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Attitude and Utilization of Comprehensive Abortion Care Services by Young People (10-24 Years) in the Tamale Metropolis

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Abstract

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

Keywords: Utilization, Comprehensive, Abortion and Young People

Introduction

Preventable pregnancy complication and child birth across the globe accounts for about 800 maternal deaths each passing day with developing countries accounting for over 99% of these deaths (WHO, 2014). Gorrette (2005) [4] tied down the high global rates of maternal mortality to low rates of contraceptive usage, high number of unintended pregnancy and limited access to safe abortion and post abortion care. Sedgh *et al*., (2007) [7] in their study indicated that there is a consistently high unsafe abortion in places with restrictive abortion laws which goes to suggest that women who experience unplanned pregnancies in these areas are most likely to resort to unsafe abortion. About, 48% of all induced abortions recorded globally are reported to be unsafe (WHO, 2007).

In developing countries 82% of unplanned pregnancies occur among an estimated 215 million women with unmet needs for modern contraceptives (Singh *et al*., 2009) [12]. It is most likely that women with unplanned pregnancies develop the intension of resorting to an induce abortion which most often are done clandestinely and are highly unsafe. The World Health Organization reported that most abortions that occur globally emanate from developing countries with a record of 35 million annually whiles developed nations record an estimated 7 million abortions (WHO, 2007).

In Africa, the annual induced abortion rate between the year 2003 and 2008 indicated an increase from 5.6 million to 6.4 million. Thirteen percent of all the pregnancies in Africa ended in abortion in 2008 (Sedgh *et al*., 2012; Singh *et al*., 2009) [11, 12]. Of the 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions. Abortion rates estimated for West Africa are among the highest worldwide (Guttmacher Institute, 2009) [6].

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

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

Ghana's desire to institute road maps towards achieving Maternal Mortality Reduction and largely honor her international commitments to reproductive health under the MDGs four (4) and five (5), has made the law on abortion liberal unlike many other African countries, yet the Ghana Maternal Health Survey (2007) report had it that 15% of women in Ghana had had at least one induced abortion in their lifetime. This could be due to the fact that the law facilitates a broad range of legal indications as well as restrictions (Turkson, 1996 [13]; Morhee *et al.,* 2006 [8]; UN 2001).

Abortion under the Ghana's *Criminal Code Law: PNDC L 102. (1985)* has been permitted since 1985 provided it is carried out by registered medical practitioners in registered facilities and where a pregnancy is as a result of rape, incest, its continuation would result in injury to a woman's physical or mental health, or the fetus has a substantial risk of a serious abnormality. Although most Ghanaians do not know the law, they have the notion that abortion is forbidden (Aniteye and Mayhew, 2013) [1]. Furthermore, Aniteye and Mayhew cited that the inclusion of this legal clause within the Criminal Code has contributed to the general perception of abortion as a crime when all the conditions indicated in the law are breached. Ghana Health Service on the other hand provides direction for the interpretation of the law on abortion through its standards and guidelines which is in sync with the World Health Organization's guidelines and standards of best practice (WHO, 2003).

In 2000, Ghana developed the National Adolescent Reproductive Health Policy which was aimed at reducing abortion among adolescents by 50% by 2010. In light of this GHS focused on improving adolescent health by preventing early, coerced and/or unprotected sex and treating its consequences (Ghana National Population Council, 2000). This notwithstanding, studies indicate that among Ghanaian women and adolescents 18% of them had their first sexual encounters through force. Coker-Appiah *et al*., (1999) [2] found that one in five Ghanaian women has been raped; however, less than 1% formally reports the crime.

The study area the Tamale Metropolitan with the total population of 223, 252. The number of males is 111,109 (49.7%) and the number of females is 112, 143 (50.2%). In terms of age, sex and locality, the Metropolis has more males than females living in the urban centers. The metropolis has a household population of 219, 971, living in 19, 387 houses.

In view of the above discussion, this study seeks to assess the attitude and utilization of Comprehensive Abortion Care among young people (10-24 years) in the Tamale Metropolis.

Literature Review

The Concept of Comprehensive Abortion Care

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

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

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

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

Knowledge and Usage of Contraception

Abortion-related deaths and injuries are primarily prevented through the reduction of unplanned or unintended pregnancies. The world currently experiences about 75 million unintended pregnancies each year with 190 women confronted with an unintended or unplanned pregnancy every minute and in effect, over half of these unplanned pregnancies end in abortion (Westley, 2005) [14]. In CAC, the use of contraceptives is promoted as an integral part of the services to prevent unintended pregnancy. Under Family planning, the choice of contraceptives method by a client is given upon counseling on the benefits and side effects of each of the various methods. However, a difficulty in accessing contraceptive methods by young and unmarried women who also have limited control over their

reproductive choices due to unequal gender roles that is construct by society. Despite wide spread knowledge on the benefits of contraception, young people are underserved and affected by barriers of cost, stigma and lack of information.

Attitude of Young People Towards Comprehensive Abortion

According to Henshaw *et al*., (1999) [7] there is the tendency for one to argue on the basis of morality that, the liberalization of abortion laws would lead to an increase in the rate of abortion especially among young women, on the other hand, data from developed countries with liberal access to safe and legal abortion and good contraceptive services have shown low rate of unsafe abortion which otherwise in developing countries where abortion is highly prohibited with clandestine or illegal abortion continues to pose a serious health challenge on women.

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

The Utilization Rate of Comprehensive Abortion Care among young people

It has also been observed that the rate at which women seek abortion is similar for women living in developed and developing countries and that contrary to common belief, legalization of abortion does not necessarily increase abortion rates (Henshaw *et al*., 1999) [7].

Prata *et al*., (2013) Hospital-level investigation in Ethiopia had data illustrating a significant improvement in abortion-related indicators from 2008 to half year of 2012 as 644, 881, 2289, 3053 and 2152 respectively.

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

Barriers to CAC Utilization

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

In Ghana, termination of pregnancy on medico-social grounds as indicated in the current law is however, not readily available in national health institutions in the country. Such services are available in some private institutions especially in urban centres (Morhee, 2006) [8].

Besides, the lack of knowledge among women and health workers regarding the legal aspect of abortion in most countries are a major barrier towards the utilization and service provision of safe abortion services respectively. Studies to determine the knowledge of abortion and its legalization in India discovered that lack of knowledge, misinterpretation that spousal consent is required before having an abortion, delusion of not knowing when an abortion is legal and the dangers of performing an abortion were key factors identified (Gupte *et al*., 1997; Banerjee *et al*., 2009).

Ghana has a high illiteracy rate especially among women and as a result, the illiteracy and social deprivation faced by many women in Ghana do not equip them with the requisite knowledge on their legal rights to safe abortion (Morhee, 2006) [8].

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

Factors that Account for the Utilization of Comprehensive Abortion Care

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

Per my observation health care can best be enhanced with effective health systems in place to meeting the growing health needs of people. However, in developing countries, the effectiveness of health systems kept in place is being thwarted by the lack or low utilization of existing health facilities established from public expenditure.

Generally, factors that account for health care utilization are vast. Young (1981) proposed a choice-making model developed from ethnographic studies of health services utilization.

The model comprises of four components which are peculiarly essential to an individual‘s choice of health care service. They include; Perceptions of gravity which has to do with and individual‘s insight on the severity of the illness and how the social network‘s (an individual‘s social relationships which exchange opinions, knowledge, and care) considers the illness severity. Gravity is therefore founded on the assumption that the culture classifies illnesses by the level of severity. The second component of the model proposes the individual‘s knowledge of a home treatment to the illness. If a person is aware of a home remedy that is efficacious, there is the tendency to resort to such treatment first before utilizing a professional health care system. These home remedy knowledge is often based on lay referral. The third component is the faith in remedy which incorporates the individual‘s belief of efficacy of

treatment for the present illness. Hence, the individual considers the option to use the treatment if they believe the treatment is efficacious. The fourth component is the accessibility of treatment which deals with the individuals' evaluation of the cost of health services and the availability of those services in terms of proximity. Young elucidated that access may be the most important influence on health care utilization (Wolinsky, 1988b).

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

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

Gaps in the Available Literature

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

Methodology

Research Design

The main motive of the research was to assess the attitude and utilization of Comprehensive Abortion Care among young people (10- 24 years) in the Tamale Metropolis, to assess the awareness and knowledge of young people on CAC services in the Tamale Metropolis, to determine the attitude of young people towards CAC services in the Tamale.

The study used a mixed method of study that utilized both quantitative and qualitative methods to confirm and cross-validate findings within the study (Creswell *et al*., 2003). It is more suitable for an in-depth examination of the association between the attitude and utilization of Comprehensive Abortion Care services by young people in the Tamale Metropolis.

The study considered all young people aged between 10 and 24 years whose total population was 70, 657 in the Tamale Metropolis from the 219,971 households (GSS, 2010). The sample size was determined using the mathematical formula propounded by Yamane (1967);

$$n = \frac{N}{1+N(\alpha)^2} \quad (1)$$

Where n is the sample size, N is the population size, and**α** is the level of precision/margin of errors. Equation 1 was used to compute the sample size based on a population (N) of 70,657 young people and 0.06 margin of error (α). When this formula was applied, equation 2 was gotten as follows;

$$n = \frac{70657}{1+70657(0.06)^2} = 277 \quad (2)$$

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

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

The mixed method sampling technique involves the selection of units or cases for a study using both probability and non-probability sampling techniques to increase external validity and transferability was used determine communities within three clusters of health sub-districts (Bilpeila, Vittin and Tamale Central Subdistricts) of the Tamale metropolis. A mixed method of data collection were used to collect data for the study. Statistical Package for Social Sciences (SPSS) version 20.0 software was used to help in the analysis of the data.

Discussions of Results and Findings

This paper's discussion was guided by the following set of questions: What is the awareness and knowledge of young people on CAC services in the Tamale Metropolis? What is the attitude of young people towards CAC services in the Tamale Metropolis? What is the utilization rate of CAC services among young people in the Tamale Metropolis? What are the existing barriers that prevent young people from accessing CAC services in the Tamale Metropolis? What factors enhance the utilization of CAC services among young people in the Tamale Metropolis?

Profile of Study Area: Tamale is the subject of the investigation, The Tamale Metropolitan Assembly was established by legislative instrument (L.I. 2068). At present,

it is one of the six Metropolitan Assemblies in the country and the only Metropolis in the three Northern regions namely: Upper East, Upper West and Northern regions. Tamale is the district as well as the regional capital of the Northern Region. The Metropolis has a total estimated land size of 646.9sqkm (PHC Report 2010). It is located in the central part of the Region and shares boundaries with the Sagnarigu District to the North-West, Mion District to the East, East Gonja to the South and Central Gonja to the South West. Geographically, the Metropolis lies between latitude 9º 16 and 9º 34 North and longitudes 0º 36 and 0º 57 west. The Metropolis is located about 180 metres above sea level with some few isolated hills. There are a total of 116 communities in the Metropolis of which 41 (35%) are urban communities, 15 (13%) being peri-urban and 60 (52%) of them being rural in nature. From the 2010 PHC, the population of the Tamale Metropolis is 223,252. The number of males is 111,109 (49.7%) and the number of females is 112,143 (50.2%). In terms of age, sex and locality, the Metropolis has more males than females living in the urban centers. The metropolis has a household population of 219,971, living in 19,387 houses. On the average, there are 1.8 households in every house of the metropolis and 11.5 people in every house. The metropolis also has an average household size of 6.3, a number lower than that for the region which stands at 7.8

Demographic Characteristics

The Gender Distribution of Respondents

This section presents descriptive statistics of respondents' background characteristics which include; age, sex, marital status, educational level, ethnicity, religion and family type. Majority of the respondents interviewed as indicated in Table 1 below were females, representing 144 (51.4%) whiles males were the minority constituting 136 (48.6%). The table also shows that, majority of the respondents interviewed were 22-24 years representing 133 (47.5%) followed by those within the age interval of 16-21 years representing 42.2% (118). Minority of the respondents interviewed were between the ages of 10-15 years representing 29 (10.3%). The marital status of the respondents showed that a higher number of them, 223 (79.6%) had never married, 49 (17.5%) were married, 6 (2.2%) were separated and 2 (0.7%) were widowed. With regards to religious affiliation a higher number of the respondents, 171 (61.1%) were Muslims, 107(38.2%) were Christians, whiles 2 (0.7%) of them were Traditionalist.

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Table 1: Demographic Characteristics

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

Source: Field Survey, 2015

According to Table 1, 140 (50%) of the respondents were Dagombas, 36 (12.9%) were Gonjas, 10 (3.6%) were Mossis, 17 (6.1%) were Mamprusis and 77 (27.5%) belonged to other tribes such as Dagabaas, Bimobas, Kasenas, Akans, Ewe and Frafras.

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

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

In-depth/Key Informant Interviews

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

1. People's awareness on CAC services;

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

"…I can"t tell but a few of them do come here for abortion services. Some are also referred or brought by their parents." Midwife, Tamale West Hospital

2. Sources of knowledge on CAC

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

3. Perception of youth on abortion

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

4. Is abortion frown upon by people in the metropolis

—…yes, especially if you look at the culture of the people, you cannot just come and go and be laughing that today I went and did abortion…ooi (laughter) they will sing a song and put your name outside. When you do it, you have to hide." Midwife, Tamale Teaching Hospital

5. Barriers to CAC service utilization

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

6. Factors that enhance CAC service utilization

—…maybe you want to continue your education, marry properly, or avoid stigma."
Midwife, Tamale Teaching hospital
"…mostly because of their education" Midwife, Tamale Central Hospital

Attitude of Young People Towards CAC Services

Table 2 below shows that majority of the respondents, 125 (44.6%) consider CAC service as safe, 63 (22.4%) were of the position that CAC service is against their religion, 38 (13.6%) consider CAC as a means of preventing pregnancy and 26 (9.3%) considered CAC as not good for their culture.

Table 2: Position on comprehensive abortion care

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

Source: Field Survey, 2015

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

"… it is a shame in Islam or Christianity or traditionally, it is a shame and doesn"t just agree to it and that is why we say we don"t agree to it, so when you do it like that it is not good to us." Male, 24 years, Urban community

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

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

Table 3 further shows that 112 (40%) of the respondents would not advise a woman with an unintended pregnancy to go in for CAC service because of religious reason, 83 (29.6%) indicated that because of the risk or danger involved, 41 (14.6%) indicated stigma as their reason, 28 (10%) indicated culture as their reason and 16 (5.7%) indicated monetary cost as their reason.

Table 3: Reasons for not recommending CAC services

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

Source: Field Survey, 2015

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

"It could also happen that when you go to the doctors or nurses to remove the pregnancy or someone who is not qualified can do it and do it completely to remove it and pregnancies that would come afterwards cannot hold, you would like to give birth and you cannot be able to give birth, that is what it is." Male, 24 years
"God forbids that and also sometimes it can give you complication that is why we don't want it." Female, 22 years.

Barriers to Accessing CAC Services

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

Furthermore, the unavailability of health facilities accredited to conduct CAC as a key barrier to the utilization of CAC services is confirmed in Andersen's (1995) behavioral

model of health service. The model explained that enabling resources should provide the means to make use of the service, hence, community and personal enabling resources must be available to use at any time. Therefore, health personnel and facilities must exist and people must have the means to get these services. These means include income, health insurance, a regular source of care, cost of traveling and waiting time among others that can determine the utilization of health care services.

The study further drew a strong association (p=0.001) between the attitude of health workers and the non-utilization of health services by young people which agrees with Witter *et al*., (2007), Harries *et al*., (2009) and Aboagye *et al*., (2007) studies which also revealed that providers' attitude is a problematic reason that impedes access to health services and this can be blamed on their religious and moral beliefs on abortion or their uncertainty on the legality of abortion or doubt about the standards and protocols for abortion care, as well as perceived lack of administrative support. These reasons were summarized in Walker *et al*. (2004) study as personal, social and structural reasons.

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

Factors that Enhance the Utilization of CAC Services

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

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

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

This study's finding supports the findings of Montgomery and Hewett (2004) which states that the level of household living standard has an influence on unmet needs for modern contraception, birth attended to by nurses, doctors or trained midwives and children height for age. The level of household income was indeed seen as an influencing factor but not a major influencing factor in the study and as cited in Druggal (2004) study, despite making safe abortion services free to promote utilization, accredited facilities in India still recorded low (10%) utilization of the service.

Conclusions and Recommendations

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

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

The study further revealed that the participant's low levels of knowledge influenced their attitudes towards comprehensive abortion care services (CAC). Consequently, health education did not affect the cultural and traditional practices of the people and this lead to

63 (22.4%) and 26 (9.3%) of the respondents indicating that abortion services were bad because it offended their religious and cultural systems respectively. This religious and cultural stances and grip on the people subsequently lead to negative thoughts and perception by the people on comprehensive abortion care services.

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

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

Four major factors acted as forefront barriers to the utilization of comprehensive abortion care (CAC) services; the place of residence, cost of service, attitude of health

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

Recommendations

1. The study found that health education and promotion on the importance of comprehensive abortion care services was very low in the area. Therefore, a robust and much innovative health education programs that consider the psychosocial and cognitive aspects of people receiving health education should be developed and implemented.
2. An inclusion of the cultural and religious components of the people into health education is crucial. Community leaders, key informants and opinion leaders must be educated to champion certain sensitive issues that could impede the acceptance of public health interventions such as the comprehensive abortion care.
3. Access to comprehensive family planning services, aimed at reducing unmet need for contraception and eliminates barriers to obtaining family planning services that would ultimately reduce number of pregnancies and the incidence of unsafe abortion and associated maternal deaths and ill health.
4. Capacity building of CAC services providers on medical abortion counseling and service provision should be carried out to mitigate the barrier of poor staff attitude expressed by respondents.
5. Government and Civil Society Organizations should promote access to safe and legal abortion services for all women especially young girls, to the full extent of the law and also publicize the availability of these services in public health facilities while ensuring its affordability for poor and rural women to gain access.
6. Ghana Health Services and Non-Governmental Organizations (NGOs) focused on Sexual Reproductive Health should assist in improving access to CAC services through the expansion of service delivery points especially in the rural areas, and equipping them with the necessary logistics.
7. To create a foundation for effective dissemination of knowledge and increased access to Comprehensive Abortion Care service in a sustainable manner, an inter-sectorial collaboration of Government, Non-Governmental Organizations (NGOs) and community leaders should be carried out.
8. In addition, more health workers should be trained as Comprehensive Abortion Care service providers to increase the number of providers available at any given time to provide instant service to the growing demand of safe abortion services in the metropolis.
9. Raise awareness among the population of the legality and availability of safe abortion services in Ghana. Each CAC accredited facility should be responsible for developing a communications plan that informs the local population of service availability. The government should work closely with legal experts, rights-based organizations and community networks to expand Information Education and Communication (IEC) to women.
10. To restrain cost of safe abortion service as a barrier, Policy makers and Civil Society Organization should support in subsidizing cost of CAC services at accredited health facilities as well as ensuring standardization of this cost in both public and private health facilities.

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