being in an unstable relationship or not having enough money to raise a child, in which they considered abortion to be acceptable or necessary (Henry and Fayorsey, 2002).

According to the Ghana Statistical Service et al., (2009) majority of women with an unintended pregnancy sought a doctor to perform an abortion, whiles minority of them went to a pharmacist or chemical seller or turned to a friend or relative for assistance or induced the abortion themselves. The remaining women sought the help of a traditional practitioner or a nurse, midwife or auxiliary midwife.

2.6 The utilization rate of comprehensive abortion care among young people

It has also been observed that the rate at which women seek abortion is similar for women living in developed and developing countries and that contrary to common belief, legalization of abortion does not necessarily increase abortion rates (Henshaw et al., 1999).

Prata et al., (2013) Hospital-level investigation in Ethiopia had data illustrating a significant improvement in abortion-related indicators from 2008 to half year of 2012 as 644, 881, 2289, 3053 and 2152 respectively. Prata et al., (2013) posited that the factors contributing to the increase in abortion–related indicators were the increased CAC service availability, the introduction of medication methods of abortion and the provision of training for service providers at all levels of the healthcare system. Prata further added that

the trends in abortion-related services showed a significant reduction in treatment of

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incomplete abortion, reversing the association between safe terminations and treatment of incomplete abortions as a percentage of total abortions. Many of the incomplete abortions however were as a result of an attempt to unsafely terminate a pregnancy and hence the reduction in rate of incomplete abortion suggested that abortion is becoming safer among young women in Ethiopia.

In developing countries, existing research on health outcomes point out the important role of the media in disseminating health related information to the public and common source of these information include; radio, television, and newspapers and magazines. According to Shariff and Singh (2002), women exposure to these sources of information increases the utilization rates for all health services in India. There is therefore a 5% increase in the probability of the use of health service who listens to radio frequently compared to a woman who does not.

When it comes to the utilization rate of abortion services among young people in Ghana, there are a host of factors that impede the ability of young people to safely seek safe abortion and records of the actual incidence of abortion are most often underreported primarily due to stigma.

Many women do not wish to report having had an abortion, hence, surveys of women tend to underestimate abortion incidence. According to the Ghana Maternal Health Survey (2012), 7% of all pregnancies end in abortion and 15% of women aged 15 had ever had an abortion. The survey also indicated that, about 15 abortions are performed for every 1,000 women of reproductive age (15–44) each year. The level of abortion in Ghana appears to be lower than in Western Africa as a whole, where the rate stands at 28 procedures per 1,000 women. In Southern Ghana, 17 abortions were observed for every 1,000 women of reproductive age (Ahiadeke, 2001). According to GSS and ICF Macro (2009), despite the possibility of underreporting compromising the accuracy of induced abortion estimates in

Ghana, there is fairly clear indication that 37% of births in the country are unplanned 23% are mistimed and 14% are unintended. It is estimated by Sundaram et al., (2012) that only 40% of abortions were reported in the 2007 Ghana Maternal Health Survey.

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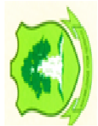

According to Rominski (2015), getting the prevalence of an induced abortion varies greatly in studies that have been published research. She cited that the highest rate reported was by Agyei and colleagues (2000) who found 47% of the female respondents in their study reporting at least one pregnancy underwent an abortion sometime in her life. Morhe et al. (2012) found 36.7% of the adolescents in their sample outside of Kumasi had experienced an abortion. Ahiadeke (2002, 2001) reports an abortion rate of 27 per 100 live births using data from the Maternal Survey Project. Krakowiak Reed et al. (2011) found 20% of their community-based sample outside Kumasi had had at least one abortion. Oliveras et al. (2009) found between 10% and 17.6% of women in their study reported their previous pregnancy ended in induced abortion. Geelhoed and colleagues (2002) found a prevalence of induced abortion of 22.6%, which falls in the range reported elsewhere (Mote et al., 2010). Glover et al. (2003) found that 70% of ever-pregnant youth in their sample reported attempting an abortion.

According to Sudhinaraset et al., (2013), the first point of call for many Ghanaian young people seeking health care is the licensed over-the-counter chemical seller shop despite the availability of safe abortion providers in health clinics. These licensed over-the-counter chemical sellers are independent businesses manned by non-pharmacists and are given license by the Pharmacy Council to operate (Lebetkin et al., 2014). Sudhinaraset et al., further explained that this high rate of utilizing of licensed over-the-counter chemical seller shop over accredited health facilities is particularly common in areas where there are few health clinics, such as rural areas. Further evidences suggest that many young people in Ghana utilize these licensed over-the-counter chemical seller shop due to the fact that they outnumber the number of pharmacies in the country making them more accessible, they

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have longer opening hours than public health facilities, very short waiting time and staff of such facilities are more friendlier than public health facility staff (Ghana Pharmacy Council, 2012; Brieger et al., 2004).

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In the Northern and Upper East Region, Pathfinder International, Ghana (2009) recorded that 1,164 women under the ages of 25 years had received CAC from May 2006-September 2008. In line with this, Pathfinder reported that despite Ghana‘s liberal law on abortion, many young people and even some providers within the public health system in these two regions do not have accurate knowledge about law on abortion. This, together with inadequate availability of services, and social stigma lead many women to resort to clandestine alternatives mostly recommended by their partners or peers. Hence, this contributes to the low rate of utilizing safe abortions services at formal health service structures.

Also, in countries with restrictive abortion laws, women attempt to end unintended pregnancies through clandestine means because of the absence of legal abortion services. They may carry out this by themselves or in collaboration with a pharmacist, herbalist, or unskilled practitioners, usually in unhygienic settings, using techniques likely to cause hemorrhage, infection or other types of morbidity (Rogo,1993; Ahiadeke, 2001; Morhee et al, 2006).

2.7 Barriers to CAC utilization

Generally, the public health systems in Africa have been observed to have neglected widespread availability or services of adequate quality CAC compelling a low access to health services such as safe abortion especially among rural folks. It is estimated that more than 70% of women in Indian live in rural areas whiles maternal health services such as abortion centres are skewed to urban areas, hence, leaving them with the option of seeking unauthorized abortion services (Barge et al., 1998 as cited in Syden, 2011).

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In Senegal, it was observed that more than two-thirds of women visited two or more health facilities before eventually receiving treatment for complications erupting from unsafe abortion, causing a delay of up to five days after the onset of symptoms (Washington DC Population Council, 2000a). In Kenya however, it was found out that women with abortion complications may seek services in several locations before finally receiving care (Rogo et al., 1999).

Furthermore, according to Andersen's (1995) behavioural model of health service, enabling resources is categorized as a key determining factor towards the utilization of a health service. It explained that enabling resources should provide the means to make use of the service, hence, community and personal enabling resources must be available to use in anytime. Therefore, health personnel and facilities must exist and people must have the means to get these services and know how to get access to them as well as make use of them. Key among these factors are income, health insurance, a regular source of care, cost of travelling and waiting time among others that can determine the utilization of health care services.

In Ghana, termination of pregnancy on medico-social grounds as indicated in the current law is however, not readily available in national health institutions in the country. Such services are available in some private institutions especially in urban centres (Morhee, 2006). Besides, the lack of knowledge among women and health workers regarding the legal aspect of abortion in most countries are a major barrier towards the utilization and service provision of safe abortion services respectively. Studies to determine the knowledge of abortion and its legalization in India discovered that lack of knowledge, misinterpretation that spousal consent is required before having an abortion, delusion of not knowing when an abortion is legal and the dangers of performing an abortion were key factors identified (Gupte et al., 1997; Banerjee et al., 2009).

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Ghana has a high illiteracy rate especially among women and as a result, the illiteracy and social deprivation faced by many women in Ghana do not equip them with the requisite knowledge on their legal rights to safe abortion (Morhee, 2006).

A study among medical, nursing and physician assistant students disclosed that 70% supported legal abortion under any circumstance (Shotorbani et al., 2004). According to Syden (2011) medical students in India who are future service providers presented a positive attitude towards abortion. However they considered abortion at unregistered clinics more harmful than at registered clinics. He further stressed this positive attitude as an important finding since these future service providers recognize the complex situation of abortion being a serious problem especially among unmarried women who prefer to have abortion provided out of registered health facilities, thus requiring stringent measures to curb it.

A strong association can be drawn between the attitude of health workers and the utilization of health services by young people and literature from Ghana suggest the significance of provider attitudes which is problematic when accessing health services in general (Witter et al., 2007). The attitude of health workers towards abortion care can be a major barrier to the provision and utilization of safe abortion services.

Literature from Ghana denotes the importance of provider attitudes that poses a general problem towards accessing health services and some studies on abortion indicate that negative attitudes of health staff impede access to services (GHS, 2005; Harries et al., 2009). Several studies identified religion and morality as cardinal that influences providers‘ attitudes to abortion service provision. Aboagye et al., (2007) assessed provision of comprehensive abortion care in three regions in Ghana, and found that provider hesitance in providing abortions because of perceived religious conflicts as well as uncertainty of the legality of abortion, doubts about the standards and protocols for abortion care, and perceived lack of administrative support. There is also a wider literature

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on the judgmental attitudes of nurses and midwives because of a range of personal, social and structural reasons and conforms to Walker et al., (2004)

Abortion, when performed by a qualified professional under safe conditions, is an extremely safe procedure, however, the cost of abortion is also a potential barrier in forestalling its utilization. Though there is very little known research on the cost of abortion in Ghana, an in-depth study in Accra disclosed that young women reported paying from Gh₵80- Gh₵200 for a hospital or private clinic abortion (Seidg et al., 2007). More generally, it has been reported that a safe abortion is prohibitively expensive for many women because few practitioners are available to perform the procedure, and they charge very high fees. As a consequence, poor women may be forced to seek risky abortions from untrained providers. An abortion carries costs beyond the price of the procedure itself. These include the economic burden on the families of women whose abortion complications lead to medical expenses and a loss of productivity; social costs including stigma and isolation; and expenses to the health care system and society (Sedgh, 2010).

Women who seek care at health institutions for induced abortions are often viewed as criminals and hence receive verbal admonishment from society which deters them from utilizing health care facilities for safe abortion services (Juarez et al., 2005 as cited in Zemene et al., 2014). There is also anti-abortion social stigma in Ghana and elsewhere which does not encourage many young people for that matter to visit accredited health facilities for fear of being seen and experiencing heavy stigmatization especially among their peers. For many, safe abortion is cost-prohibitive since the service has been left in the hands of a few private practitioners who charge exorbitant fees. Accordingly, only wealthy and educated women have access to legal abortion than their fellow women mostly in the rural setting who are not wealthy and uneducated (Morhee, 2006).

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2.8 Factors that account for the utilization of Comprehensive Abortion Care

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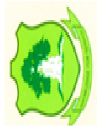

In the event of choosing when to seek health care and assessing which health care option to utilize for prevention and treatment of illness, several influential factors come to play such as culture, economics, access, perceptions, knowledge, belief in efficacy, age, gender roles and social roles.

Per my observation health care can best be enhanced with effective health systems in place to meeting the growing health needs of people. However, in developing countries, the effectiveness of health systems kept in place is being thwarted by the lack or low utilization of existing health facilities established from public expenditure. The use of maternal health care facilities where CAC services are rendered is believed to have reduced maternal mortality caused by unsafe abortion. However, abortions in unauthorized centres continue to be a preferred destination most especially among young unmarried people.

Despite attempts instituted under the Medical Termination of Pregnancy (MTP) Act, (1971) in India to curtail the heightening rate of unsafe abortion in the country through the provision of free abortion services in authorized public facilities to mitigate possible economic barriers to safe abortion care, only 10% of 6-7 million abortions are conducted in these authorized centres (Chabra et al, 1994; Khan et al., 1998 as cited in Druggal, 2004).

Generally, factors that account for health care utilization are vast. Young (1981) proposed a choice-making model developed from ethnographic studies of health services utilization. The model comprises of four components which are peculiarly essential to an individual‘s choice of health care service. They include; Perceptions of gravity which has to do with and individual‘s insight on the severity of the illness and how the social network‘s (an individual‘s social relationships which exchange opinions, knowledge, and care) considers the illness severity. Gravity is therefore founded on the assumption that the culture

classifies illnesses by the level of severity. The second component of the model proposes the individual's knowledge of a home treatment to the illness. If a person is aware of a home remedy that is efficacious, there is the tendency to resort to such treatment first before utilizing a professional health care system. These home remedy knowledge is often based on lay referral. The third component is the faith in remedy which incorporates the individual's belief of efficacy of treatment for the present illness. Hence, the individual considers the option to use the treatment if they believe the treatment is efficacious. The fourth component is the accessibility of treatment which deals with the individuals' evaluation of the cost of health services and the availability of those services in terms of proximity. Young elucidated that access may be the most important influence on health care utilization (Wolinsky, 1988b).

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Figure 2: Choice-Making Model (Young, 1981)

Zemene et al., (2014) ascertain that factors that influence the utilization of post abortion care (PAC) services in some selected government health institutions recounted that less than half of the respondents utilized post abortion services. This was however an improvement over an earlier study conducted in south west Ethiopia which had lower responses for the utilization of PAC service. The possible reasons for this disparity according to the study were time gap and access to information about the service in the study area.

Zemene et al., (2014) also established that women with knowledge about the elements of PAC were four (4) times more likely to utilize PAC services compared to those without

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knowledge. This therefore indicated that there is an association between knowledge of women and the utilization of PAC services.

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A study on adolescents' utilization of reproductive health services in Kenya identified that the young people's exposure to Information, Education and Communication (IEC) materials, guidance and counseling on the dangers of unplanned pregnancy, provision of contraceptives had a great influenced on their utilization (Kamau, 2006).

The utilization of health services particularly abortion services largely depend on a host of factors and according to Manju (2013), despite records of high knowledge on safe abortion and its legalization in Nepal since 2002, through mass dissemination of information and expansion of more comprehensive abortion care (CAC) centers, the country still observes low utilization of abortion services and rights which he explained may be due to social constraints.

Biddlecom et al (2007) reports that reproductive health services such as contraceptive and STI services, are under-utilized in African countries by sexually active adolescents because they are not aware such services exist. Also, Hock-Long, Herceg-Baron and Whittaker (2003) discussed that a structural barrier that hinders adolescents' access to sexual and reproductive health services such as safe abortion services is due to parental consent requirements. Therefore, before adolescents utilize health care services, their parents or guardians should be in the known and in most cases take them to the health facility for treatment.

Wong's (1987) observed that there is a significant difference in the type of maternal health care mostly used by women in the rural and urban areas. For urban women, the most frequently used type of care tended to be modern public health services, while rural women frequently used traditional practitioners. It can be deduced that the importance of place of residence in determining women's use of maternal health care is the availability of health

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facilities. It is evident that, medical facilities are generally more readily accessible in urban than rural areas. In addition, urban women tend to be more educated and therefore, have greater knowledge about the benefits of utilizing health facilities. In a similar vein, Obermeyer (1993) study in Morocco revealed that, residence is the strongest predictor of use of maternal health care. He indicated that urban women are two or three times more likely to use health services than rural women.

Also, Kausar, Griffths and Matthews (1999) argued that people in poorer households in rural and in the urban areas often have a lower utilization of services relating to maternal health care whiles those who find themselves in a high socio-economic grade rather utilize maternal health care services at a high rate. This finding therefore presents a strong urban-rural dichotomy regarding the use of maternal health services. According to Montgomery and Hewett (2004), the level of household living standard has a significant influence on three measures of health; unmet needs for modern contraception, birth attended to by nurses, doctors or trained midwives and children height for age. Hence, they deduced that the standard of both the household and neighbourhood can make a functional important difference to health service utilization. According to Isreal and Wedeen (2010), the relatively high charges for abortion services especially in public sectors that are accredited to provide safe abortion services whiles Post Abortion Care (PAC) is free, turn many young people to patronize unsafe abortion services. Therefore, in the event that they face post abortion challenges, they then present the case to the hospital for PAC. Isreal and Wedeen also indicated that an initiative by Pathfinder International to waive fees on CAC and ultra-scan for elective abortion increased access and utilization of safe abortion service.

Confidential health services are essential in promoting the health of young people. The development stage of young people is very critical both physically and emotionally since this stage forms the grounds for them to identify themselves and be autonomous. It is

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therefore common to find young people experiencing a lot of depression, rage, suicidal thoughts, sexually transmitted disease (STD), pregnancy, or sexual abuse which poses a grave danger to themselves or those around them. A healthcare professional can help enormously by encouraging screening and treatment. The healthcare provider's duty of confidentiality becomes complicated when the interests of an adolescent's parents or guardian must be factored into the provider-patient relationship. The parents' financial responsibility for, and guiding role in, raising their children and the state's interest in protecting family autonomy are concerns the health care provider must respect. Healthcare providers must also balance parents' and minors' interests while keeping in mind laws that govern confidentiality and that mandate parental notification (Loxterman, 1997).The 2014 International Planned Parenthood Federation (IPPF) guideline states that in place where laws as well dominant social attitude do not support abortion services, some organizations may choose to rely on young people‘s right to autonomy and need for confidentiality. According to the IPPF Declaration (2009) on *Sexual Rights* all people, including young people have the right to autonomously and freely decide on issues regarding their sexual and reproductive health and right and right to privacy regarding those decisions. This right to privacy is largely protected if health professionals‘ duty to protect doctor-patient information and relationship is upheld. Young people are fearful that information they provide to health professionals will be provided to their parents, guardians which may delay their timeliness in deciding to access health services or not access it at all.

Surveys show that most adolescents will seek routine medical care with their parents' knowledge making parental involvement or notification mandatory (Gans et al., 1991). However, this drastically affects adolescent decision-making, and reduces the likelihood that teens will seek timely treatment. In a regional survey of suburban adolescents, only 45 percent of adolescents surveyed would seek care for depression if parental notification was required; and Less than 20 percent would seek care related to birth control, STDs, or drug

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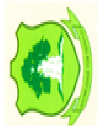

use if parental notice was mandated (Marks et al., 1983). A teen, struggling with concerns over sexual health or drug and alcohol abuse, may be reluctant to share concerns with a parent for fear of embarrassment, disapproval, or violence. Loxterman (1997) explains that a parent or relative may be the cause or focus of the teen's emotional or physical problems. Additionally, some teens wish to have their confidentiality protected because they value their privacy and autonomy. The guarantees of confidentiality, and the adolescent's awareness of this guarantee, are essential in helping teens seek needed care.

Engender Health et al., (2002) established that in the Dominican Republic, most of the adolescents interviewed reported a delay of several days in receiving care because of visits and referrals to multiple health care facilities. Most of the women arrived at the hospital where they were treated in intense pain and with an abortion in process. At one of the facilities, several of the clients arrived seeking care for bleeding and pain, but didn‘t know they were pregnant until a provider told them. Some of the young women had experienced a spontaneous abortion, or miscarriage, while others may have induced an abortion (Lema et al., 1997).

The GMHS report (2012) stated that 13% of adolescents‘ experience one or more health problems after unsafe abortion. 10% of women experienced pain, half of whom reported that the pain was severe; 8% reported bleeding; 6% each experienced fever and foul-smelling discharge, which are both indications of infection; and 1% reported that they suffered a perforation or other injury as a result of the procedure. Out of the 13% women who experienced a problem following their abortion, 41% received no treatment. Almost half of women with a problem received antibiotics, and the rest received an unspecified treatment.

In addition, the Social and economic characteristics in Ghana that may predict which women are likely to obtain an abortion include; never having married, being in their 20s,

having no children, coming from a wealthy household and living in an urban area. Compared with other women, women who have had an abortion in the past have twice the odds of obtaining the procedure (Blanc & Gray, 2002). According to Sundaram et al., (2012), there is a high motivation for women who experience repeated abortions to avoid an unintended birth as compared to other and they may also be more informed of where they can seek an abortion as well as have adequate knowledge about the legal status of abortion in Ghana. Sundaram findings further revealed that the reasons Ghanaian women most often mention for having an abortion are; being financially unprepared to take care of a child, needing to delay childbearing in order to continue schooling or work, and wanting to space or limit the number of children they have.

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Sedgh (2010) recounted that the odds of having an abortion in Ghana are 67–80% higher among women in the top two wealth quintiles than among the poorest women; the odds are about 40% higher among women living in urban areas than among women in rural areas. The odds of having an abortion are twice as high among never-married women as among those who are married, and they are about seven times as high among women with no children are as among those with at least three children. This is likely due to the stigma associated with out-of-wedlock childbearing, the wish to postpone childbearing until marriage and the possibility that some unmarried women have insufficient financial support for bringing up a child.

Aniteye and Mayhew (2013) highlighted in their study that social stigma which is tied to community sanctions and shame lead to low underreporting of abortion in the municipality which is similar to other areas in Ghana. They study reported utilization of hospitals for abortion among adolescents mostly with the reason to continue their education. A qualitative study among female teenagers (13-19 years) by Heny and Fayorsey (2002) in Accra revealed that adolescents who had experienced at least an unintended pregnancy utilized clinics and hospitals for abortion.

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2.9 Gaps in the Available Literature

Though there is some significant body of literature in relation to the attitude and utilization of CAC service among young people, there are gaps remaining. An association between attitude toward abortion and the utilization of CAC services with the choice of an unsafe abortion has been drawn by several research but outcomes vary on account of location. With an estimated 66,500 deaths resulting from unsafe abortion globally, 15% of maternal mortality in Ghana attributed to unsafe abortion and 8 deaths among young women in the Northern region also as a result of unsafe abortion, an examination of the attitude and utilization of CAC services by young people in the Ghanaian context taking Tamale metropolis into perspective is warranted (Rasch, 2011; GMDGA Framework 2010; Ziem and Gyebi, 2012). In Ghana several research on CAC have been conduct but very few studies have been conducted in the Tamale metropolis to analysis the attitude of young people (10 to 24 years) both males and females towards Comprehensive Abortion Care services as well as its utilization. This study therefore provides an analysis of data in Ghana and the Tamale metropolis from 2006 to 2015 regarding attitude and utilization of CAC services among young people.

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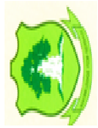

2.10 Summary

This brief literature review presents the importance of a variety of characteristics that determine the attitude and utilization of comprehensive abortion care services. In this study, CAC services are viewed under five categories; Knowledge and Awareness, Attitude, Utilization rate, Factors influencing utilization and barriers. Age, sex, marital status, level of education, ethnicity, religion, family type and source of information are the independent variables which are presumed to have a direct association either positively or negatively with the attitude and utilization of CAC services. The next chapter discusses the research methodology used for the study.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the activities and processes that were undertaken to gather data for the study. It gives full details of how data was collected and processed for this study. The discussion was centered on; the study design, background of the study area, study population, sample size determination, sampling technique, sampling unit, data collection methods, data analysis method and the ethical consideration.

3.2 Study Design

The study adopted a cross-sectional descriptive design which allows a phenomenon of a target population to be studied by taking data from a cross section of that population at a point in time. Kumar (2005) underscored the relevance of this study design and indicated that it is very useful in obtaining an overall picture as it stands at the time of the study.

The study was a concurrent mixed method of study that utilized both quantitative and qualitative methods to confirm and cross-validate findings within the study (Creswell et al., 2003). This approach is more suitable as it creates room for the triangulation of views sought from both the focus groups interviews and that of the survey. It is more suitable for an in-depth examination of the association between the attitude and utilization of Comprehensive Abortion Care services by young people in the Tamale Metropolis.

Also, the study was for a four (4) month period that commenced in January 2015 and ended in April 2015.

3.3 Study Area

The Tamale Metropolitan Assembly was established by legislative instrument (L.I. 2068). At present, it is one of the six Metropolitan Assemblies in the country and the only Metropolis in the three Northern regions namely: Upper East, Upper West and Northern

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regions. Tamale is the District as well as the Regional capital of the Northern Region. The Metropolis has a total estimated land size of 646.9sqkm (PHC Report 2010). It is located in the central part of the Region and shares boundaries with the Sagnarigu District to the North-West, Mion District to the East, East Gonja to the South and Central Gonja to the South West. Geographically, the Metropolis lies between latitude 9º 16 and 9º 34 North and longitudes 0º 36 and 0º 57 west. The Metropolis is located about 180 metres above sea level with some few isolated hills. There are a total of 116 communities in the Metropolis of which 41 (35%) are urban communities, 15 (13%) being peri-urban and 60 (52%) of them being rural in nature. From the 2010 PHC, the population of the Tamale Metropolis is 223,252. The number of males is 111,109 (49.7%) and the number of females is 112,143 (50.2%). In terms of age, sex and locality, the Metropolis has more males than females living in the urban centers. The metropolis has a household population of 219,971, living in 19,387 houses. On the average, there are 1.8 households in every house of the metropolis and 11.5 people in every house. The metropolis also has an average household size of 6.3, a number lower than that for the region which stands at 7.8. The Metropolis is a Cosmopolitan area with Dagombas as the majority. Other minority ethnic groupings are Ganjas‘, Mampurisi, Akan, Dagaabas, and tribes from the Upper West and East Region. The area has deep rooted cultural practices such as festivals, naming and marriage ceremonies. Majority (90.5%) of the population in Tamale Metropolis is Muslims and Christians constitute only 8.8 percent. About 0.2 percent has no religious affiliation. Among the Christians, the Catholics have the highest proportion of 3.0 percent, followed by Pentecostal/Charismatic (2.4%) and Protestants (2.4%).The proportion of Traditionalists in the Metropolis is 0.3 percent The Health services in the Metropolis are managed at three (3) levels namely: Metropolitan Health Administration level, Sub-district level and the Community level. Under the Health division, the Metropolis is sub-demarcated into three (3) sub-districts, each with a management team known as the Sub-

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district Health Management Team (SDHMT). The three sub-districts are: Bilpela Sub-district, Tamale Central Sub-district and Vittin Sub-district. Tamale Metropolis has eighteen (18) health facilities made up of Government, Quasi-government and Private health facilities. The fertility rate for the Tamale Metropolis is 2.8 percent children per woman age 15-49 years, and this is lower than the regional average of 3.54 percent. Tamale Metropolis has a crude death rate of 5.6 percent of every 1000 population. Pregnancy related deaths for female‘s age 15-54 years, 2.0 percent of the population within this category die in the Metropolis as compare to 2.2 percent and 1.9 percent for both the northern region and Ghana respectively. Deaths not due to pregnancy related is 98.0 percent for the Metropolis whiles that of the region are 97.8 percent and that of the country are 98.1 percent. The economically active population is (63.3%) of which (92.6%) are employed and (7.4%) are unemployed. The proportion of economically active males are 65.5 percent of which (92.8%) are employed and (7.2%) are unemployed while that for the female economically active population is 61.1 percent with (92.3%) employed while (7.7%) are unemployed.

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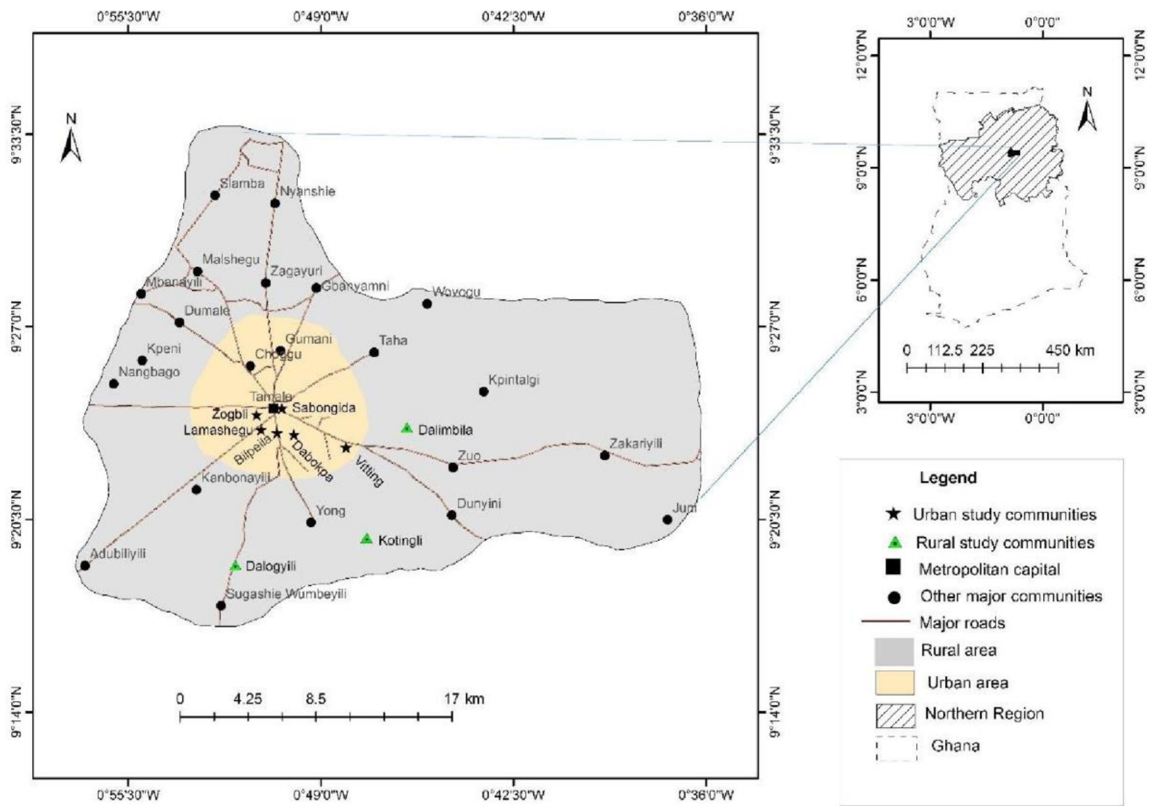

Figure 3 Map of Tamale Metropolitan Assembly
Source: Tamale Metropolis Profile, 2010

3.4 Study Population

The population of this study were young people comprised of both males and females between the ages of 10-24 years from six urban communities; Sabongida, Zogbeli, Lamashegu, Bilpeila, Vitting and Dabokpa and three rural communities; Kotingli, Dalogyili and Dalimbila where they have lived for at least 12 months before this research was conducted. This age range was considered for respondents due to high cases of unsafe abortion among individuals 10-24 years in the Metropolis (Tamale Metropolitan Health Directorate Annual Report, 2014).

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Table 1 Urban and Rural Population distribution by Age

Ages of Population	Urban Population	Rural Population
10-14	17,798	4,824
15-19	19,802	4,396
20-24	19,979	3,858
Total	**57,579**	**13,078**

Source: Ghana Statistical Service, 2010

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3.4.1 Inclusion Criteria

This study included young people (10-24) and health workers providing CAC services in the Tamale Metropolis.

3.5 Sample Size Determination

Sampling size determination denotes all the stages and processes involved in reaching the exact number of unit for the study. In considering a sample size, the scientist first of all has to determine the population universe and the sample frame (Twumasi, 2001). The population is usually the bigger unit from which a sample is selected from (Kumar, 2011). Usually, each unit in the population should be capable of providing relevant information on the issue understudy. This study focused on the attitude and utilization of CAC among young people in the Tamale Metropolis. The study considered all young people aged between 10 and 24 years whose total population was 70, 657 in the Tamale Metropolis from the 219,971 households (GSS, 2010). The sample size was determined using the mathematical formula propounded by Yamane (1967);

———...eq. (1)

Where **n** is the sample size, **N** is the population size, and**α** is the level of precision/margin of errors. Equation 1 was used to compute the sample size based on a population (N) of

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70,657 young people and 0.06 margin of error (α). When this formula was applied, equation 2 was gotten as follows;

.... = 277 eq. (2)

By way of catering for non-response, 10% of the sample size was calculated and added to the sample size calculated to give a total of 305. In addition to this, three (3) health workers were selected as key informants for an in-depth interview andthirty (32) young people for Focus Group Discussion.

Therefore, 340 respondents were selected and interviewed in the course of the study.

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3.6 Sampling Technique

A mixed method sampling strategy was used to select respondents for the study. According to Collins et al., (2006), the mixed method sampling technique involves the selection of units or cases for a study using both probability and non-probability sampling techniques to increase external validity and transferability. In order to increase validity and reliability of this study, a multi-stage sampling procedure was employed to determine communities within three clusters of health sub-districts (Bilpeila, Vittin and Tamale Central Sub-districts) of the Tamale metropolis. The first stage was a purposive selection of the three cluster of sub districts (Bilpeila, Vittin and Tamale Central Sub-districts) in the metropolis where three accredited abortion centres are located (Tamale West Hospital, Tamale Central Hospital and Tamale Teaching Hospital). The second stage involved the selection of 9 communities, that comprised Six (6) urban and three (3) rural communities. Each cluster had two (2) urban, and one (1) rural community selected from the sub-district list of communities using simple random sampling method. In the third stage, Yamane (1967) sampling formula was adopted to calculate 399 households for the study. A systematic random sampling method was employed to select the 399 households sampled. An average

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of 44 households was selected from each of the three clusters by dividing the sampled households (399) by the number of communities (9) selected. One respondent between the ages of 10-24 years was randomly selected and interviewed from each household taking.

The study also, used purposive sampling to select three (3) Health workers who possessed relevant knowledge and experience in CAC services for an in-depth interview. They were drawn from three different health facilities in the metropolis; Tamale West Hosptial, Tamale West Hospital and Tamale Teaching Hospital which are accredited to provide CAC service.

A total of 32 respondents were selected to participate in the Focus Group Discussion of the study. A stratified focus group discussion was therefore conducted with respondents segregated by sex (male and female). According to Morgan (1997) segregation into homogeneous groups is most acute, such that an issue raised by a given topic corresponds to diversity in perspectives between men and women. Such differences in perspectives may either reduce the comfort level in the discussion or affect how clearly either perspective gets discussed. He further explained that in segmented samples, emphasis is laid on homogeneity in the focus group composition since such homogeneity only allows for more free-flow conversations among participants but also facilitates analyses that examine differences in perspective between the groups. Each segment of the focus group constituted eight (8) respondents who were randomly selected to make a total thirty-two (32) respondent.

3.7 Data collection Methods and Tools/Instruments

The study employed a mixed method of data collection which was in line with general social science research principles where both primary and secondary sources of data are employed. The study therefore made use of structured questionnaire, Key Informant Interview Guide (KIIG) and Focus Group Discussions Guide.

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The quantitative primary data for the study was collected using closed and open ended questionnaire. The questionnaire comprised of questions on socio-demographic characteristics; awareness and knowledge on CAC services; attitude of the respondents towards CAC, utilization rate of CAC, factors that influence the utilization of CAC and barriers that prevent young people from accessing CAC services. Dichotomous response patterns such as ―Yes" or ―No" were included as well as open-ended responses such as ―please give reasons", ―please indicate" and multiple responses were also added. Rating scales were also integrated in the instrument.

The Key Informant Interview Guide (KIIG) used in the study covered the five specific objectives of the study in other to solicit in-depth information through a face to face method. These interviews lasted averagely for fifty-five (55) minutes. This gave room for further probing on issues regarding the attitude and utilization of CAC service among young people in the Tamale metropolis. Kumar (2005) therefore indicated that, KIIG gives the researcher the opportunity to clarify issues to the respondents.

A focus group discussion (FGD) as a rapid assessment and semi-structured data gathering method was used to collect qualitative primary data from the key informants using a FGD guide (Kumar, 1987). Escalada and Heong (2006) described FGD as a cost-effective method for stimulating views and opinions of prospective clients, customers and end-users.

Secondary data was sourced from consulting Health Journals on the Internet. Other documents consulted include the Ghana Demographic Health Survey, Ghana Health Service Annual Reports and the Ghana Statistical Services. Secondary data refers to data that have been collected and made available by a primary source, which are often collected for a specific purpose but can also be used to address questions in other fields of research and also assist with factual statistics about a population of interest (Andersen et al., 2011).

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3.8 Data Analysis

According to Borg and Gall (1983), results of quantitative studies should be presented in numerical form, whereas the results of qualitative studies should be presented either as verbal data (e.g. transcripts of interviews) or visual data (e.g. video recording of the events). Therefore, quantitative primary data was analyzed with the help of the Statistical Package for Social Sciences (SPSS) version 20.0 software. The analyzed quantitative data were summarized and presented primarily using tables and charts. Qualitative data gathered through Key Informant Interviews and recorded Focus Group Discussions were transcribed and manually analyzed. The study adopted Debus (1988) suggested guideline for qualitative data analysis. The researcher reviewed notes from the focus group discussions and listened severally to voice recordings of the discussion to validate transcription. Upon transcription, information gathered was categorized under common themes which include; Knowledge and Awareness on Comprehensive Abortion Care, Attitude of Adolescents towards Comprehensive Abortion Care and Factors Influencing the Utilization and Non-utilization of CAC in the Tamale Metropolis. The positions of respondents were summarized and assessed to identify the extent to which each position was held by participants. Verbatim phrases that represented each of the positions were pulled out.

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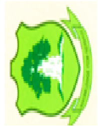

3.9 Quality Control

Three (3) research assistants were recruited and received two-day training about the objectives of the study and the procedures of the data collection using the designed research instrument. The research instrument was discussed during the trainings and translated into the local language to ensure that they understood the questions and the kind of information each question meant to collect. The questionnaire was also pretested in two (2) unselected communities in the Savelugu-Nanton Municipality in the Northern Region with the research assistants to assess clarity, comprehensiveness, flow and consistency.

The feedback was discussed and research instrument validated accordingly. The choice of Savelugu-Nanton Municipality which is not part of this study's catchment area was to avoid bias in terms of resampling respondents in the actual study and had similar characteristics of the study area, Tamale Metropolis.

The researcher crossed check data collected for completeness as well as validation of information. This was done to identify missing data, correct mistake, in order to avoid deviation and errors in the data collected. The researcher undertook serial numbering of corrected data sheets and kept them for processing and analysis

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3.10 Ethical Considerations

Privacy and confidentiality of the respondents are mandatory in every study. According to Polit and Beck (2008), ethics constitute the system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants. Permission in the form of an appraisal and approval of the research proposal was sought from the school of Allied Health Sciences Research Committee. Following approval, permission was sought from the Tamale Metropolitan Health Directorates to conduct the study. Permission was obtained from each respondent through informed verbal consent before administering the questionnaire. Respondents were made to understand essence and nature of the study and upon giving their consent to be part of the study, they were assured that all information they gave were to be treated confidentially. Also, the participants were informed that their participation in the study was purely voluntary and that they could withdraw from the study if they so wished at any point in the data collection process

3.11 Limitations of the Study

Considering the cultural and traditional differences that exist around the globe, the outcome of this study can only be extrapolated to people living in similar conditions in the Tamale metropolis.

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The sampling of health workers for the in-depth interview was skewed to only health workers in government hospitals since there was no accredited private health facility in the metropolis to conduct CAC services.

Due to the limited research and reliability of data on CAC, literature on CAC was equally limited especially in the Northern region and Tamale metropolis to be more specific.

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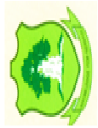

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CHAPTER FOUR

PRESENTATION OF RESULTS AND ANALYSIS

4.1 Introduction

This chapter presents the findings on the study. Total respondents interviewed were 280. Tables were used for the presentation of the results. The chapter is organized based on the five (5) objectives of the study; awareness and knowledge of young people on CAC services; attitude of young people towards CAC services; utilization level of CAC services among young people; factors that influence the utilization of CAC services among young people and the barriers that prevent young people from accessing CAC services in the Tamale Metropolis.

4.2 Demographic Characteristics of Study Sample

A total of 305 quantitative interviews were scheduled and a total of 280 instruments were found useable for analysis whilst the remaining 20 were discarded. Hence, a response rate of 93.3% was realized from the quantitative survey. Also, a total of 35 qualitative interviews were conducted and all instruments used during the data collection were found viable for analyzed.

This section presents descriptive statistics of respondents‘ background characteristics which include; age, sex, marital status, educational level, ethnicity, religion and family type.

Majority of the respondents interviewed as indicated in Table 2 below were females, representing 144 (51.4%) whiles males were the minority constituting 136 (48.6%). The table also shows that, majority of the respondents interviewed were 22-24 years representing 133 (47.5%) followed by those within the age interval of 16-21 years representing 42.2% (118). Minority of the respondents interviewed were between the ages of 10-15 years representing 29 (10.3%). The marital status of the respondents showed that

a higher number of them, 223 (79.6%) had never married, 49 (17.5%) were married, 6 (2.2%) were separated and 2 (0.7%) were widowed. With regards to religious affiliation a higher number of the respondents, 171 (61.1%) were Muslims, 107(38.2%) were Christians, whiles 2 (0.7%) of them were Traditionalist.

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Table 2 Demographic Characteristics

Background Characteristics	Frequency (F)	Percentage (%)
Sex		
Female	144	51.4
Male	136	48.6
Age		
10-15	29	10.3
16-21	118	42.2
22 -24	133	47.5
Marital status		
Never married	223	79.6
Married	49	17.5
Separated	6	2.2
Widowed	2	0.7
Religious Affiliation		
Islam	171	61.1
Christianity	107	38.2
Traditional	2	0.7
Ethnicity		
Dagomba	140	50
Others	77	27.5
Gonja	36	12.9
Mamprusi	17	6.1
Mossi	10	3.6
Level of education		
None	10	3.6
Primary	13	4.6
Middle/JHS	36	12.9
Secondary	138	49.3
Tertiary	83	29.6
Family Type		
Extended	171	61.1
Nuclear	109	38.9

Source: Field Survey, 2015

According to Table 2, 140 (50%) of the respondents were Dagombas, 36 (12.9%) were Gonjas, 10 (3.6%) were Mossis, 17 (6.1%) were Mamprusis and 77 (27.5%) belonged to other tribes such as Dagabaas, Bimobas, Kasenas, Akans, Ewe and Frafras.

Respondents who had secondary education were reported to be the highest interviewed representing 138 (49.3%) followed by tertiary education representing 83(29.6%), Middle or JHS representing 36 (12.9%), Primary representing 13 (4.6%) whiles 10 (3.6%) of the respondents who were the minority had no education.

The Table further reveals that, 171 (61.1%) of the respondents live with their extended family members while 93 (33.2%) live in nuclear families.

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4.3 Knowledge and Awareness on CAC Services

This section presents the descriptive statistics of respondents‘ Knowledge and Awareness on CAC.

Table 3. Source of Health Information

Variable	Frequency (F)	Percent (%)
Radio	57	20.4
TV	56	20.0
Friends/peers	45	16.2
Relatives	26	9.5
Health Workers	64	22.8
News papers	23	8.1
Others	9	3.1
Total	**280**	**100**

Source: Field Survey, 2015

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Table 3 above shows that the major source of health information for respondents was through Health workers representing 64 (22.8%), followed by Radio 57 (20.4%) and TV 56 (20%), Friends or Peers 45 (16.2%), Relatives26 (9.5%) and Newspapers 23 (8.1%). Minority of the respondents 9 (3.1%) mentioned other sources of health information.

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The study also found that 259 (92.5%) of the respondents had ever heard of contraceptives whiles 21(7.5%) of the respondents had never heard or had no knowledge and therefore were not familiar with contraceptives.

During the focus group discussion to ascertain the knowledge of participants on contraceptives, a respondent said;

"...the way I know it, it is something that a family or a woman and a man use that would prevent them from like pregnancy or giving birth to children following each other that is how I know it." Male, 23years, Rural community

Findings of the study revealed that, majority 167 (59.7%) of the respondents were of the view that abortion in Ghana is illegal whiles the remaining 113 (40.4%) were of the view that it is legal to have abortion in Ghana. The study also discovered that majority 158 (56.5%) of the study participants had low level of knowledge on CAC services whiles on the contrary only 122(43.6%) said they had knowledge. Of those who indicated that they had knowledge on CAC majority of them, 83 (29.6%) as indicated in Table 4below stated that they had heard of CAC, but do not know much about it. However, 80 (28.6%) of the respondents who were the next highest response indicated that CAC is a legal form of abortion care for all age groups, 68 (24.3%) of the respondent also indicated that CAC is about safe abortion services, 25 (8.9%) of the respondents further mentioned that it is only for teenagers with pregnancy, 16 (5.7%) mentioned that it is about contraceptives usage. Minority of the respondents, 8 (2.9%) however indicated that CAC is only meant for pregnant women.

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Table 4. Knowledge about comprehensive abortion care

Knowledge on CAC	Frequency(f)	Percent (%)
It is a legal form of abortion care for all	80	28.6
It is only meant for pregnant women	8	2.9
It is only for teenagers with pregnancy	25	8.9
I don't know anything about it	83	29.6
It is about safe abortion services	68	24.3
It is about contraceptive usage	16	5.7
Total	**280**	**100**

Source: Field Survey, 2015

In identifying whether there is an age limit to CAC service in the study, it was revealed that majority of respondents 165 (58.9%) in the study indicated that there was an age limit to CAC services whiles minority, 115 (41.1%) of the respondents stated otherwise by indicating that there was no age limit to CAC services. In Table 5 below, majority of the respondents representing 72.1% did not know what age limit is required to access CAC services. 40 (14.3%) of the respondents however indicated that persons of the ages 15-18 years with pregnancy, 14 (5%) indicated persons between ages 19 -21 years with pregnancy, 13 (4.6%) also indicated that persons between ages 11-14 years with pregnancy and the minority and 11 (3.9%) indicated persons aged 22 years and above with pregnancy as the age limit for CAC services.

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Table 5: Age limit to CAC service

Age Limit	Frequency(f)	Percent (%)
Persons aged between 11-14 with pregnancy	13	4.6
Persons aged between 15-18 with pregnancy	40	14.3
Persons aged between 19-21 with pregnancy	14	5
Persons aged 22 and above with pregnancy	11	3.9
I don't know	202	72.1
Total	**280**	**100**

Source: Field Survey, 2015

It was also evident from the study that majority, 206 (73.6%), of the respondents did not know of any health centres accredited to provide CAC services. On the other hand, 74 (26.5%) of the respondents who constitute the minority knew health centres accredited for CAC services. Also, 143 (51.1%) of the respondents shown in Table 6below strongly agreed that abortion services in unregistered facility are more harmful whiles 59 (21.1%) also agreed to this. 26 (9.3%) of the respondents were neutral in their response. Nonetheless, 40 (14.3%) of the respondents disagreed that abortion services in unregistered facilities are more harmful whiles 12 (4.3%) also strongly disagreed to this.

Table 6: Abortion services in unregistered facilities are more harmful than abortion care services in registered health facilities

Abortion in unregistered facilities are harmful	Frequency(f)	Percent (%)
Strongly Agree	143	51.1
Agree	59	21.1
Neutral	26	9.3
Strongly disagree	12	4.3
Disagree	40	14.3
Total	**280**	**100**

Source: Field Survey, 2015

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Table 7. Place of residence

Place of residence	Have you heard about comprehensive abortion care							
	Yes	**%**	**No**	**%**	**No response**	**%**	**Total**	**%**
Urban	99	47.1	106	50.5	5	2.4	210	100
Rural	23	32.9	44	62.9	3	4.3	70	100
Total	**122**	**43.6**	**150**	**53.6**	**8**	**2.9**	**280**	**100**

Source: Field Survey, 2015

Assessing the awareness level of respondents on CAC services, Table 7 above reveals that, 106 (50.5%) of the respondents against 99 (47.1%) in the urban areas had never heard of CAC. Majority, 44 (62.9%) of the respondents against 23 (32.9%) in the rural area had

never heard of CAC services. The table also shows a comparative high percentage of respondents who have not heard of CAC in the Rural area than the Urban area.

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4.4 Attitude of young people towards CAC Services

Table 8 below shows that majority of the respondents, 125 (44.6%) consider CAC service as safe, 63 (22.4%) were of the position that CAC service is against their religion, 38 (13.6%) consider CAC as a means of preventing pregnancy and 26 (9.3%) considered CAC as not good for their culture.

Table 8: Position on comprehensive abortion care

Response	**Frequency(f)**	**Percent (%)**
It is safe	125	44.6
It prevents pregnancy	38	13.6
It makes sex enjoyable	5	1.8
It is unsafe	15	5.4
It is not good for my culture	26	9.3
My religion is against it	63	22.4
Others	8	2.9
Total	**280**	**100**

Source: Field Survey, 2015

A focus group discussion results to confirm this revealed the following responses; *"... it is a shame in Islam or Christianity or traditionally, it is a shame and doesn't just agree to it and that is why we say we don't agree to it, so when you do it like that it is not good to us." Male, 24 years, Urban community*

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"To me it is not good, what my friend said earlier is what I want to add, we think that if you don't like something you don't do it, if you do such thing [sexual intercourse] it means you like it and that is why I am saying it is not good" Male, 23 years, Rural community

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Finding from the study indicate that, majority, 174 (62.1%) of the respondents said No, they would not advise any woman with an unintended pregnancy to go in for CAC services whiles 106 (37.9%)of the respondents said Yes, they will advise a woman to go in for CAC services in the event of unintended pregnancy.

Table 9 further shows that 112 (40%) of the respondents would not advise a woman with an unintended pregnancy to go in for CAC service because of religious reason, 83 (29.6%) indicated that because of the risk or danger involved, 41 (14.6%) indicated stigma as their reason, 28 (10%) indicated culture as their reason and 16 (5.7%) indicated monetary cost as their reason.

Table 9: Reasons for not recommending CAC services

Response	Frequency (f)	Percent (%)
Because of religious reason	112	40
Because of the stigma	41	14.6
Monetary reason	16	5.7
The risk/dangers involved in abortion care	83	29.6
Because of our culture	28	10
Total	**280**	**100**

Source: Field Survey, 2015

A focus group discussion results to confirm this reveal the following responses;

"It could also happen that when you go to the doctors or nurses to remove the pregnancy or someone who is not qualified can do it and do it completely to remove it and

pregnancies that would come afterwards cannot hold, you would like to give birth and you cannot be able to give birth, that is what it is." Male, 24 years

"God forbids that and also sometimes it can give you complication that is why we don"t want it." Female, 22 year

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Table 10: Who will you first consult in case of unintended pregnancy

Response	Frequency(f)	Percent (%)
Health worker	151	53.9
Friend/peer	56	20
Family member	53	18.9
Herbalist/concoction dealer	17	6.1
Chemical shop dealer	3	1.1
Total	**280**	**100**

Source: Field Survey, 2015

Table 10 shows that majority, 151 (53.9%) of the respondents indicated that they would first consult a health professional or health worker in case of an unintended pregnancy, 56 (20%) indicated their Friend or peer, 53 (18.9%) indicated Family member, 17 (6.1%) indicated Herbalist or concoction dealer and 3 (1.1%) indicated Chemical shop dealer.

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Table 11: Attitude of health professionals towards CAC clients

Friendly Attitude of Health professionals	Frequency (f)	Percent (%)
Agree	86	30.7
Strongly agree	19	6.8
Neither agree nor disagree	85	30.4
Disagree	60	21.4
Strongly disagree	18	6.4
No response	12	4.3
Total	**280**	**100**

Source: Field Survey, 2015

Results from the study as indicated in Table 11 shows that 86 (30.7%) of the respondents Agreed that Health professionals who provide CAC services are friendly whiles 19 (6.8%) strongly agreed to this. On the other hand, 60 (21.4%) of the respondents disagree to this declaration while 18 (6.4%) strongly disagreed. However, results showed that 85(30.4%) of the respondents neither agreed nor disagreed to the assertion that health professionals had friendly attitude towards CAC clients.

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Table 12 Advise towards Comprehensive abortion care

	Will you advise any woman with an unintended pregnancy to go in for Comprehensive abortion care							
Religious Affiliation	**Yes**	**%**	**No**	**%**	**No response**	**%**	**Total**	**%**
Christianity	36	33.6	62	57.9	9	8.4	107	100
Islam	69	41.3	90	53.9	8	4.8	167	100
Traditional	0	0	2	100	0	0	2	100
No response	1	50	0	0	1	50	2	100
Total	**106**	**38**	**154**	**55.4**	**18**	**6.5**	**278**	**100**

Source: Field Survey, 2015

Table 12 shows that 62 (57.9%) of the respondents who were Christians said No, they would not advise any woman with an unintended pregnancy to go in for CAC service whiles 36 (33.6%) respondents said Yes, they would advise any woman with an unintended pregnancy to take up CAC services. However, 90 (53.9%) of those who were Muslims said No to advising a woman with an unintended pregnancy to seek CAC services whiles 69 (41.2%) said Yes. Also, 2 (100%) of those who were traditionalist said they would not advise any woman with an unintended pregnancy to go in for CAC service. In general, majority of the respondents 154 (55.4%) said they would not advise women with unintended pregnancy to use CAC services based on their religious affiliation whiles 106 (38%) said they would advise despite their religious affiliation.

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4.5 Utilization rate of CAC services

Table 13: Last time termination of an unintended pregnancy was heard

Responses	Frequency(f)	Percent (%)
Less than a week	21	7.5
A week ago	19	6.8
Less than two weeks	9	3.2
Two weeks ago	9	3.2
Less than three weeks	8	2.9
Three weeks	22	7.9
A month and more	141	50.4
Total	**280**	**100**

Source: Field survey, 2015

In Table 13below, majority 141 (50.4%) of the respondents in the study indicated that the last time they heard of an unintended pregnancy termination case was a month and more ago. However, 22 (7.9%) mentioned three weeks ago, 21 (7.5%) said less than a week ago, 19 (6.8%) said a week ago,9 (3.2%) said the less than two weeks, 9 (3.2%) said two weeks and 8 (2.9%) who were the minority said the last time they heard of pregnancy termination was less than three weeks ago.

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Table 14: Method(s) for terminating unintended pregnancy in the Metropolis

Abortion Methods	Frequency	Percent
Visiting accredited health centre	25	8.9
The use of herbal concoction	54	19.3
The use of Guinness mix with sugar	23	8.2
The use of abortion drugs from friends/relatives	128	45.7
Visiting pharmacy/ chemical dealers	50	17.9
Total	**280**	**100**

Source: Field survey, 2015

In identifying the commonest methods people rely on to terminate an unintended pregnancy in the study, majority of the respondents as indicated in Table 14 above, resort to taking abortion drugs given to them by their friends or relatives in the event of an unintended pregnancy, others 54 (19.3%) also resort to the use of herbal concoction, 50 (17.9%) of the respondents mentioned that people resort to visiting a pharmacy or chemical dealer for abortion, 25 (8.9%) however do visit accredited health centres for unintended pregnancy termination. However, minority 23 (8.2%) of the respondents indicated that people commonly use Guinness mix with sugar to terminate an unintended pregnancy in the Tamale metropolis.

4.6 Factors that influence the utilization of CAC services

Table 15: Factors that influence the utilization of CAC services

Factors	Mean Rank	Rank
Access	1.9	1
Awareness	2.51	2
House hold income status	2.95	3
Autonomy (choice)	3.68	4
Youth friendly services	4.25	5

Source: Field survey, 2015

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The factors that influence the utilization of CAC services among young people from the perspectives of respondents are presented in Table 15. The results from the table revealed the most widely reported factors that influence the utilization of CAC services among the youth in the study area in order of importance. Respondents were asked to rank in order of severity or importance, the factors that most influence their utilization of CAC services, 1 meaning the most important and 5 the least important. Therefore, Access to CAC services with a mean ranking of 1.90 was considered the major factor that influenced CAC service utilization among respondents. This was followed by Awareness of CAC services with a mean rank of 2.51, house hold income to cater for the expense of CAC services with mean rank of 2.95, and Choice to utilize CAC services with 3.68 as its mean rank. However, the least influencing factor to the utilization of CAC services with a mean ranking of 4.25 was Youth Friendly Service.

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4.7 Barriers that prevent young people from accessing CAC services

Table 16: Barriers to access to comprehensive abortion care.

Explanatory Variables	Odds Ratio	Std. Err.	z-statistic	P>z
Age	0.831	0.043	-2.520	0.542
Education				
No education	1.427	1.629	0.480	0.628
Basic Education	1.625	1.629	0.480	0.628
Above Basic Education	1.561	0.803	0.400	0.686
Place of residence				
Rural	2.888	0.050	-2.130	0.033
Urban	1.272	1.102	0.280	0.781
Cost of service	0.892	0.046	-2.190	0.028
Attitude of health workers	0.981	1.867	1.740	0.001
Stigma	1.794	1.216	-0.860	0.038
Unacceptable	1.001	0.000	1.580	0.114
Availability	0.962	0.050	0.740	0.031
Constant	0.199	0.271	-1.190	0.235

Source: Computed from Field survey, 2015

The results presented in table 16 above showed that residing in the Rural community is a significant (P=0.033) barrier to the utilization of CAC services. It also showed that the cost involved in utilizing CAC service was a significant barrier (P=0.028). The attitude of health workers who provide CAC services was identified in the study as a very significant (P=0.001) barrier toward the utilization of CAC services. Stigma from the community was also revealed by the respondents to be a significant barrier to CAC service utilization. Also, availability of facilities that provide CAC service was found to be a significant

barrier to the utilization of CAC service (P=0.031). Age, Level of Education and Unacceptability were found to have no significant relation.

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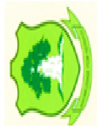

4.8 In-depth/Key informant Interviews

Three in-depth interviews were conducted on health workers who provide CAC services and had the ability to furnish the researcher with relevant information regarding the study. They were selected from three health facilities where CAC services were provided. The in-depth interviews asked the following questions with their respective responses;

1. People*'s* awareness on CAC services;

—...they are not, because what education has gone on to let them know that anybody who is pregnant and doesn't want it, can easily walk in here for the service" Midwife, Tamale Teaching Hospital

"...I can't tell but a few of them do come here for abortion services. Some are also referred or brought by their parents." Midwife, Tamale West Hospital

2. Sources of knowledge on CAC

—...maybe from their friends or staff on one-on-one bases." Midwife, Tamale Central Hospital

3. Perception of youth on abortion

"...many people know that God doesn't like abortion so if you cause abortion, you have sinned and some are afraid that when they do abortion, they will not be able to conceive again." Midwife, Tamale Central Hospital

4. Is abortion frown upon by people in the metropolis

—...yes, especially if you look at the culture of the people, you cannot just come and go and be laughing that today I went and did abortion...ooi(laughter) they will sing a song and

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put your name outside. When you do it, you have to hide." Midwife, Tamale Teaching Hospital

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5. Barriers to CAC service utilization

—*...location to the facility, privacy and confidentiality at the facility, low awareness on CAC and people frown on hearing abortion and you are not even comfortable taking about it" Midwife, Tamale Teaching hospital*

6. Factors that enhance CAC service utilization

—*...maybe you want to continue your education, marry properly, or avoid stigma." Midwife, Tamale Teaching hospital*

"...mostly because of their education" Midwife, Tamale Central Hospital

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CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the key findings of the study taking into consideration the study objectives, the variables of the study and existing literature.

5.2 Awareness and Knowledge on CAC Services

The study generally discovered that respondents had low knowledge and were less aware on CAC services as well as the legal status of abortion in Ghana. With regard to the sources of information on CAC, the respondents indicated that Health workers representing 64 (22.8%) were their major source of information on CAC which could be attributed to interactions they have with health professional either during health checkup or during general community health talks. The other sources of information were Radio 57 (20.4%), TV 56(20%), Friends or Peers 45 (16.2%), Relatives26 (9.5%) and Newspapers 23 (8.1%). Minority of the respondents 9 (3.1%) however mentioned other source of health information. This outcome of the study is in sync with Manju (2012) which realized health workers as the main source of reproductive health and rights information. The study further indicated that, relatives or family was the least source of reproductive health and rights information for young people and further explained that most family members find it difficult to educate young people on their reproductive health and rights issues because they have inadequate knowledge or awareness. Hence, this study turns to agree with this assertion, as relatives or family were among the least sources of information for young people in the metropolis and also, based on the fact that most of the respondents, 158 (56.5%) in the study presented low awareness and knowledge on CAC, it is also an indication that relatives or family barely give health education regarding sexual and reproductive health to their children.

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Also, the low rate of awareness and knowledge on CAC among the respondents affirmed the 2007 Ghana Statistical Service report which indicated that young people especially female adolescents have low knowledge on reproductive health services like Comprehensive Abortion Care services in the Tamale metropolis as compared to other regions in Ghana. There is therefore a high tendency for young people to resort to clandestine or unsafe method of terminating pregnancy in the event of an unintended pregnancy.

The study found that despite the availability of three (3) main CAC service centres in the metropolis, majority, 206 (73.6%) of the young people were not aware of the existence of these CAC centres, rather, only 74 (26.4%) of the respondents knew of such centres. However, despite the low knowledge about the existence of CAC centres, majority 202 (72.2%) of the respondents in the study agreed that abortions done in unregistered facilities was more harmful as compared to abortion services in registered facility. This finding is in consonance with findings by Syden (2011) where majority of medical students interviewed were also of the view that abortions conducted in unregistered facilities were more harmful. This suggests that, respondents will ideally prefer to visit or refer their partner to a registered facility in the event that they need an abortion, provided all factors surrounding the utilization of the service are favourable.

In relation to contraceptives, the study found that majority, 259 (92.5%) of the respondents knew about contraceptives whiles 21(7.5%) had never heard about contraceptives. This indicates that a lot of education has been done, especially by health workers who are reported to be their main source of health information, as well as the media, as discussed previously. This agrees with Srivastava et al., (2005) after he established that high illiteracy level on information about contraceptives required intensify campaigns to promote awareness and utilization using the media, health workers and social circle. However, this result from the study which indicates high awareness and knowledge about

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contraception by the respondents, this outcome is in contrast with both Samba (2006) and Devgaria (2011) study, which reports that most single women especially adolescents are not targets of family planning education and service and that almost half of young men and women had no knowledge about modern methods of contraception. It is worthy of note that despite this high awareness of contraception methods among the respondents, this does not necessarily reflect high utilization or correct usage of contraception methods among the respondents. Hence, more education towards contraceptive update or right usage is required as a key focus during health education or campaigns by health workers as well as also media promotions.

5.3 Attitude towards CAC Services

In relation to attitude towards CAC services, the study discovered high negative attitude towards CAC as only125 (44.6%) of the respondents' position on CAC indicated that it is safe. Majority, 147 (52.5%) of the respondents mentioned that CAC is not safe and it is against their culture and religion. Most 167 (59.7%) of the respondents were of the position that abortion in Ghana is illegal. This negative attitude towards CAC service and legal status of abortion in Ghana confirms Animaw et al.,(2014) study which disclosed that among female university and college students in Ethiopia, majority of them did strongly agree that abortion is not accepted by their religion and community from which they come from. Also majority of the students in the survey had a negative attitude towards the law to liberalize induce abortion. Findings of this study also confirms that of Syden (2011) which indicates that one fourth of medical students interviewed in India considered abortion morally wrong. The import of this viewpoint by majority of the respondents that CAC is not safe, leaves much to be desired and therefore do not have confidence that safe abortion is guaranteed at these accredited facilities. Also, considering the study area, which has strong religious and cultural values that forbid abortion, these respondents turn to hold strong religious or cultural assertions against abortion thus, makes it difficult for young

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people in the Tamale Metropolis to utilize or even listen to discussion regarding abortion services. As suggested in the conceptual framework of this study, religion and culture are predisposing factors that influence an individual's attitude towards comprehensive abortion care. This therefore can lead to many young people be ing exposed to misleading information about abortion and its techniques.

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Again in relation to recommendation of CAC, majority of the respondents 174 (62.1%) said they would not recommend CAC, while 106 (37.6%) of them indicated they would recommend CAC services. Majority 151 (53.9%) again indicated that their consult for abortion would be a health professional in case of an unintended pregnancy, while the minority sought to consult friends, family members, herbalist and license over the counter chemical sellers. This finding is similar to that of the Ghana Statistical Service et al.,(2009), which indicates that majority of women with an unintended pregnancy sought a health professional to perform an abortion, while minority of them went to a pharmacist or chemical seller or turned to a friend or relative for assistance or induced the abortion themselves. The remaining women sought the help of a traditional practitioner or a nurse, midwife or auxiliary midwife. The study's findings is however not in covenant with Sudhinaraset et al., (2013) findings which revealed that the first point of call for many Ghanaian young people seeking health care is the licensed over-the-counter seller shop which is more accessible and has longer working hours as compared to the public health facilities. Generally, the study gives an indication that, respondents would prefer the assistance of health professional if they have to terminate an unintended pregnancy or refer their partner for an abortion. Therefore, enabling factors such as the availability of the CAC service or service providers (health workers) and their financial capability to patronize the service as demonstrated in the conceptual framework of this study would lead to young people patronizing health centres for save abortion.

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5.4 Utilization Rate of CAC Services

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In relation to the utilization rate of Comprehensive Abortion Care services, the study found out that though abortion termination rates in the metropolis was not heard of very often, there is low utilization of CAC services among young women with an unintended pregnancy or young men recommending CAC to their partners in the metropolis. In this regard, the study revealed that only 25 (8.9%) of the respondents mentioned they will use or recommend CAC services during an unintended pregnancy. Considering the low level of knowledge about CAC found in the study, Shariff and Singh (2002) made a good case which is in agreement with the study and which indicates that, the more young people especially women are exposed to information about the availability of a health services, the higher their rate of utilizing. Finding from the study also underscores Zemene et al., (2014) study outcome which disclosed that women who were aware or had knowledge about elements of CAC were four (4) times likely to utilize the service compared to those without knowledge or awareness. Therefore, low knowledge on CAC by young people in the metropolis leads to low utilization of the service. Shariff and Singh also indicated that listening to radio frequently compared to not listening gives one a 5% increase in probability to utilize health service which is not in in agreement with the study which has radio as the second highest source of health information for 57 (20.4%) respondents, yet utilization or intention to utilize CAC service is low, suggesting that very little discussion on CAC is done on radio.

According to results from the study, most young people would prefer to prescribe or use other clandestine means to terminate an unintended pregnancy, which could be associated with the low knowledge on the legal status of abortion in Ghana by young people. This agrees with a study by Morhee et al., (2006) which revealed that in countries where there is a restrictive law on abortion, women are tempted to end unintended pregnancies through clandestine means due to the absence of legal abortion services in the country. Some of

these clandestine methods the study identified which are further in consonance with Morhee et al., (2006) study are the use of herbal concoction, use of Guinness mix with sugar, use of drugs prescribed by peers and family member. Some of the respondents opt to visit the pharmacy or drug stores and purchase drug without prescription.

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5.6 Barriers to Accessing CAC Services

Public health systems in Africa have generally been observed to have neglected widespread availability, especially among rural communities and inadequate quality services, particularly regarding reproductive health service. This has compelled a low access to health services such as safe abortion, especially among rural folks. Results from this study underscored this challenge as it revealed that residing in the rural area was identified as a significant (p=0.033) barrier to the utilization of CAC services, which also agrees with findings cited in Syden, (2011) study, which indicated that maternal health services such as abortion centres are skewed to urban areas, hence, leaving them with the option of seeking unauthorized abortion services.

Furthermore, the unavailability of health facilities accredited to conduct CAC as a key barrier to the utilization of CAC services is confirmed in Andersen‘s (1995) behavioural model of health service. The model explained that enabling resources should provide the means to make use of the service, hence, community and personal enabling resources must be available to use at anytime. Therefore, health personnel and facilities must exist and people must have the means to get these services. These means include income, health insurance, a regular source of care, cost of travelling and waiting time among others that can determine the utilization of health care services.

The study further drew a strong association(p=0.001) between the attitude of health workers and the non-utilization of health services by young people which agrees with

Witter et al., (2007), Harries et al., (2009) and Aboagye et al., (2007) studies which also revealed that providers‘ attitude is a problematic reason that impedes access to health services and this can be blamed on their religious and moral beliefs on abortion or their uncertainty on the legality of abortion or doubt about the standards and protocols for abortion care, as well as perceived lack of administrative support. These reasons were summarized in Walker et al.,(2004) study as personal, social and structural reasons.

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Another cardinal barrier identified in the study which other literature supports is the anti-abortion society stigma (p=0.038) especially from their peers which discourages many young people to visit even accredited health facilities for safe abortion services. The basis of this societal stigma as identified in the study and which agrees with the study in Philippines by Juarez et al., 2005 as cited in Zemene et al., 2014 is that, abortion is viewed as criminal and sinful by most people in society and thus administer verbal admonishment and dissociation to people who utilize abortion services. This therefore deters young people with an unintended pregnancy to utilize save abortion services for fear of being seen and stigmatized.

Cost of service (p=0.028) was also identified as another barrier that young people in the study face regarding access to CAC service. This supports the study by Seidg et al., (2007) which indicates that, abortion, when performed by a qualified professional under safe conditions, is an extremely safe procedure, however, the cost of abortion is also a potential barrier in forestalling its utilization. Though there is very little known research on the cost of abortion in Ghana, an in-depth study in Accra disclosed that young women reported paying from Gh₵80- Gh₵200 for a hospital or private clinic abortion. More generally, it has been reported that a safe abortion is prohibitively expensive for many women because few practitioners are available to perform the procedure, and they charge very high fees. Morhee (2006) study also confirmed that for many, safe abortion is cost-prohibitive since the service has been left in the hands of a few private practitioners who charge exorbitant

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fees and only wealthy and educated women have access to legal abortion than their fellow women mostly in the rural setting.

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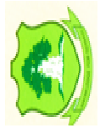

5.5 Factors that Enhance the Utilization of CAC Services

Factors that influence the utilization of CAC as identified by the study according to priority were; access to CAC services due to proximity, which is in sync with Wong‘s (1987) study in Philippines where the place of residence of a woman is a strong determinant to the utilization of maternal health care. This is also confirmed in Young (1981) proposed fourth component of the choice-making model which explains that accessibility of treatment which deals with the individuals‘ evaluation of the cost of health services and the availability of those services in terms of proximity was a factor to choose the service.

The study further agrees with Wong‘s finding that women who tend to be more educated have greater knowledge about the benefits and where to utilize health facilities. It also confirms Young (1981) second component of his choice-making model which explains that the individual‘s knowledge of a home treatment to the illness is a strong reason why a treatment or services would be utilized.

This study is also in consonance with that by Zemene et al., (2014) which drew an association between the knowledge of women and the utilization of PAC services. According to Sundaram et al., (2012), there is a high motivation for women who experience repeated abortions to avoid an unintended birth when they have adequate knowledge about the legal status of abortion in Ghana as compared to others who do not have such knowledge. Therefore, the more young people have knowledge on how and where to receive CAC services the more they are likely to utilize it.

This study‘s finding supports the findings of Montgomery and Hewett (2004) which states that the level of household living standard has an influence on unmet needs for modern contraception, birth attended to by nurses, doctors or trained midwives and children height

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for age. The level of household income was indeed seen as an influencing factor but not a major influencing factor in the study and as cited in Druggal (2004) study, despite making safe abortion services free to promote utilization, accredited facilities in India still recorded low (10%) utilization of the service.

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CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This Chapter presents a summary of the study based on the results gathered with recommendations, aimed at enhancing a positive attitude of young people and the general public towards CAC services and also influence increase in the utilization of CAC services.

6.2 Conclusion

Public health efforts on the awareness of Comprehensive Abortion Care services received less coverage, 158 (43.6%) which reflected low and poor levels of awareness and knowledge in terms of the study areas considered for this study. Although respondents of the study had sources of information on health concerns, these mediums however could not influence a positive perception about the benefits of comprehensive abortion care services (CAC).

It was revealed that discussions on reproductive health held on media outlets especially television and radio stations most often were not done with health professionals who could aid in the proper and accurate dissemination of health information during these discussions to the general public. However, religious leaders rather took the responsibility to edify their people about reproductive health issues and the acceptance of CAC. This indicated that public health interventions did not influence the determinants of the people that should lead to their understanding, acceptance and usage of CAC services.

The study further revealed that the participant‘s low levels of knowledge influenced their attitudes towards comprehensive abortion care services (CAC). Consequently, health education did not affect the cultural and traditional practices of the people and this lead to 63 (22.4%) and 26 (9.3%) of the respondents indicating that abortion services were bad

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because it offended their religious and cultural systems respectively. This religious and cultural stances and grip on the people subsequently lead to negative thoughts and perception by the people on comprehensive abortion care services.

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The study participants exhibited a low use of Comprehensive Abortion Care services within the study locations. A few of the respondents 25 (8.9%) knew young women who used CAC service in the area which is an indication that, more young people resort to unsafe or unaccredited abortion services. By and large, respondents used the following methods as abortion services; herbal concoction, use of Guinness mixed with sugar, use of drugs prescribed by peers and family member and the use of non- prescription drugs.

Although most respondents in the study indicated health workers as their major source of health information, they did not receive information regarding CAC services from them probably due to the personal beliefs they hold about abortion. Thus, health professionals or workers who should have helped and facilitated the use of abortion services on the contrary contributed to the non-usage of the service.

Four major factors acted as forefront barriers to the utilization of comprehensive abortion care (CAC) services; the place of residence, cost of service, attitude of health workers and availability of the service. Those who reside in rural areas are more at a disadvantage to utilize CAC services as compared to those in the urban setting. Financial challenges in the form of paying for the service and the cost of travelling to access the service is one barrier to young people utilizing CAC service in the Tamale metropolis. In addition, the poor receptiveness of health workers makes young people avoid going to health facilities in other to escape their scold. Finally, though some young people would prefer to utilize CAC services in the event of an unintended pregnancy, these service delivery points are not readily available for them to use.

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6.3 Recommendations

1. The study found that health education and promotion on the importance of comprehensive abortion care services was very low in the area. Therefore, a robust and much innovative health education programs that consider the psychosocial and cognitive aspects of people receiving health education should be developed and implemented.

2. An inclusion of the cultural and religious components of the people into health education is crucial. Community leaders, key informants and opinion leaders must be educated to champion certain sensitive issues that could impede the acceptance of public health interventions such as the comprehensive abortion care.

3. Access to comprehensive family planning services, aimed at reducing unmet need for contraception and eliminates barriers to obtaining family planning services that would ultimately reduce number of pregnancies and the incidence of unsafe abortion and associated maternal deaths and ill health.

4. Capacity building of CAC services providers on medical abortion counseling and service provision should be carried out to mitigate the barrier of poor staff attitude expressed by respondents.

5. Government and Civil Society Organizations should promote access to safe and legal abortion services for all women especially young girls, to the full extent of the law and also publicize the availability of these services in public health facilities while ensuring its affordability for poor and rural women to gain access.

6. Ghana Health Services and Non-Governmental Organizations (NGOs) focused on Sexual Reproductive Health should assist in improving access to CAC services through

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the expansion of service delivery points especially in the rural areas, and equipping them with the necessary logistics.

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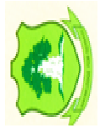
7. To create a foundation for effective dissemination of knowledge and increased access to Comprehensive Abortion Care service in a sustainable manner, an inter-sectorial collaboration of Government, Non-Governmental Organizations (NGOs) and community leaders should be carried out.

8. In addition, more health workers should be trained as Comprehensive Abortion Care service providers to increase the number of providers available at any given time to provide instant service to the growing demand of safe abortion services in the metropolis.



9. Raise awareness among the population of the legality and availability of safe abortion services in Ghana. Each CAC accredited facility should be responsible for developing a communications plan that informs the local population of service availability. The government should work closely with legal experts, rights-based organizations and community networks to expand Information Education and Communication (IEC) to women.

10. To restrain cost of safe abortion service as a barrier, Policy makers and Civil Society Organization should support in subsidizing cost of CAC services at accredited health facilities as well as ensuring standardization of this cost in both public and private health facilities.

6.4 Areas for Further Research

The researcher identified the following gaps in the study and therefore suggests these topics for further research;

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1. Integration of comprehensive abortion-care services in Maternal and Child Health clinics in the Tamale Metropolis
2. An assessment of complications from comprehensive abortion care services in the Tamale Metropolis.
3. Evaluation of the quality of Comprehensive Abortion Care services provided in the Northern Region.

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REFERENCES

UNIVERSITY FOR DEVELOPMENT STUDIES

Aboagye, P.K., Gebreselassie H., Asare G.Q., Mitchell M.H. E. & Addy J.(2007). *An assessment of the readiness to offer contraceptives and comprehensive abortion care in the Greater Accra, Eastern and Ashanti regions of Ghana*. Chapel Hill, NC, Ipas.

Agyei, W. K. A., Biritwum B. R., Ashitey A. G. &Hill B. R. (2000). *Sexual behaviour and contraception among unmarried adolescents and young adults in Greater Accra and Eastern regions of Ghana.*Journal of Biosocial Science, 32(4):485-512.

Ahiadeke, C. (2001). *Incidence of induced abortion in southern Ghana, International Family Planning Perspectives*. 27(2):96-101&108

Ahman, E. &Shah, H. I.(2007). *Generating National Unsafe Abortion Estimates:Challenges and Choices*. http://www.guttmacher.org/pubs/compilations/IUSSP/IUSSP-Chapter1.pdf

Anand, T., Ramesh, A., & Shekhar, D. (2010). *Increasing Awareness and Access to Safe Abortion Among Nepalese Women*. Center for Research on Environment. Downloaded from, www.crehpa.org.np. Accessed on September.

Andersen, R. M. (1995). *Revisiting the behavioral model and access to medical care: does it matter?* Journal of Health and Social Behavior, 36, 1, 1-10

Aniteye, P.& Mayhew,S. H.(2013).*Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation*. Licensee BioMed Central Ltd. http://www.health-policy-systems.com/content/11/1/23

Aniteye and Mayhew Health Research Policy and Systems 2013, 11:23 Page 13 of 14. Accessed from: http://www.health-policy-systems.com/content/11/1/23

UNIVERSITY FOR DEVELOPMENT STUDIES

Asha, Mohamud (2014).*The future is a girl at age 10*: *why we need to invest in adolescents and young girls to reduce maternal mortality*, ASRH Policy Advisor, UNFPA ESARO

Attibu, R. I. E. (2015). *Sexual Behaviour among Adolescents in Senior High Schools within the Tamale Metropolis, Northern Region of Ghana*. (Doctoral dissertation, University of Ghana).

Bailey, P. E., Bruno, Z. V., Bezerra, M. F., Queiros, I. &Oliveira, C. M. (2003).*Adolescents "decision-making and attitudes towards abortion in north-east.* Brazil.J Biosoc Sci, 35:71–82.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Banerjee, S. K., Clark, K. A. &Warvadekar, J. (2009). *Results of a Government and NGO Partnership for Provision of Safe Abortion Services in Uttarakhand. India*. New Delhi: Ipas India

Barge, S., Khan M. E., Rajagopal, S., Kumar, N. & Kumber, S. (1998). *Availability and quality of MTP services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh.* International Workshop on Abortion Facilities and Post-Abortion Care in the Context of RCH Programme; New Delhi, India.

Biddlecom, A. E., Munthali, A., Singh, S., & Woog, V. (2007). *Adolescents" views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi andUganda*. African Journal of Reproductive Health, 11(3), 1-13.

Blanc, A.K., &Grey, S. (2002). Greater than expected fertility decline in Ghana: untangling a puzzle, *Journal of Biosocial Science*, 34(4):475-495.

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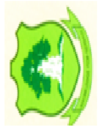


Borg, W. R. &Gall, M. B. (1983). *Educational research: An introduction* (4th ed.). London: Longman.

Brieger WR et al., (2004). *Interactions between patent medicine vendors and customers in urban and rural Nigeria, Health Policy and Planning*, 2004, 19(3):177–182.

Chhabra, R. &Nuna, C.(1994).*Abortion in India: an overview*. New Delhi: Ford Foundation.

Coker-Appiah,D.&Kathy,C. eds.(1999). *Breaking the silence and challenging the myths of violence against women and children in Ghana: Report of a national study on violence.* Ghana, Gender Studies & Human Rights Documentation Centre

Collins, K.M.T., Onwuegbuzie, A. J., &Jiao, Q.G.(2006).*Prevalence of mixed methods* sampling *design in social science research and beyond.* Paper presented at the meeting of the American Educational Research Association, San Francisco

Cook R. J., Dickens B. M. and Bliss L. E. (1999). *International developments in abortion laws from 1988 to 1998*. Am J of Pub Hlth; 89(4): 579586

Criminal Code of Ghana, 1960 (1985). *Abortion or miscarriage.* Act 29. Sections 58-59 and 67. Law No. 102.

Debus, M. (1988). *A handbook for excellence in focus group research*. HEALTHCOM Project special Report Series. Washington, D.C.: Porter/Novelli

Deogaria, P. C. (2011).*Knowledge, Attitude and Perception about Reproductive Health in Jkarkhand*. Social Modernity, vol 1, No. 1

Devgaria, P. C. (2011).*Knowledge, Attitude and Perception about Reproductive Health in Jharkhand*

UNIVERSITY FOR DEVELOPMENT STUDIES

Drugs Controller General, India. (2006). *Increasing Access to Comprehensive Abortion Care Services in India Baseline Study.* Number of permission and date of issue MF-7059/06 Council P, editor. 2008

Duggal, R.&Ramachandran V.(2004). *The abortion assessment project – India: Key findings and recommendations.* Reprod Health Matters;12(24):122-9.

Duggal, R. (2004). *The political economy of abortion in India: cost and expenditure patterns*. Reprod Health Matters. 12(24 Suppl):130-7.

Engender Health (2009). *COPE® for Comprehensive Abortion Care: A Toolbook to Accompany the COPE® Handbook*

Engender Health and Centro de Estudios Sociales y Demográficos (2002). *Postabortion care services for adolescents in the Dominican Republic*. Santo Domingo, Dominican Republic.

Escalada, O. M. & Heong, K. L(2009). *Focus group discussion.* http://ricehoppers.net/wp-content/uploads/2009/10/focus-group-discussion.pdf. Accessed 08 Jul. 2015

Faundes, A., Duarte, G. A., Neto, J. A. & de Sousa, M. H. (2004). *The closer you are, the better you understand: The reaction of Brazilian obstetrician gynecologists to unintended pregnancy*. Reprod Health Matters, 12:47–56.

Ghana Health Service (2014). *2004 to 2008: strategic plan for the implementation of Comprehensive Abortion care services in Ghana*. Accra: GHS‘2014

Ghana Health Service (2013). *Family Health Division Annual Report*. Accra: GHS‘2013

Ghana Health Service (2005). *A Strategic Assessment of Comprehensive Abortion Care in Ghana*. Report. GHS: Accra;

Ghana Health Service (2006).*Prevention and management of unsafe abortion: Comprehensive abortion care services, Standards and Protocols.* Accra: GHS.

Ghana Statistical Service, Ghana Health Service and Calverton, M. D (2007). *Ghana Maternal Health Survey 2007.* Accra, Ghana: USA: Macro International,

Ghana National Population Council (2000). *Adolescent reproductive health policy*. Accra, Ghana, Ghana National Population Council

Ghana National Population Council (2000). *Adolescent reproductive health policy*. Accra, Ghana, Ghana National Population Council.

Ghana Pharmacy Council, MIS/Publications Unit, Collated Data, Accra, Ghana: Ghana Pharmacy Council, 2012.

UNIVERSITY FOR DEVELOPMENT STUDIES

Ghana Statistical Service, Ghana Health Service and ICF Macro (2009). Ghana Demographic and Health Survey 2008, Accra, Ghana. GSS and GHS; and Calverton, MD, USA: ICF Macro.

Ghana Statistical Service, Ghana Health Service &ICF Macro (2009). *Ghana Demographic and Health Survey 2008, Accra, Ghana*. GSS and GHS; and Calverton, MD, USA: ICF Macro.

Ghana Statistical Service, Ghana Health Service, &Macro International Inc. (2009). *Ghana Maternal Health Survey 2007*. Calverton, Maryland, USA, GSS, GHS, and Macro International

Glover, K. E., Bannerman, A., Pence, W. B., Jones, H., Miller, R., Weiss E. and Nerquaye-Tetteh, J. (2003).*Sexual Health Experiences of AdolescentsIn Three Ghanaian Towns*. International Family Planning Perspectives, 29(1):32–40

www.udsspace.uds.edu.gh

UNIVERSITY FOR DEVELOPMENT STUDIES

Gorrette, N., Nabukera, S. & Salihu, H. M.(2005). *The abortion paradox in Uganda: fertility regulator or cause of maternal mortality*. J Obstet Gynaecol.

Gumanga, S. K., Kolbila, D. Z., Gandau, B. B. N., Munkaila, A., Malechi, H., Kyei-Aboagye, K. (2011).*Trends in maternal mortality in Tamale Teaching Hospital, Ghana*. Ghana Medical Journal.

Gupte, M., Bandewar, S.&Pisal, H.(1997). *Abortion Needs of Women in India: A Case Study of Rural Maharashtra*. Reproductive Health Matters.

Guttmacher Institute (2009). *Facts on abortion and pregnancy in Africa*. New York: Guttmacher Institute. Available at www.guttmacher.org.

Guttmacher Institute (2009). *Unsafe abortion in Kenya, in brief*. Available at www.guttmacher.org.

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

Henshaw, S. K., Singh, S. &Haas,T. (1999). *The Incidence of Abortion Worldwide*. Family Planning perspectives.

Hesse A. & Samba A.(2006).*Comprehensive Reproductive Health in Ghana*. A DAWN global project in collaboration with DAWN Anglophone Africa, 2006. Accessed from: https://www.dawnnet.org/feminist-resources/sites/default/files/articles/ghana.pdf

Hessini, L. (2005). *Global progress in abortion advocacy and policy: an assessment of the decade since ICPD.* Reprod Health Matters, 13(25):88–100

UNIVERSITY FOR DEVELOPMENT STUDIES

Hindin, M. J., Christiansen, C. S., Ferguson, B. J. (2013). *Setting research priorities for adolescent sexual and reproductive health in low- and middle-income countries.* Bull World Health Organ, 91:10–18.

Hock-Long, L., Herceg-Baron, R., Cassidy, A. A., & Whittaker, P. G. (2003). *Access to adolescent reproductive health services: Financial and structural barriers to care.* Perspectives on Sexual and Reproductive Health, 35(3), 144-147

Ipas (2008). *Ipas in Ghana*, Chapel Hill, NC, USA: Ipas.

LoxtermanJ.J.D.,(1997). *Adolescent Access to Confidential Health Services*. http://www.advocatesforyouth.org/publications/publications-a-z/516-adolescent-access-to-confidential-health-services

Joyce, T. J., Kaestner, R. & Korenman, S. (2000). *The effect of pregnancy intention on child development.* Demography, 37, 1, 83-94.

Juarez, F., Cabigon, J., Singh S. &Hussain R.(2005). *The incidence of induced abortion in the Philippines: current level and recent trends*. Int Fam Plan Perspect 31: 140-149.

Kamau, A. W. (2006). *Factors influencing access and utilization of reproductive health services by adolescents in Kenya: Murang"a District*. A Dissertation Presented in partial fulfillment of the requirements for the degree Doctor of Public Health in the faculty of Health Sciences, School of Public Health, University of Bielefeld, Germany. Retrieved October 31, 2011, from http://pub.unibielefeld.de/publication/2305119

Khan, M. E., Barge, S., Kumar N., Almorth S. (1998).*Abortion in India:Current situation and future challenges.* In: Pachauri S, editor. Implementing a Reproductive Health agenda in India. The beginning New Delhi, Population Council.

UNIVERSITY FOR DEVELOPMENT STUDIES

Kuffour, E. O., Esantsi, F. S., Tapsoba, P., Quansah-Asare, G., Askew, I. (2011)*Introduction Of Medical AbortionIn Ghana*

Kumar, R. (2005). *Research Methodology: A step–by–step guide for beginners* (2nd ed.). London: Sage Publications.

Leal, O. F. (2012). "*Those of you who have never had an abortion, raise your hand!" Rethinking ethnographic data on the dissemination of abortion practices among low-income populations in Brazil*. Cien Saude Colet, 17:1689–1697.

Lebetkin E, Orr T, Dzasi K, Keyes E, Shelus V, Mensah S, et al. (2014) *Injectable contraceptive sales at licensed chemical shops in Ghana: access and reported use in rural and Periurban Communities.* Int Perspect Sex Reprod Health.

Lopez, L.M., Tolley E. E., Grimes D. A., Chen-Mok, M.(2009).*Theory-based strategies for improving contraceptive use: a systematic review*. Contraception.

Mitchell, E. M. H.& Halpern, C. T. (2005). *Moral panic as curricula: The abortion content of Kenyan high school social ethics text books.* Cult Health Sex, 7:S52–S53.

Morhee, R.A.S. &Morhee,E.S.K. (2006). *Overview of the law and availability of abortion services in Ghana.*Ghana Medical Journal,40(3).

Ms. Gogontlejang Phaladi, Botswana PMNCH Pre-Forum, Johannesburg, 29 June 2014

Ndola, P., Suzanne B.&Amanual,G. (2013).*Comprehensive abortion care: evidence of improvements in hospital-level indicators in Tigray, Ethiopia*. Published online Jul 23, 2013. doi: 10.1136/bmjopen-2013-002873

Obermeyer, C. M. (1993). *Culture, maternal health care and women"s status: A comparison of Morocco and Tunisia.* Studies in Family Planning, 24, 6, 354-365

UNIVERSITY FOR DEVELOPMENT STUDIES

Ojha, N., Sharma S. &Paudel J.(2003). *Post legalization challenge: minimizing complications of abortion, Nepal*. Kathmandu University Medical Journal 2(2), Issue 6, 131-136.

Oliveras, E. (2006). *Abortion in the fertility transition in Accra, Ghana*. Unpublished

Otoide, V. O., Oronsanye, F. & Okonofua, F. E.(2001). *Why Nigerian adolescents seek abortion rather than Contraception: Evidence from Focus-Group Discussions.* International Family Planning Perspectives, 2001, 27(2):77-81

International Planned Parenthood Federation (2014) *Youth And Abortion: Key strategies and promising practices for increasing access to abortion services.* London: IPPF; and IPPF

International Planned Parenthood Federation(2009). *Young people"s guide to "Sexual Rights: an IPPF declaration.* Sexual Rights: an IPPF declaration. London: IPPF; and IPPF. 2011. Exclaim: London: IPPF.

Israel E., &Wedeen L., et al.,(2010). *Comprehensive Safe Abortion Programming: The Pathfinder International Approach.*PathfinderInternational. Accessed from: https://cmsadmin30.convio.net/preview!www.pathfinder.org/publications-tools/pdfs/Comprehensive-Safe-Abortion-Programming-The-Pathfinder-International-Approach.pdf

Peres, S. O. & Heilborn, M. L.(2006). *Considering and submitting to abortion among young people in the context of legal prohibition: the hidden side of teenage pregnancy*. Cad Saude Publica, 22:1411–1420.

Polit, D. F., & Beck, C. T. (2008).*Nursing research: generating and assessing evidence for nursing practice Eighth Edition*. Lippincott Williams &Wilkins. Philadelphia, Pa.

www.udsspace.uds.edu.gh

Rahman, A., Katzive, L.&Henshaw, S. K. (1998). *A Global Review of Laws on Induced Abortion, 1985-1997.* Family planning perspectives 24(2,)

Rasch, V., Massawe, S., Yambesi, F. &Bergstrom, S.(2004). *Acceptance of contraceptives among women who had an unsafe abortion in Dar esSalaam*. Tropical Medicine and International Health.

Sedgh, G.,Henshaw S, Singh S, Ahman E, Shah IH. (2012). *Induced abortion: incidence and trends worldwide from 1995 to 2008*, Lancet, (forthcoming).

Sedgh G. (2010). *Abortion in Ghana*. In Brief, New York: Guttmacher Institute, No. 2.

Sedgh, G. et al., (2007). *Women with an unmet need for contraception in developing countries and their reasons for not using a method*, *Occasional Report*, New York: Guttmacher Institute, 2007, No. 37.

UNIVERSITY FOR DEVELOPMENT STUDIES

Shariff, A. & Singh, G. (2002). *Determinants of maternal health care utilization in India: evidence from a recent household survey*. New Delhi: NCAER.

Shotorbani S., Zimmerman F. J., Bell J. F., Ward D. & Assefi N. (2004) *Attitudes and intentions of future health care providers toward abortion provision.* Perspect Sex Reprod Health. 36(2):58-63.

Singh S et al., (2009). *Abortion Worldwide: A Decade of Uneven Progress, New York*: Guttmacher Institute.

Singh S. (2006). *Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries.*Lancet, 368:1887–1892.

Singh, S. et al., (2009). *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health, New York*: Guttmacher Institute. Available online at http://www.guttmacher.org/pubs/FB-AIU-summary.pdf

www.udsspace.uds.edu.gh

UNIVERSITY FOR DEVELOPMENT STUDIES

Singh, S., Monteiro M. F.&Levin J. (2012).*Trends in hospitalization for abortion-related complications in Brazil, 1992–2009: why the decline in numbers and severity?* Int J Gynaecol Obstet, 118:60007–60001.

Singh, S., Wulf D., Hussain R., Bankole A. & Sedgh G. (2009). *Abortion worldwide: A decade of uneven progress.* New York: Guttmacher Institute. Available at www.guttmacher.org.

Srivastava, R., Srivastava, D.K., Jina R., Srivastava K., Sharma N.,&Sana S. (2005) *Contraceptive knowledge, attitude and practice (KAP Survey)*. J Obstet Gynecol India; 55: 546-50.12.

Stanton M. E., Higgs S. E., & Koblinsky M. (2013) Investigating Financial Incentives for Maternal Health: An Introduction. J Health Popul Nutr. 2013 Dec; 31(4 Suppl 2): S1–S7

Syden, F. (2011) *Knowledge and Attitudes Regarding Abortion care Among Indian Medical Students.* Department of Women‘s and Children‘s Health, International Maternal and Child Health Uppsala University, Uppsala, Sweden

Sudhinaraset, M., Ingram, M., Lofthouse, HK., Montagu, D. (2013). *What is the role of informal healthcare providers in developing countries? A systematic review*. PLoS One.; 8(2):e54978.

The Population Council (2000a). *Train more providers in post abortion care*. OR Summaries 4, Senegal. Washington, DC: Population Council.

The Population Council (2000b). *Upgrading post abortion care benefits patients and providers*.OR Summaries 3, Bukina Faso. Washington, DC: Population Council.

Turkson, Richard (1996). *The role of law in population and development.*National Population News Bulletin, 1(3) 6-7.

UNIVERSITY FOR DEVELOPMENT STUDIES

United Nations (2004). *Key actions for further implementation of the Programme of Action of the International Conference on Population and Development*.A/S-21/5/Add.1. New York. Accessed at: www.unfpa.org/upload/lib pub file/561 filename icpd5-key-04reprint_eng.pdf.

United Nations (2009). *Programme of action of the International Conference on Population and Development, Cairo, Egypt*, 5–13 September 1994. New York. Accessed at: www.unfpa.org/icpd/icpd-programme.cfm

United Nations Department of Economic and Social Affairs, Population Division (2001). *"Ghana: Abortion policy," in Abortion policies*: A global review. Vol. 2, Gabon to Norway. New York, N.Y.: United Nations.

Walkera, D., Camperoa L., Espinozab H., Hernándeza, B.,Anayac L., Reynosob S., Langerb A.(2004).*Deaths from complications of unsafe abortion: misclassified second trimester deaths. Reproductive Health Matters*, 12:27–38.

Westley, E. (2005). *Saving Women"s Lives Safe Motherhood The Health Impact Of Unsafe Abortion.*Pg. 19 Family Care International, Inc. Design by Green Communication Design, Montreal Canada: https://www.familycareintl.org/UserFiles/File/pdfs/pub pdfs/gsm20.pdf.

Worku Animaw and Binyam Bogale (2014). *Awareness and Attitude to Liberalized Safe Abortion Services among Female Students in University and Colleges of Arba Minch Town, Ethiopia*. Science Journal of Public Health. Vol. 2, No. 5, 2014, pp. 440-446. doi:10.11648/j.sjph.20140205.20

World Health Organization (2003). *Safe abortion*: *Technical and policy guidance for health systems*. Geneva, WHO.

www.udsspace.uds.edu.gh

UNIVERSITY FOR DEVELOPMENT STUDIES

World Health Organization (2004). *Resolution WHA57.12. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets. In: Fifty-seventh World Health Assembly, Geneva, 17–22 May 2004. Geneva, (WHA57/2004/REC/1).*

World Health Organization (2007). *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003.* 5th edition.Geneva. Accessed at www.who.int/reproductivehealth/publications/unsafeabortion 2003/ua estimates03.pd f

World Health Organization (2007). *Unsafe abortion: Global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. Geneva, World Health Organization. Available online at http://www.who.int/reproductivehealth/publications/unsafeabortion 2003/ua estimates03.pdf

World Health Organization (2007). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, fifth ed.,Geneva: WHO.

World Health Organization (2007).*Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*, 5th ed. Geneva,

World Health Organization (2011). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed., Geneva: WHO, 2011.

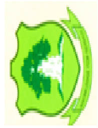
World Health Organization (2011).*Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, 6th ed. Geneva,

www.udsspace.uds.edu.gh

Zemene A., Feleke A., Alemu A., Yitayih G. &Fantahun A. (2014). *Factors Influencing Utilization of Post Abortion Care in Selected Governmental Health Institutions, Addis Ababa, Ethiopia*. Fam Med Med Sci Res 3: 115. doi: 10.4172/2327-4972.1000115

Ziem J. & Gyebi E. (2012). *N/R Records 70 Maternal Deaths In First Half Of 2012.*Wednesday, August 8, 012 Retrieved from http://savannahnewsblogspotcom.blogspot.com/2012/08/nr-records-70-maternal-deaths-in-first.html

UNIVERSITY FOR DEVELOPMENT STUDIES



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APPENDIX

APPENDIX A

UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE

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Designed Questionnaire for Service Providers

I am currently conducting a study on the Attitude and Utilization of Comprehensive Abortion Care Services in the Tamale Metropolis. The purpose of this study is to assess the attitude and utilization of adolescents on the Comprehensive Abortion Care facility in the Tamale Metropolis.

This study is primarily an academic exercise, and therefore, you are assured of confidentiality and anonymity in any information that you provide.

A	Background Characteristics	
1	Age	10-15..................... ..1 16-21..................... ..2 22+...........................3
2	Sex	Male.........................1 Female 2
3	Marital Status	Never married...........1 Married ....2 Separated .... 3 Divorced ....4 Widowed .... 5 Others (specify) 6
4	Highest Level of education	None ....1 Primary 2

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		Middle/JSS................3 Secondary..................4 Tertiary..................5
5	Ethnicity	Dagomba................1 Gonja................2 Mossi................3 Mamprusi................ 4 Others (Specify by writing)................5
6	Religious Affiliation	Christianity................1 Islam.................2 Traditional................3 Others...............4
7	Family Type	Nuclear..................1 Extended................2
8	Source of Information on health ***Tick all that apply***	Radio .... 1 TV... 2 Friends/Peers .... 3 Relatives .... 4 Health Centre/health workers 5 Newspapers .... 6 Others (Specify)...............7
	Section B:	**Knowledge and Awareness On Comprehensive Abortion Care**
9	Have you heard of contraceptive ...	Yes 1

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	before?	No....2
10	If yes, what is/are your source(s) of knowledge about contraceptives? ***Tick all that apply***	Radio.....1 TV.....2 Friends/Peers....3 Relatives...4 Health Centre/health workers....5 Newspapers......6 Others (Specify)...7
11	Have you ever heard of abortion? ..	Yes................................ 1 No 2
12	Is abortion legal in Ghana?	Yes... ..1 No... ...2
13	When was the last time you heard it?	A week ago.................. 1 Two weeks ago............2 Three weeks ago...........3 A month ago ....4 A year ago ....5 Others (Specify....6
14	What is/are your source(s) of knowledge about abortion? ***Tick all that apply***	Radio.....1 TV.....2 Friends/Peers....3 Relatives...4

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		Health Centre/health workers....5 Newspapers......6 Others (Specify) 7
15	Have you heard/know any person who has aborted unintended pregnancy before?	Yes... 1 No... 2
16	If Yes, from whom did she seek assistance to abort the pregnancy? ***Tick/circle all that apply***	Pharmacist prescription....1 Herbalist prescription...2 Peers/Friends prescription....3 Self-medication....4 Nurses and Midwifes prescription... 5 Family/Relatives prescription... 6 Others (Specify)...7
17	What are the methods of illegal abortion	*Please indicate* ....
18	Have you heard about Comprehensive Abortion Care (CAC)?	Yes... 1 No... 2
19	If Yes, what do you know/heard about Comprehensive Abortion Care?	It is a legal form of abortion care for all .... 1 It is only meant for pregnant women... 2 It is only for teenagers with pregnancy 3 I don't know anything about it.............. 4 It is about safe abortion services 5

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	Tick/circle all that apply	It is about contraceptive usage...6
20	Is there an age limit to Comprehensive Abortion Care Services?	Yes... 1 No... 2
21	If yes at what age limit is CAC required? ***Tick/circle all that apply***	Persons aged between 11-14 with pregnancy....1 Persons aged between 15-18 with pregnancy.....2 Persons aged between 19-21 with pregnancy......3 Persons aged 22 and above with pregnancy..4 I don't know...5
22	Under what circumstance/condition does a pregnancy require Abortion?	On condition to prevent the death of the mother... 1 To choose the right time for pregnancy...2 Birth spacing....3 On condition of the mother's education..4 Family support....5 When pregnancy result from rape or incest....6 When the women is not psychological prepared......7 Others (Specify)...8
23	Do you know any Health Centre (s) accredited for Comprehensive ...	Yes... 1 No.... 2

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	Abortion Care Services in the Metropolis?	
24	Abortions care services in unregistered facilities are more harmful than abortion care services in registered health facilities	Strongly Agree .... 1 Agree .... 2 Neutral ....3 Strongly Disagree.................................4 Disagree 5
	Section B:	**Attitude of Adolescents towards Comprehensive Abortion Care**
25	Have you ever used a contraceptive before?	Yes................................. 1 No......................................2
26	If Yes, which of the contraceptives have you used .... before? ***Tick all that apply***	Condom............................ ..1 IUD.................................2 Pills.................................3 Emergency contraceptive.......................................4 Injectable..................................5 Withdrawal method.................................6 Others (Specify..................................7
27	What will be or was your reason for using a contraceptive?	Prevent unintended pregnancy................................. 1 Prevented STD's.................................2 For sexual satisfaction.....................................3 Birth Spacing.................................4
28	What is your position on comprehensive abortion care?	It is safe.................................1 It prevents pregnancy................................. 2

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		It makes sex enjoyable....3 It is unsafe......4 It is not good for my culture....5 My religion is against it......6 Others 7
29	Will you advise any woman with an unintended pregnancy to go in for abortion?	Yes...1 No....2
30	If No why? ***Tick/circle all that apply***	Because of religious reason... 1 Because of the stigma ....2 Monetary reason... 3 The risk/dangers involved in abortion care.......4 Because of our culture....................................5 Because of the tradition ....6 Because of fear....7 Others specify...8
31	Who will you first consult in case of unintended pregnancy?	A health professional/ worker...1 A friend/peers...2 A family member....3

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		A herbalist/concoction dealer .... 4 A pharmacy..5 Chemical shop dealer..................................6
32	Why do you think people in need of abortion do not patronize health care services?	***Please give reasons*** ....
33	Health professionals working in abortion services have friendly attitude towards terminating unintended pregnancy among adolescent	Agree...1 Strongly agree ....2 Neither agree nor disagree ....3 Disagree ....4 Strongly disagree 5
	Section D	**Utilization rate of CAC**
34	How often do you hear of pregnancy termination cases in the Metropolis?	Not often .... 1 Often .... .2 Very often .... .3 Almost every day.................................... .4 Others (Specify 5
35	When was the last time you heard about unintended pregnancy termination related case in the Metropolis?	Less than a week ....1 A week ago ....2 Less than two weeks ....3 Two weeks ago ....4 Less than three weeks ....5 Three weeks ago ....6 A month and more 7

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		Others (Specify.................................. 8
36	What are/is the commonest method(s) people rely on to terminating unintended pregnancy in the Metropolis? Tick all that apply	Visiting accredited health centre.....................................1 The use of herbal concoction.....................................2 The use of Guinness mix with sugar..................................... 3 The use of drugs.....................................4 Visiting chemical dealers.....................................5 Visiting pharmacy.....................................6 Friends/peers.....................................7 Family members/relatives.....................................8 Others (Specify).....................................9
37	When was the last time you heard of pregnancy termination at an accredited heath care centre?	Less than a week..................................1 A week ago..................................2 Less than two weeks..................................3 Two weeks ago..................................4 Less than three weeks..................................5 Three weeks ago..................................6 A month and more..................................7 Others (Specify)..................................8
39	**Section E**	**Factors Influencing the Utilization and Non-utilization of CAC in TMA**
40	For what reason(s) will you not go for abortion care services?	Pains enduring in abortion procedure..................................... 1 Insults and harassment by health workers.....................................2 The risk involved in the process.....................................3

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	Tick all that apply	The cost involve in the process...4 Lack of support from my partner..5 Fear of the side effect..6 Others (Specify)..7
41	Which of the following factors influences you most to utilize CAC services.	Access to CAC...1 Awareness about CAC...2 Household income status...3 Autonomy...4 Youth Friendly Service...5
43	Traditional herbal concoctions are perceived as the best method for terminating unintended pregnancy	Agree... 1 Strongly agree...2 Neither agree nor disagree...3 Disagree...4 Strongly disagree...5
44	Adolescents prefer to have abortion services outside the hospitals	Agree... 1 Strongly agree...2 Neither agree nor disagree...3 Disagree...4 Strongly disagree...5
45	Abortion is morally wrong regardless of its purpose	Agree...1 Strongly agree...2 Neither agree nor disagree...3 Disagree...4 Strongly disagree...5
46	Abortion is against my religion?	Agree... 1 Strongly agree...2

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		Neither agree nor disagree ....3 Disagree ....4 Strongly disagree 5
47	A woman need to have her partner/spouse approval to have an abortion	Agree .... 1 Strongly agree ....2 Neither agree nor disagree.........................3 Disagree..4 Strongly disagree......................................5
48	Persons known to have terminated unintended pregnancy are stigmatized by their peers and family members	Agree .... 1 Strongly agree ....2 Neither agree nor disagree.........................3 Disagree..4 Strongly disagree......................................5
49	Health professionals working on abortion care services normally hold it confidential	Agree .... 1 Strongly agree ....2 Neither agree nor disagree.........................3 Disagree..4 Strongly disagree......................................5
50	Health professionals unnecessarily delay in terminating unintended pregnancy	Agree .... 1 Strongly agree ....2 Neither agree nor disagree.........................3 Disagree..4 Strongly disagree......................................5
51	Counselling is done as the first and most thing by experts before they start the abortion procedure	Agree .... 1 Strongly agree ....2 Neither agree nor disagree.........................3

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		Disagree ....4 Strongly disagree 5
52	How can CAC services be made know to adolescents who may be victim of an unplanned pregnancy?	*Please indicate*
53	What measures can be put in place to encourage adolescents to patronize CAC services?	*Please indicate*
54	Who should campaign for CAC services?	*Please indicate* ....
55	How can Health services promote the utilization of CAC services?	*Please indicate* ....

Thank you!

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APPENDIX B

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UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE In-depth/Group Interview Guide for Health Workers at the various Accredited Health Centers

Thematic Areas and Issues for Discussion

Section A: Knowledge and Awareness on Comprehensive Abortion Care

1. Do you think people (youth/adolescent) in the Metropolis are aware of the CAC services?

1.1 What are the source(s) of knowledge of the youth/adolescent about abortion care in the metropolis?

1.2 What will you say is the perceptions of the youth/adolescent about abortion? Please cite a case or cases if any?

1.3 What are the sources of knowledge of the youth/adolescent about contraceptives usage in the metropolis?

Section B: Attitude of Adolescents towards Comprehensive Abortion Care

2. In your opinion what is the general attitude of people in the Metropolis towards abortion?

2.1 In your opinion what is the commonest method people/youth rely on when terminating pregnancy?

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2.2 In your opinion how is/are unintended pregnancies handled by the youth/adolescent in the Metropolis?

2.3 In your opinion how do parents handle unintended pregnancies cases involving their daughter or son?

2.4 Will you say abortion is frown upon by people in the metropolis if yes please cite some cases?

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Section D: Factors Influencing the Utilization and Non-utilization of CAC in TMA

3. How often do people come for abortion care services in this Health Centre?

3.1 Under what circumstance is a pregnancy required for Comprehensive Abortion Care? Please cited a case or cases if any?

3.2 What will you say are the factors influencing the utilization of abortion care services?

Please cite a case or cases if any?

3.3 What will you say are the factors influencing the non-utilization of abortion care services?

3.4 What challenges are you facing in dealing with abortion cases?

3.5 Any suggestions to addressing these challenges?

Thank You!