KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

PREDICTORS OF POSTABORTION FAMILY PLANNING UPTAKE IN

THE NEW JUABEN MUNICIPALITY, GHANA.

BY:

PHYLLIS ABRAH (MRS)

(B/A NURSING WITH PSYCHOLOGY)

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

PREDICTORS OF POSTABORTION FAMILY PLANNING UPTAKE IN THE NEW JUABEN MUNICIPALITY, GHANA.

BY:

PHYLLIS ABRAH(MRS)

(B/A NURSING WITH PSYCHOLOGY)

A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH, SCHOOL OF MEDICAL SCIENCES, IN PARTIAL FULFILMENT OF THE REQUIREMENT

FOR THE AWARD OF

MPH(POPULATION AND REPRODUCTIVE HEALTH)

MAY, 2014.

DECLARATION

This thesis is the result of my independent research. l hereby declare that references cited in the work has been duly acknowledged.

Signature …………………………………………..

Phyllis Abrah

(STUDENT)

Signature …………………………………………..

Dr. Easmon Otupiri

(SUPERVISOR)

Signature …………………………………………

Dr. Harry Tagbor

(HEAD, DEPARTMENT OF COMMUNITY HEALTH)

DEDICATION

This dissertation is dedicated to my husband, Mr Samuel Abrah, my mother Ms. Susana Birago Owusu and Mr Dominic Korsah Otchere for their relentless contributions.

ACKNOWLEDGEMENT

I will like to thank the Almighty God for His grace and favor that has made me able to successfully complete this work.

My deepest gratitude goes to my supervisor Dr Easmon Otupiri for his guidance, support and numerous feedbacks in the development of this thesis.

I also wish to acknowledge the lecturers and staff of the community health department for their immerse contribution throughout the course, especially Dr Harry Tagbor (HOD), Mr Emmanuel Nakua and Mr Gabriel Kisseh. God richly bless you all.

Am grateful to mention Dr E.L. Senaya (Municipal Health Director), Mrs. Evelyn Owusu Acheaw (DDNS/PH), Mr Benjamin Boakye and Mr Seth Opoku-Larbi, for their enormous contribution during the processing of this thesis.

Finally I want to thank all my participants for consenting to participate in the study. I also want thank KNUST for giving me the opportunity to be one their students and helping me achieve my dreams.
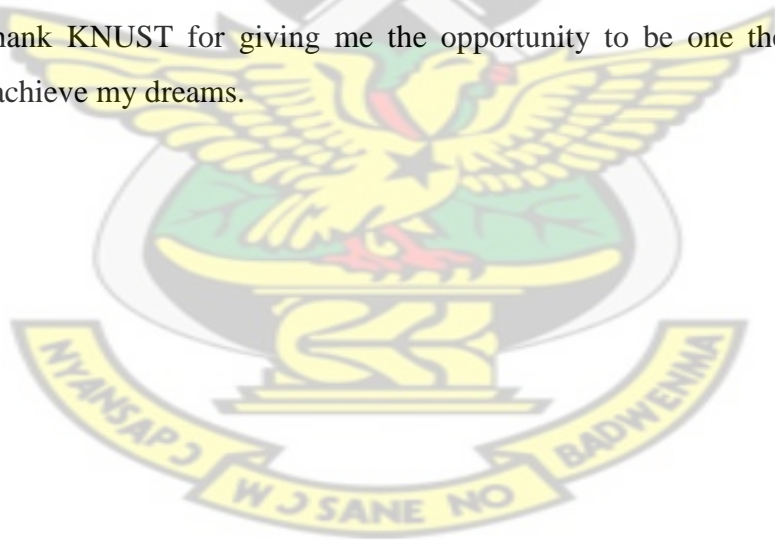
LIST OF ABBREVIATIONS/ ACRONYMS

AOR-   Adjusted Odds Ratio

CAC-   Comprehensive Abortion Care

CI-   Confidence Interval

FP-   Family Planning

GHS-   Ghana Health Service

IEC-   Information, Education and Communication

IPAS-   International Project Assistance Services

OCP-   Oral Combined Pill

OR-   Odds Ratio

PAC-   Post Abortion Care

PAC-M   Post Abortion Care- Medical

PAC-S   Post Abortion Care- Surgical

PAFP-   Post Abortion Family Planning

POP-   Progesterone Only Pill

UN-   United Nations

USAID-   United States Agency for International Development

WHO-   World Health Organization
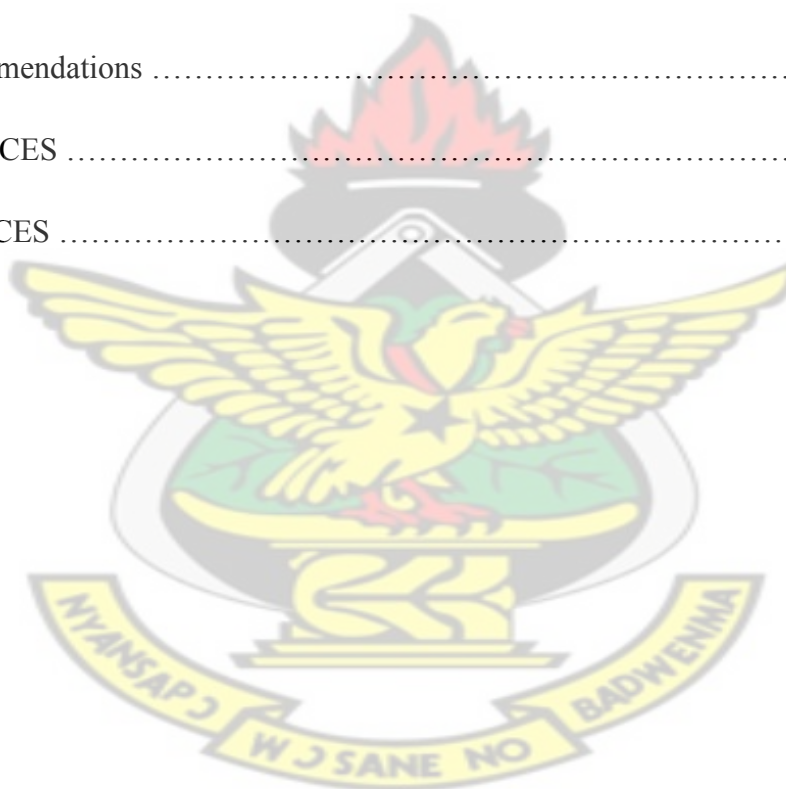
TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIQURES

KNUST

LIST OF APPENDICES

KNUST

ABSTRACT

Post abortion care has been identified as a key strategy to reduce maternal mortality in developing countries. It plays a vital role in the treatment of complications associated with unsafe abortion as well as providing post abortion family planning counseling and services to prevent repeat unplanned pregnancies and repeated abortions. According to World Health Organization (WHO), 47,000 women died from complications of unsafe abortion, and the percent of maternal deaths attributed to unsafe abortion remains unchanged at 13% worldwide in 2008, despite global efforts.A descriptive cross-sectional study assessed factors that determine contraceptive uptake among post abortion women in the New Juaben Municipality of Ghana. Using quantitative method of data collection, a structured questionnaire was used to gather data from six hundred and thirty four (634) respondents. Facilities and participants were selected based on multistage sampling technique. The most seekers of post abortion care (PAC) were aged between 20 – 29 years (60.6%), and 59.9% of those who accepted family planning were in the same age category. Abortion seekers were generally well educated; 96.5% of the women have had formal education. Knowledge on contraceptive methods available was high; 67% of the respondents knew about one (1) to four (4), whereas 33% knewfive (5) to seven (7) contraceptive methods. Respondents' knowledge on when fertility returns following abortion was low;(45.1%) of respondents had no idea, and only 16.7% knowing that, fertility returns within 2 weeks after abortion. The existence of very good relationship between service providers and clients seeking PAC services contributed to contraceptive uptake.Majority (74.6%) of institutions provided postabortion care (PAC), thus on site family planning services and 89.1% had a protective service environment.Majority of clients do not know or have no idea about the opening and closing time of institutions offering PAC services. The cost of PAC services is generally low and institutions providing PAC services are far away from clients. Socio-demographic characteristics, knowledge on family planning, range and accessibility to post abortion family planning counseling and services serves as a predictive factor in contraceptive uptake.Misconceptions on the use of contraceptives and the fear of side effects are a few barriers to the uptake of family planning.Service providers and all health institutions could strengthen the education on PAC especially on when fertility returns after abortion,not only to prevent repeat unintended pregnancy and abortion, but also because it is integral to achieving the Millennium Development Goal 5.

14

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Postabortion care services have been identified as a key strategy to reduce maternal mortality in developing countries (Curtis, Huber & Moss-Knight, 2010). It plays a vital role in the treatment of complications associated with unsafe abortion as well as providing postabortion family planning counseling and services to prevent repeat unplanned pregnancies and abortions.

Women usually seek abortion for a variety of reasons, including limiting family size, delaying childbearing or contraceptive failure, lack of access to contraceptives, or as a result of rape. Unmet need for family planning is the root cause for induced abortion, legal or illegal. Women who have had an induced abortion are at special risk of repeat induced abortions. For these and all women, family planning should be voluntary, readily available, and information should be comprehensible and concise (Guttmacher Institute, 2008; Williamson et al., 2009).

Many women do not receive immediate postabortion family planning services, even though they are at risk of pregnancy within two to three weeks postabortion. While many of these women desire to replace the pregnancy that was lost, experts recommend birth spacing of six months after a spontaneous abortion of a desired pregnancy for optimal pregnancy outcomes. Therefore all women should receive counseling and family planning services after any abortion, whether spontaneous or induced, irrespective of the

pregnancy termination or evacuation procedure used. Women continue to lack access to modern contraception, or do not use it for a range of reasons, including health concerns, social disapproval and partner opposition. Women not using any contraception account for approximately two-thirds of unintended pregnancies in developing countries (Guttmacher Institute, 2008).

The World Health Organization estimates that worldwide around 20 million unsafe abortions occur annually, more than 95% of which occur in less developed countries. Those abortions that are unsafe, performed by untrained practitioners working in unhygienic conditions, are responsible for about 80,000 preventable deaths of women each year. Globally, 20 percent of all pregnancies end in induced abortions; nearly half ofthese abortions (around 20 million) are clandestine and generally unsafe. According to the WHO, about 180 to 200 million pregnancies occur every year globally. Out of these, 75 million are unwanted pregnancies (WHO, 2007).

It has also been estimated that in the year 2000, 19 million illegal or unsafe abortions were carried out, of which 18.5 million were in developing countries (Ahman & Shah, 2002).

According to a study conducted in the late 1990s in southern Ghana, 17 abortions were observed for every 1,000 women of reproductive age(Singh et al., 2009).The level of abortion in Ghana appears to be lower than in Western Africa as a whole, where the rate stands at 28 per 1,000 women (Singh et. al., 2009).

Unsafe abortion and its consequences impose heavy economic and healthburdens on women and society. Every year, unsafe abortion accounts for around 70,000 deaths worldwide (13% of all pregnancy-related deaths) and anestimated 5 million women are hospitalized for the treatment of seriouscomplications related to abortion, such as sepsis

16

or hemorrhage, with manysuffering long-term ill-health as a consequence. The vast majority (95-97 %)of these deaths occurs in the world's poorest countries, and is at their highest inAfrica. Almost half of all unsafe abortion deaths occur amongst adolescents, girlsunder the age of 19 (WHO, 2007).

The United Nations' Millennium DevelopmentGoal calling for the reduction of maternal mortality by 75% between 1990and 2015 will not be met without addressing unsafe abortion (UN, 2000).

Globally, contraceptive use is increasing; recent estimates suggest that just over half (55%) of married women aged 15-49 in developing countries are using some form of contraception (Tripney et al, 2011). Contraceptive use has also increased among unmarried sexually active women in many developing countries; for example, about 37% of unmarried 15–24 year old women in sub-Saharan Africa use contraceptives (Singh et al., 2009). Women not using any contraception account for approximately two-thirds of unintended pregnancies in developing countries (Guttmacher Institute, 2008).

The consequences of unplanned pregnancy for single women are harsh;they are often faced with social stigma and exclusion, expulsion from the family, abandonment and poverty. For married mothers, repeat pregnancies at short birth-to-pregnancy intervals pose considerable economic burden on poor families and increased risks to the health of the mothers and infants (Grimes et al, 2006).

In settings where access to safe services is limited, particularly countries where it remains illegal, women may have little choice other than to go to untrained providers. Data indicate an association between restrictive abortion laws and abortion-related deaths: 34 deaths per 100,000 childbirths in countries with more restrictive abortion laws, compared to one or fewer per100,000 childbirths in countries with less restrictive

laws (WHO, 2007). The World Health Organization also deems unsafe abortion to be one of the easiest preventable causes of maternal mortality and ill-health.

Postabortion clients are women and girls with a clear need for family planning. Postabortion care (PAC) has three components: (1) emergency treatment for complications of spontaneous or induced abortion; (2) family planning counseling and service provision and, where financial and human resources are available, evaluation and treatment for sexually transmitted infections (STIs) as well as HIV counseling and/or referral for testing of postabortion women; and (3) community empowerment through community awareness and mobilization (Curtis, 2007).

Strong evidence demonstrates the feasibility, acceptability, and effectiveness of providing family planning services at the same time and location as postabortion services. Despite this evidence, many postabortion clients leave facilities without providers offering them family planning counseling or services. Postabortion family planning is one of several high-impact practices in family planning (USAID, 2011).

According to the Ghana Maternal and Health Survey report for the year 2007, abortion rate in Ghana is 0.4 per woman; 7% of all pregnancies end in abortion and 15% of women aged 15-49 have ever had an abortion. 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 accordance with the data on abortion by age, first pregnancies are more likely to end in abortion than second or higher order pregnancies (11 percent compared with 7 percent or less). These findings indicate that in Ghana, abortion is used more commonly to delay the start of childbearing than to limit the number of children.

The human costs of unsafe abortion are dramatically apparent in Ghana. While most causes of maternal mortality have declined since 1987, abortion-related complications and deaths have risen in some parts of the country from 13.1% to 26.5% in 2000, making it the leading cause of maternal death. In 1994, before government intervention, unsafe abortion provision in Berekum district led to a temporary spike in maternal mortality of 790 deaths per 100,000 live births (Aboagye et al., 2007).

Although postabortion family planning counseling and service delivery is part of all post abortion care models, PAC services have historically sought to reduce maternal mortality by treating the symptoms of hemorrhage and sepsis rather than by treating women's unmet need for family planning, thus overlooking the potential of post abortion care to interrupt the cycle of repeat unplanned pregnancy, abortion and complications leading to maternal death. For many post abortion patients, the lack of family planning counseling and services quickly leads to another induced abortion, because fertility returns within two to three weeks after miscarriage or induced abortion. This makes it essential to ensure that post abortion family planning counseling and service delivery are offered to all women who present for emergency obstetric or post abortion care, regardless of the method of treatment (sharp curettage, electric or manual evacuation) or place of treatment (operating theatre or PAC treatment room) as well as to all postpartum women (Curtis et al, 2010).

Studies show that providing family planning services as part of postabortion care can increase contraceptive use and reduce repeat abortions. In Zimbabwe the standard practice is that abortion clients had to obtain contraceptives from a nearby maternal and child health facility for a nominal fee. A study found that clients receiving standard PAC services were more than three times as likely to experience an unplanned pregnancy in

the 12 months following an abortion as PAC clients who were offered ward-based family planning services and methods for free, after adjusting for marital status; desire to have another child, and previous contraceptive use (Johnson et al., 2002). Program implementers note that providing additional family planning counseling at follow-up visits is also an important factor in reducing repeat abortions (Johnson et al., 2002; Savelieva et al., 2003).

Women are at risk of pregnancy almost immediately after abortion. Fertility returns sometimes as soon as one week after an abortion. Timely family planning services can prevent a subsequent unplanned pregnancy. Spacing between pregnancies is important for women's and children's health. After a miscarriage or an induced abortion, women should wait at least six months before becoming pregnant again to reduce the incidence of maternal anemia, premature rupture of membranes, low birth weight, and preterm delivery in the next pregnancy(Wilcox et al., 2000).

International Project Assistance Services (IPAS) emphasizes contraceptive counseling and services as part of comprehensive abortion care. Information and contraceptive methods offered at the time of services are essential so that women can prevent repeat unwanted pregnancies and unsafe abortion. Family planning services for all women should include information and referrals to safe abortion for those who experience contraceptive failure (IPAS, 2011).

1.2   PROBLEM STATEMENT

Despite global efforts, in 2008, 47,000 women died from complications of unsafe abortion, and the percentage of maternal deaths attributed to unsafe abortion remains unchanged at 13% worldwide (WHO, 2011). Even though postabortion family planning

counseling and service delivery is part of all postabortion care models, PAC services have historically sought to reduce maternal mortality by treating the symptoms of hemorrhage and sepsis rather than by treating women's unmet need for family planning, thus overlooking the potential of postabortion care to interrupt the cycle of repeat unplanned pregnancy, abortion and complications leading to maternal death. The available global evidence on postabortion contraception use is scarce especially from developing and low-income countries including Ghana.

The institutional maternal mortality ratio for the Eastern Region of Ghana in 2011 and 2012 were 135 with a ratio of 207 per 100,000 live births and 116 with a ratio of 166 per 100,000 live births respectively. The New Juaben Municipality recorded 43 maternal deaths in 2012. This high mortality rate is a burden to the New Juaben Municipal Health Management Team and needs to be addressed. Regional coverage for family planning for 2012 was 215,313 (34.6%) as against 205,914 (37%) in 2011, indicating a decrease of 2.4%. (GHS- Eastern Region Annual Health Report, 2012).

Although there has been integration of family planning services into PAC for some years now, there are no data available in the New Juaben Municipality that would unveil the much needed information to inform postabortion care family planning programming. Thus information on key areas such as the socio-demographic profile of clients seeking post abortion care, the knowledge, attitude and practices of clients towards postabortion care in regards to contraception, the range and accessibility of family planning counseling and contraceptive services offered as part of postabortion care, the postabortion contraception acceptance rate in the Municipality, and the barriers to postabortion family planning counseling and services in the Municipality are not available.

1.3 RATIONALE OF STUDY

It is important that managers, policy-makers and providers take a comprehensive view of reproductive health, which includes post-abortion family planning, to reduce the toll of unsafe abortion and to improve the health of women, their partners, and the safety of motherhood. Family planning programmes that seek to help all women who wish to avoid additional unwanted pregnancies will help reduce needless, preventable deaths caused by unsafe abortion.

The study findings will contribute to efforts to scale up and institutionalize postabortion counseling and family planning uptake in the Municipality.

Recommendations for Further Studies

There is a strong need to conduct comprehensive evaluation through employing multi-country prospective cohort studies to determine method continuation rates; impact of post-abortion family planning use on maternal mortality or illness, unsafe abortions and unplanned pregnancies.

22

1.4 CONCEPTUAL FRAMEWORK
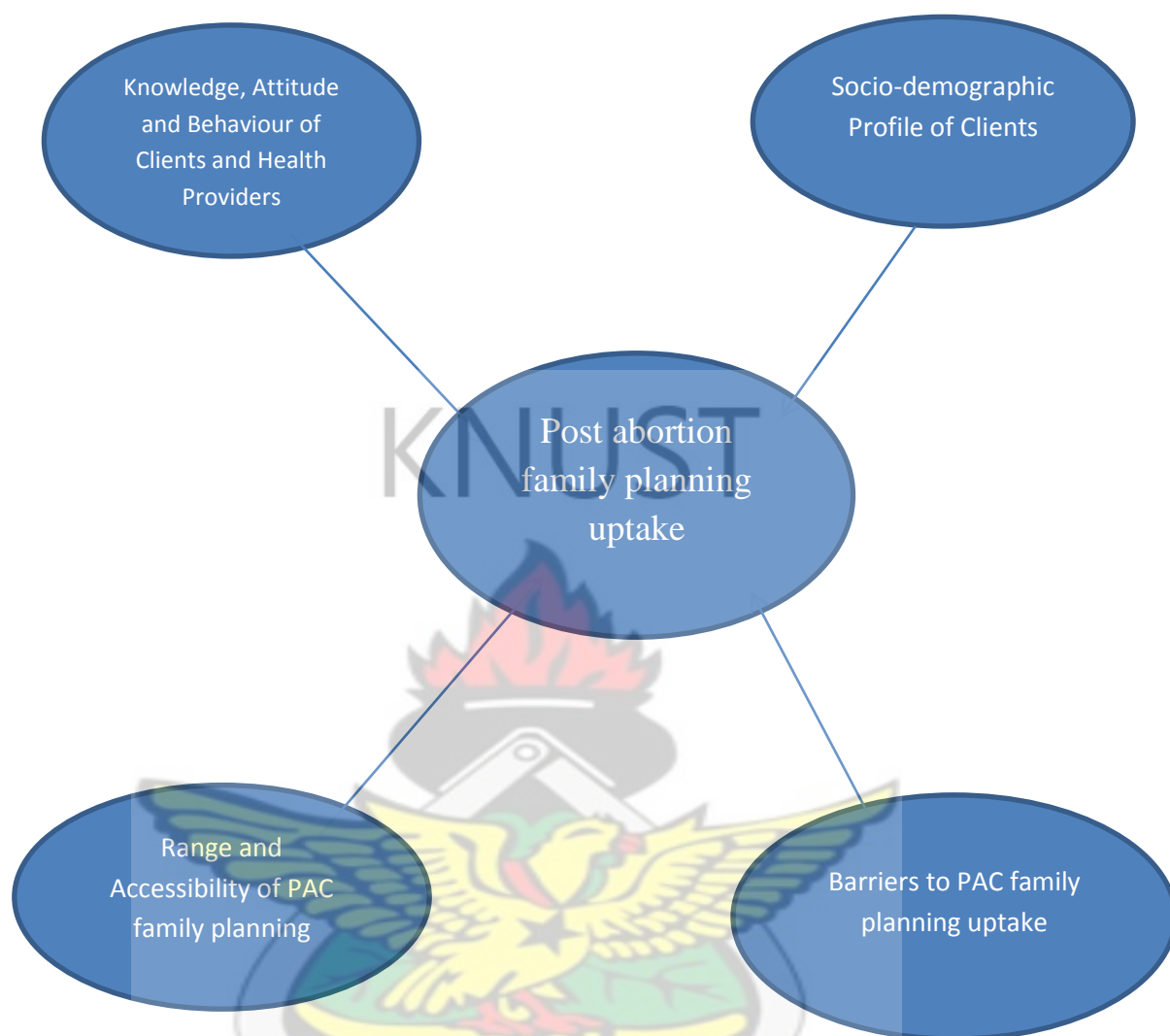
Many factors contribute to the uptake of contraception among post abortion women and these include socio- demographic characteristics such the age, education, occupation, income as well as past contraceptive history.

The knowledge of women on contraceptive options can boost up postabortion contraception uptake. The accessibility of postabortion family planning services and the range of services available affect the uptake. There is clear evidence that if contraception is offered to a woman before she leaves the PAC service area, uptake of a method will be higher than if she is referred elsewhere for FP counseling. . Again, environmental, social and organizational barriers can affect the uptake of post abortion family planning; when

family planning services are provided at the same time and facility where a woman receives PAC services, it leads to higher contraceptive uptake.

1.5 RESEARCH QUESTION

What factors determine postabortion family planning uptake in New Juaben?

1.6 MAIN OBJECTIVE

The general objective of the study is to determine the predictors of postabortion family planning uptake in the New Juaben Municipal of the Eastern Region.

1.7 SPECIFIC OBJECTIVES

- To identify the socio-demographic profile of clients seeking postabortion care in the Municipality.
- To explore the knowledge and attitude of clients towards postabortion care with regards to contraception in the Municipality.
- To describe the range and accessibility of family planning counseling and contraceptive services offered as part of postabortion care in the Municipality.
- To identify the barriers in providing postabortion family planning services in the Municipality.

1.8 PROFILE OF STUDY AREA

Location and Size

New Juaben Municipality is located in the Eastern Region of Ghana. It is the one of the six municipalities and covers a land area of 110 square kilometers with an estimated population of 191,525. It shares boundaries with East Akim Municipality on the north, Akwapim North District on the south, Yilo Krobo District on the east and Suhum Kraboa

Coaltar District on the west. The Municipality is strategically located and it shares boundaries with districts that are famous in agricultural production, thus providing an opportunity to develop agro processing facilities to make use of raw materials from these areas. The rural portion is rich in fertile agricultural lands and suitable for large scale farming, cattle rearing and poultry.

Demographic Characteristics

The 2010 Population and Housing Census put the population of the Municipality at 183,727 with female population constituting 51.7% and 48.3% for males. The population density is 684 persons per square kilometer.

Koforidua, the regional and municipal capital, harbors over 65% of the entire population of the Municipality. Some of the remaining 52 settlements have smaller population sizes which do not normally measure up to the population thresholds required for the provision of essential socio-economic services.

The Municipality has a dependency ratio of 64.7 which implies that there are about 65 persons in the dependent age for every 100 persons in the working age group. This is compared with the regional dependency figure of 90.7.

Age and Sex Composition

The age structure of the district shows a relatively large proportion of children and a small proportion of older persons, that is, 65+ years. The age and sex distribution of the municipal population is shown in Table 1.1 below

Table 1.1: Age Composition of Population

Target Population		% Population	Population
Children	0 - 11 months	4	7661
Children	12 - 23 months	2.7	51712
Children	24 - 59 months	8.8	16854
Children	5 - 14 years	27	51712
Women (WIFA)15 - 49 years		23.1	44242
Men	15 - 49 years	20	38305
Men and Women	50 - 60 years	8	15322
Men and Women	60+ years	6.4	12258
Total		**100**	**191525**

Source: **Ghana Health Service-Municipal Health Directorate, 2012**

The proportion of the urban population in the Municipality is 88.4%.

Infrastructure

The New Juaben Municipality has a range of health facilities that offer different levels of health services to its inhabitants. The facilities range from government and mission hospitals, private clinics, polyclinic, health centres, reproductive and child health centres, and private maternity homes, among others.

Human resources within the health facilities comprises of Nurses, Midwives, Doctors and Pharmacists.

Below is a data on the network of the health facilities and human resources in the municipality:

26

Regional Hospital	-	1
Mission Hospital	-	1
Health Centres	-	2
Private Clinics	-	11
Private Maternity Homes	-	3
RCH Centres	-	10
Trained TBAs	-	80
CHPS	-	15
Chemical Shops	-	70

Human Resource Position

Nurses	-	387
Doctors (public sector)	-	38
Doctors (private sector)	-	6
Pharmacists (public sector)	-	5
Pharmacists (private sector)	-	8

Abortion Trend

The municipality has a high record of women seeking abortion services in the various reproductive and child health centres. These facilities also offer family planning counseling and services as part of the postabortion care. In the year 2012, a total number of 1,611women took up family planning following comprehensive abortion.

Table 1.2 identifies the trend of abortion and postabortion family planning counseling and uptake recorded in 2012.

Table 1.2 Trend of Abortion in Facilities in New Juaben Municipal (Jan – Dec 2012)

Facility	Total	Elective Abortion	No counseled	No accepting F/P
Jumapo	15	14	15	13
Oyoko	47	47	47	47
Asokore	12	12	12	11
Akwadum	175	171	175	148
Koforidua	79	52	79	73
Zongo	135	135	135	86
Magazine	246	140	246	244
Regional Hospital	1073	551	1046	989
Municipal Health	**1782**	**1122**	**1755**	**1611**

Source: Ghana Health Service-Municipal Health Directorate, 2012

CHAPTER TWO

2.0 LITERATURE REVIEW

INTRODUCTION

This chapter reviews literature from similar studies on predictors of post abortion family planning uptake.

2.1 SOCIO-DEMOGRAPHIC DATA OF CLIENTS SEEKING POSTABORTION CARE

Azmat et. al., (2012), reported a facility -basedstudy focusing on postabortion contraceptive uptake in Pakistan. A sample of 17,262 women was selected from nine health centres from July 2010 to June 2011. They included variables pertaining to socio-demographic profile of respondents and this included women age, education, husband's education, women occupation status, average family monthly income, and number of alive children; reason for postabortion care: type of treatment for complication arising from unsafe abortion and following an incomplete abortion medical (PAC-M) or surgical (PAC-S), counseling, and post procedure contraceptive services uptake by method, last contraceptive method used and whether women has ever been to the (index) centre before, and women's health condition after treatment of postabortion. Of the total women who received PAC services, three-fifths of the women were aged 25 to 34 years. One in four women had more than four childrenalive. Low education was found among study participants and their husbands.

About 84% of these women were housewives, and the average family monthly income of majority (46.3%)was =6000PKR (equivalent to 157 Ghana cedis).

A quantitative study was also conducted in 2009-2010 among 1,889 women aged 15-49 years in four communities- two slums (Korogocho and Viwandani) and two non-slums (Jericho and Harambee) in Nairobi, Kenya. Findings indicated that factors that

29

influenced current use of contraceptive methods were the woman's age, marital status, residence, education, and previous unintended pregnancy. Older women (≥20 years) [OR: 4.74 (95%CI: 2.83-7.94) were more likely to report contraceptive use compared with younger women (<20 years) 2.06 (95%CI:1.17-3.62). Married women were approximately 4 times as likely to use contraceptives compared with single women. Women living in non-slum communities [OR= 1.51 (95%CI: 1.16-1.95) and those with a previous unintended pregnancy [OR= 1.53 (95%CI: 1.23-1.91) were more likely to use a contraceptive method. Women with some form of education (primary or higher) were more likely to report use of a method with those in the highest level of education being 3 times as likely to use a method when compared with those with no formal education (OR= 3.01; 95%CI: 1.29-7.03) (Levandowski, 2011.)

This research study sought to identify the socio-demographic profile of clients seeking post abortion care in the Municipality, and it covered such areas as age, education, occupation, socio-economic status, marital status, religion, parity and contraceptive history.

2.2 KNOWLEDGE, ATTITUDE AND PRACTICE OF CLIENTS TOWARDS POSTABORTION CONTRACEPTION

A household random survey of 1,528 postabortion women aged between 15–49 years was undertaken at Amukpe community in Nigeria, to determine their knowledge, practice and perceptions of contraception. The sample size for the study was calculated based on the population of the community of 71,356 people arrived at from the figures of the 1991 population census with the females consisting 31,206 of this total figure. Eligible women of reproductive age group comprised 60% of the female population

30

giving an actual figure of 19,000. This information was fed into Epi-info version 3.2.2 computer statistical package giving a sample size of 1,422. But a convenient sample of 1,528 was collected using a detailed questionnaire.

The level of contraceptive awareness was high (92.3%) and 88% of the respondents became aware of contraception in the last 14 years. Friends/relatives (40.6%), followed by nurses (31.7%) and then doctors (17.3%) were the common sources of contraceptive awareness. The contraceptive prevalence rate (current use) was 29%, and 71% of respondents were not using any method of contraception.

The most widely known contraceptive methods were injectables, condoms, Progesterone Only Pill (POP) and Oral Combined Pill(OCP).For those that were presently using contraception, the pill (44.2%), condoms (26.0%) and injectables (14.7%) were the most widely used contraceptive methods. The fear of side effects (33.8%), lack of knowledge (16.6%) and lack of spousal consent (13.0%) were the leading reasons for present non-use of contraceptives.

The specific knowledge of emergency contraception was poor. The factors associated with low contraceptive usage were poor level of training and ineffective conveyance of relevant information to clients by health personnel, low literacy levels, extremes of reproductive age and extremes of parity. Others were fear of side effects, lack of knowledge, and lack of spousal consent (Omo- Aghoba et. al, 2009).

A study carried out in Zimbabwe on women with abortion diagnosis indicated a satisfactory response on knowledge on contraceptive methods among the surveyed women. According to the National Survey on Demography in Women and Child

Healthcare, 99.9% of the women in the 15 – 49 year age-group were aware of at least one contraceptive method (Schor et al, 2000).

Two Brazilian studies were conducted in the Southeast and in the Northeast of the country on postabortion clients and showed that 92.2% and 95.5%, respectively, of the women reported to know at least one modern contraceptive method. These data show that contraceptive methods awareness is universal in the study area (Schor et al, 2000, Correia et al, 2009).

Despite the high knowledge level on contraceptive methods among the studied women, slightly more than half of the pregnancies (52%) were reported as being unwanted, although only one-third of them were using a contraceptive method at the time of conception. When conception occurred, half of them were taking oral contraceptives, in which this might imply incorrect method use or method failure. (Correia et al, 2009).

Another Brazilian study found that a large number of women, who reported that they knew about several contraceptive methods, actually knew very little about them. All of the women were asked specific questions about each contraceptive method, and slightly more than half had erroneous concepts of the methods they claimed to know about (Correia et al, 2009).

In this research study, an assessment of clients' knowledge, attitude and practices on postabortion contraception as well as the attitude of the providers towards the clients was undertaken.

2.3 THE RANGE AND ACCESSIBILITY OF FAMILY PLANNING COUNSELING AND CONTRACEPTIVE SERVICES

To provide a service environment that protects the dignity of women seeking postabortion care, necessary measures are taken, such as provider training and values clarification exercises, to ensure that women are treated with respect and to prevent stigmatization and negligence. Equitable access to family planning services are ensured, regardless of the uterine evacuation method used. The contraceptives which can be used after surgical or medical uterine evacuation treatment are the same, and most can be initiated on the day of treatment of an incomplete abortion with a few exceptions. Some evidence suggests that postabortion clients are more or less likely to be offered family planning counseling and services depending on which method of uterine evacuation they receive (Nielsen et al., 2009). It is important that all providers and facilities treating women for incomplete abortion offer immediate and on-site family planning counseling and services as an integral part of postabortion care (Rasch et al., 2004), regardless of the uterine evacuation method.

Postabortion family planning uptake is high when quality services are offered before discharge (Ceylan et al, 2009).The structure and administration of services affect postabortion clients' choice of and access to family planning services. Service programs that are integrated under one administrative authority enhance access to family planning services postabortion, while vertical programs may result in fragmented service-delivery systems that are more difficult for clients to negotiate.

Studies in Cambodia and Tanzania found that PAC clients served in facilities with on-site family planning services were significantly more likely to accept a contraceptive method than clients served in facilities that refer for family planning services

(McDougall et al., 2009; Wanjiru et al., 2007). Family planning guidance indicates that helping a woman to initiate an effective method of contraception is an essential task in providing postabortion care, and it should not be deferred to a follow-up visit (Hatcher et al., 2009).Studies have shown that women are most likely to begin using an FP method if they can immediately obtain it at the time of their PAC treatment, instead of returning for another visit or being referred elsewhere to obtain it.

In Kenya, for example, Solo et al. (1999) found that FP provided on the ward was adopted by 92% of women, as opposed to 54% of women who had to travel to a separate site. Ideally, FP counseling and services should be provided on the emergency ward by the same providers. Even if this is not possible, steps should be taken to ensure that no woman who wants a contraceptive method goes home without one. One possibility is to combine postpartum and postabortion FP as a routine service provided to women prior to discharge.

When family planning counseling and services are offered after all types of post abortion treatment, acceptance is high. Numerous studies have shown that when attention is paid to programming that includes contraceptive technology updates to providers; reorganization of services to allow post abortion family planning counseling and provision of methods prior to discharge from the facility; and ensuring that contraceptives are available at the point of service delivery, post abortion contraception acceptance rates can increase rapidly, from 0–10% prior to program interventions to 50–80% within one to two years after implementation. Therefore, family planning methods need to be provided at the point of post abortion services before the patient leaves the facility (Curtis et al, 2010).

2.4 CULTURAL AND ORGANIZATIONAL BARRIERS TO FAMILY PLANNING USE/ ATTITUDE OF SERVICE PROVIDERS.

In Egypt, a study by Youssef et al(2007)found low family planning uptake among PAC clients, even in facilities that offered clients contraceptives on the hospital ward. Study authors discovered that providers on the maternity ward lacked motivation and incentives to provide family planning services; rapid staff turnover reduced effectiveness of the service delivery models; and women lacked the empowerment to make family planning decisions without involvement of their partners (Youssef et al., 2007). Providing training to sensitize facility management and staff on the importance of postabortion family planning can improve provider attitudes (Cobb et al., 2001).It is important that providers learn to recognize and respond to the psychological, emotional, and physical needs of the patient and maintain a nonjudgmental attitude.

The findings of the 2001 USAID global evaluation report, situational analyses in Latin America and the Caribbean and country action plans from Bolivia, Kenya and Senegal identified barriers for post abortion family planning at various levels.

At the national level, barriers to providing postabortion family planning included lack of sufficient financing for family planning in the national budgets, lack of adequate training, lack of supportive supervision and lack of availability of PAC services at health centers and other lower-level facilities.

At the facility level, barriers to post abortion family planning included lack of written guidelines for family planning in hospitals, insufficient staff for family planning counseling and service delivery, lack of IEC materials for client education and lack of access to contraceptive methods during the afternoon, night and weekend shifts.

Another barrier was related to contraceptive methods and this included lack of contraceptive methods at the service delivery point, even when contraceptives were

available in the facilities; lack of availability of a wide range of methods, thus limiting client choice; and lack of record-keeping systems that serve as reminders to use the oldest stocks first, thereby preventing the expiration of methods before they are used, and of systems that note whether women receiving PAC services receive family planning counseling and methods before they are discharged from the facility.

At the provider level, barriers included a lack of knowledge about the early return to fertility; denial of certain or all methods to some groups, such as adolescents or women who have not yet delivered a child; a lack of patient counseling on PAC procedure, on timing of return to fertility, and on choosing and obtaining a family planning method before discharge from the facility.

At the client level, obstacles to use of postabortion family planning services included fear of side effects; a belief that the risk of becoming pregnant is low, due to age, infrequent sexual intercourse or other reasons; lack of awareness or knowledge of family planning methods; and partner disapproval of contraceptive use.

RECOMMENDATIONS TO SCALE UP AND INSTITUTIONALIZE POSTABORTION CARE AND FAMILY PLANNING UPTAKE

Postabortion family planning has been implemented in countries using two main methodologies. In countries where abortion is legal, programs offer post abortion family planning only. When women make an appointment for their abortion, they also receive family planning counseling. After their abortion has been completed, women are provided with family planning services before discharge from the facility.

In countries where abortion is illegal, emergency treatment and post abortion family planning counseling and services are provided as a single service. Both examples have resulted in increased family planning uptake and reduced repeat abortion. When deliberate efforts are made to strengthen the family planning component of post abortion

care, improvements in family planning uptake can be realized within 12 months of implementation (Curtis et al, 2010).

Policies and funding decisions need to emphasize post abortion family planning needs. Providing sufficient resources for post abortion family planning from national budgets and international donors is essential. These resources include not only the training for post abortion care services, but family planning commodities and other equipment needed to provide the package of post abortion care services, which must be included in national, regional, district and facility budgets. Training for in-service and preservice providers should reflect the new priorities. Accordingly, job descriptions will need to change so that the scope of work is inclusive of post abortion family planning counseling and service delivery (Curtis et al, 2010).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 STUDY METHOD AND DESIGN

A cross-sectional approach, using quantitative method of data collection was used to study 634 women. Facilities and participants were selected based on a multistage sampling technique. Using simple random sampling technique, five of the seven health facilities that offer comprehensive abortion care and family planning were selected. The study area was the New Juaben Municipality of Ghana, and the study duration was from July 2013 to December 2013.

3.2 DATA COLLECTION TECHNIQUES AND TOOLS

Questionnaires were used as data collection tools, comprising of closed and open ended questions. They were administered to the selected sample of the population, following explanation of procedure and obtaining informed consent. Data were collected on socio-demographic characteristics, knowledge on contraception, range and accessibility of contraceptive services, barriers to postabortion contraception, and postabortion contraception acceptance rate.

Pre-testing of the questionnaire was undertaken at theAsokore health centre.This health facility offers postabortion care services and has similar characteristics with the study health centres.

Three research assistants, who are practicing midwives, were trained to assist in data collection. They had knowledge in reproductive health issues and could communicate effectively in the local language (Twi). Data were presented in tabulae and graphics based on simple proportions for socio-demographic and health service indicators.

3.3 STUDY POPULATION

The study population was postabortion women in their reproductive age (15- 49 years) in the selected health facilities.

3.4 STUDY VARIABLES

Table 3.1 Description of study variables

Variable	Operational definition	Indicator	Scale of measurement	Objective addressed
Age	Age at last birthday	Age in completed years	Continuous	1
Education	Highest educational level attained	Primary Secondary Vocational Tertiary Others	Nominal	**1**
Occupation	Economic activity of respondent	Artisan Civil servant Trader Unemployed Others	Nominal	**1**
Income	Average monthly income in Gh cedis	Less than 100 100 to 150 151 to 200 201 to 250 More than 250	Nominal	**1**
Marital status	Current marital status	Single, Married, Divorced, Widowed, Cohabitat	Nominal	**1**
Religion	Religious group	Christian Hindu Moslem Traditionalist	Nominal	**1**

Residence	Area where respondent resides	Urban Peri-urban Rural	Nominal	**1**
Parity	Number of children alive	As reported by respondent	Continuous	**1**
Contraceptive history	Past and current contraceptive history	As reported by respondent	Nominal	**1**
Knowledge on PAFP	Types of contraceptive methods known	List of modern methods of contraception	Nominal	**2**
Source of knowledge	Who gave the information	Midwife/ Nurse Friend Family member Media	Nominal	**2**
Misconceptions	List of side effects of contraceptives	As reported by respondent	Nominal	2
Range of PAFP services	List of PAFP methods	As reported by respondent	Nominal	3
Accessibility of PAFP services	Location of PAFP service	On the same ward, In a separate department. In a different facility	Nominal	**3**
Service environment	Protective service environment	As reported by respondent	Nominal	**3**
Barriers to PAFP	Attitude of providers, Cost, Time, Distance	As reported by respondent	Nominal	**4**
Acceptance of PAFP	Uptake of family planning following abortion	As reported by respondent	Nominal	**5**

3.5 SAMPLING

The sample size for the study was calculated with the formula below:

$$n = \frac{z^2 pq}{d^2}$$

Where n = required sample size

z = reliable coefficient; 95% which is 1.96 from the distribution of Z table

p = proportion of women in the reproductive age who partake CAC in the study area (0.25)

q = 1- p = (1-0.25)

d = degree of error allowed (0.05)

$$n = \frac{(1.96)^2 (0.25) (0.75)}{(0.05)2}$$

$$n = \frac{(3.8416) (0.1875)}{0.0025}$$

$$n = \frac{0.7203}{0.0025}$$

n = 288.12

Provision was made for non- respondents, which were calculated by adding 10% of the total sample size:

$$\frac{10 \times 288}{100} = 28.8$$

n = 317

Sampling Technique:

The calculated sample size of 317 was multiplied by two (2) to account for the design effect in multi-stage sampling to get a total of 634 participantswho were selected from five (5) of the seven (7) health facilities that offer postabortion family planning services in the Municipality.

Using simple random sampling, the health facilities were selected by means of lottery to pick out five facilities randomly; namely Zongo health centre, Akwadum health centre,

41

Magazine health centre, Regional hospital and Koforidua Polyclinic. Selection of participants from the five health facilities were based on the average attendance per month in each of the facilities.A ratio was then worked using the facility that had the least attendance rate. Once the ratio was calculated, selection of participants was done.The lowest monthly attendance ratewas used as the denominator to calculate ratios for the other health facilities. That ratio was used because all the selected health facilities had different attendance rates per month. This was also to avoid bias and to give all the attendants equal opportunity of being selected.

Sampling interval at each facility was calculated based on the duration of study and the average monthly attendance rates of each facility. For the five facilities, the average monthly attendance rates were ten (10) for Koforidua Polyclinic, fifteen (15) for the Zongo health centre, twenty(20) for the Akwadum health centre, thirty (30) for the Magazine health centre, and ninety (90) for the Regional hospital.

Data were collected simultaneously at the sites for the duration of the study. Selection of these clients was also done using systematic random sampling technique; this was to ensure that each client had an equal opportunity to be a part of the study.

3.6 PRE-TESTING

The questionnaire was piloted in the Asokore health center. Although this facility was not used for the research study the pre-testing helped to determine ease of understanding, appropriateness and other characteristics of a questionnaire that influence its success.

3.7 DATA HANDLING

Data collected from respondents were handled with confidentiality. Privacy was ensured during the period of interview and filling of questionnaire. Assistance was given to

respondents who were illiteratesby interpreting the questions to them, and recording their responses. There was periodic compilation of completed data.

3.8 DATA ANALYSIS

Data collected were summarized and illustrated using frequency distribution tables for sample data grouping. The electronic software, Statistical Product for Social Solutions (SPSS) version 16was used to create the database and analyze statistics.

3.9 ETHICAL CONSIDERATION

Ethical consent was sought from the Committee for Human Research and Publication Ethics (CHRPE), Kwame Nkrumah University of Science and Technology/ Komfo Anokye Teaching Hospital before the study was conducted. An introduction letter from the Department of Community Health, KNUST was takento the New Juaben Municipal Health Directorate, to ask for permission to conduct the research at the selected health facilities. Administrative Clearance was also obtained from all the five (5) health facilities in which the study was conducted.

3.10 LIMITATIONS OF STUDY

The study did not seek information from service providers on postabortion family planning uptake. It was limited to postabortion women in their reproductive age.

3.11 ASSUMPTIONS

- It was assumed that only women in their reproductive age would access postabortion care services.

- Results generated from the study areas can represent the entire Municipality.

KNUST

CHAPTER FOUR

RESULTS

4.0   INTRODUCTION

This chapter presents the results of data gathered from respondents from five of the seven health facilities that offer postabortion family planning services in the New Juaben Municipality. Out of the total number of six hundred and thirty four (634) respondents used for the study, four hundred and ninety one (77.4%) accepted a contraceptive method, while one hundred and forty three (22.6%) did not accept a contraceptive method. However, three hundred and fifty six (56.2%) of the respondents had used contraceptives before, whiletwo hundred and seventy eight (43.84%) had never used a contraceptive before.

4.1 Socio-demographic data of respondents

Among the respondents who took part in the study, 202 (31.9%) wereagedbetween 20-24years, but no respondent was older than 45 years.It was noted that majority (96.5%)of clients interviewed have had some form of formal education and can be deduced that, the level of education among clients who seek PAC services in the New Juaben Municipality is generally high. With regards to their occupation 423(66.8%) were employed .Students formed 18.6% of the sample. More so, concerning their marital status, 63.1% of respondents interviewed were single whereas 30% were married. Five hundred and thirty four (84.2%) of respondents interviewed were Christians while 87(13.7%) were Moslems and 13(2.1%) were not affiliated to any religion. Majority (58.8%) of respondents were urban residents. When respondents were asked about the number of children alive, 292(46.1%) of respondents interviewed did not have children while17(2.7%) had five(5+) or more children alive.

Table 4.1 Socio-demographic characteristics of the respondents (n=634)

Variable	Frequency	Percentage
Age		
15 - 19	77	12.1
20 - 24	202	13.9
25 - 29	182	28.7
30 - 34	98	15.5
35 - 39	71	11.2
40 - 44	4	0.6
Educational Level		
No Formal Education	22	3.5
Basic/primary	149	23.5
Secondary	327	51.6
Commercial/Vocational	38	6
Tertiary	98	15.5
Occupation		
Unemployed	93	14.7
Artisan	95	15
Civil Servant	126	19.9
Trader	202	31.9
Others(students)	118	18.6
Average Monthly Salary		
Less than 100Gh	312	49.2
100Gh - 150Gh	121	19.1
151GH - 200Gh	85	13.4
201Gh - 250Gh	12	1.9
More than 250Gh	104	16.4
Marital Status		
Single	400	63.1
Married	190	30
Divorced	13	2.1
Widowed	8	1.3
Cohabitat	23	3.6
Religion		
Christian	534	84.2
Moslem	87	13.7
Others (no religion)	13	2.1
Residence		
Urban	373	58.8
Peri-urban	186	29.3
Rural	75	11.8
Parity		
None	292	46.1
One	118	18.1
Two	101	15.9

Three	54	8.5
Four	52	8.2
Five or more	17	2.7

Source: Field Survey, 2013

Socio-demographic differences between FP acceptors and non- acceptors

As part of PAC services 77.4% of the respondents accepted a family planning methodwhile22.6% did not accept any method. When acceptors were compared with non-acceptors in issues of socio-demographic variables, they differed by age, education level, occupation, income, residence and parity ($p \leq 0.05$).

Table 4.2 Socio- demographic characteristics of study samples by their current contraceptive practice

Predictive Variable	Acceptors 491 (77.4)	Non- acceptors 143 (22.8)	P- value
Age			0.023
15 -19	65 (13.2)	12 (8.4)	
20 - 24	142 (28.9)	60 (41.9)	
25 -29	152 (31.0)	30 (21.0)	
30 - 34	74 (15.1)	24 (16.8)	
35 - 39	54 (11.0)	17 (11.9)	
40+	4 (0.8)	0 (0.0)	
Education			<0.001
No Formal Education	18 (3.7)	4 (2.80)	
Basic/Primary	94 (19.1)	55 (38.5)	
Secondary	259 (52.7)	68 (47.6)	
Commercial/Vocational	32 (6.5)	32 (6.5)	
Tertiary	88 (17.9)	10 (7.0)	
Occupation			0.027
Unemployed	73 (14.9)	20 (14.0)	
Artisan	73 (14.9)	22 (15.4)	
Civil Servant	103 (21.0)	23 (16.1)	
Trader	142 (28.9)	60 (42.0)	
Student	100 (20.4)	18 (12.6)	
Income (GH cedis)			0.001
Less than 100	252 (51.3)	60 (42.0)	
101 - 150	77 (15.7)	44 (30.8)	
151 - 200	69 (14.1)	16 911.2)	
201 - 250	12 (2.4)	0 (0.0)	
More than 250	81 (16.5)	23 (16.1)	
Marital Status			0.415
Single	313 (63.7)	87 (60.8)	
Married	145 (29.5)	45 (31.5)	
Divorced	9 (1.8)	4 (2.8)	
Widowed	8 (1.6)	0 (0.0)	
Cohabitat	16 (3.3)	7 (4.9)	
Religion			0.056
Christian	416 (84.7)	118 (82.5)	
Moslem	62 (12.6)	25 (17.5)	
None	13 (2.6)	0 (0.0)	
Residence			0.010
Urban	290 (59.1)	83 (58.0)	
Peri- urban	134 (27.3)	52 (36.4)	
Rural	67 (13.6)	8 (5.6)	
Parity			0.001
No child	214 (43.6)	78 (54.5)	

One	103 (21.0)	15 (10.5)
Two	85 (17.3)	16 (11.2)
Three	33 (6.7)	21 (14.7)
Four	43 (8.8)	9 (6.3)
Five or more	13 (2.6)	4 (2.8)

Source: Field Survey, 2013

Data are presented as n (%) frequencies and percentages, and they are compared using chi-square/ fisher's exact test where necessary.

Correlates of socio-demographic characteristics (multivariate logistic regression)

The multivariate logistic regression analysis stipulates the effects of the socio-demographic characteristics on family planning uptake. The logistic regression was used for variables of acceptors and non-acceptors. The adjusted odds ratios (AOR) were derived after adjusting for other covariates in the model.

The 95% confidence interval (CI) was used to estimate the precision of the AOR. A large CI indicates a low level of precision of the OR, whereas a small CI indicates a higher precision of the OR.

The socio- demographic characteristics associated with PAFP acceptance within the respondents are recorded in Table 4.3. Compared with age group 15 – 19 years, those aged 20 -24 years were more significantly likely to take up family planning (AOR = 2.29, 95% CI: 1.153 – 4.54, p value =< 0.05). Educational status also played a significant role in family planning uptake; respondents with tertiary education were five times more likely to take up family planning (OR = 5.15, 95% CI: 2.47 – 10.72, p value =< 0.001).

The study revealed that respondents who have no religious affiliation are significantly less likely to take up family planning (OR = 0.13, 95% CI: 0.01 – 2.21, p value = <

0.001). Respondents with a higher level of education were more significantly likely to take up family planning; tertiary education (OR = 5.15, 95% CI: 2.47 – 10.72).

Parity is an important factor to consider in deciding the family planning uptake by respondents. Those who have two children were more likely to take up family planning after comprehensive abortion (OR = 1.94, 95% CI: 1.07 – 3.51, p value = < 0.01).Respondents' whose incomes are between GH100 and GH150 are more likely to take up family planning method (AOR = 2.40, 95% CI: 1.51 – 3.82, p value = < 0.001).

It was observed that respondents who reside in the rural areas were more significantly likely to use family planning method (OR = 2.40, 95% CI: 1.10 – 5.19, p value = < 0.05).
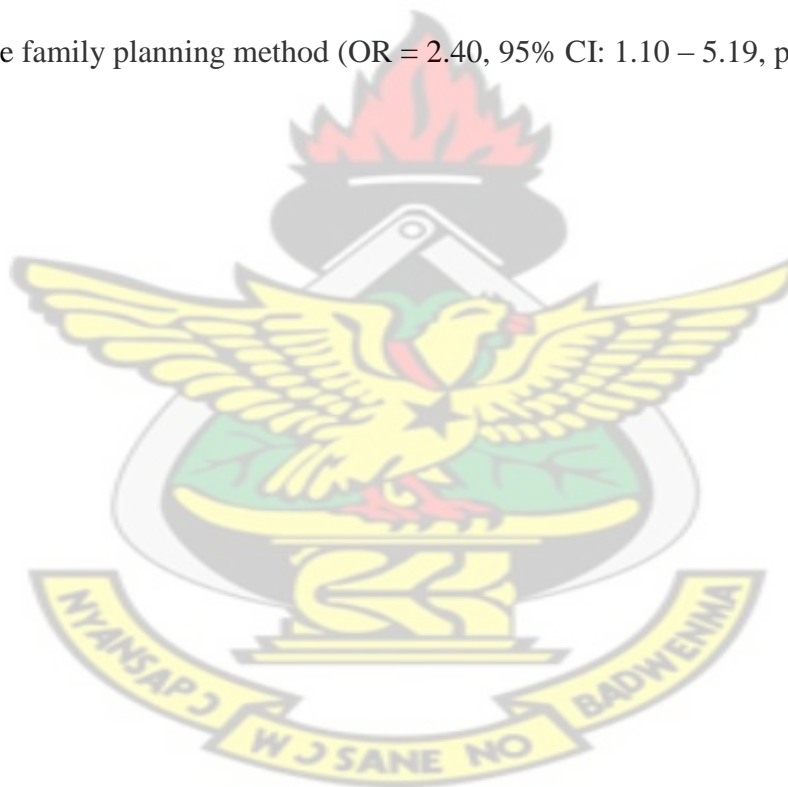
Table 4.3 **Unadjusted and adjusted effects of socio-demographic characteristics on family planning uptake**

Predictive Variable	Model 1		Model 2	
	OR	**95% CI**	**AOR**	**95% CI**
Age				
15 – 19[ref.]	1.00		1.00	
20 – 24 years	0.44	0.22–0.87*	2.29	1.15 – 4.54*
25 – 29 years	0.93	0.45 – 1.94	1.07	0.51 – 2.22
30 – 34 years	0.57	0.26 – 1.23	1.76	0.81 – 3.79
35 – 39 years	0.59	0.26 – 1.33	1.70	0.75 – 3.88
40 – 44 years	0.34	0.02 – 6.50	3.09	2.14 – 4.03
Marital Status				
Single [ref.]	1.00		1.00	
Married	0.89	0.59 – 1.35	1.12	0.74 – 1.68
Divorced	0.62	0.19 – 2.08	1.60	0.481 – 5.32
Widowed	2.04	0.39 – 5.02	0.35	0.16 – 0.78
Cohabitat	0.63	0.25–1.59	1.57	0.63 – 3.95
Religion				
Christian [ref.]	1.00		1.00	
Moslem	0.70	0.42 – 1.17	1.42	0.86 – 2.36
None	0.13	0.01 – 2.20***	1.23	1.04 – 1.42
Occupation				
Artisan [ref.]	1.00		1.00	
Civil Servant	1.35	0.70 – 2.60	0.74	0.38 – 1.43
Trader	0.71	0.41 – 1.25	1.40	0.80 – 2.46
Unemployed	1.10	0.55 – 2.19	0.91	0.46 – 1.81
Other(Student)	1.67	0.84 – 3.34	0.60	0.30 – 1.19
Parity				
None[ref.]	1.00		1.00	
One	2.50	1.37 – 4.56**	0.40	0.22 – 0.73
Two	1.94	1.07 – 3.51**	0.52	0.28 – 0.93**
Three	0.57	0.31 – 1.05	1.75	0.95 – 3.20
Four	1.74	0.81 – 3.74	0.57	0.27 – 1.23
Five or more	1.18	0.37 – 3.74	0.84	0.27 – 2.67
Level of Education				
Primary/Basic[ref.]	1.00		1.00	
Secondary	2.23	1.45 – 3.41***	0.45	0.29 – 0.69***
Commercial/Vocational	3.12	1.22 – 7.93*	0.32	0.13 – 0.81*
Tertiary	5.15	2.47–10.72***	0.19	0.09 – 0.40***
No formal Education	2.63	0.85 – 8.18	0.38	0.12 – 1.18
Average monthly income				
Less than GH100[ref.]	1.00		1.00	
GH100 - GH150	0.42	0.26 – 0.66***	2.40	1.51 – 3.82***
GH151 - GH200	1.03	0.56 – 1.89	0.97	0.53– 1.80
GH201 - GH250	1.97	0.41 – 4.84	1.10	0.88 – 1.32***
More than GH250	0.89	0.49– 1.44	1.19	0.69 – 2.05
Residence				
Urban[ref.]	1.00		1.00	

Peri-urban	0.74	0.49 – 1.10	1.36	0.91 – 2.03
Rural	2.40	1.10 – 5.19*	0.42	0.19 – 0.90*

*indicates significant at p<0.05, ** significant at *p* <0.01, *** significant at *p* <0.001

Source: Field Survey, 2013

4.2 KNOWLEGDE ON POSTABORTION CONTRACEPTION

Table 4.5 illustrates the knowledge of respondents' on postabortion family planning. When data were collected on the types of contraceptive methods known to respondents' it was established that 373(58.8%) of respondents know about the pill, 78(12.3%) the IUD, 76(12.0%)the condom, 8(1.3%) the spermicides, 67(10.6%) the injectables, 5(0.8%) the implants, 5(0.8%) know about periodic abstinence, and 22(3.5%) know about sterilization.

Concerning sources of respondents' information with respect to the knowledge on contraceptive methods, it was clear that 265(41.8%) of respondents had their information from health providers while 208(32.8%) of respondents interviewed had their source of information from friends. When respondents were asked whether or not they have used contraceptive methods before, 356(56.2%) of respondents had used contraceptives.

Table 4.5 also illustrates respondents' knowledge on when PAFP should be used; responses gathered shows clearly that 278(43.8%) of respondents said PAFP should be used immediately after abortion while 165(26.0%) respondents said they do not have idea on when to use PAFP. When respondents were asked on the time fertility returns following abortion, 286(45.1%) said they have no idea when fertility returns following abortion and 106(16.7%) of respondents said that fertility return within 2 weeks after abortion.

Respondents were also asked about side effects related to the use of contraceptives. It was found that, 49(7.7%), 34(5.4%),85(13.4%) and 97(15.3%) of respondents interviewed said weight gain, palpitation/dizziness, infertility and irregular menstruation were side effects/misconception of contraception respectively.

Table 4.4Knowledge on postabortion contraception

Variable	Frequency	Percentage
Types of contraceptive methods known		
Pill	373	58.8
IUD	78	12.3
Condom	76	12
Spermicide	8	1.3
Injectable	67	10.6
Implant	5	0.8
Periodic abstinence	5	0.8
Sterilization	22	3.5
Source of information		
Health provider	265	41.8
Friends	208	32.8
Family member	62	9.8
Others (media)	99	15.6
Past use of contraceptives		
Yes	356	56.2
No	278	43.8
Knowledge on best time to take PAFP		
Two weeks after abortion	52	8.2
After one month	69	10.9
Before intercourse	18	2.8
Following menses	52	8.2
Immediately after abortion	278	43.8
No idea	165	26
Time fertility returns		
After one month	75	11.8
After one year	77	12.1
After menses	30	4.7
Few days after abortion	60	9.5
Within two weeks	106	16.7
No idea	286	45.1
Misconceptions/ side effect		
Fibroid	50	7.9
Heart problem	63	9.9
Hypertension	31	4.9

Implant travel to the heart	5	0.8
Infertility	85	13.4
Irregular menses	97	15.3
Palpitation/Dizziness	34	5.8
Profuse bleeding	37	6.3
Weight gain	49	7.7
Weight loss	49	7.7
None	134	21.1

Source: Field Survey, 2013

Differences in knowledge on contraception among acceptors and non-acceptors

Knowledge on contraception, with regards to the methods, source of information and side effects, differed significantly among acceptors and non-acceptors (p $\leq$0.05).

Table 4.5Differences in knowledge of respondents on contraception

Predictive variable	Acceptors 491 (77.4)	Non-acceptors 143 (22.6)	P- value
Knowledge on Contraceptive methods			**<0.001**
Pill	276 (56.2)	97 (67.8)	
IUD	61 (12.4)	17 (11.9)	
Condom	60 (12.2)	16 (11.2)	
Spermicide	8 (1.6)	0 (0.0)	
Injectable	67 (13.6)	0 (0.0)	
Implant	0 (0.0)	5 (3.5)	
Periodic Abstinence	5 (1.0)	0 (0.0)	
Sterilization	14 (2.9)	8 (5.6)	
Source of Knowledge			**0.007**
Health Provider	200 (40.7)	65 (45.5)	
Friend	153 (31.20	55 (38.5)	
Family member	58 (11.8)	4 (2.8)	
Others (media)	80 (16.3)	19 (13.3)	
Past use of Contraceptives			**0.744**
Yes	274 (55.8)	82 (57.3)	
No	217 (44.2)	61 (42.7)	
Misconceptions/side effect			**<0.001**
Fibroid	30 (6.1)	20 (14.0)	
Health Problem	44 (9.0)	19 (13.3)	
Hypertension	24 (4.9)	7 (4.9)	

Implant travel to heart	5 (1.0)	0 (0.0)
Infertility	62 (12.6)	23 (16.1)
Irregular menses	88 (17.9)	9 (6.3)
Palpitation/Dizziness	30 (6.1)	4 (2.8)
Profuse bleeding	31 (6.3)	6 (4.2)
Weight gain	49 (10.0)	0 (0.0)
Weight loss	34 (6.9)	15 (10.5)
None	94 (19.1)	40 (28.0)

Source: Field Survey, 2013

Correlates of knowledge on family planning (multivariate logistic regression)

Table 4.6 illustrates the effect of knowledge on PAFP uptake; the more people are knowledgeable about contraception, the higher their level of uptake. Getting information from family members can also serve as a motivator in accepting a family planning method. People who got contraceptive information from family members were 4.71 times more likely to take up PAFP (OR: 4.71 (95% CI: 1.65 – 13.48).

The type of misconception associated with family planning has an effect on its uptake. In model 1 respondents' who mentioned irregular menses, palpitation/dizziness and weight gainas side effect, were more significantly likely to take up postabortion family planning (p $\leq$ 0.05)

Table 4.6 **Unadjusted and adjusted effects of knowledge on family planning uptake**

Predictive variable	Model 1		Model 2	
	OR	95% CI	AOR	95% CI
F/P Methods				
Pills (ref.)	1		1	
IUD	1.26	0.70 - 2.26	0.79	0.44 - 1.42
Condom	1.32	0.73 - 2.40	0.76	0.42 - 1.38
Spermicide	1.59	1.39 - 1.80***	1.70	1.51 - 1.90***
Injectable	1.69	1.47 - 1.90***	1.78	1.58 - 1.98***
Implant	2.93	2.58 - 3.29***	2.79	2.49 - 3.09***
Periodic Abstinence	3.11	2.73 - 3.50***	3.05	2.72 - 3.39***
Sterilization	0.62	0.25 - 1.51	1.63	0.66 - 3.40
Source of Knowledge				
Health Provider (ref.)	1		1	
Friends	0.9	0.60 - 1.37	1.11	0.73 - 1.68
Family Members	4.71	1.65 - 13.48**	0.21	0.07 - 0.61**
Media	1.37	0.77 - 2.43	0.73	0.41 - 1.30
Misconceptions				
None (ref.)	1		1	
Fibroid	0.36	0.20 - 0.52***	0.43	0.28 - 0.57***
Heart Problems	0.9	0.73 - 1.07***	0.98	0.82 - 1.14***
Hypertension	1.59	1.34 - 1.80***	1.7	1.51 - 1.90***
Implant Travel	1.69	1.47 - 1.90***	1.78	1.58 - 1.98***
Infertility	1.15	0.63 - 2.10	0.87	0.48 - 1.60
Irregular Menses	4.16	1.91 - 9.07***	0.24	0.11 - 0.52***
Palpitation/Dizziness	3.19	1.06 - 9.66*	0.31	0.10 - 0.95*
Profuse Bleeding	2.2	0.85 - 5.68	0.46	0.18 - 1.78
Weight Gain	3.11	2.73 - 3.50***	3.05	2.72 - 3.39***
Weight Loss	0.97	0.47 - 1.96	1.04	0.51 - 2.11

*indicates significant at p<0.05, ** significant at p <0.01, *** significant at p <0.001

Source: Field Survey, 2013

4.3   RANGE AND ACCESSIBILITY OF FAMILY PLANNING COUNSELLING AND SERVICES

Table 4.7demonstrates the location of PAC services; whether the facility had on-site family planning services (at the same department), separate department or different facility. It emanated that majority of the respondents interviewed 473(74.6%) said the PAC services were located at the same department. With regards to responses gathered from respondents on whether or not they feel protected and safe at PAC service delivery points, majority 565(89.1%) of respondents said that they feel safe at PAC service delivery points while 69(10.9%) did not make any comment. Respondents were able to locate the PAC service facilities through friends 379(59.8%), family members 159(25.1%) and own means 96(15.1%). According to the respondents, available contraceptive methods included Pills (69.7%), IUD (7.9%), Injectables (11.7%), Implants (4.9%), Condom (1.9%), and Female Sterilization (3.9%).
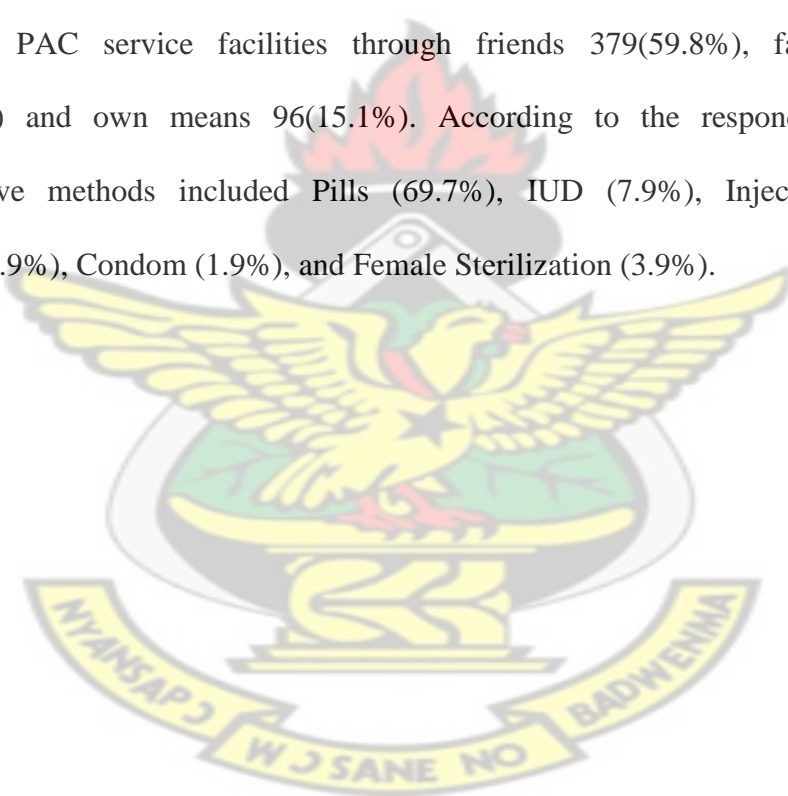
Table 4.7 Range and accessibility of PAC services

Variable	Frequency	Percentage
Location of PAC Service		
Same department	473	74.6
Separate department	145	22.9
Different facility	16	2.5
Source of Information		
Friend	379	59.4
Family member	159	25.1
Others	96	15.1
Protective Service Environment		
Yes	565	89.1
No comment	69	10.9
Range of contraceptive methods		
Pill	442	69.7
IUD	50	7.9
Injectable	74	11.7
Implant	31	4.9
Condom	12	1.9
Sterilization (female)	25	3.9

Source: Field Survey, 2013

Differences in response on range and accessibility of PAC services

Majority of respondents (76.2%) who accepted FP method were provided the service at the same department where PAC service is offered. Although FP services were available at the same department where comprehensive abortion was done, 99 (69.2%) of respondents did not accept a FP method. About 90% of the respondents who accepted FP started the method before leaving the health facility; thus before the resumption of their menses.

Table 4.8:Differences in response on range and accessibility of PAC services

Predictive variable	Acceptors 491 (77.4)	Non-acceptors 143 (22.6)	P-value
Location of PAC service			**0.003**
Same department	374 (76.2)	99 (69.2)	
Separate department	101 (20.6)	44 (30.8)	
Different facility	16 (3.3)	0 (0.0)	
Range of contraceptive methods			**<0.001**
Pill	340 (69.2)	102 (71.3)	
IUD	27 (5.5)	23 (16.1)	
Injectable	60 (12.2)	14 (9.8)	
Implant	31 (6.3)	0 (0.0)	
Condom	8 (1.6)	4 (2.8)	
Sterilization (female)	25 (5.1)	0 (0.0)	
Service Environment			**0.894**
Protective	438 (89.2)	127 (88.8)	
No comment	53 (10.8)	16 (11.2)	

Source: Field Survey, 2013

Correlates of range and accessibility of PAC services (multivariate logistic regression)

The location and range of PAC services have an association with postabortion family planning uptake. Where the PAC service is located at the same department, and the service environment is protective with a wide range of contraceptive methods, the higher will be the uptake of a contraceptive method. Offering PAC services at a separate department can affect the uptake (OR: 0.61(95% CI: 0.40 – 0.92).

Table 4.9 Unadjusted and adjusted effects of PAC services on family planning uptake

Predictive Variable	Model 1		Model 2	
	OR	95% CI	AOR	95% CI
Location of PAC Service				
Same Department (ref.)	1		1	
Separate Department	0.61	0.40 - 0.92*	1.65	1.08 - 2.50*
Different Facility	3.65	3.16 - 4.15***	3.86	3.37 - 4.36***
Range of F/P Methods				
Pills (ref.)	1		1	
IUD	0.35	0.19 - 0.64**	2.84	1.56 - 5.17**
Injectable	1.29	0.69 - 2.40	0.78	0.42 - 1.45
Implant	2.12	1.87 - 2.37***	2.28	2.04 - 2.52***
Condom	0.6	0.18 - 2.03	1.67	0.49 - 5.65
Sterilization(female)	3.19	2.79 - 3.59***	3.4	3.01 - 3.80***
Service Environment				
No comment (ref.)	1		1	
Protective	1.04	0.58 - 1.88	2.83	1.78–6.58

*indicates significant at p<0.05, ** significant at *p* <0.01, * significant at *p* <0.001**

Source: Field Survey, 2013

4.4   BARRIERS TO POSTABORTION CONTRACEPTION

Table 4.10 demonstrates respondents' response on barriers to PAC services. It was found out that 444(70%), 115(18.1%) and 75(11.8%) of respondents interviewed said cost of PAC was affordable, cheap and expensive respectively.Data were also collected on the waiting period of respondents before PAC service is offered. The data showedthat 487(76.8%), 113(17.8%), and 34(5.4%) of respondents interviewed spend few minutes, 1 to 2 hours and more than2hours respectively as waiting time at service delivery site.

When data were gathered from respondents on the opening time of facilities offering PAC, it was noted that 265(41.8%), 145(22.9%) and 224(35.3%) of respondents

interviewed said facility opens in the morning, not sure of opening time and have no idea of opening time respectively.

Table 4.8 also depicts responses gathered from respondents on the closing time of facilities offering PAC. It showed that, 215(33.9%) of respondents know that their facility closes in the evening while 263(41.5%) of respondents interviewed have no idea. Majority 467(73.7%) of respondents commented that opening and closing of facility was normal, while88(13.9%) of respondents interviewed commented that facility should run on 24 hours and 22(3.5%) said facilities should run on weekends.

Information was gathered on religious support of utilization of PAC services by respondents. 314(49.5%) of respondents interviewed commented that their religion does not support utilization of PAC services while 320(50.5%) said their religion does support the utilization of PAC services. When data were gathered on distance from residence of respondents to health facilities offering PAC, majority 355(56.0%) of respondents commented that distance from their residence to health facility is far, while279(44%) of respondents said they live near to facilities providing PAC service.
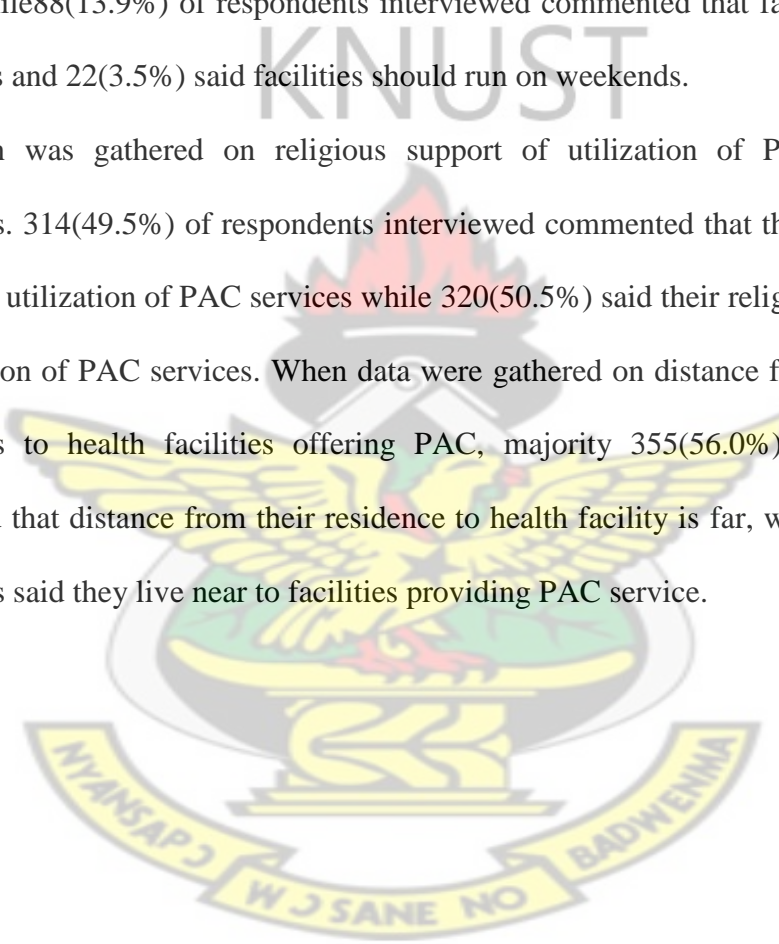
Table 4.10 Barriers to postabortion contraception

Variable	Frequency	Percentage
PAC service cost		
Cheap	115	18.1
Affordable	444	70
Expensive	75	11.8
Waiting period		
Few minutes	487	76.8
One to two hours	113	17.8
More than two hours	34	5.4
Time facility opens		
In the morning	265	41.8
Not sure	145	22.9
No idea	224	35.5
Time facility closes		
In the evening	215	33.9
Not sure	156	24.6
No idea	263	41.5
Religious support		
Yes	320	50.5
No	314	49.5
Distance from home		
Near	279	44
Far	355	56

Source: Field Survey, 2013

Differences in response on barriers to PAC services

The cost of postabortion contraceptive services was found be generally affordable for both acceptors (69.7%) and non-acceptors (71.3%) of family planning. 81.9% of respondents who took up family planning said they waited for only some few minutes to receive the service. 32.2% of respondents who did not take up family planning said they had to wait for about two hours before they were attended to. Although 62 (43.4%) of the respondents have religious support, they did not accept a family planning method. About 64% of the respondents who did not take up family planning lives very far from the health facility.

Table 4.11 Differences in response on barriers to PAC services

Predictive variable	Acceptors 491 (77.4)	Non-acceptors 143 (22.6)	P-value
Cost of PAC services			**<0.001**
Cheap	77 (15.7)	38 (26.6)	
Affordable	342 (69.7)	102 (71.3)	
Expensive	72 (14.7)	3 92.1)	
Waiting period			**<0.001**
Few minutes	402 (81.9)	85 (59.4)	
One to two hours	67 (13.6)	46 (32.2)	
More than two hours	22 (4.5)	12 (98.4)	
Religious support			**0.053**
Yes	258 (52.5)	62 (43.4)	
No	233 (47.5)	81 (56.6)	
Distance from home			**0.036**
Near	227 (46.2)	52 (36.4)	
Far	264 (53.8)	91 (63.6)	

Source: Field Survey, 2013

Correlates of barriers of PAC services (multivariate logistic regression)

The cost of PAC services continues to show an association with the uptake of PAFP. The cheaper the cost of PAC service, the higher the likelihood of patronage (AOR: 11.84, 95% CI: 3.50 – 40.06). In model 2, respondents who spent less than two hours in the health facility were 3.25 times more likely to take up PAFP (AOR: 3.25, 95% CI: 2.09 – 5.05).

Table 4.12 Unadjusted and adjusted effects of barrierson family planning uptake

Predictive Variable	Model 1		Model 2	
	OR	95% CI	AOR	95% CI
Cost of PAC Service				
Expensive(ref.)	1		1	
Affordable	0.14	0.04 - 0.45**	7.16	2.21 - 23.20**
Cheap	0.08	0.03 - 0.29***	11.84	3.50 - 40.06***
Waiting Period				
Few Minutes (ref.)	1		1	
One to Two Hours	0.31	0.20 - 0.48***	3.25	2.09 - 5.05***
More than Two Hours	0.39	0.19 - 0.81*	2.58	1.23 - 5.41**
Religious Support				
No (ref.)	1		1	
Yes	1.45	0.99 - 2.11	0.69	0.48 - 1.01
Distance to Health Facility				
Near (ref.)	1		1	
Far	0.67	0.45 - 0.98*	1.51	1.03 - 2.21*

Table 4.13 also represents respondents' views on attitude of service providers with respect to PAC. It was revealed that, 313(49.4%) of respondents said, service providers' attitude was very good. 298(47.0%) and 23(3.6%) of respondents said, service providers' attitude were good and fair respectively.

Data were gathered on whether or not all information pertaining to PAC was given to respondents. It was found that 588(92.7%) of respondents received all information on PAC while 46(7.3%) did not receive adequate information on PAC.

It was ascertained that majority 610(96.2%) of respondents were satisfied with services provided on PAC while 24(3.8%) of respondents were not satisfied with services provided.

Table 4.13 Attitude of service providers

Variable	Frequency	Percentage
Attitude of service provider		
Very good	313	49.4
Good	298	47
Fair	23	3.6
Given all information		
Yes	588	92.7
No	46	7.3
Satisfaction with service		
Yes	610	96.2
No	24	3.8

Source: Field Survey, 2013

Differences in response on attitude of service providers

About half of the respondents (50.1%) who accepted an FP method commended the service providers as having a very good attitude towards them. The non- acceptors also gave a good report about the service providers.

Almost all the respondents were given the information they needed on PAC and were also satisfied with the service provided**.**

Table 4.14 Differences in response on attitude of providers

Predictive variable	Acceptors 491 (77.4)	Non-acceptors 143 (22.6)	P-value
Attitude of Providers			**<0.001**
Very good	246 (50.1)	67 (46.9)	
Good	225 (45.8)	73 (51.0)	
Fair	20 (4.1)	3 (2.1)	
Given all information			**<0.001**
Yes	452 (92.1)	136 (95.1)	
No	39 (7.9)	7 (4.9)	
Satisfaction with service			**<0.001**
Yes	471 (95.9)	139 (97.2)	
No	20 (4.1)	4 (2.8)	

Source: Field Survey, 2013

Correlates of attitude of service providers (multivariate logistic regression)

Attitudes of service providers may serve as barriers to family planning uptake. A good attitude of service provider enhances contraceptive uptake following comprehensive abortion (AOR: 1.19, 95% CI: 0.82 – 1.74).

Table 4.15 Unadjusted and adjusted effects of attitude of providers on family planning uptake

Predictive Variable	Model 1		Model 2	
	OR	95% CI	AOR	95% CI
Attitude of Provider				
Very Good (ref.)	1		1	
Good	0.84	0.58 - 1.23	1.19	0.82 - 1.74
Fair	1.82	0.52 - 6.29	0.55	0.16 - 1.91
Given all Information				
No (ref.)	1		1	
Yes	0.6	0.26 - 1.36	1.68	0.73 - 3.83
Satisfaction with Service				
No (ref.)	1		1	
Yes	0.68	0.23 - 2.02	2.68	2.60 – 2.77

Source: Field Survey, 2013
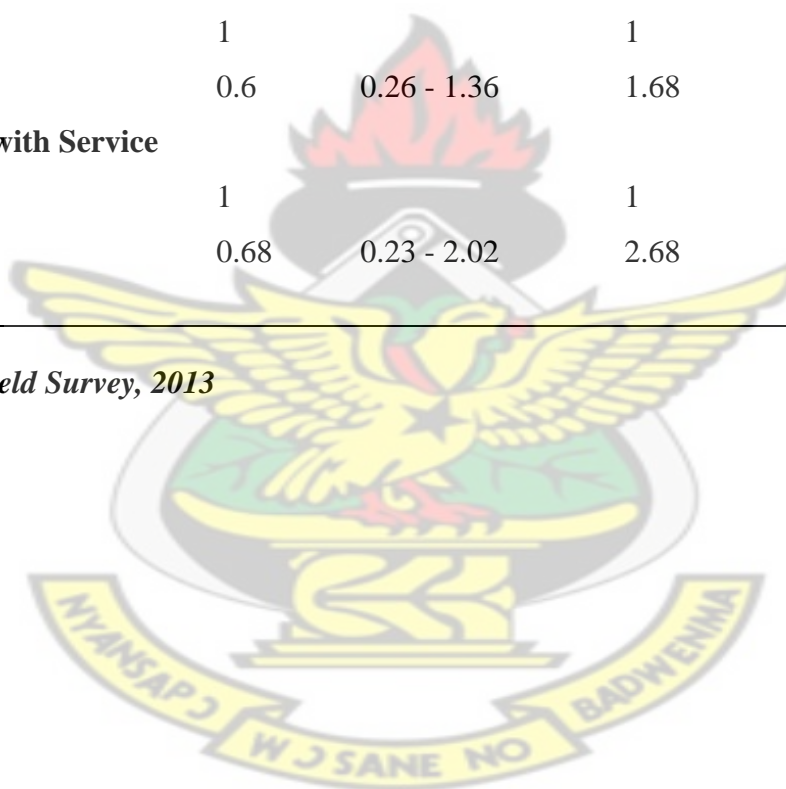
CHAPTER FIVE

5.0 DISCUSSIONS

This chapter discusses the findings of the research study in relation to the specific

objectives. They are also compared with literature reviewed on similar studies in chapter

two.

5.1 SOCIO-DEMOGRAGHIC DATA OF RESPONDENTS.

Out of the total respondents receiving PAC services, a majority (60.6%)of them were

aged between20 and 29 years, and out of the number who took up family planning 59.9%

were aged between 20 and 29 years, suggesting a possible trend between age and PAFP

uptake. This finding is comparable to a study done in Pakistan by Azmat et al., (2012),

where three- fifths of the respondents receiving PAC services were aged 25 to 34 years.

With regards to education, a high level of education was observed within the respondents

in this present study, where 96.5% of the respondents have had at least basic education

up to the tertiary level (Table 4.1). Respondents with tertiary education were 5 times

more likely to take up PAFP when compared with those with no formal education (OR =

5.15, 95% CI: 2.47- 10.72).A study by Levandowski (2011)also indicated that women

with some form of formal education were more likely to use a contraceptive method;

with women having higher educationbeing3 times more likely to use a method (OR =

3.01, 95% CI: 1.29 – 7.03).The results are however contrary to the findings of a report by

Azmat et al., 2012,in which low education was found among respondents who took up

family planning.

In consistence with the educational level of the respondents in this study, employment

level was also high (81.4%);where64.8% of respondents who took up family planning

were employed. Interestingly it was noted that more than half of the respondents (68.3%)

earned an average monthly income less than 150 Ghana cedis. This findings in line with Azmat et al's (2012) study, where the average family monthly income of participants (46.3%) who partook PAC services was 6000PKR (equivalent to 157 Ghana cedis).

With regards to marital status, 63.7% of respondents who took up family planning were single as compared with 29.5% who were married. This may be due to the fact that the pregnancies were unplanned and they wouldn't want to start a family now. A study by Levandowski (2011), reported that married women were more likely to use contraceptives compared with single women, which does not correspond to this present study.

Majority of the respondents interviewed were Christians 534(84.2%) followed by Moslems 87(13.7%). It was revealed that 84.7% of the respondents who took up PAFP were Christians as compared with Moslems (12.6%).It can therefore be said that one's religion ascertains whether one would patronize in PAC services or take up PAFP. In this study respondents were ready to take up family planning despite their religious doctrine.

56.4% of women who took up PAFP had one or more children as compared with women with no children (43.6%).What it means here is that women would take up PAFP irrespective of their parity. Again, women living in urban areas (59.1%) were more likely to take up PAFP. This finding is in line with that of Levandowski (2011), where it was noted that women living in non-slum communities were more likely to use a contraceptive method.

5.2 KNOWLEDGE AND ATTITUDE OF RESPONDENTS ON POSTABORTION CONTRACEPTION

The study revealed that, knowledge on contraceptive methods available was high;230(67%) and 120(33%) of the respondents know about one to four contraceptive methods and five to seven contraceptive methods respectively. It can be deduced from this study that the less people are aware of types of contraceptives the less likely for them to get involve in PAC services. It was also noted that 41.8% of sources of respondents' information on contraception came from health providers and42.6% from friends/ family members. Sources of contraceptive known by people have much influence (<0.001) on the patronage of PAC services. The results are similar to studies done by Omo- Aghoba et. al,(2009), where the level of contraceptive awareness of respondents was high (92.3%), and the common sources of contraceptive awareness were from health providers (49%), followed by friends/relatives (40.6%).

Assessing whether or not respondents have used contraceptives before, it was established that, 56.2% of respondents have ever used contraceptives while 43.8% have not used contraceptive before. It was observed that the ever use of contraceptive has a significant influence (0.002) on the uptake of postabortion family planning. The time to use PAFP is paramount (<0.001) for people to partake PAC services. It was also ascertained that respondents' knowledge on when fertility return following abortion was low with 45.1% of respondents having no idea and only 16.7% knowing that, fertility return within 2 weeks after abortion. The analysis indicated that the time fertility return to patients who have involved in abortion has significant (<0.001) association in whether an individual would patronize PAC services. Situational analyses in Latin America and the Caribbean and country action plans from Bolivia, Kenya and Senegal identified such factors as lack

of knowledge about the early return to fertility; denial of certain or all methods to some groups, such as adolescents or women who have not yet delivered a child; a lack of patient counseling on PAC procedure, on timing of return to fertility, and on choosing and obtaining a family planning method before discharge from the facility (2001, USAID global evaluation report). This affirms the situation in the New Juaben Municipality.

Studies in Malawi shows that better sexuality education could dispel widespread misperceptions about contraceptives and change attitudes that discourage use of contraception prior to a first pregnancy.Irregular menstruation(15.3%), Infertility (13.4%), Heart problems (9.9%) and Weight gain (7.7%) were the leading responses from respondents on side effects/misconception of contraception. The study found that misconception or having side effect after the usage of contraceptives has significant influence (<0.001) on PAFP uptake.

Studies in Malawi have shown that significant misinformation and fear persisted in the community with regard to contraception, and common misperceptions, such as association with infertility, reduced libido and other health problems limited the use of contraception.

Differences in Knowledge on Contraception among FP Acceptors and Non-acceptors

Table 4.6stipulates that majority of respondents who were FP acceptors276(56.2%) and non-acceptors97(67.8%) of contraceptives were aware of pills as a contraceptive method. It was revealed that none (0.0%) of the FP acceptors knew implant as a contraceptive method, whiles 0(0.0%) of non-acceptors had no knowledge on spermicide, injectable and periodic abstinence, as FP methods. More so, majority of respondents had their source of information from the health provider. It was found that there is significant

(0.007) association between sources of information of respondents and their family planning uptake. 274 (55.8%) of respondents who had ever used contraceptives still accepted an FP method. At an insignificant level of 0.744, the previous use of contraception does not influence family planning uptake.

Respondents were asked of their opinion whether contraceptives have side effects. It was found that there was misconception among FP acceptors that contraception promotes irregular menses 88(17.9%) and infertility 62(12.6%), whereas majority of non-acceptors40 (28.0%),indicated that the use of contraceptives has no side effect.23(16.1%) of non-acceptors also said it causes infertility. It was revealed that there is significant (<0.001) association between acceptors and non-acceptors of contraceptives and the misconception or side effect they think is associated with using contraceptives.

5.3 RANGE AND ACCESSIBILITY OF FAMILY PLANNING SERVICES

The study demonstrates that, majority (74.6%) of institutions where PAC services are provided have on site family planning services at the same department, with (22.3%) at different department and (2.5%) in different facilities. Locations of PAC services have significant influence (<0.001) on people's patronage of PAC services. It is therefore essential to provide a confined place for the operation of PAC service so that people will be very bold to enter and receive PAC services. This implies that proper location of PAC services will result in an increase usage of PAC services in a particular area.

Studies have shown that service programs that are integrated under one administrative authority enhance access to family planning services post abortion, while vertical programs may result in fragmented service-delivery systems that are more difficult for clients to negotiate. Studies in Cambodia and Tanzania found that PAC clients served in

facilities with on-site family planning services were significantly more likely to accept a contraceptive method than clients served in facilities that refer for family planning services (McDougall et al., 2009; Wanjiru et al., 2007).

Studies in Kenya, for example, Solo et al. (1999) found that FP provided on the ward was adopted by 92 percent of women, as opposed to 54 percent of women who had to travel to a separate site.

The study also found out that, 89.1% of respondents feel protected and safe at PAC delivery facilities. The study found a significant (<0.001) association between the patronage of PAC services and the service environment of operation. Studies have shown that providing services in an environment that protects the dignity of women seeking post abortion care should be treated with respect and to prevent stigmatization and negligence. This clearly shows that clients that visit PAC delivery sites are treated with respect and dignity that they deserve.

5.4 BARRIERS TO POSTABORTION CONTRACEPTION (PAC)

The study showed that the cost of PAC services is generally low. 70% of respondents interviewed said cost of PAC services is affordable. If the cost of PAC is high it will deter most people from patronizing the service and vice versa. It also emanated from the study that 76.8% of clients assessing PAC service wait for few minutes. It was established that days of operation of PAC services has significant influence (0.003) on the utilization of PAC services. The days the facilities are opened have major impact on the people who want to patronize the PAC services. Respondents commended the provision of PAFP services 24/7.This is because some people will prefer utilizing PAC

services early in the morning or afternoon whiles others prefer utilizing the PAC services late in the evening.

The study has also shown that 50.5% of respondents' religion does not support utilization of PAC services. It was revealed that the support of a religion to PAC services has insignificant association (0.003) with the utilization of PAC services. It was also established from the study that 68% of respondents live nearer to facilities where PAC services are offered. This is because people usually prefer the PAC facilities to dissociate from the areas where there are a lot of people so that they can feel free to go there anytime.

The study showed that service providers generally have good attitude towards respondents interviewed. Very good attitude (49.4%); good attitude (47.0%) and fair (3.6%) were service providers' attitude towards client during PAC section .It was also revealed that provision of PAC services by service providers was highly satisfactory which 96.2% of respondents testified to that. Adequate information was given to respondents on PAC where 92.7% of respondents confirmed that they received adequate information on PAC.

It can be confirmed that the way respondents are treated at facilities offering PAC services in the Municipality would encourage the uptake of postabortion family planning.

Providing high quality care in service provision, by interacting with women in a positive manner, providing them with the information they need and helping them to make informed choices.

The study has also shown that the contraceptive prevalence rate (current use) among respondents is 77.4% which is high. It is therefore paramount for governmental and non-

governmental organization to increase awareness of the need to patronize family planning methods without any side effect, to defuse the misconception that reduces the patronage of people's interest in PAC services.

Lastly, it was observed that 90% of respondents who took up family planning started before the return of menses whereas 10% waited after return of menses.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

The conclusions drawn are based on the findings derived from the study and their respective discussion.

6.1 CONCLUSIONS

The findings outlined led to the following conclusions about the predictors of postabortion family planning uptake in the New Juaben Municipality.

Judging from the findings of the research, the conclusion drawn was that socio-demographic characteristics such as age, educational level, occupation, average income level, residence and parity had a significant impact on postabortion family planning uptake. The most seekers of PAC services were aged between 20-29 years (60.6%), and 59.9% of those who accepted family planning were in the same age category. About 52% of respondents who sought for PAC services have had secondary education, and 52.7% of family planning acceptors have also had secondary education. With regards to occupation 66.7% of PAC seekers were employed, and 64.1% of FP acceptors were also employed, but majority of them earned an average monthly income of less than 100Gh cedis. Again 59.1% of PAFP acceptors were urban dwellers and 56.4% had one or more children.

With regards to knowledge on family planning, majority of respondents had knowledge on modern contraceptive methods; making it easier for them to take up a method before leaving the facility. It was however realized that many of the respondents (45%) did not have an idea as to the time fertility returns following abortion. Respondents also had a lot of misconceptions on the use of contraceptives.

The range and accessibility of PAFP counseling and services served as a predictive factor in FP uptake. The study showed that 74.6% of the health facilities had on-site family planning services, with protective service environment. It can also be concluded that institutions that provides abortion and PAC services at the same department is likely to have majority of clients accepting family planning method before leaving the facility.

With regards to barriers to postabortion contraception, majority of respondents spent only few minutes to receive PAC services. The service providers also had a good attitude towards them. The cost of PAC services was generally low and institutions providing PAC services were readily accessible to clients. It was found that 47.5% of respondents who took up family planning did not have religious support. Distance to the health facility is also a significant factor in contributing to post abortion family planning uptake in the Municipality. Providing quality and satisfied services to clients are found to increase the utilization of PAC services.

6.2 RECOMMENDATIONS

Based on the conclusions, the following recommendations have been provided;

Service providers and all health institutions could strengthen the education on PAC especially on when fertility returns after abortion.

The Municipal Health Directorate could ensure that all health institutions provide on-site family planning services to enhance PAFP uptake.

All institutions providing PAC services could have directional signs showing the closing and opening time and range of services that is offered.24 hours and weekends services could also be introduced at health institutions providing PAC to maximize utilization by clients.

Governmental and non-governmental organizations related to health could increase awareness creation through the mass media and organized programmes at communities to increase patronage of PAC services.

REFERENCES

Aboagye P.K., Gebreselassie H., Mitchell E.M.H., 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.

AGI (Alan Guttmacher Institute). (2007). *Facts about the Unmet Need for Contraception in Developing Countries*. Washington, DC: Alan Guttmacher Institute.

Ahman E., Shan I. (2002). Unsafe Abortion: Worldwide Estimate for 2000. Elsevier Science Ltd. *JSTORreproductive health matters Vol. 10, 19*, Available from: http: www.Abortion Women Decide, P- 13 - 17.hfm (Accessed on 10[th]March, 2013).

Akinrinola B., Singh S., Has-Taylar, GUTTMACHER INSTITUTE, (1998). *Reasons Why Women have Induced Abortion. Evidencedfrom 27 countries*. Available from: http:// www.guttacher.org (Accessed on 9th February, 2013).

Azmat S.K., Hameed W., Ishaque M., Mustafa G., Ahmed A. (2012). Post abortion care family planning use in Pakistan. Pakistan Journal of Public Health.Vol. 2, No. 2.

Brooke Levandowski, (2011). Determinants of Women's Contraceptive Use and Non-Use in Varied African Settings.IPAS, United States of America.

CeylanA., Ertem M., Saka G., Akdeniz N. (2009).Post abortion family planning counselling as a tool to increase contraception use. Available from http://www.biomedcentral.com/1471-2458/9/20. (Accessed on 10th March, 2013).

Cobb L., Putney P., Rochat R., Solo J., Buono N., Dunlop J., Vandenbroucke M. (2001). Global Evaluation of USAID's Post Abortion Care Program. Washington, DC: POPTECH.

Correia D. S., Pontes A. C., Cavalcante J.C., Egito E. S., and Maia E. M.(2009).Adolescents: Contraceptive Knowledge and use, a Brazilian Study.*Scientific World Journal*, **9:**37-45.

Curtis C. (2007). Meeting Health Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID'S Postabortion Care Program.

Curtis C., Huber D., Moss-Knight T. (2010).Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion, *International Perspectives on Sexual and Reproductive Health,* 2010, 36(1):44–48.

Grimes D. A., Benson J., Singh S., Romero M., Garatra B., Okonofua F. E., Shah I. H. (2006). Unsafe Abortion: the Preventable Pandemic. The Lancet 368: 1908- 1919.

Guttmacher Institute (2008). *In Brief.Facts on InducedAbortion in the United State.* Available from: http:// www.guttacher.org (Accessed on 9[th]February, 2013).

GHS- Eastern Region Annual Health Report, (2012). Koforidua.

GSS/GHS /Macro International Inc.(2009). Calverton, Maryland, U.S.A.

Hatcher R. A., Trussell J., Nelson A. L. (2009).Contraceptive Technology.19th edition. New York: Ardent Media, Inc.

IPAS at the International Conference on Family Planning, (2011).Dakar,

Senegal.Available from http: //www.fpconference2011.org.(Accessed on 9 [th]February,

2013).

Johnson B. R., Ndhlovu S., Farr S. L. and Chipato T. (2002).*Reducing Unplanned Pregnancy and Abortion in Zimbabwe through Post Abortion Contraception: Studies in Family Planning,* 33: 195- 202.

McDougall J., Fetters T., Clark K. A. and Rathavy T. (2009). Determinants of Contraception Acceptance among Cambodian Abortion Patients, *Studies in Family Planning.* 40(2): 123- 132.

Nielsen K. K., Lusiola G., Kananma J., Bantamby J., Kikumbih N., Rasch V. (2009). Expanding comprehensive postabortion care to primary health facilities in Geita District, Tanzania. Afr. J. Reprod. Health; 13(2):129-38.

Omo-Aghoja L. O., Omo-Aghoja V. W.,Aghoja C. O.,Okonofua F. E.,Aghedo O.,Umueri C., Otayohwo R.,Feyi-Waboso P.,Onowhakpor E. A. and Inikori K. A. (2009). Factors Associated With the Knowledge, Practice and Perceptions of Contraception in Rural Southern Nigeria:Ghana Med J. 2009 September; 43(3): 115–121.

Postabortion Care (PAC) 1994, Consortium, International Conference on Population and Development (ICPD), Cairo.

Rasch V., Massawe S., Yambesi F., Bergstrom S. (2004).Acceptance of contraceptives among women who had an unsafe abortion in Dar es Salaam. Trop Med Int Health 2004 Mar;9(3): 399-405.

Savelieva I. L.,David P. H., Reichenbach L., Vartapetova N., PotemkinaR. (2003).*Postabortion Family Planning Operations Research Study in Perm, Russia*, Washington, DC: Population Council.

Sedgh G., Bankole A., Singh S., Wulf D. (2008). .*Abortion Worldwide: A Decade of Uneven Progress.* Cited in Guttmacher Institute. (Accessed on 13[th]November, 2012).

Schor N., Ferreira A. F., Machado V. I., França A. P., Pirotta K. C. M., Aluarenga A. T., Siqueira A. A. (2000). Women and contraception: knowledge and use of contraceptive methods.

Singh S., Hussain R., Bankole A., Sedgh G. (2009). .*Abortion Worldwide: A Decade of Uneven Progress,* New York: Guttmacher Institute. (Accessed on 20[th]November, 2012).

Solo J., Billings D., Aloo-Obunga C., Ominde A., Makumi M. (1999).Creating Linkages betweenIncomplete Abortion Treatment and Family Planning Services in Kenya. Stud Fam.Plann. Mar; 30(1):17-27.

Solo J. (2007).*USAID Postabortion Care Strategy Paper,* Washington, DC: United States Agency for International Development (USAID).

Tripney J., Schucan B. K., Kwan I., Kavanagh J. (2011). The impact of postabortioncare family planning counseling and services in low-income countries: a systematicreview of the evidence (Technical report). London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

United Nations (UN), (2000). United Nations Millennium Declaration: Resolution Adopted by the General Assembly. 55/2. New York, NY: UN.

United States Agency for International Development (2011). High impact practices in family planning. Washington, D.C.: USAID.

United States Agency for International Development (2007). What Works: A Policy and Program Guide tothe Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions. Module2:PostabortionCare.Washington, DC. Available from http://www.infoforhealth.org/pac/research/CompendiumFPHIVSTI.pdf Accessed on 10[th]March, 2013.

Varkevisser M. C., Pathmanathan I., Brownlee A., (2003). Designing and Conducting Health Systems Research Projects, Vol. 1: Proposal Development and Fieldwork. KIT publishers, Amsterdam and IDRC.

Wanjiru M., Askew I., Munguti N., RamaRao S., Homan R., Kahando R., Pile J. M. (2007). Assessing the feasibility, acceptability and cost of introducing comprehensive post abortion care in health centers and dispensaries in rural Tanzania. Final report. New York: Population Council.

Wilcox A. J., Baird D. D., Weinberg C. R. (2000). The Timing of the 'Fertility Window' in the Menstrual Cycle: Day Specific estimates from a Prospective Study. BMJ 2000. Nov 18; 321 (7271): 1 259- 62.

Williamson L.M., Parkes A., Wight D., Pettigrew M., Hart G.J. (2009). Limits to Modern Contraceptive use Among Women in Developing Countries: A Systematic Review of Qualitative Research.

World Health Organization (2007).*Facts on Induced Abortion Worldwide.* Guttmaccher Institute in Brief.Department of Reproductive Health.Available from: http: //www.guttmatcher.org (Accessed on 9th February, 2013).

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

Youssef H., Adbel-Tawab N., and Bratt J. (2007).Linking family planning with postabortion services in Egypt: testing the feasibility, acceptability and effectiveness of two models of integration, Washington, DC: Population Council.
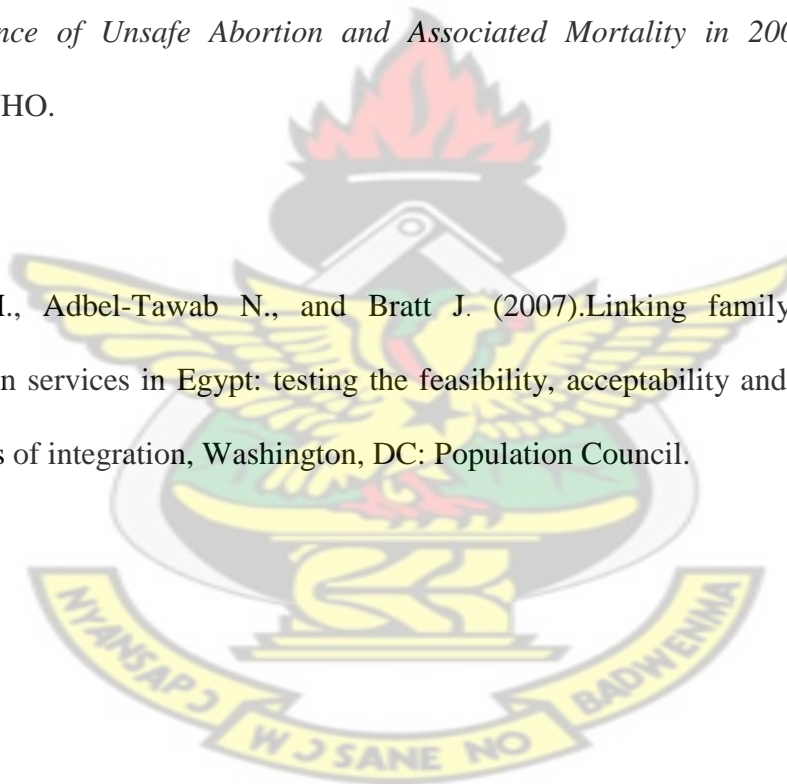
KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

COMMUNITY HEALTH DEPARTMENT

RESEARCH QUESTIONNAIRE

This questionnaire is meant to ask you some questions on post abortion family planning. Your participation is purely voluntary and confidentiality will be strictly ensured.

INSTRUCTIONS:

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

SECTION A: SOCIO – DEMOGRAPHIC DATA

1. Age (years)
a) 15-19 [ ]
b) 20-24 [ ]
c) 25-29 [ ]
d) 30-34 [ ]
e) 35-39 [ ]
f) 40-44 [ ]
g) 45-49 [ ]

2. Level of Education

a) Primary   [ ]

b) Secondary [ ]

c) Commercial/ Vocational [ ]

d) Tertiary   [ ]

e) Others (specify) ……………….

3. Occupation

a) Artisan   [ ]

b) Civil Servant [ ]

c) Trader [ ]

d) Unemployed [ ]

e) Others (specify) ……………….

4. Average monthly income in GH¢

a) Less than 100 [ ]

b) 100 to 150   [ ]

c) 151 to 200   [ ]

d) 201 to 250   [ ]

e) More than 250 [ ]

5. Marital status

a) Single   [ ]

b) Married [ ]

c) Divorced [ ]

d) Widowed [ ]

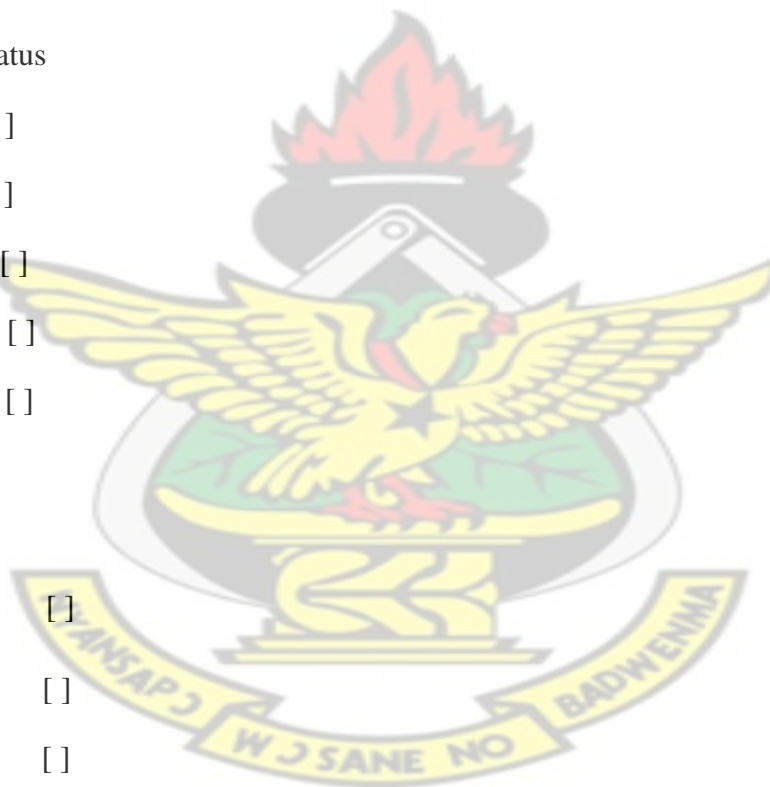e) Cohabitat [ ]

6. Religion

a) Christian   [ ]

b) Hindu   [ ]

c) Moslem   [ ]

d) Traditionalist [ ]

e) Others (specify)………………

7. Residence

a) Urban   [ ]

b) Peri- urban [ ]

c) Rural   [ ]

8. Number of Children Alive

a) None   [ ]

b) One   [ ]

c) Two   [ ]

d) Three [ ]

e) Four   [ ]

f) Five or more [ ]

SECTION B: KNOWLEDGE ON POST ABORTION CONTRACEPTION

9. What types of contraceptive methods do you know?

a) Pill   [ ]
b) IUD   [ ]
c) Condom   [ ]
d) Spermicides [ ]
e) Injectable   [ ]
f) Implants   [ ]
g) Diaphragm [ ]
h) Periodic abstinence [ ]
i) Withdrawal [ ]
j) Other traditional methods [ ]
k) Female sterilization [ ]
l) Male sterilization [ ]
m) Other method (specify) ……………

10. What is your source of information?
a) Midwife [ ]
b) Friends [ ]
c) Family members [ ]
d) Others (specify)……………

11. Have you used any contraceptive method before?
a) Yes [ ]
b) No [ ]

12. When is the best time to use contraception following abortion?

....……………………………………………

……………………………………………………………………………………………

87

13. What time does fertility return following abortion?

…………………………………………………………………………………………

14. What are the misconceptions or side effects of contraception?

…………………………………………………………………………………………

…………………………………………………………………………………………

SECTION C: RANGE AND ACCESSIBILITY OF FAMILY PLANNING COUNSELING AND SERVICES

15. What range of services is provided at the facility?
a) Oral contraceptives [ ]
b) IUD   [ ]
c) Injectable [ ]
d) Implants   [ ]
e) Condoms   [ ]
f) Spermicides [ ]
g) Sterilization [ ]
h) Others (specify) …………………..

16. Where is the location of the family planning service?
a) On the ward where CAC is provided [ ]
b) On a separate department [ ]
c) In a different facility [ ]
d) Others (specify) …………………….

17. How did you get to know about the service?
a) Friends   [ ]
b) Family Members [ ]
c) Others (specify) …………………….

18. Does the service environment protect the dignity of clients?
a) Yes [ ]
b) No [ ]

SECTION D: BARRIERS TO POST ABORTION CONTRACEPTION

19. What do you think about the cost of post abortion contraceptives?
a) Expensive [ ]
b) Affordable [ ]
c) Cheap [ ]

20. How long does it take you to receive service?

……………………………………………………………………………………………………

21. What time does the facility start working?

……………………………………………………………………………………………………

22. What time does the facility close?

……………………………………………………………………………………………………

23. What do you think about the opening and closure time of this facility?

……………………………………………………………………………………………………

24. Does your religion support utilization of the service?
a) Yes [ ]
b) No [ ]

25. What is the distance from your residence to the health facility?

   a) Close
   b) Far

26. What was the attitude of the service provider?
a) Very good [ ]
b) Good   [ ]
c) Fair   [ ]
d) Poor   [ ]

27. How long did you wait for the provision of the service?
a) Few Minutes   [ ]
b) One to Two Hours [ ]
c) Three hours or more [ ]
d) Service deferred to a follow up visit [ ]
e) Others (specify) …………………..

28. Were you given all the needed information on postabortion care?
a) Yes [ ]
b) No [ ]

29. Are you satisfied with the PAC service provided?
a) Yes [ ]
b) No [ ]

SECTION F: POST ABORTION CONTRACEPTION ACCEPTANCE RATE

30. Have you ever had a comprehensive abortion care?
a) Yes [ ]
b) No [ ]

31. Were you given any counseling?
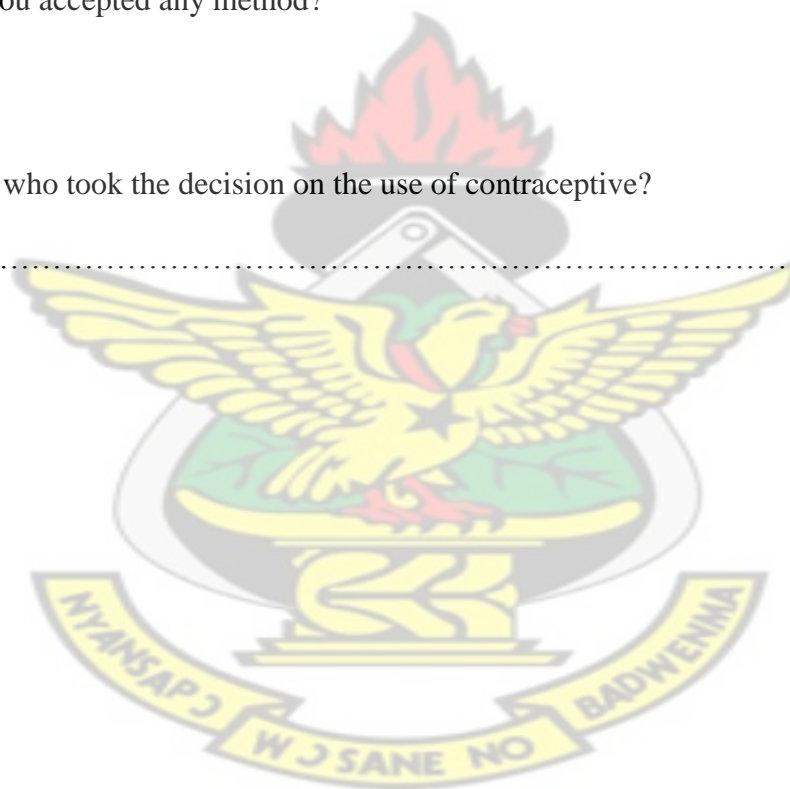a) Yes [ ]
b) No [ ]

32. Have you accepted any method?
a) Yes [ ]
b) No [ ]

33. If yes, who took the decision on the use of contraceptive?

………………………………………………………………………………………………

Figure 2: MAP OF NEW JUABEN MUNICIPALITY