

CHALLENGES AND BARRIERS TO ADOLESCENTS' POST-ABORTION CARE
SERVICES: IMPLICATIONS FOR REPRODUCTIVE HEALTH POLICY IN NIGERIA

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A thesis submitted in fulfilment for the degree
Philosophiae Doctor in Nursing, in the Faculty of Community and Health Sciences,
University of the Western Cape



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2017

ABSTRACT

The prevention of abortion related complications and mortality is dependent on the availability, accessibility and usability of emergency post-abortion care (PAC) throughout the health care system. Unfortunately, abortion is not legal in Nigeria and Nigerian women, especially adolescents, are often unable to obtain adequate post-abortion care services due to a variety of reasons. A review of literature shows that adolescent PAC patients receive worse care than older women seeking PAC services. There is widespread recognition of the need to overcome these barriers and make it easier for women to obtain the PAC services they need. Therefore, overall aim of this research study was to provide empirical information on the barriers and challenges to adolescents' PAC and develop a policy document to inform reproductive health services for Nigerian hospitals. To develop this policy document, the study specifically sought to assess knowledge of reproductive-health and related post-abortion care services among health care providers; describe the adolescents' perception of post-abortion care received; determine the service providers' perspectives on adolescents' post-abortion care challenges and barriers; analyze the challenges and barriers faced by adolescents in obtaining post-abortion care services; explore ways in which the knowledge about challenges and barriers to adolescents' post-abortion care can be used to inform policy; develop policy document and make recommendations in key areas to improved PAC services in Nigeria as part of working towards improving reproductive health services.

This study was conducted in two phases. In phase one of the study, a mixed-method approach, using both quantitative and qualitative research designs were used. The quantitative design was used to assess knowledge of service providers on the facility, its infrastructure, inventory of services provided and PAC-related service statistics in each service-delivery point, as well as technical skills and training level of staff involved in post-abortion care. This gave background information on PAC services in these centres. A purposive sampling technique was used to select a sample size of 315 health care providers and the instrument for data collection was a questionnaire adapted from USAID Post-Abortion Care (PAC) Assessment Tool and Pathfinder International Youth-Friendly PAC assessment tool. Data collected were analyzed using Statistical Product Service Solutions (SPSS) version 21. While, the qualitative design was used to explore the adolescents' feelings and thoughts regarding abortion and post-abortion care received. The

service providers and stakeholders' perspectives about the challenges and barriers to adolescents' post-abortion care and suggestions for the way forward was also assessed. A purposive sampling technique was used in selecting (i) Adolescents with post-abortion complications admitted to the selected hospitals (ii) Health care providers (doctors and nurse-midwives) and (iii) Stakeholders. In-depth interviews (IDIs) guide and focus group discussions (FGDs) guide were used to guide the interviewer. A total of 20 semi-structured IDIs were conducted with adolescent patients receiving PAC; three FGDs were conducted with 32 health-care professionals while and one FGD was conducted with 7 stakeholders. The qualitative data analyses were conducted using Ritchie and Spencer (1994) five stages of analysis to identify themes and categories.

Phase Two of the study was conducted through interactive sessions with expert using the Delphi method to develop policy document and make recommendations in key areas to improved PAC services in Nigeria. A purposive sampling technique was used to select 50 expert panellists. The instrument for data collection was a self structure questionnaire informed by the result of the phase one of the study. Data collected were analyzed using descriptive methods and this was achieved through the use of Statistical Product Service Solutions (SPSS) Version 21. Permission for the study was obtained from the Senate Higher Degrees Committee, and the Research Ethics Committee of the University of the Western Cape, hospital authorities and participants involved in the study. The researcher ensured voluntary participation, and the participants were not harmed in any way. Counselling was provided during interviews where necessary. Participants were given detailed information about the study without the researcher or her representatives withholding information or giving false information concerning the study. Confidentiality and anonymity of participants were maintained. Informed consent was signed by the participants. In the case of participants under the age of 18, parental consent forms were signed and informed assent forms were signed by these participants (under 18). Focus group discussion (FGD) confidentiality binding forms were also signed by all participants before the FGD.

Findings of the quantitative study showed that the health care institutions have the necessary facilities and trained staff needed for PAC services. However, all the respondents maintained that only doctors carry out manual vacuum aspiration (MVA) procedures, despite the fact that both doctors and nurse-midwives have received training in PAC services with manual vacuum aspiration. Most of the respondents demonstrated ignorance of any other reproductive health

services where adolescents can be referred for PAC services. Findings from qualitative study revealed that adolescents found it difficult to discuss issues of pregnancy and abortion with their parents or guardians due to fear of stigmatization or rejection. The majority of the adolescents were of the view that health care providers, particularly nurses, were unfriendly and judgmental while providing PAC services to them, and that this significantly affected the PAC care services they received. However, the majority of the health care providers on the other hand maintained that the inability of the adolescents to open up and confide in the health care providers on issues concerning pregnancy and abortion affect the PAC services these adolescents seek and receive from the health care providers. The major challenges and barriers identified were finance, unfriendly and judgmental attitudes of health care workers, delayed treatment due to hospital protocol, health care providers' failure to provide privacy, lack of proper PAC counselling, non-availability of support systems, and non-legalization of abortion. Most of the respondents were also of the view that legalizing abortion will enhance access to PAC services and reduce the stigmatization from the society and also make the care givers less judgmental and discriminative in dealing with the adolescents. Further resolutions were provided for the challenges and barriers identified, which included need for community involvement and participation in order to address the abortion stigma and provide support for adolescents with unwanted pregnancy as well as PAC patients. In addition to this, the care providers suggested that government enact laws and policies that favor adolescents with abortion complications. Nevertheless, all respondents recommended improve access to education through free education and provision of scholarships. Youth empowerment was suggested to keep the adolescents away from sexual involvement and help to meet certain needs that these adolescents and their parents are unable to meet financially.

A critical evaluation and discussion of the findings from phase one was also done by a panel of expert in order to develop policy document to improved PAC services in Nigeria. There was a high degree of consensus among the expert panellists on challenges and barriers to adolescents' post-abortion care (PAC), as well as the solutions to overcome it. The percentage agreement ranged between 70.3% and 100%, while the mean ranged between 1.00 and 2.11. However, no unilateral agreement was reached on the issue of legalization of abortion as a means of improving adolescents' PAC services. It was recommended that abortion laws should be opened for public comment and revised in order that stigmatization is reduced and access to PAC services is increased. This consensus informed the development of a policy document on PAC services

KEY WORDS

Adolescent

Barriers

Challenges

Post-Abortion Care

Informed Policy

Unsafe Abortion

Reproductive Health

Post-Abortion Family Planning



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DECLARATION

I declare that “CHALLENGES AND BARRIERS TO ADOLESCENTS POST-ABORTION CARE SERVICES: IMPLICATIONS FOR REPRODUCTIVE HEALTH POLICY IN NIGERIA” is my own original work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Full name: Olayinka Abolore Onasoga

Signature:



Date: September, 2017



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DEDICATION

This project is dedicated to God Almighty – the essence of my existence, to the loving memory of my father Engr. L.A. Onasoga who motivated me even in death to finish the PhD programme, and to my loving husband Ayobamibo Oluwatunmise Ogunnowo who supported me throughout the programme.



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ACKNOWLEDGEMENT

I am grateful to God Almighty for His grace, mercies and guidance in helping me to successfully complete this work. I could not have even started without Him. He has seen me through the thick and thin. I am forever grateful, O Lord.

My profound gratitude and appreciation goes to my supervisor Dr. Sathasivan Arunachallam, for consenting to be my supervisor given the short notice, without any precondition I thank him for his time, expertise, advice, comments, encouragement, constructive criticism and suggestions in spite of his engagements and heavy workload, to ensure that this work was completed in time. May God Almighty richly bless and increase your wisdom in Jesus name.....Amen. I am equally grateful to Professor Adejumo Oluyinka and Professor Karien Jooste whom I owe an intellectual debt of gratitude as my former supervisors, for their excellent guidance, comments and immense contribution to this work and my life. Then too, let me say that I sincerely appreciate Miss Nicolette Johannes who is always ready to help no matter what. Thank you.

There are no words to express my sincere appreciation for the love, support, endurance, and understanding extended to me by my loving husband Ayobamibo Oluwatunmise Ogunnowo, who provided unstinting motivation throughout this process.

My special thanks go to my mentor Dr. J A Afolayan who has been a father to me in all respects. May God Almighty bless you and meet you in your need in Jesus name.....Amen. I am also appreciative of the contributions of my colleagues Mrs. Rafiat Anokwuru, Dr Aluko, Mrs Aimegheme F, Mrs. Durojaiye Abiola, Mrs. Bukola Ibitoye-Atoyebi, Dr Rejuaro FM, Mr. Bitrus D, Yusuf Abdur-Rashid, Mrs Arowoiya Ayorinde, my analyst, Pastor Femi, among others. May the good Lord reward you abundantly.

I thank the management of St Philomena Hospital, Central Hospital and University of Benin Teaching Hospital, Benin City for granting me permission to use their facilities. The study would not have happened without you. My appreciation also goes to my study participants for taking part in the study and for providing me with constructive feedback and suggestions.

Finally, I am greatly indebted to my daughters Kike, Wanle and Mariam. May the breath of the Lord Almighty give you all a bright life in Jesus name.....Amen.

ACRONYMS AND ABBREVIATIONS

ACNO: Assistant Chief Nursing Officer
ANC - Ante-Natal Care
CDC: Centers for Disease Control and Prevention
CNO: Chief Nursing Officer
CTOP: Choice on Termination of Pregnancy
EC: Emergency Contraception
FGD: Focus Group Discussion
FLHE: Family Life and HIV Education
FMOH: Federal Ministry of Health
FMOW: Federal Ministry of Women's Affairs
FP: Family Planning
HIP: High Impact Practices in Family Planning
HIV: Human Immunodeficiency Virus
HMB: Hospital Management Board
HO: House Officer
ICPD: International Conference on Population and Development
IDI: In-Depth Interview
IPAS: International Projects Assistance Services
IPPF: International Planned Parenthood Federation
LGAs: Local Government Authorities
MO: Medical Officer
MVA: Manual Vacuum Aspiration
NACA: National Agency for Control of AIDS
NO: Nursing Officer
NO I: Nursing Officer I
NO II: Nursing Officer II
O&G: Obstetrics and Gynaecology
OAU: Organisation of African Unity
PAC: Post-Abortion Care
PACC: Post-Abortion Care Consortium
PEP: Peer Education Plus
PEPFAR: President's Emergency Plan for AIDS Relief
PHC: Primary Health Care
PNO: Principal Nursing Officer
RH: Reproductive Health
SMOH: State Ministry of Health
SNO: Senior Nursing Officer
SRHS: Sexual and reproductive health services
STDs/ STIs: Sexually Transmitted Diseases/ Sexually Transmitted Infections



TIAM: Treatment of Incomplete Abortion and Miscarriage
TOP: Termination of Pregnancy
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
USAID: United States Agency for International Development
VSI: Venture Strategies Innovations
WHO: World Health Organisation
YFS: Youth friendly services

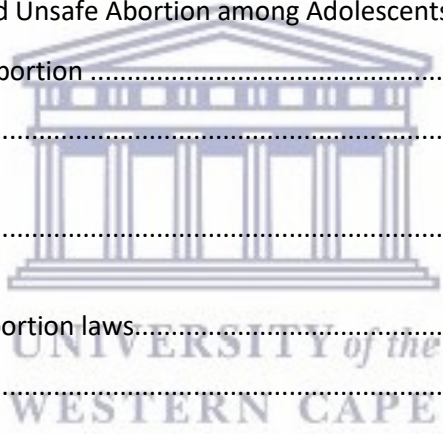


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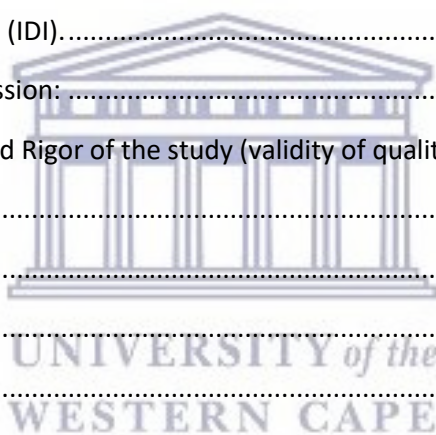
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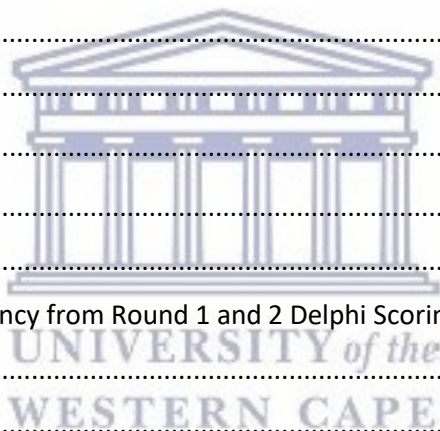
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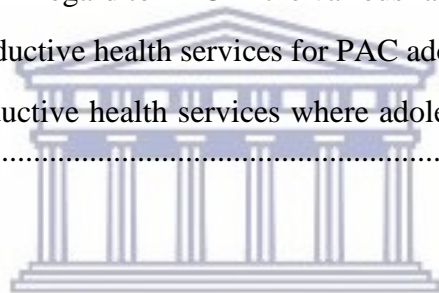
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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The International Conference held on Population and Development (ICPD) in Cairo in 1994 recognized unsafe abortion as a major public health problem (Daire, Kloster, & Storeng, 2018). The participants called for prompt, high quality and sympathetic medical services to treat the complications of unsafe abortion. In addition, the ICPD emphasized the importance of post-abortion counselling and family planning services as part of a comprehensive package of post-abortion care to promote reproductive health and prevent repeated abortions (Haberland & Rogow, 2015).

The concept of post-abortion care (PAC) was developed to help integrate the treatment of abortion - related complications into reproductive health services, as well as facilitate the availability of quality services to treat women suffering from complications related to abortion in the context of an increasingly restrictive political environment (Wendot, Scott, Nafula, Theuri, Ikiugu, & Footman, 2018; Barot, 2014). In 2002, the Post-Abortion Care (PAC) Consortium updated its model of post-abortion care to include five essential, interrelated elements: treatment, family planning services, counselling, other reproductive and related health services, and community and service provider partnerships (Zulu, Ali, Hallez, Kass, Michelo, & Hyder, 2018; Barot, 2014).

The International Projects Assistance Services (IPAS) and VSI (2011) stated that PAC links curative services, such as the treatment of incomplete abortion and miscarriage (TIAM), with preventive services, like family planning. As part of a comprehensive reproductive health strategy, PAC services can also be vital in preventing unintended pregnancies, thereby

contributing to the reduction of maternal morbidity and mortality (Huber, Curtis, Irani, Pappa & Arrington, 2016; IPAS & VSI, 2011).

Globally, about 210 million women become pregnant each year. Of these, 99 million have unintended pregnancies, 31 million have spontaneous abortions or stillbirths, and 56 million have induced abortion. Of these induced abortions, about 25 million are unsafe with almost all occurring in developing countries (Bearak, Popinchalk, Alkema, & Sedgh, 2018; Ganatra, (Gerds, Rossier, Johnson, Tuncalp, Assifi, et.al, 2017). World Health Organization (WHO, 2018b) stated that, of the 25 million unsafe abortions occurring annually, one third (approximately 8 million) were performed under the least safe conditions by untrained persons using dangerous and invasive methods. Furthermore, 3 out of 4 unsafe abortions occurred in Africa and Latin America and the risk of dying from an unsafe abortion was the highest in Africa (WHO, 2018b; Say, Chou, Gemmill, Tunçalp, Moller, Daniels, et.al. 2014).

Huber, Curtis, Irani, Pappa and Arrington (2016) affirmed that 75 million women worldwide need post-abortion care (PAC) services each year, following safe or unsafe induced and spontaneous abortions. Complications arising from spontaneous abortions and unsafely induced abortions pose a serious global threat to women's health and are the major contributor to countries' high levels of maternal death, ill health and disability (WHO, 2016).

Nigeria has one of the highest maternal mortality ratios in the world, at 560 maternal deaths per 100,000 births, with little improvement in recent years (IPAS, 2015; World Health Organization, 2014). In 2012 alone, 1.25 million Nigerian women had abortions, double the number estimated in 1996 and almost all of these abortions were performed clandestinely (Guttmacher Institute, 2015). Many of these "backstreet" abortions were performed by unskilled providers, or used

unsafe methods, or both. An estimated 497,000 had complications warranting treatment in a health facility and only 212,000 women were treated in health facilities, while the remaining 285,000 women did not have access to the quality of post-abortion care they needed (IPAS, 2015; World Health Organization, 2014).

Existing evidence suggests that more than a quarter of the cases of unsafe abortions are among adolescents, as they are often unable to obtain the PAC services for a variety of reasons, ranging from restrictive laws and policies to the judgmental attitude of the health care provider (Bearak et al., 2018; Izugbara, Egesa, & Okelo, 2015; Ikeako, Onoh, Ezegwui & Ezeonu, 2014).

Studies have shown that in places where abortion and post abortion services are available, adolescents may be unable to use the health services needed by them because the laws or society forbid provision of such services to unmarried adolescents or because the cost of the health services is beyond their reach (WHO, 2014; Thapa, Neupane, Basnett, Ramnarayan & Read, 2012). Even where adolescents are able to obtain the health services they need, they may be discouraged from doing so because of the lack of willingness and commitment among health care providers to deliver timely, thoughtful and supportive post-abortion care directly or indirectly (Rehnström, Gemzell-Danielsson, Faxelid & Klingberg-Allvin, 2015). The health facility is usually perceived to be unfriendly, and there is a lack of confidentiality and privacy. This is why women, especially adolescents, are reluctant to seek help from these health facilities (Rehnström, et al., 2015).

There is widespread recognition of the need to overcome these barriers and make it easier for women, especially adolescents, to obtain the PAC services they need. In many countries, both government and non-governmental organizations are undertaking initiatives to reach out to meet

reproductive health needs. Studies reveal that challenges remain in the implementation of quality PAC services, with social, religious, policy and legal restrictions on abortion and contraception (Mutua, Maina, Achia & Izugbara, 2015; Rehnström, et al., 2015; Ikeako, et al., 2014; Mustafa, 2015; Thapa , et al., 2012; Okonofua, et al., 2011). Advocacy will be needed to increase awareness and implementation of post-abortion care in Safe Motherhood, essential emergency obstetric care and other global health initiatives. One of the greatest challenges will be finding creative ways to meet the increasing need for high-quality contraceptives, post-abortion care and other reproductive health services in the context of stable or declining resources. Health care providers will need strategies such as the introduction of elements of the PAC model, staggered over time, in prioritized order, or altering service provider guidelines and networks to maximize the use of already overburdened and limited resources. This study aims to document, stimulate, advance research and provide needed information on the barriers and challenges to PAC in Edo State, in order to inform policy development on sexual and reproductive health in Nigeria.

1.4 Statement of problem

Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion worldwide (WHO, 2018b; Say, Chou, Gemmill, Tunçalp, Moller, Daniels, et.al. 2014). The consequences of unsafe abortion may be more severe for the adolescents and several studies have documented higher complication rates and mortality from unsafe abortion among young women aged 10–24 years (WHO, 2018b; Cooksey,2017; Mumah, Kabiru, Mukiira, Brinton, Mutua, Izugbara et al., 2014; Herrick, Kuhns, Kinsky). Moreover, unsafe has been depicted as a schoolgirl's problem in Nigeria, where 60% of patients admitted to hospitals with unsafe abortion-related complications are adolescent girls (Federal Ministry of Health, 2009); and existing evidence showed that these adolescents receive worse care than older women seeking PAC

services (Shahabuddin, Delvaux, Abouchadi, Sarker & De Brouwere, 2015; Tesfaye and Oljira, 2013).

In Nigeria, abortion is only permitted when the woman's life is at risk; therefore, access to safe abortion is legally restricted. The Nigerian abortion laws and the stigma around premarital sexual activity limit access to sexual and reproductive health services including safe abortion among adolescents. This means that many adolescents with unplanned pregnancies are more likely to resort to unsafe abortion; present with severe complications and to receive lower quality treatment following unsafe abortions (Cleeve, Faxelid, Nalwadda & Klingberg-Allvin, 2017; Tesfaye & Oljira 2013). Furthermore, in Edo State where this study was conducted, the adolescents faced several reproductive health (RH) vulnerabilities including unsafe abortion, as the state has some of the country's highest rates of commercial sex, international sex trafficking and risky sexual behavior with few adolescent friendly reproductive health facilities (Edo State Ministry of Health, 2010).

There remain significant challenges and barriers to improve adolescents post-abortion care services in Nigeria. Many people and providers have negative attitudes and perceptions about abortion and its possible legalization. Some providers are reluctant to perform abortion or treat post-abortion complications because of ethical or moral reasons. Furthermore, most health systems provide treatment for abortion complications as part of emergency obstetric care, the infrastructure to make these services widely available is usually lacking and providers are sometimes insufficiently trained to provide post-abortion care (Mutua, Maina, Achia & Izugbara, 2015; Melkamu, Betre & Tesfaye, 2010). Besides, most of the Nigerian studies, which sought to assess issues related to post abortion care service in Nigeria targeted either knowledge, perception or practice of post-abortion care (PAC) services among health care professionals, or

implementation of post-abortion care and effective linkage to other post-abortion services (Hassan, 2014; Ikeako, Onoh, Ezegwui & Ezeonu, 2014; Kalu, Umeora & Adeoye 2012).

There is paucity of studies focusing on challenges and barriers on adolescents' post abortion care in Nigeria. Therefore, this study aims to provide in-depth surveys about the challenges and barriers on adolescents' post abortion care from adolescents, health care providers and other stakeholder perspectives, in order to develop a policy document to inform adolescents' sexual and reproductive health services in Nigeria

1.5 Aim of the study

The aim of the research study is to provide empirical information on the barriers and challenges to adolescent PAC and develop a policy document to inform reproductive health services in Nigeria.

1.6 Specific objectives

- To determine the availability of reproductive health and related post-abortion care services among Health care providers in selected secondary and tertiary health facilities in Edo state
- To describe the adolescents' perception of post-abortion care received in Edo State, Nigeria
- To determine the service providers' perspectives on adolescents' post-abortion care challenges and barriers in Edo State, Nigeria
- To identify the challenges and barriers faced by adolescents in obtaining post-abortion care services
- To utilize the knowledge around challenges and barriers to adolescents' post-abortion care to develop policy document.

1.7 Research questions

- What are the available reproductive health and post-abortion care services in selected secondary and tertiary health facilities in Edo state?
- How do the adolescents perceive the PAC services received from the health care services in Nigeria?
- What are the perceptions of the service providers on the challenges and barriers to post-abortion care among adolescents in Edo State, Nigeria?
- What are the problems faced by adolescents in obtaining post-abortion care in Nigeria?
- How can post-abortion care services for adolescents be improved in order to inform policies and laws in Nigeria?

1.8 Research Paradigm

A paradigm, according to Creswell & Plano-Clark (2017) is a worldview. Teddlie and Tashakkori (2010) refer to a paradigm as “a worldview together with the various philosophical assumptions associated with that point of view.” Similarly, Lincoln and Guba (1994) call paradigm “a basic system or worldview that guides the investigator”. Paradigms are opposing worldviews or belief systems that are a reflection of and guide the decisions that researchers make (Teddlie & Tashakkori 2010). Nieuwenhuis (2011) holds that a paradigm is a “worldview” or a set of assumptions or beliefs about fundamental aspects of reality which gives rise to a particular worldview. Four dominant worldview (paradigms) are identified, namely positivism/post positivism, constructivism/interpretivism, transformative and pragmatism (Tashakkori & Teddlie, 2010; Creswell & Plano-Clark, 2017). The Positivism/post positivism is closely identified with quantitative research while constructivism/interpretivism with qualitative research, making

neither particularly suitable for mixed methods research (Hall, 2013). Only the transformative and pragmatism worldviews are seen to be compatible with mixed methods research. Notwithstanding, the researcher's worldview in this study is that of pragmatism.

Pragmatism is oriented 'toward solving practical problems in the "real world" (Feilzer, 2010) rather than on assumptions about the nature of knowledge. The proponents of pragmatism are "not committed to any one system of philosophy and reality" but advocate the use of "pluralistic approaches to drive knowledge about the problem" (Creswell 2014; Johnson & Onwuegbuzie, 2004; Maxcy, 2003; Morgan, 2014a). It is generally regarded as the philosophical partner for the Mixed Methods approach. It provides a set of assumptions about knowledge and enquiry that underpins the Mixed Methods approach and which distinguishes the approach from purely quantitative approaches that are based on a philosophy of (post)positivism and purely qualitative approaches that are based on a philosophy of interpretivism or constructivism (Feilzer, 2010; Johnson & Onwuegbuzie, 2004; Maxcy, 2003). Pragmatism advocates for the mixture of objectivist and subjectivist ontology and epistemology to understand a social phenomenon and give the researcher the freedom to choose methods techniques and procedures that suit the study's needs and purposes (Creswell, 2014; Wahyni, 2012). However, in this study the researcher believed that the combination of the two world views would create room for better understanding and explanation of the phenomena in this study. In relation to the use and justification of pragmatism as an appropriate paradigm for this research, it is important to consider its meta-theoretical, ontological, epistemological and methodological aspects.

1.8.1 Meta-Theoretical Assumptions

Meta-theory can be defined as the 'philosophical discussion of the foundations, structure or results of some theory'. Meta-theoretical assumptions are concerned with the reality that guides

the researcher to understand how things are and how things work (Scotland, 2012). In this study, the meta-theoretical assumptions are based on the four main concepts in nursing namely, “person, health, environment and nursing”. The study is based on the researcher’s meta-theoretical assumptions regarding these four concepts:

The person

Griffin and Lander (2014) view person as an individual considered to be the central phenomenon of interest to nurses. Person refers to the recipient of care. The person herein refers to the adolescent patients with abortion complications. The person is a unique individual and is recognized as a holistic being, composed of body, mind and spirit. The person is part of a family, community and society. Furthermore the person is integrated and interactive with their health, environment and nursing (PAC).

Health

The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Preamble to the Constitution of the World Health Organization, 1946). Similarly, Health is defined as the dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment, through optimum use of one’s resources to achieve maximum potential for daily living (Sieloff & Messmer, 2013). Health in this study refers to the degree of wellness or illness experienced by the adolescent patients.

Environment

Environment refers to all the internal and external conditions, circumstances, and influences affecting the adolescent patients seeking or receiving PAC. However, the health providers

especially nurse-midwives are responsible for ensuring a therapeutic environment. There is a need for health care providers to deliver timely, thoughtful and supportive post-abortion care to the adolescent patients.

Nursing

Nursing refers to the actions, characteristics, and attributes of the individual providing post-abortion care to the adolescent patients. This includes provision of holistic, non-judgmental post-abortion care to the adolescent patients. Patients' significant others need to know that their loved ones are cared for by competent honest and caring health providers. From a pragmatic perspective, nursing is an open encounter that combines strategies and approaches to practice. The pragmatist uses different paradigmatic perspectives depending on what is useful and relevant to the situation.

1.8.2 The Ontological Assumption

Ontology is defined by Crotty (2003) as “the study of being”. It is concerned with “what kind of world we are investigating, with the nature of existence, with the structure of reality as such”. Guba and Lincoln (1989) state that the ontological assumptions are those that respond to the question ‘what is there that can be known?’ or ‘what is the nature of reality?’

Pragmatist researchers adopt external but multiple views of reality (as opposed to positivist and realist) and choose the best one to answer the research question. For pragmatists, an ideology or reality is true if it works (practically) to solve problems in a particular context. This view of practical reality is also affected by the belief: what works for whom in specific context, which is not philosophical in nature but has practical value for the study (Morgan, 2014a). Pragmatists believe that there is reality but it keeps changing with time based on our actions. Pragmatist researchers appreciate all of the objective, subjective and inter-subjective realities and their

interrelations (Johnson & Christensen, 2014; Johnson & Gray, 2010) to work out what is “best” in a specific context. Pragmatists are therefore, interested in finding out what, why and how something, in the case of present research works in specific contexts.

Ontology attempts to explain how the phenomenon is subjectively perceived and analysed by the researcher, and participants to extrapolate the universal truth about the phenomenon. Hence, there is no single reality; there are multiple realities constructed by an individual from her / his own perception and interpretation of a given phenomenon (Edmonds & Kennedy, 2013). An individual’s ontological position is their answer to the question: “What is the nature of reality as perceived by the research participants in various situations?”. Creswell (2014) holds the point of view that reality is constructed by individuals involved in the research situation. The reality in this study is the experiences of adolescent patients in receiving PAC services, the health care providers and others stakeholders’ views about PAC services. The researcher will use direct quotations from interviews as supporting information. Data that would be gain from observations and interactions during the interviews will be divided into sets of themes and summarised in order to provide clear meanings that reflected the experiences of these adolescents, the health care providers and others stakeholders. The reality of this study was complex, since it was built on the variety of individual opinions of the study participants.

1.8.3 The Epistemological Assumption

Epistemology is concerned with the nature and forms of knowledge (Crotty, 2003; Cohen et al., 2007). Epistemological assumptions are concerned with the possible ways of gaining knowledge of social reality, whatever knowledge is understood to be, how knowledge can be created, acquired and communicated, in other words what it means to know. Guba and Lincon (1989)

explain that epistemology asks the question: What is the nature of the relationship between the would-be knower and what can be known?

Pragmatists believe that either noticeable phenomena or subjective meanings or both can provide legitimate and acceptable knowledge depending upon the research question or objective of the research (Morgan, 2014a). They therefore integrate different perspectives to generate and analyse valid data. The implication of this pragmatist epistemology for this study is that the objective knowledge that will be collected through questionnaires, and the subjective knowledge that will be collected through semi structured interviews will be examined critically and evaluated based on set scientific criteria. The researcher assumed that the knowledge gained through these interviews and questionnaires maximized the findings. For this reason, the researcher would openly discuss findings / values with the panel of experts. This is to enable the researcher to develop policy document on adolescents' PAC services to improve reproductive health services. The development and enhancement of scientific and legitimate knowledge is the focus of the study which is free from ambiguity and is in line with consensual scientific views acceptable by the scientific community.

1.8.4 Theoretical Assumptions

Theoretical frameworks guide the paths of a research and offer the foundation for establishing its credibility (Adom, Hussein, & Agyem, 2018). Ravitch and Carl (2016) stated that the theoretical framework assist researchers in situating and contextualizing formal theories into their studies as a guide. Based on the pragmatic world view, the researcher adopted theories that were drawn from the concept of patient-centred care and Donabedian model of quality as the theoretical foundation in this study. The concept of client-centered care has received increased attention in

recent years, and it is now considered an essential aspiration of high-quality health care systems. The framework is about collaborative and respectful partnership between the service provider and the recipient of care (McCormack, 2003). In this study, the patient-centred care focuses on the adolescent's individual needs, aspirations and expectations, rather than the needs of the institution or health professionals. This is important because adolescents are considered integral components of the healthcare decision-making and delivery processes. Furthermore, the Donabedian model assumes the existence of three essential factors in assessing quality. This includes; structure, process, and outcome and possibly a causal relationship between them. Both the Donabedian model and Patient-centered care are dimensions of quality in which the quality within a healthcare delivery unit (PAC Unit) is assessed, and individualized care is given to adolescent post-abortion Patients (Berwick, 2009; McCormack, 2003)

1.8.5 Methodological Assumptions:

Methodology is “the strategy, plan of action, process or design underlying the choice and use of particular methods and linking the choice and use of the methods to the desired outcomes” (Crotty, 2003). For pragmatists, the criterion to decide the appropriateness of a method is to evaluate it in terms of achieving its purpose (Maxcy, 2003). Usually, choice of methods in pragmatism is linked to the research questions.

This study employed a mixed-method approach using both quantitative and qualitative research designs to explain the challenges and barriers to adolescents' post-abortion care. The overall purpose of this design is that the latter (qualitative data) help to explain or build upon the results of the former (quantitative data). The use of both the quantitative and qualitative methodologies was necessary because neither quantitative nor qualitative methods are sufficient to capture the trends and details of the situation. When both quantitative and qualitative designs are used, they

complement each other and allow for a more robust analysis, taking advantage of the strengths of each (Morgan, 2014b; Tashakkori and Teddlie, 2010). Leech and Onwuegbuzie (2009) maintained that key feature of mixed methods research is its methodological pluralism or eclecticism, which frequently results in superior research when compared to mono-method research. Creswell and Plano-Clark (2017) also stressed the need to justify the use of mixed methods to achieve the purpose and valid knowledge.

1.8.5.1 Mixed method

Mixed methods research is an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks (Johnson & Onwuegbuzie, 2004). The core assumption of this form of inquiry is that the combination of qualitative and quantitative approaches provides a more complete understanding of a research problem than either approach alone (Creswell & Plano- Clark 2017). Tashakkori and Teddlie (2010) note that there are three areas where a mixed method is superior to a mono-methods approach. Firstly is the ability to answer research questions that other approaches cannot; mixed methods can answer simultaneously confirmatory and exploratory questions. Secondly they provide stronger inferences through depth and breadth in answer to complex social phenomena. Thirdly they provide the opportunity through divergent findings for an expression of differing viewpoints.

The mixed-methods research design was used for the first phase in this study, which focused on collection and analysis of both quantitative and qualitative elements of the data that were generated from the study setting. However, collection and analysis of quantitative data is followed by the collection and analysis of qualitative data. The overall purpose of this design is that the

later (qualitative data) helps to explain or build upon the results of the former (quantitative data). Mixed-Methods was adopted for this study for the following reasons: One it enables researchers to address a range of confirmatory and explanatory questions with both the quantitative and qualitative approaches simultaneously (Yin, 2014); Two, it provides strengths that offset the weaknesses of both strands (quantitative and qualitative) of the research and, thus, has the potential of providing stronger inference. Three, it provides opportunity for divergent views and perspectives, thereby making researchers to be aware of the fact that issues are more multifaceted than they may think. Four, mixed methods research being ‘practical,’ allows the researchers freedom to use all methods possible to address a research problem as well as combining inductive and deductive reasoning processes. Five, it eliminates different kinds of bias, explains the true nature of a phenomenon under investigation and proves various forms of validity or quality criteria. In this study, the approach provided a more complete and deeper understanding of the subject under investigation, which has greater scope than all previous related studies. The mixed methods research design was employed for this study in line with definition and explanation of mixed-methods by Creswell and Plano-Clark, (2017), as it involves integrating quantitative (surveys) and qualitative (FGDs + in-depth interviews) data collection and analysis into a single study. The collection and analysis of data from both quantitative and qualitative data were done concurrently but separately with the quantitative data supporting that of the qualitative, then the results from the two data sources were merged and integrated (Van Griensven et al., 2014; Hakansson, Oguttu, Gemzell-Danielsson & Makenzius, 2018).

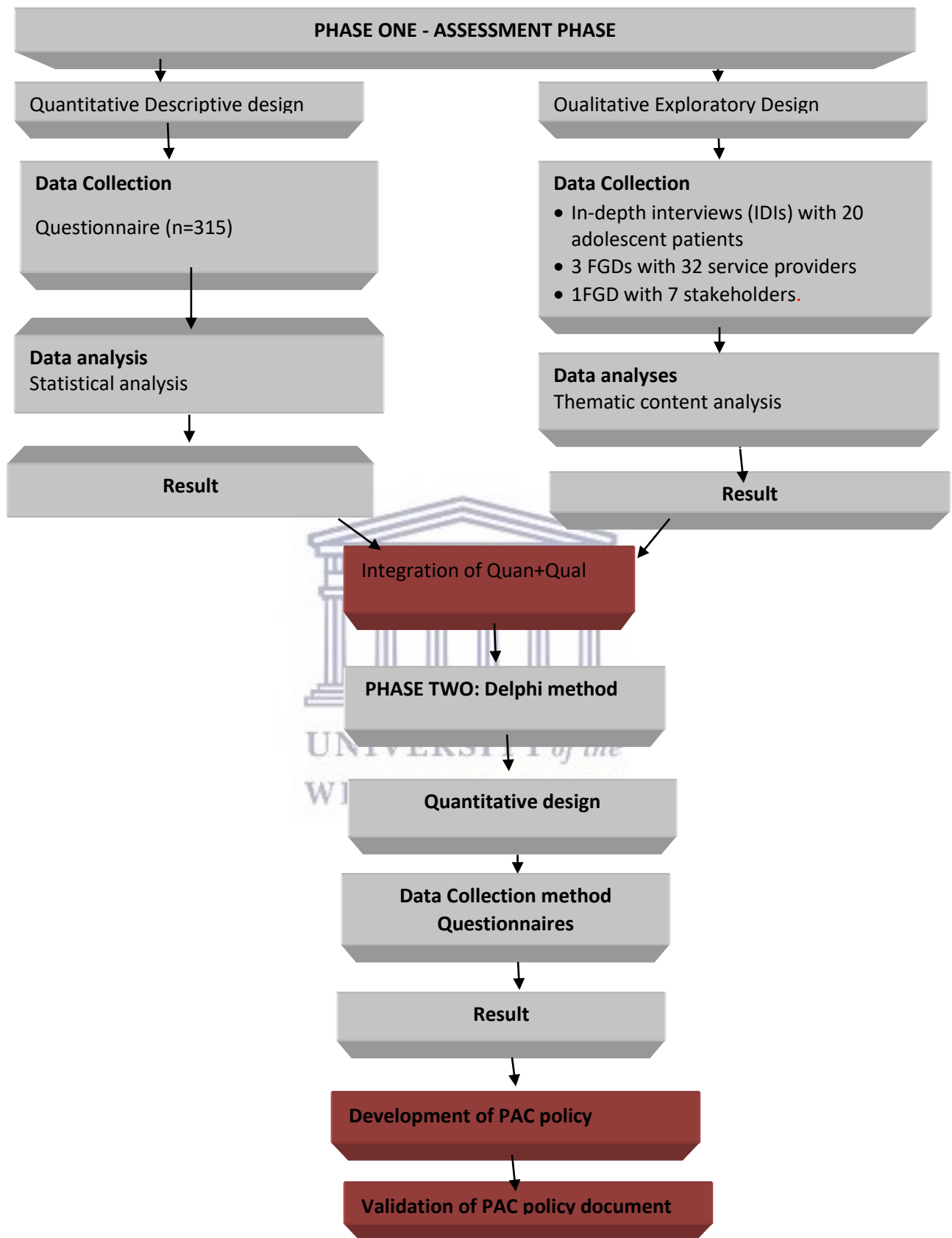


Figure 1.1 Mixed method design for the study

1.8.5.2 Phases of the Research Process

The study is designed to be carried out in two phases.

Phase one is the assessment phase and Phase Two is the interactive phase. Each phase is discussed in detail, showing the steps and approaches used in the study (see chapter three).

Table 1.1: Summary of the Research Methodology

Phase 1	Design	Data source	Instrument	Sample and sampling techniques	Methods of data analysis
Objective 1	Quantitative	Health care providers (nurses and doctors)	Questionnaire	315 respondents, purposive sampling	Descriptive statistics
Objective 2	Qualitative	Adolescents with abortion complications	Individual in-depth interviews	Purposive sampling	Thematic analysis: All the raw data gathered were sifted, charted and sorted in accordance with key issues and Themes
Objective 3	Qualitative	Health care providers (nurses and doctors)	Focus group discussions		
Objective 4	Qualitative	Key persons /stakeholders working or involved with adolescents	Focus group discussions		
Phase 2 Objectives 5 and 6	Policy Delphi Survey	Panel of Experts on adolescent Reproductive health issues	Questionnaire	Purposive sampling	

1.9 Significance of the study

Unwanted pregnancy in adolescents is an issue that cannot be ignored because adolescents face certain risks in pregnancy and abortion which are less experienced by older women. For example, the risk of haemorrhage, anemia, depression, obstetric fistula, organ failure, maternal and perinatal mortality is four times higher in adolescents than adult women (Guttmacher institute,

2018; Morris & Rushwan, 2015; WHO, 2014; Tebeu, Fomulu, Khaddaj, de Bernis, Delvaux, & Rochat, 2012).

This study is an attempt to explore barriers and challenges in the post-abortion care programme in Edo State, Nigeria with a view to providing verifiable data on the situation of adolescents' PAC. The study seeks also to reflect opinions that can be used to deal with existing barriers and challenges in the adolescents' post-abortion care programme in Nigeria. The information will be used to highlight implications and make recommendations in major areas to inform health policy on adolescent health, with the aim of improving the quality of PAC delivery to adolescents. The findings of this study are expected to reflect both consumer and provider perspectives of PAC challenges and barriers, which will help to strengthen advocacy networks to promote adolescent health needs and concerns in the broader context, and call on health systems to offer a complete range of high-quality preventive and treatment services. Also, the findings of this study will have the potential to guide care providers in planning intervention programmes to improve adolescent health. Finally, it may serve as reference material for other researchers as well as provide a basis for further research work in adolescent social and health related welfare.

1.10 Researcher's motivation for the study

The researcher was privileged to work in both private and public health care facilities designed to render gynecological and obstetric services to women of all ages, including adolescents. She had witnessed various cases of abortion-related complications and deaths during the time spent in the clinical settings as a student and a registered nurse-midwife in Edo. Most of these patients were adolescents, an experience borne out in the literature (Amusan, 2012; Olaitan, 2010; IPAS, 2003). A significant number of these complications arise from unsafe abortion. Morbidity and mortality

was inevitable in some cases owing to the delay in seeking help and/or evidence of mismanagement from both formal and informal alternative health facilities.

The researcher also observed that personnel at healthcare facilities and the general public are usually more “unfriendly” and “judgmental” regarding adolescent patients with unwanted pregnancy and abortion complications. Thus the adolescents were reluctant to confide in health professionals, contributing to unsafe abortion among these adolescents. In addition, the researcher noted that many adolescent patients were faced with various kinds of challenges and barriers in obtaining PAC services in these health facilities, which may well have been the cause of repeated abortion among adolescents in Nigeria. Furthermore, the researcher was involved in a trainer of trainees’ workshop on PAC sponsored by IPAS. All these experiences aroused the researcher’s interest in pursuing work that relates to adolescents’ PAC. Moreover, personal experience with adolescents provided insight into the challenges and barriers in obtaining PAC. Therefore the researcher was motivated, being a nurse-midwife, to pursue the project in order to develop a working document, to improve adolescents’ PAC in Nigeria.

1.11 Operational definitions

Adolescents: World Health Organization defines adolescents as persons from 10-19 years of age, while youth covers a slightly older population from aged 15-24 years. Together, adolescents and youths are collectively known as young people, with their ages ranging from 10-24 years (WHO, 2018b). In this study, adolescents are females between 15 and 24 years of age and the terms “adolescent”, “young people” and “youth” will be used interchangeably to refer to persons within the age range specified.

Challenges: The word “challenges” denotes demanding task that calls for special effort or dedication. It is anything or situations that need great mental or physical effort in order to be done

successfully (Collins English Dictionary, 2018). In this study, challenges are the issues that impede the success of adolescent PAC services, as expressed by participants in this study.

Barriers: They are conditions that make it difficult to make progress or to achieve an objective (Collins English Dictionary, 2018). In this study, barriers are obstacles to adolescent PAC services as expressed by adolescent participants in this study.

Adolescents' Perspective: Expressed opinion or perception or viewpoint on challenges and barriers to adolescent PAC as described by the adolescents.

Post-Abortion Care: This includes treatment of complications of spontaneous or unsafely induced abortion, as well as Post-abortion family planning counselling, referral, and service linkages to other reproductive health care services (Post-abortion Care Consortium, 2015).

Post-abortion patients: These are any adolescents presenting with signs and symptoms of abortion and declared by the provider in charge as having had an abortion regardless of the cause and type.

Reproductive Health Policy: Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society (WHO, 2018). Reproductive health policy is a clear and rigorous guidelines or documents or strategies to improve adolescent PAC services.

Health professional or healthcare provider: This is an individual who provides preventive, curative, promotional or rehabilitative **health care** services in a systematic way to people, families or communities (WHO 2018a, Gupta, Maliqi, França, Nyonator, Pate, Sanders, et al, 2011). In this study they are health professionals involved in history taking, physical examination, and treatment and counselling of post-abortion patients at the health care facilities where post-

abortion care is carried out. The terms “health care provider”, “care giver” and “service provider” will be used interchangeably in this study.

Stakeholders: The Agency for Healthcare Research and Quality (AHRQ, 2014) defines "stakeholders" as persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision. Stakeholders may be patients, caregivers, clinicians, researchers, advocacy groups, professional societies, businesses, policy makers, or others. In this study stakeholders include adolescent representatives, legal practitioners, clergymen, teachers and those who work closely with adolescents such as youth leaders, facilitators, motivational speakers, etc.

1.12 Outline of thesis

The thesis is organized into six chapters as follows:

Chapter One gives an overall introduction to the thesis, providing the general background to abortion, and barriers and challenges to adolescents’ post-abortion services in Nigeria. This chapter states the problem, aim, objectives, the significance of the study, and research questions.

Chapter Two discusses a comprehensive literature review on abortion laws, adolescent PAC and the barriers and challenges to obtaining these PAC services, in order to inform Nigeria’s reproductive health policy, as well as the theoretical framework underpinning the study.

Chapter Three discusses the methodology of the study, providing information on the exploratory mixed-methods design used. The chapter has two phases: Phase One is assessment while Phase Two is the interaction using the results of the findings from Phase One.

Chapter Four provides findings of the quantitative study.

Chapter Five and Six presents the Delphi

Chapter Seven deals with development of policy document, conclusions, recommendations to help improve adolescents' PAC services in Nigeria.

1.13 Summary

This chapter described general background information and the rationale for the researcher embarking on the scope of this study area. It also gave a brief overview of the main aim and objectives and sought to orientate the reader regarding the relevant terminologies used in the study.



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CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter presents a relevant conceptual and empirical review of literature on the issues surrounding abortion and post-abortion care, as well as the theoretical framework underpinning the study.

2.2. Conceptual discourse

This section of the literature review deals with the discussion of basic concepts relating to abortion and post-abortion care.

2.2.1. Concept of adolescent

The term adolescence is derived from the Latin word “adolescere” meaning “to grow up”. So, literally, adolescence means the state of growing up from childhood to adulthood. Adolescence is viewed as a transitional period whose chief purpose is the preparation of children for adult roles (Varghese et al., 2015). Adolescence connotes the period of life beginning with the appearance of secondary sex characteristics and terminating with the cessation of somatic growth. Adolescents are persons between the ages of 10 and 19; the broader term “youth” refers to individuals within the age range of 15 to 24 years, while individuals aged 10 to 24 are often referred to as “young persons”. People tend to use the terms “adolescents”, “teenagers”, “youths” and “young people” interchangeably (USAID, 2012). The United Nations attempted to classify adolescents into the following: youth adolescent (10-19 years), young adolescent (10-14years), older adolescent (15-19years), and youth (15-24years) (Plan International, 2015).

Adolescents constitute a significant proportion of the population. 1 in 6 persons in the world is an adolescent. This accounts for about 1.2 billion adolescents aged 10 to 19 years worldwide of

which about 85% live in developing countries (WHO, 2016; WHO, 2014; van der Gaag, 2013). 226 million youth aged 15-24 years live in Africa, accounting for about 19% of the global youth population (United Nations, Department of Economic and Social Affairs, Population Division, 2015).

Plan International (2015) stated that adolescents are an important resource of any country, and that they are at a vulnerable stage in their development as they have to face and deal with many challenges. Among these challenges are the barriers to obtaining safe abortion and post-abortion care and contraceptives. The period of adolescence is seen as a defining period for many adolescents because many of them experience major life defining events, such as their first sexual encounter and possibly, parenthood. Existing evidence shows that sexual debut occurs at or before age 14 and by age 18, more than 60% of African adolescents have had sexual intercourse (Bearman & Brückner, 2015; Aboki, Folayan, Daniel & Ogunlayi, 2014; Folayan, Odetoyinbo, Brown & Harrison, 2014; Nigerian Demographic and Health Survey, 2013).

Nigeria is the most populous country in sub-Saharan Africa with a population of over 178 million. It has a growing population of young people, with adolescents constituting 22 percent of the country's population (Rafael, Seemeen, Edmore, Oluwole, 2015; Nigeria Demographic and Health Survey, 2013). About 28% of adolescents in Nigeria are said to be sexually active (Nigerian Demographic and Health Survey, 2013; Nnebue, Chimah, Duru, Ilika & Lawoyin, 2016). Despite their early sexual initiation and being sexually active, many adolescents in Nigeria lack the skills to delay the onset of sex and to negotiate safe sex (Envuladu, Van de Kwaak, Zwanikken & Zoakah, 2017; Nnebue, Chimah, Duru, Ilika & Lawoyin, 2016). Furthermore, Bearman and Brückner (2015) stated that the commencement of sexual activity at age 14 or earlier has several implications for adolescents. It is an important indicator of the possibility of

sexually transmitted diseases, unintended pregnancy and unsafe abortion among adolescents (Envuladu, Van de Kwaak, Zwanikken & Zoakah, 2017). This is why the unique stage of development in adolescents, and their susceptibility to certain forms of threats and risks creates certain support needs specific to adolescents (Plan International, 2015).

2.2.2. Unwanted Pregnancy

Unwanted pregnancy is a worldwide problem. With decreasing age of menarche and onset of sexual activity, adolescents are exposed early to unplanned and unprotected sexual intercourse leading to unwanted pregnancy and invariably, abortions. Unwanted or unintended pregnancy poses a major challenge to the reproductive health of adolescents in developing countries and is higher among unmarried adolescents (Thomas, Gedif, Abeshu, & Geleta, 2016).

Unwanted pregnancy is unintended or unplanned pregnancy, which may occur in unmarried or married women. So, unwanted pregnancy, whether it comes about legally or illegally, is a common problem in our society today (Finer & Zolna, 2016). Izugbara (2014) viewed unwanted pregnancy as unintended or unplanned pregnancies that are mistimed, or which occur at an inopportune time, as a result of unfavourable circumstances or among women who do not want to become pregnant or have more children. Unintended pregnancies mostly arise as a result of non-use or inconsistent or incorrect use of contraceptives; adolescents are more likely to fall prey to inconsistent or non-use of effective family planning methods than older women (Lindh, Hognert & Milsom; 2016; Ikamari, Izugbara, & Ochako 2013).

How adolescents face these unwanted pregnancies depends on their particular conditions and the contexts in which they live. While some will accept their unwanted pregnancies, others will resort to abortion regardless of whether it is legal or not. However, pregnant adolescents are more likely than adults to follow the route of unsafe abortion (UNFPA, 2015).

According to evidence from large scale longitudinal studies, an unwanted pregnancy may severely threaten a woman's well-being. Also, denying women the right to abortion may increase the risk of negative effects on emotional development and mental health later in life, among children born unwanted (Biggs, Upadhyay, McCulloch & Foster; 2017). Unwanted pregnancy can have significant negative consequences for individual women, their families and society as a whole. An extensive body of research links births resulting from unintended or closely spaced pregnancies to adverse maternal and child health outcomes, and a host of social and economic challenges (Conde-Agudelo, Rosas-Bermudez & Norton, 2016; Sonfield et al., 2013).

Pregnancy among adolescent girls is usually frowned upon by society, especially those societies that place a high premium on moral values, chastity and education. A desperate pregnant adolescent girl usually finds herself alone in her dilemma to keep or terminate a pregnancy (Amusan, 2012). Young pregnant girls in some societies in Nigeria often face the harsh consequence of being thrown out of the home by their parents (Ogunjuyigbe & Adepoju, 2014; Amusan, 2012). They are often subjected to rejection and denial by the person who impregnated them and they also face the risk of dropping out of school. Because of the fear of being subjected to shame and ridicule, and because of the family name which is at stake, pregnant adolescent girls may engage in unsafe induced abortion procedures which is usually a danger to their health, and which can lead to serious reproductive health outcomes, and even death (Udmuangpia, Häggström-Nordin, Worawong, Tanglakmankhonge & Bloom, 2017). For these reasons, reducing the unintended pregnancy rate among adolescents is a national public health goal (Guttmacher Institute, 2016a).

There are several factors that can lead to unwanted or unplanned pregnancy. Some of them are:

sexual intercourse without the use of a condom, unplanned sex in the absence of contraceptives, incorrect use of the chosen method of contraception (e.g. condom breakage and slippage), not using contraceptives due to lack of information on their availability and how to use them, not using an available contraceptive because of misconceptions (e.g. concerning its safety), rape and/or incest.

2.2.3. Concept of abortion

Abortion is the termination of a pregnancy before foetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period (Mhango, 2017; Ameh, 2012). According to Thomas, Gedif, Abeshu and Geleta (2016) abortion is the premature expulsion from the uterus of the products of conception, which include the placenta, amniotic sac, and foetus. Abortions may be performed surgically, by dilation and curettage (D&C) or medically, by administration of medications such as Mifepristone (also known as RU486 or Mifeprex) and Misoprostol. An abortion can occur spontaneously or it can be purposely induced. Spontaneous abortions (sometimes called miscarriages) are those for which a termination of a pregnancy is not provoked voluntarily (Rao, Turner, Harrington, Nampanjeni, Banda, & Norris, 2017). A spontaneous abortion is one that takes place naturally, a situation over which the mother has no control. Induced abortion is a longstanding method of fertility control practiced around the world and it is defined as a procedure to terminate a known intrauterine pregnancy deliberate (Hooker, Fraenk, Brölmann & Huirne, 2016; Ikeanyi & Okonkwo, 2014). An induced abortion can be considered therapeutic or illegal (Zane, Creanga, Berg, Pazol, Suchdev, Jamieson, et.al, 2015). Induced abortion can be safe or unsafe. Most illegal abortions are unsafe because they are carried

out by unqualified individuals in unhygienic conditions using crude means, which eventually leads to abortion complications (Sedgh et al., 2016; Zane et al., 2015; Ikeanyi & Okonkwo, 2014).

2.2.4. Global and regional trends on abortion

As of 2010–2014, an estimated 55.9 million abortions occur each year. Of these, 49.3 million occurred in developing regions and 6.6 million in developed regions (Sedgh et al., 2016). Whereas absolute numbers are influenced by population size, annual rates are not. Overall, 35 abortions occur each year per 1,000 women aged 15–44 globally. This shows a marked reduction from the estimated 40 abortions per 1000 in women aged 15-44 between 1990 and 1994 (Bearak et al., 2018; Sedgh et al, 2016)

WHO, (2018b) stated that the rate of abortions was significantly higher in developing regions than in developed regions as of 2010-2014. The annual abortion rate has declined significantly to 27 abortions per 1000 women in developed countries during 2010–2014, but developing nations did not experience the same decline in the same time period (36 per 1,000) (WHO, 2018b; Bearak et al., 2018; Guttmacher Institute, 2018; Sedgh et al., 2016). In developing nations, the percentage of pregnancies ending in abortion rose from 21% to 24% in developing countries between 1990–1994 and 2010–2014 (Ganatra, 2017).

The majority of unsafe abortions (97%), occurred in developing countries in Africa, Asia and Latin America (WHO, 2017). Regionally, the highest annual rate of abortion in 2010–2014 was in the Caribbean, estimated at 59 per 1,000 women of reproductive age, followed by South America, at 48 per 1,000. The lowest rates were in Northern America, at 17, and in Western and Northern Europe—at 16 and 18, respectively (Guttmacher Institute, 2018). Across all world sub-regions, Eastern Europe experienced the largest decline in its abortion rate, from 88 per 1,000 in 1990–1994 to 42 per 1,000 in 2010–2014 (Guttmacher Institute, 2018)

In Africa, the overall abortion rate is 34 per 1,000 women and the sub-regional rates range from 31 in Western Africa to 38 in Northern Africa as of 2010–2014. In Latin America and the Caribbean, sub-regional abortion rates range from 33 in Central America to 48 in South America to 59 in the Caribbean. The overall regional rate has hardly changed since 1990–1994. In Asia, the average abortion rate is 36 per 1,000 women. Most sub-regional rates are close to this figure; Central Asia is higher at 42. The regional rate has changed little since 1990–1994 (as shown in Table 2.1.).

Table 2.1: Rate and percentage on global and regional estimates of induced abortion

Global and regional estimates of induced abortion, 1990-1994 and 2010-2014			
World and region	Abortion rate*		% of all pregnancies ending in abortion
	1990-1994	2010-2014	2010-2014
World	40	35+	25
Developed Countries	46	27+	27
Developing Countries	39	36	24
Africa	33	34	15
Asia	41	36	27
Europe	52	29+	30
Latin America and the Caribbean	40	44	32
Northern America	25	17+	17
Oceania	20	19	16

*Abortions per 1,000 women aged 15-44. +Difference between 2010-2014 and 1990-1994 was statistically significant (source: Guttmacher Institute, 2018)

2.2.5. Trends of abortion in Nigeria

The estimated abortion rate in Nigeria was 33 abortions per 1,000 women aged 15–49 in 2012. Although this rate is greater than the 1996 estimated rate (23 per 1,000), the most prudent conclusion may be that the abortion rate has increased only slightly, as the two rates were calculated using different approaches. Nationally, one in seven pregnancies (14%) ended in induced abortion in 2012. (Guttmacher Institute, 2015). The rates of abortion vary within Nigeria,; In 2012, there were 27 abortions per 1,000 women aged 15–49 in the South West and

North Central zones; 31 per 1,000 in the North West and South East zones; and 41 and 44 per 1,000 in the North East and South South zones, respectively (Guttmacher Institute, 2015). The proportion of pregnancies ending in induced abortion was lowest in the South West (11%), and highest in the North East (16%) and South South (17%). The higher rates of abortion in the North East and South South zones can be explained by two of the main underlying factors that increase women's need for abortion: the desire for smaller families and the non-use of contraception (Bankole, et al., 2015)

2.2.6. Reasons for abortion

Adolescents' reasons to terminate unwanted pregnancies varied and some of these reasons differ significantly from the older women (González de León, et.al, 2015). Chae, Desai, Crowell, Sedgh & Singh (2017) noted that personal, socioeconomic and health factors are reasons contributing to the choice of abortion in women globally. However, the most frequently cited specific reasons why adolescents opt for abortions include unwanted pregnancy, being single and financial constraint (Chae et al., 2017; Abbas, 2014).

Bearak et al., (2018) affirmed that the reasons why women choose to terminate pregnancy are often closely related to union status and age; however, the decision to have an abortion is also influenced by other social, economic, partnership and health factors. Nevertheless, various studies have shown reasons for choice of abortion among adolescents as: not ready to have a child, fear of expulsion from school, too young for motherhood, refusal of the boyfriend or partner to accept the pregnancy, contraception failure, lack of finances to support a child, need to continue education, shame and stigmatisation for unmarried women, fears of negative family and community reactions, unstable relationships, partner or parental coercion, rape and incest (Chae et al., 2017; González de León, et.al, 2015, Okoro-Eweka 2014; Abbas, 2014).

The fact that the pregnancy is unwanted is often the basis for why abortion is chosen, however, not all adolescents who decide to seek an abortion will succeed in obtaining one, especially when the adolescent's social environment or her personal beliefs/values rule out abortion as an option, or when abortion is difficult to access (Burgess, 2017; Chae et al., 2017; Bankole, Adewole, Hussain, Awolude, Singh, & Akinyemi, 2015).

2.2.7. Unsafe abortion

Globally, at least 8% of maternal mortality is attributable to unsafe abortion (Sorhaindo & Morris, 2016; Singh & Maddow-Zimet, 2016). Unsafe abortion is defined by the World Health Organization (WHO) as the procedure for termination of an unintended pregnancy carried out by individuals lacking the requisite skills or in an environment that does not conform to medical standards, or both (WHO, 2018b; IPAS, 2016). Unsafe abortions may be performed by the woman herself, by non-medical persons, or by health workers in unhygienic conditions. Such abortions may be induced by the insertion of a solid object (usually root, twig or catheter) into the uterus, by improperly performed dilatation and curettage procedure, the ingestion of harmful substances, or the exertion of external force.

Unsafe abortions have been eliminated in developed countries, but still persist in developing countries where it remains a major cause of morbidity and mortality (WHO, 2018b). About 7 million women are admitted to hospitals as a result of complications of unsafe abortions every year in developing countries (WHO, 2018b). In some areas of these developing countries, about half of the admissions to hospital gynecological wards were women needing treatment after unsafe abortions between 2010 and 2014 (Singh & Maddow-Zimet, 2016).

According to the World Health Organization, every 8 minutes a woman dies of complications arising from an unsafe abortion in developing countries (Manandhar et al., 2015; Shah, Ahman, & Ortayli, 2014). Mortality from unsafe abortion is estimated to 220 deaths per 100 000 unsafe abortions in developing regions and 520 deaths per 100 000 unsafe abortions in sub-Saharan Africa (Ganatra et.al, 2017). Getting accurate data for abortions and worse, unsafe abortions is challenging as many countries still have very weak data collection and monitoring and evaluation systems. However, in 2012, nearly seven per 1,000 women of reproductive age in Africa were treated for complications from unsafe abortion. In all, about 1.6 million women in African region are treated for such complications each year (Singh & Maddow-Zimet, 2016). Africa is the world region with the highest number of abortion-related deaths. In 2014, at least 9% of maternal deaths in Africa were from unsafe abortion. (Gutmacher Institute, 2018)

Unsafe abortion is a serious problem in Nigeria and each year, Nigerian hospitals provide care to 142,000 women experiencing complications from abortion, with reports of between 20,000 and 60,000 annual mortalities. Abortion carries a 14-year jail sentence for both the provider and the patient in Nigeria, and this drives them into the hands of quacks and other, unskilled health professionals (Abbas, 2014). Nevertheless, women who live in countries where abortion has been legalized still patronize unskilled persons for termination of unplanned pregnancies because of other reasons, including lack of knowledge of available services, limited trust in the health system, religion and social issues (Yegon, Kabanya, Echoka & Osur, 2016).

In Nigeria, given the high poverty rates and the high maternal mortality rates, thousands of women each year choose to terminate pregnancies they do not want and which are not in their best interest (Giwa, 2013). Though data on unsafe abortions are incomplete because of the clandestine nature of the practice, unsafe abortion has been found to contribute up to 40% of

maternal mortality figures in Nigeria (Abbas, 2014). Nevertheless, restrictive abortion laws, stigma, poverty, gender inequalities and lack of access to adequate health care lead to the decision of adolescents to undergo illegal abortions (Yegon, Kabanya, Echoka & Osur, 2016). In almost all developing countries women's access to safe abortion is restricted by the law, which results in high rates of preventable complications and premature deaths (Yegon, Kabanya, Echoka & Osur, 2016).

Feminists, advocates for women's reproductive rights and public health researchers have contributed significantly to the political debate about abortion at both global and country levels, and many of the efforts to support women's right to legal abortion have been successful (Finer and Fine, 2013; Center for Reproductive Rights, 2013). At the same time, however, movements to stigmatize abortion have gained political strength throughout the world (González de León, Billings, Chhabra, & Maja, 2015). Their focus on criminalization and moral religious standpoints has discouraged the debate about abortion in many places. New regulations to limit access to legal abortion have been imposed even in countries with liberal abortion policies and in many others laws continue to be severely restricted (González de León, et.al, 2015).

2.2.8. Unintended Pregnancy and Unsafe Abortion among Adolescents

The vast majority of abortions result from unintended pregnancies. The estimated unintended pregnancy rates in developed and developing regions are 45 and 65 per 1,000 women aged 15–44, respectively, as of 2010–2014; both values represent significant declines since 1990–1994. Current rates are highest in Latin America and the Caribbean (96 per 1,000) and Africa (89 per 1,000) (Bearak et al., 2018). Globally, 56% of unintended pregnancies end in induced abortion;

regionally, this proportion ranges from 36% in Northern America to 70% in Europe (Bearak et al., 2018).

The rates of adolescent pregnancy have decreased worldwide but remain high in places where poverty affects large sectors of the population. Girls living in marginalized rural and urban areas in developing countries, with limited or no access to education, employment and health care are most at risk of having early pregnancies (UNFPA, 2016; Jejeebhoy et al., 2013).

Worldwide, 95% of births to adolescents aged 15-19 occur in low and middle-income countries. About 19% of young women become pregnant before they turn 18 years and around 20,000 adolescents give birth each day; 90% of adolescent pregnancies occur within marriage or a union (UNICEF, 2016). Data on younger adolescents are scarce, and according to estimate, births to girls aged 10-14 account for at least 2 million of the 7.3 million births each year within the adolescent group (UNFPA, 2016).

Adolescent pregnancies are often unintended as a result of the different factors. These are: limited or no access to health care, negative attitudes of health providers toward the use of contraceptives by unmarried adolescents, unexpected sex and lack of knowledge about how to avoid pregnancy, inconsistent use of contraceptives or use of ineffective methods, and refusal of their partners to use condoms or other contraceptive methods. Adolescent pregnancy, however, does not always result from accidents or misinformation. Sometimes adolescents seek to become mothers due to the strong influence of traditional cultural values that shape women's gender roles. Early marriage remains common in low and middle-income countries and adolescents are often pressured by their partners and families to prove their fertility soon after marriage (Singh, et.al, 2018; Jejeebhoy et al., 2013). Moreover, adolescents are especially vulnerable to sexual abuse and their pregnancies often result from forced sex, rape or incest (Ikeanyi & Okonkwo, 2014). Consequently, a

significant proportion of them opt for induced abortion to avoid unwanted births (Ikeanyi & Okonkwo, 2014; Jejeebhoy et al., 2013). In the Nigerian setting, unwanted pregnancy is a social stigma, and this can be seen especially in the unmarried adolescents who go to great lengths to have an induced abortion. The lack of resources and support to take care of the babies, the fear of becoming a school drop-out and the fear of the social consequences of premarital childbirths also compel most of the adolescent victims to opt for induced abortion (Ikeanyi & Okonkwo, 2014). In Nigeria, induced abortion is not carried out in public health institutions, rather, it is carried out in private settings in the hands of doctors or by other health practitioners, or by unskilled operators and quacks, and the rest are self-induced (Ikeanyi & Okonkwo, 2014).

2.2.9. Consequences of unsafe abortion

Globally, 5 million women suffer severe consequences of unsafe abortions ranging from pain and haemorrhage to more serious conditions such as sepsis, septic shock, pelvic infections, uterine perforation, injury to the genital tract and internal organs annually (WHO, 2018b; Guttmacher Institute, 2015). The consequences of unsafe abortions predominantly affect women in countries with highly restrictive laws, which are concentrated in developing regions (Singh, et.al, 2018). Studies have shown that unsafe abortion is most often associated with retained products of conception, hemorrhage, sepsis, uterine and bowel perforation, pelvic abscess, endotoxic shock, renal failure, and death (Singh, et.al, 2018; Emechebe, Njoku, Udofia, & Ukaga, 2016; Mcharo, 2016; Kalilani-Phiri, Gebreselassie, Levandowski, Kuchingale, Kachale, & Kangaude, 2015; Abbas 2014). Long-term sequelae include ectopic pregnancy, cervical incompetence, cervical dystocia, chronic pelvic pain, and infertility with grave implications for the future reproductive health of the woman (Emechebe et.al, 2016).

Infection and sepsis was the most frequent reported complication in all the studies that investigated causes of maternal death due to unsafe abortion (Kalilani-Phiri, et.al, 2015; Tebeu, Halle-Ekane, Itambi, Mbu, Mawamba, & Fomulu, 2015; Dinyain, Omoniyi-Esan, Olaofe , Sabageh, Komolafe, & Ojo, 2014; Abbas 2014) . A study conducted in tertiary hospitals in Nigeria, reported post-abortion sepsis (55%) to be the cause of maternal death due to unsafe abortion, while another study from Ghana reported (78%) post-abortion (Dinyain, et.al, 2014; Ganyaglo, & Hill, 2012). Similar numbers were reported in a study from a University Teaching Hospital in Cameroon with 66% of unsafe abortion deaths related to post-abortion sepsis (Tebeu, et.al, 2015). A study combining results from Benin, Cameroon and Senegal also reported sepsis as the most important risk factor for maternal morbidity and death (Salomonsen, 2017). Hemorrhage was reported as the second most frequent complication due to unsafe abortion, and in a study conducted in Nigeria, one in five patients treated for complications of abortion were in need of a blood transfusion (WHO,2018; Guttmacher Institute, 2015)

Unsafe abortion-related complications are one of the major causes of hospital admissions in developing countries, which results in a significant drain on the scarce financial resources to provide other reproductive health services (Shah & Ahman, 2012). In Africa and Latin America, for example, the annual costs of treating women who experience abortion-related complications impose a financial burden equal to more than half of what is spent on obstetric emergencies by government health facilities (Singh et.al, 2018; González de León, et.al, 2015). In Nigeria, unsafe abortion places a serious burden on the nation's health system as well on the health and well-being of women and their families. According to Guttmacher Institute, (2015) post abortion care in Nigerian hospitals cost US\$132 per patient, of which 72% (US\$95) was paid by families. In additional, about 40% of women undergoing abortion experience complications serious enough to

require medical treatment and only about 10% deaths due to cases of unsafe abortion were averted among women treated in Nigerian secondary and tertiary hospitals in 2012 as a result of prompt PAC intervention by the health care providers (Guttmacher Institute, 2015).

2.2.10. Religion and abortion

Religion is acknowledged as a powerful force that has a strong influence on social behavior and human interaction (Czachesz, 2011 cited by Mcharo, 2016). Religious views on practice of abortion tend to vary in most countries particularly in African countries, where babies are seen as treasures and gift from God (Iboudo et al., 2014). The major religious groups in the African region are Islam, Christianity (mostly Catholicism and Pentecostalism) and to a lesser extent several traditional African religion (Mcharo, 2016; Iboudo et al., 2014), and their opinions on abortion ranges from strict (permitting no abortions for any reason) to more accommodating views, especially for early abortions (Maguire, 2016; Mcharo, 2016). However, most religious ideologies and teaching condemned induced abortion and regarded it as murder in African regions (Mcharo, 2016; Iboudo et al., 2014).

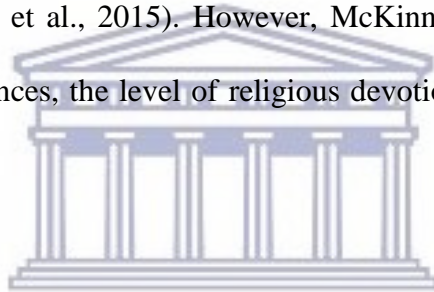
Nigeria is a multi-religious society with religion that is deeply entrenched in the culture of its people. This is largely reflected in the various religious practices amongst the different ethnic groups in the country. The Nigerian religion exemplifies morals and advocates uprightness and piety (George & Amusan, 2012). The predominant religions in Nigeria are Islam, which constitutes about 50%, followed by Christianity 40% and other traditional religions 10%. Muslims are predominantly in the northern part while the Christians are mostly in the central and southern parts of the country (CIA 2013). Major school within Christianity and Islamic religion prohibit induced abortion, except to save the woman's life. Christianity is strictly against abortion mainly because it regarded as 'murder'. The Roman Catholic Church has been noted to

have the most conservative views towards abortion. For example, the Roman Catholics discourage the use of modern contraceptives and they are more likely to judge abortion negatively than other denominations (Olaitan, 2017).

The *Quran* does not explicitly address abortion, but, there is general agreement that abortion is only permitted for the most serious reasons, such as saving a woman's life. Majority of Muslims believed that abortion is strictly prohibited after the foetus has acquired life or soul of its own which is estimated to be about 120 days of gestation. This means that to an extent some Muslims support abortion (before 120 days of gestation) however, minority of scholars oppose abortion at any stage of development, based on the belief that the embryo is already on its way to having a soul from the moment of conception (Olaitan, 2017; Clements, 2015).

A study conducted in Pakistan found that religiously minded people or clergy viewed abortion as a grave sin and therefore strongly opposed PAC services (Azmat et.al, 2012). This attitude not only affected negatively the seeking of PAC services by women who were experiencing abortion-related complications but also the providers of PAC services. The clerics considered the PAC providers as murderers (Mcharo, 2016; Azmat et al., 2012). Therefore some health care providers may have religious or conscientious objection to provision of PAC services. Furthermore, Iboudo et al., (2014) maintained that where there are moral or religious constraints against induced abortion, then higher prevalence of unsafe abortion will be observed. This is the case in Brazil, Burkina Faso, and Nigeria with multifaceted religions that condemned abortion (Storenga & Ouattarad, 2014; Iboudo et al., 2014). Furthermore, Selebalo-Bereng and Patel (2018) noted that Christian youth had the most negative attitudes towards abortion mostly due to the religious teachings and ideologies. These religious teachings may also influence the perceptions and the use of PAC services among the believers in case of abortion complications; given the powerful

ability of religion to shape and change people's attitudes and behaviour (Olaitan, 2017; Mcharo, 2016). Aniteye and Mayhew (2013) noted that abortion providers in Ghana experience conflicts between their religious and moral beliefs about the sanctity of life (foetal) and their duty to provide safe-abortion care. The religious views of obstetricians were tempered by their exposure to international debates, treaties, and safe-abortion practices and better awareness of national research on the public health implications of unsafe abortions. Midwives were more driven by fundamental religious values condemning abortion as sinful. In addition to personal views and dilemmas, 'social pressures' and the actions of facility managers affected providers' decision to openly provide abortion services. In general, religion influences healthcare providers' belief that abortion was a sin (Rehnström et al., 2015). However, McKinnon & Hayes, (2018) stated that irrespective of religious differences, the level of religious devotion is inversely proportional to a liberal stance on abortion.



2.2.11. Abortion Laws

2.2.11.1 Global perspective of abortion laws

In 1994, 179 governments signed the International Conference on Population and Development Programme of Action, signalling their commitment to prevent unsafe abortion. Since this important milestone, more than 30 countries worldwide have liberalized their abortion laws while only a handful have tightened legal restrictions on abortion (Center for Reproductive Rights. 2017). Most of these restrictive laws are adopted from European colonial laws when advances in medicine were limited and aimed to safeguard women against unsafe abortion. Many have remained static even when the "mother country" laws have evolved (Center for Reproductive Rights. 2017; Singh, Remez, Sedgh, Kwok and Onda, 2018).

The mid-to-late 20th century saw a wave of amendments to criminal codes, where most countries clarify exceptions under which induced abortion is not subject to penalties (Singh, et.al, 2018). The reforms started in the early-to-mid 1950s in Soviet Bloc and satellite states across sub-regions of Europe (Eastern, Northern and Southern) and Asia (Western and Central). In the 1960s and 1970s, reform extended to some developing countries, including China, Cuba, India and Tunisia. By the mid-1980s, abortions were broadly legal throughout most of Europe and in Northern America (Singh, et.al, 2018). From 1985 to 2010, nearly all remaining European countries lifted restrictions to permit abortion on broad grounds including one country in Sub-Saharan Africa (South Africa), three in South or Southeast Asia (Cambodia, Nepal and Vietnam), and one in South America (Guyana) (Center for Reproductive Rights, 2014).

Globally, abortion laws fall along a continuum ranges from category 1, from outright prohibition to category 6, allowing abortion without restriction as to reason. As of 2017, 42% of women of reproductive age live in the 125 countries where abortion is highly restricted (prohibited altogether, or allowed only to save a woman's life or protect her health) (Singh, et.al, 2018). The vast majority (93%) of countries with such highly restrictive laws are in developing regions. In contrast, broadly liberal laws are found in nearly all countries in Europe and Northern America, as well as in several countries in Asia. However, some countries with broadly liberal laws have increasingly added restrictions that chip away at access to legal procedures; these include the United States and several countries in the former Soviet Bloc or zone of influence (Bearak et al., 2018)

26 countries prohibit abortion without any exemption, of which only Andorra, Malta and San Marino are in developed regions, while Egypt Philippines and El Salvador are in developing region countries. They account for 60% of the population of women in countries where abortion

is not permitted on any ground (UN, Department of Economic and Social Affairs, Population Division, 2015). 39 countries permit abortion only to save a woman's life; of these, only one (Ireland) is in the developed world, while the remaining 38 countries are in developing nations and they include populous countries such as Bangladesh, Brazil, and Nigeria. This category accounts for one-fifth of the world's women of reproductive age (Singh, et.al, 2018).

The laws in another 36 countries allow abortion to save a woman's life and to protect her physical health. Of these the vast majority (33) are in developing regions. Furthermore, 24 more countries allow abortion to protect a woman's mental health. Of these two (2) are in the developed world (New Zealand and the special jurisdiction of Northern Ireland), while the remaining 22 in developing-world countries range from the small island of Nauru to the midsize nations of Algeria, Colombia and Thailand (Chabin, 2014; Singh, et.al, 2018). 13 countries add socioeconomic reasons to the three medical grounds (life, physical health and mental health) enumerated above, while 24 added at least one of three additional grounds: in cases of rape or incest, or when the foetus is diagnosed with a grave anomaly.

Currently, some 6% of the world's 1.64 billion women of reproductive age live in a country where abortion is prohibited altogether, without any explicit exception while 21% live in a country where abortion is explicitly allowed only to save a woman's life. An additional 11% live where abortion is also permitted to protect a woman's physical health, another 4% where abortion is also permitted to protect a woman's mental health, and 21% where abortion is also permitted on socioeconomic grounds. Finally, some 37% of the world's women of reproductive age live in countries where abortion is available without restriction as to reason, however, the maximum gestational limits specified in almost all cases (Singh, et.al, 2018).

2.2.11.2 Abortion laws in Africa

An estimated 93% of women of reproductive age in Africa live in countries with restrictive abortion laws (i.e., countries in the first four categories in Table 2). Even in countries where the law allows abortion under limited circumstances, it is likely that few women are able to obtain a safe, legal procedure (Guttmacher Institute, 2018; Singh, et.al, 2018).

Abortion is not legally permitted on any grounds in 10 out of 54 African countries. Four (4) countries in Africa have relatively liberal abortion laws: Zambia permits abortion for health and socioeconomic reasons, whereas Cape Verde, South Africa and Tunisia permit abortion without restriction as to reason, with gestational limits. Nigeria, allow abortion to save a woman's life (Guttmacher Institute, 2018)

Table 2.2: Legality of abortion in African countries



Countries in Africa can be classified into six categories, according to the reasons for which abortion is legally permitted.

Reason	Countries
Prohibited altogether, (no explicit legal exception)	Angola, Congo-Brazzaville, Congo-Kinshasa, Egypt, Gabon, Guinea-Bissau, Madagascar, Mauritania, São Tomé and Príncipe, Senegal
To save life of woman	Côte d'Ivoire, Libya, Malawi, Mali (a,b), Nigeria, Somalia, South Sudan, Sudan (a), Tanzania, Uganda
To save life of woman/preserve physical health*	Benin (a,b,c), Burkina Faso (a,b,c), Burundi, Cameroon (a), Cen. African Republic (a,b,c), Chad (c), Comoros, Djibouti, Equatorial Guinea (d,e), Ethiopia (a,b,c), Guinea (a,b,c), Kenya, Lesotho (a,b,c), Morocco (e), Niger (c), Rwanda (a,b,c), Togo (a,b,c), Zimbabwe (a,b,c)
To save life of woman/preserve physical or mental health	Algeria, Botswana (a,b,c), Eritrea (a,b), Gambia, Ghana (a,b,c), Liberia (a,b,c), Mauritius (a,b,c,d), Mozambique (a,b,c), Namibia (a,b,c), Seychelles (a,b,c), Sierra Leone, Swaziland (a,b,c)
To save life of woman/preserve physical or mental health/socio-economic reasons	Zambia (c)
Without restriction as to reason	Cape Verde, South Africa, Tunisia

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. *Notes:* Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal anomaly. Some restrict abortion by requiring (d) parental or (e) spousal authorization. Countries that allow abortion without restriction as to reason have gestational age limits (generally the first trimester); for legal abortions in categories 2 through 5, gestational age limits differ by prescribed grounds.

Guttmacher Institute, 2018

2.2.11.3 Nigerian abortion law

In Nigeria, abortion is governed by two different laws base on geographical location. In Northern Nigeria, the Penal Code, Law No. 18 of 1959, is in effect, while in the south, it is the Criminal Code of 1916. Under the Penal Code, an abortion may be legally performed only to save the life of the pregnant woman. Outside of this provision, a person who voluntarily causes a woman with child to miscarry can be convicted for up to fourteen years' imprisonment, and/or liable for the

payment of a fine. A woman who causes her own miscarriage is subject to the same penalty. Harsher penalties are applied for the person, who performs or assists in the abortion if the woman dies as a result (Center for Reproductive Rights, 2015; Criminal Code Act, 1990; Laws of the Federation of Nigeria; 1990)

The Criminal Code, which is modeled on the English Offences against the Person Act of 1861, permits an abortion to be legally performed only to save the life of the mother. Section 297 provides that “a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother’s life, if the performance of the operation is reasonable, having regard to the patient’s state at the time and all the circumstances of the case” (Criminal Code Act, 1990; Laws of the Federation of Nigeria; 1990). Any person who, with intent to procure the miscarriage of a woman, unlawfully administers to her any noxious thing or uses any other means is subject to fourteen years’ imprisonment. A woman who undertakes the same act with respect to herself or consents to it is subject to seven years’ imprisonment. Any person who supplies anything knowing that it is intended to be unlawfully used to procure a miscarriage is subject to three years’ imprisonment (Criminal Code Act, 1990; Laws of the Federation of Nigeria; 1990). Abortion is therefore allowed in Nigeria to save the life of the woman, to preserve physical and mental health, but not allowed for rape or incest, foetal impairment, economic or social reasons or on request.

The abortion laws in Nigeria have yet to undergo any substantial reforms. A 1982 attempt to liberalize abortion law by the Nigerian Society of Obstetrics and Gynaecology in Nigeria was defeated when the Nigerian legislature failed to pass the termination of pregnancy bill due to overwhelming opposition by religious groups. The bill was intended to have permitted abortion, if two physicians certified that the continuation of pregnancy was harmful to the mother or the

existing children in the family, and also if the baby had physical or mental abnormalities which would have resulted in it being seriously handicapped (Odia, 2014). Another attempt was made in 2012 to reform the abortion law when a bill was passed into law to accommodate termination of pregnancy in cases of rape or incest by the state Governor of Imo State in the South-East of Nigeria. However, various religious and cultural groups, including the Association of Catholic Medical Practitioners of Nigeria clamoured that the law be withdrawn because it did not reflect the yearnings of the people. In 2013 the law was abrogated with a public apology from the governor of Imo State (Odia, 2014; Nkwopara, 2013).

2.2.11.4 Relationship between unsafe abortion and abortion law

The legal status of abortion is one factor that determines the extent to which the procedure is safe, affordable, and accessible. In countries where abortion is legal, abortions are more likely to be performed by trained health professionals, be more available, and cost less. In these countries, maternal deaths and injuries related to abortion tend to be lower (Population Reference Bureau, 2011).

In some countries, written laws or policies on abortion do not necessarily reflect what is actually practised (Population Reference Bureau, 2011). Sedgh et al., (2012) stated that the likelihood that a woman will have an abortion for an unintended pregnancy is almost the same, whether abortion is legally restricted or not. Legal restrictions on abortion do not result in fewer abortions, nor do they result in significant increases in birth rates. However, the legal status of abortion is an important indicator of women's ability to enjoy their reproductive rights. Legal restrictions on

abortion often cause high levels of illegal and unsafe abortion, and there is a proven link between unsafe abortion and maternal mortality (WHO, 2015; Center for Reproductive Rights, 2013).

The World Health Organization (WHO) recognizes that in countries with restrictive abortion laws, induced abortion rates are high, most abortions are unsafe, and women's health and lives are frequently jeopardized (WHO, 2015). Legal restrictions on abortion do not reduce the likelihood that women facing an unplanned pregnancy will seek abortion services. Instead, they compel women to risk their lives and health by seeking out unsafe abortions. Where induced abortion is highly restricted or unavailable, “safe abortion has become a privilege of the rich, while poor women have little choice but to resort to unsafe providers” (Center for Reproductive Rights, 2017). Conversely, the removal of legal restrictions on abortion has shifted previously clandestine, unsafe procedures to legal and safe ones, resulting in reduced rates of maternal mortality (Center for Reproductive Rights, 2017).

Existing data indicate an association between unsafe abortion and restrictive abortion laws. According to estimates for 2014, complications from unsafe abortions are common in developing regions, where abortion is often highly restricted (Guttmacher Institute, 2016a). Almost all abortion-related deaths occur in developing countries with more restrictive abortion laws, with the highest number occurring in Africa. Recent studies estimate that 8-18% of maternal deaths worldwide are due to unsafe abortion; the number of abortion-related deaths in 2014 ranged from 22,800 to 44,000 globally (Sedgh et al., 2016. Guttmacher Institute, 2018).

The same correlation appears when a given country tightens or relaxes its abortion laws. In Romania, for example, where abortion was available upon request until 1966, the abortion mortality ratio was 20 per 100,000 live births in 1960. New legal restrictions were imposed in 1966, and by 1989 the ratio reached 148 deaths per 100,000 live births. The restrictions were

reversed in 1989, and within a year the ratio dropped to 68 of 100,000 live births; by 2002 it was as low as 9 deaths per 100,000 births. Similarly, in South Africa, after abortion became legal and available on request in 1997, Southern Africa had the lowest abortion rate of all African sub-regions, at 15 per 1,000 women in 2010-2014 (Sedgh et al., 2016; Guttmacher Institute 2016b).

Existing evidence suggests that the highest annual rate of abortion in the 2010-2014 period was in the Caribbean, where abortion laws are the most restrictive, with an estimate of 65 per 1,000 women of childbearing age, followed by South America, 47 per 1,000 women of childbearing age. The lowest rates were in North America, and Western and Northern Europe where abortion is legal and widely available and contraceptive use is high. The rate for these regions is 17 and 18 per 1,000 women of childbearing age respectively (Sedgh et al., 2016; Guttmacher Institute, 2016b). We see then that less restrictive abortion laws do not necessarily guarantee safe abortions for those in need; better education and access to health care are also required. In India for instance, unsafe illegal abortions persist despite India's having passed the Medical Termination of Pregnancy Act in the early 1970s. The intention of the act was to remove legal hindrances to terminating pregnancies in the underfunded (national) health care system, but women still turn to unqualified local providers for abortion (WHO 2018b).

Irrespective of the relationship between unsafe abortion and abortion law, unsafe abortion should be prevented through the promotion of sex education, family planning, and safe abortion services to the full extent of the law, and post-abortion care in all cases.

2.3. Concept of Post-Abortion Care (PAC)

Post-abortion care (PAC) is a global approach to solving the problem of maternal mortality and morbidity arising from abortion complications in both spontaneous and induced abortion (Mutua, Maina, Achia, & Izugbara, 2015; Adinma, 2012). It consists of a series of medical and related interventions designed to manage the complications of abortion. Its overall aim is to reduce maternal morbidity and mortality from abortion and its complications, and to improve women's sexual and reproductive health, and their quality of life in general. A comprehensive post-abortion care service has been identified as useful in ameliorating the often adverse health consequences associated with unsafe abortion in regions with restrictive abortion laws (Adinma, 2012).

Post-abortion care (PAC) is one of the integrated service delivery models in global public health that combines emergency and preventive services, for maternal and child survival, and FP. The model that is commonly drawn upon internationally for starting PAC programmes was developed by USAID and includes three core components: emergency treatment, FP counselling provision, and community empowerment through awareness and mobilization. By preventing unintended pregnancy and subsequent abortions, PAC contributes to ending preventable child and maternal deaths and is therefore considered as a high-impact practice (Gemzell-Danielsson, Kopp Kallner, & Faúndes, 2014; Curtis, Huber, & Moss-Knight, 2010).

The components of PAC include community and service provider partnerships, counselling, treatment, contraceptive services and reproductive and other health services (Corbett and Turner, 2003; IPAS, 2015). As such, PAC links curative services, such as treatment of incomplete abortion and miscarriage (TIAM), with preventive services, like family planning (IPAS and VSI, 2011). As part of a comprehensive reproductive health strategy, PAC services can also be vital in

preventing unintended pregnancies, thereby contributing to the reduction of maternal morbidity and mortality.

2.3.1. Origin of PAC

The term “post-abortion care” was first articulated as a critical element of women's health initiatives in IPAS's 1991 strategic planning document by International Projects Assistance Services or IPAS (Ministry of Health, Nutrition and Indigenous Medicine, 2015; Corbett & Turner, 2003). The objective of this was to encourage “the integration of post-abortion care and family planning services in health care systems” as a means of breaking the cycle of repeat unwanted pregnancies and improving the overall health status of women in the developing world (Mcharo, 2016; Adinma, 2012; Corbett & Turner, 2003). In 1991, IPAS listed post-abortion family planning and other reproductive health care as essential elements of a framework for providing quality abortion care, based on Bruce's Quality of Care framework and in 1998, IPAS and PRIME published a framework for quality of post-abortion care (Mcharo, 2016).

In 1993, Engender Health, IPAS, IPPF, the JHPIEGO Corporation and Pathfinder International formed the Post-Abortion Care Consortium to educate the reproductive health community about the consequences of unsafe abortion, and to promote post-abortion care as an effective public health strategy. In 1994, IPAS published the original post-abortion care model, which comprised three elements: 1) emergency treatment services for complications of spontaneous or unsafely induced abortion, 2) post-abortion family planning counselling and services, and 3) links between emergency abortion treatment services and comprehensive reproductive health care (Ministry of Health, Nutrition and Indigenous Medicine, 2015). The focus of the original model was on the treatment of abortion-related complications (Corbett and Turner, 2003). However, the initial PAC model was revised and updated by the Post-Abortion Care Consortium Community Task Force in

2002, where two major elements were added, namely, community provider partnership and counselling (PACC, 2002). The updated and expanded model reflects both provider and client perspectives. It shifts the focus of PAC services from a treatment-oriented approach to a public health approach, which considers the broad range of sexual and reproductive health needs of women (Mcharo, 2016; Corbett and Turner, 2003).

The Essential Elements of the PAC model reflects an enhanced vision of high-quality, sustainable services. To expand access, some ministries of health authorized midwives and other providers at primary-level facilities to offer post-abortion care services, including treatment with manual vacuum aspiration. They were also authorized to refer abortion complications that could not be managed by primary-level providers, to tertiary and other hospital facilities where abortion complications could be managed effectively. As post-abortion care gained global support, governments and agencies began to implement programmes; a USAID evaluation in 2001 confirmed that more than 40 countries had post-abortion activities (Kulczycki, 2017; Prada & Singh, 2012). PAC has found wide acceptability in developing countries as a very important tool in combating maternal mortality from abortion. In countries like Nigeria and Ghana, and many other developing countries of Asia, middle level providers, especially nurse-midwives have been trained in PAC and have been employed widely in the provision of abortion treatment services both in the private and public health facilities, especially in rural areas. PAC has also been incorporated by the Nursing and Midwifery Council of Nigeria into the training curriculum of midwifery in Nigeria (Benson, Healy, Dijkerman, & Andersen, 2017; Adinma et al., 2010; Corbett & Turner, 2003).

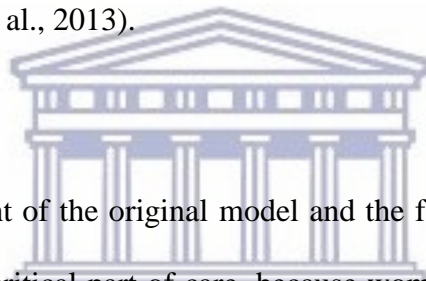
2.3.2. Essential Elements of the PAC Model

The Essential Elements of the PAC model, endorsed by the PAC Consortium in May 2002, reflects, from a provider and a consumer perspective, an enhanced vision of high-quality, sustainable services. The model's five elements reflect a shift from facility-based medical treatment to a public health approach that responds to women's broader sexual and reproductive health needs.

1. **Community and Service Provider Partnerships:** This element of the model recognizes community members' vital role in treatment, prevention and advocacy efforts. Community health education and mobilization have been identified as key strategies to combat unsafe abortion, increase access to quality of post-abortion care programmes, and improve women's reproductive health and lives (Singh, Remez, Sedgh, Kwok and Onda, 2018; Rogers & Dantas, 2017).

2. **Counselling:** Effective counselling enhances a woman's understanding of the psychosocial circumstances surrounding her reproductive past and future, and increases her confidence in her ability to participate in her own health care. Client-centred counselling ensures that women, rather than their providers, make voluntary choices about their treatment, contraceptive methods and other options. Post-abortion care counselling covers more than fertility and contraception (although it must emphasize these elements) and consists of more than mere information provision and sensitive communication. This kind of counselling provides an opportunity to help women explore their feelings about their abortion, assess their coping abilities, manage anxiety and make informed decisions (Baig, Jan, Lakhani, Ali, Mubeen, Ali, & Adnan, 2017; Corbett and Turner, 2003).

Quality of post-abortion contraceptive counseling has also been shown to be an important predictor of post-abortion contraceptive acceptance and use over time. A study carried out in Turkey to describe the impact of post-abortion family planning counseling in bringing about contraceptive usage in women who had induced abortion showed that 75.9% of the women followed were using one modern contraceptive method at the end of one year post abortion with significantly decreased in post-abortion pregnancy rate (Ceylan et al., 2009 cited by Pearson, 2015; Hassan, 2014). In Bangladesh, women who received high quality of post-abortion contraceptive counseling had three times higher odds of modern method use three months post-abortion, compared to women who received low quality counseling (AOR=3.01; 95% CI: 1.43 – 6.37) (Pearson, 2015; Sultana et al., 2013).



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3. Treatment: The first element of the original model and the focus of many post-abortion care activities, treatment remains a critical part of care, because women who have had an incomplete spontaneous or unsafely induced abortion will, in many cases, need uterine evacuation and other medical intervention. The revised model recognizes that post-abortion care does not always involve complications and that complications are not always life-threatening, but may be in the absence of swift and appropriate medical attention (Ahmed, Omer, Mahgoub, Ismail, Allah, & Seham, 2016; Corbett & Turner, 2003).

4. Family Planning and Contraceptive Services: Post abortion women are at risk of pregnancy almost immediately and the levels of unmet need for modern contraception are much higher among single, sexually active women than among in-union women because stigma continues to impede single women especially adolescents from getting contraceptive counselling and services (Bearak et al., 2018). All post abortion women should receive voluntary post abortion family

planning counselling and should be offered FP services at the site of care because fertility return within few weeks and timely FP services can prevent a subsequent unplanned pregnancy (High Impact Practices in Family Planning (HIP), (2012). Therefore, the revised post-abortion care model recognizes the fact that some women receiving post-abortion treatment need family planning services to help them space births, while others need contraceptive services because they have no plans to conceive. The model emphasizes the importance of overcoming barriers to the provision of family planning and contraceptive services during the same visit and at the same location as post-abortion treatment. When a facility does not provide these services at the time of abortion-related treatment, the opportunity to provide them may be lost. Women may not make another visit, to that facility or any other, for such services. In addition, if the facility is not the one that a woman would go to for her contraception, or if it does not have her method of choice, providers need to link her to a referral site. Ideally, the woman would leave the treatment facility with an interim substitute until she obtains her preferred method at a referral site. For this to happen, facilities' contraceptive service infrastructure must be adequate, and providers must be knowledgeable about which methods are appropriate for women following treatment. Making a wide range of birth spacing practices and contraceptive methods available to all women of reproductive age (including, where authorized, emergency contraception) is an effective strategy for preventing unwanted pregnancies and unsafe abortion, and for helping women achieve their reproductive goals (Samuel, Fetters & Desta, 2016; Corbett & Turner, 2003). According to Curtis, Douglas and Moss-Knight (2010), post-abortion family planning benefits individuals, families, communities and countries in many ways, and this includes increased modern contraceptive use and decreased abortion, reduced maternal and child mortality, prevention of mother-to-child HIV transmission and new HIV infections, and reduced social costs. Despite the benefits of post-

abortion family planning counselling and services, evaluation of post-abortion care programmes globally, found that in the delivery of post-abortion care services, family planning counselling and services did not receive as much attention as did emergency treatment (Tang, Wu, Li, Wang, Xu, Temmerman, et al., 2017).

5. Reproductive and Other Health Services: The PAC model encourages the provision of all appropriate reproductive health services at the time women receive treatment for abortion complications, preferably at the same facility. When it is not possible for a facility to provide the needed services, then it should have a functional referral or counter-referral systems and follow-up mechanisms, including record keeping, to ensure that women's needs are being met (Baig et al., 2017; Corbett & Turner, 2003). Reproductive and other health services include: (1) STI/HIV prevention education, screening, diagnosis and treatment; (2) Prevention and screening for sexual and/or domestic violence, immediate treatment as needed, and referral for medical/social/economic services and support; (3) Screening for anaemia, and treatment and/or nutrition education; (4) Infertility diagnosis, counselling and treatment; (5) Nutrition education; (6) Hygiene education; and, and (7) Cancer screening and referral, as needed (Post-abortion Care Consortium, 2015; Denno, Hoopes, & Chandra-Mouli, 2015).

2.3.3. Adolescent reproductive health services

The ICPD Program of Action describes services included under the umbrella of sexual and reproductive health services (SRHS). They are: prevention of reproductive tract and sexually transmitted infections including HIV; prenatal, delivery and postnatal care; family-planning counselling and services; abortion services and post-abortion care; treatment and information and counselling about human sexuality (Denno et.al, 2015).

Global analysis of reproductive health care services reflects common activities like family planning promotion and distribution of family planning devices, prevention, cure and management of sexually transmitted diseases, prevention and management of maternal and perinatal mortality and morbidity. While some countries had already adopted provision of safe abortion into its reproductive health program, in some other countries legalizing abortion is burning issue of discussion. The United Nations also recommends integrating cross cutting issues such as gender based violence, infertility, malnutrition and anemia, and reproductive tract cancers within national reproductive program (Khanal, 2016; UN 2006).

Treatment and prevention of Sexual Transmission Infections including HIV/AIDS

Adolescents display sexual behaviours that place them at risk of diseases, and because they experiment sexually, they face the consequences of indiscriminate sexual activities. In Nigeria as many other parts of sub-Saharan Africa, sexual intercourse is the main mode of transmission of HIV and AIDS as well as other sexually transmitted infections. Nigeria's development is compromised by the sexual and reproductive health issues afflicting its youth. Lack of sexual health information and services make young people vulnerable to sexually transmitted diseases and unintended pregnancy. Incidence and prevalence estimates suggest that young people aged 15–24 years acquire half of all new STIs and that one in four sexually active adolescent females has an STI, such as chlamydia or human papillomavirus (HPV) (CDC, 2016). Compared with older adults, sexually active adolescents aged 15–19 years and young adults aged 20–24 years are at higher risk of acquiring STDs for a combination of behavioral, biological, and cultural reasons (CDC, 2016). Treating STIs is essential because they can facilitate the transmission of HIV as well as causing lasting damage such as infertility. Only a minority of adolescents have access to any acceptable and affordable STI/HIV services. In most countries, comprehensive and accurate

knowledge about HIV is low and HIV testing in this age group is rare (Morris, & Rushwan, 2015).

Prenatal, delivery and postnatal care services

Adolescents face a higher risk of complications and death as a result of pregnancy than older women. In terms of complications, anemia, HIV and other STIs, postpartum hemorrhage, and mental disorders, such as depression, are associated with adolescent pregnancy. Pregnancy and delivery for girls who have not completed their body growth expose them to problems that are less common in adult women; 9% – 86% of women with obstetric fistula develop the condition as adolescents, with traumatic, often lifelong consequences. Complications from pregnancy and childbirth are the leading cause of death in girls aged 15–19 years in low and middle income countries where almost all of the estimated three million unsafe abortions occur (UNFPA, 2017; Morris, & Rushwan, 2015). Their babies also face a higher risk of dying than the babies of older women. Yet adolescents face enormous barriers to accessing reproductive health information and services (UNFPA, 2017). However, many organizations are working to improve adolescent reproductive and sexual health through advocacy and prevention programs/ services.

Family planning and counselling services

Globally, it is estimated that more than 220 million women in low and middle income countries have an unmet need for family planning. Overall, little progress has been made in increasing uptake of contraception. While increases in use have been slightly higher with adolescents than older women, this group are more affected by contraceptive failure and discontinuation rates, and use of traditional methods of contraception are still notable. One major outcome of unmet need for family planning is unwanted pregnancy and, consequently, high levels of unsafe abortion

(Morris, & Rushwan, 2015). Increasing access to modern contraception among adolescent girls is a crucial starting point for improving their long-term health (UNFPA, 2017).

Management of sexual dysfunctions

Most adolescents' sexual health research has focused primarily on STIs, unintended pregnancy, and sexual coercion. Relatively little is known about sexual functioning or problems in function that adolescents experience and the extent or impact of sexual dysfunction on adolescents' sexual health, but there is growing awareness that young people can suffer from sexual dysfunction just as adults. Many adolescents surveyed did not feel that their sex lives were hindered by their sexual dysfunction. Among those who were distressed, women (31%) were more likely to report that a sexual dysfunction affected their sexuality than were men (9%). Pain during intercourse was the dysfunction most likely to impact women's sex lives, followed by lack of desire, difficulty reaching orgasm, and lack of pleasure during intercourse. Premature ejaculation, lack of sexual desire, lack of pleasure during intercourse, and difficulty reaching orgasm were most prominent in hindering men's sex lives (Monson, 2017).

Sexual education services

In sub-Saharan Africa, where a fourth of all adolescents are reported to have sexual experience, education on sexual and reproductive health are generally reported to be low (Kyilleh, Tabong & Konlaan, 2018). Adolescents' knowledge and access to reproductive health services is important for their physical and psychosocial wellbeing. It has been found that the lack of knowledge about the consequences of unprotected premarital sex among adolescent females predisposed them to unwanted pregnancies, unsafe abortion and its complications, and sexually transmitted infections. Knowledge on reproductive health services is essential to enable them make informed choices. The type of choices made by these adolescents could either impact positively or negatively on

their lives, their families and the society at large (Kyilleh, Tabong & Konlaan, 2018). Other components of adolescents' reproductive health services are dealing with harmful practices, sexual health, parental care, treatment of non-infectious diseases connected to reproduction e.g. Cancers within the structure of adolescent friendly services (Denno, et.al, 2015).

Adolescents must have access to services in an environment free of disapproval because adolescents are known to often be embarrassed or ashamed to express themselves openly regarding sexual issues in the presence of strangers, sometimes even with their parents (WHO, 2018). Therefore, when the SRH of young people is ultimately threatened, it can lead them to seek unsafe services elsewhere, consequently leading to increase rate of morbidity and mortality among young people. However, evidence has shown that youth friendly health services are more effective when combined with community interventions/programs (Denno, et.al, 2015).

2.3.4. Adolescent reproductive health programs

Youth-targeted programmes aiming at behavioral changes which lead to a healthy lifestyle are of paramount importance. Efforts are directed at promoting adolescent-friendly services in prenatal, postpartum and post-abortion programmes in hospitals in countries such as Brazil, Chile, Ghana, Kenya, Mexico, South-Africa and Nigeria. A supportive environment is a key factor for youth-targeted programmes, therefore the community and family should be involved with the support of appropriate programmes.

In Nigeria, Family Life and HIV Education (FLHE) program is the central piece of the government's efforts to improve ASRH outcomes. The school-based sexuality education program was initiated in 2003 to targets in-school adolescents from ages 10-17 years (NACA 2014). The introduction of the Family Life HIV Education in schools is to infuse life skills and reproductive health information into the school curriculum for the benefit of adolescents most of whom are

students (Nwokocha, Isiugo-Abanihe, Omololu, Isiugo-Abanihe, & Udegbe, 2015). While the FLHE reaches in-school adolescents, those who are out-of-school do not have access to the same type of streamlined education. However, ongoing efforts to reach these group of adolescents including the Peer Education Plus (PEP) program, implemented by the Society for Family Health, a civil society organization, in partnership with the National Agency for Control of AIDS (NACA). PEP targets high risk populations, ages 15-24 years, through training peer educators, with a focus on HIV/AIDS and reproductive health. The Federal Ministry of Women's Affairs (FMOW) also runs a mentorship program for girls who drop out of school due to pregnancy or are single parents to teach them life skills. The program includes SRH education. Association for Reproductive and Family Health, Action Health, and Life Vanguard have also led similar programs. However, these are smaller programs and are not connected to the FLHE (each is run by a different ministry or agency) making it difficult to reach out-of-school adolescent systematically (Rafael, et.al, 2015). The aims of these programs are to: (1) Reduce the incidence of unwanted pregnancies among adolescents (2) curb the spread of HIV/AIDS among young people (FMOH, 2018).

2.3.5. Adolescent reproductive health policies

The concern about the health and development of adolescent has been expressed both regionally and internationally, including the 1985 International Year of the Youth (UN General Assembly), the 1990 UN convention on the Rights of the Child, The OAU African charter on the Rights and Welfare of the Child and the UN Special Session on Children. The WHO regional committee for Africa also concluded in 1995 that the health situation of adolescents is not satisfactory and subsequently adopted the Adolescent Health Strategy for African Region and endorsed the resolution urging member states to accord adolescent health and development priority in their

national and social economic development agenda. Furthermore, The United Nations Inter-Agency Task Force for the implementation of ICPD program of actions has prepared standard guidelines on sexual and reproductive health which includes global targets and encourages its member countries to devise program of action relevant to their country's situation and capacity (Khanal, 2016). Based on this standard document, governments from different countries have derived their own policies and strategies on sexual and reproductive health after conducting their need and resource assessment

In Nigeria, the National Adolescent Health Policy was formulated in 1995 by the Federal Government, through the Federal Ministry of Health (FMOH, 2018). However, two policies have been crucial in the direction the country has taken on ASRH. The first is the National Reproductive Health Policy and Strategy (2001), which paved the way for Nigeria's largest SRH education program known as the Family Life and HIV Education (FLHE) Program. It was also the first to provide an overarching framework for addressing SRH. The second is the National Policy on Health and Development of Adolescents and Young People in Nigeria (2007). The policy is the first comprehensive policy on adolescent health and its' goal is to promote the optimal health and development of adolescents and other young people in Nigeria (FMOH, 2018; *Rafael, et.al, 2015*). The policy identified major areas of adolescent health care and these include sexual behaviour, reproductive health, nutrition, accidents, drug abuse, career and employment. These major areas invariably became the focus of the policy. The policy emphasizes the importance of access to information and youth friendly services (YFS); and encompasses reproductive health, HIV/AIDS, risky behaviors, and education. In addition the policy emphasized building the capacity of health workers, social welfare officers, counsellors and other relevant staff to provide quality and friendly services to adolescents. Nevertheless, the followings

are brief lists of health policies and strategies that focus directly on adolescents' sexual and reproductive health

- National Reproductive Health Policy, which has an overall goal of creating an enabling environment for appropriate action, and provide the necessary impetus and guidance to national and local initiatives in all areas of reproductive health.
- The Revised National Health Policy aims to strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the accelerated achievement of the health-related Millennium Development Goals (MDGs).
- The National Policy on Population for Sustainable Development affirms that: “Young people are the future leaders of the nation. Government shall recognize their special needs and make appropriate provision for their growth and development with meaningful participation in national development, including the provision of an enabling environment for gainful employment.”
- The National Youth Policy identifies the need to create a societal condition in which the rights of the youth are advanced and protected, their welfare enhanced, and their effective functioning and self-actualisation ensured.
- The Child Rights' Act stipulates that “every child is entitled to enjoy the best attainable state of physical, mental and spiritual health” and that “every Government, parent, guardian, institution, service, agency, organisation or body responsible for the care of a child shall endeavour to provide for the child the best attainable state of health”.

- The Adolescent Health Strategy for the African Region and its Implementation Framework aims at identifying and responding to the health needs of adolescents in the Member States as well as to promote their healthy development
- African Youth Charter recognises the right of every young person to enjoy the best attainable state of physical, mental and spiritual health as well as the right to quality education and gainful employment. It also recognises that every young person shall have the right to participate in all spheres of the society.
- Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa of the African Union Commission which identifies young people's sexual and reproductive health rights as one of the major issues in the context of achieving universal access to comprehensive sexual and reproductive health services in Africa.
- The Maputo Plan of Action was adopted by African regions and it stipulated the following output: “youth friendly sexual and reproductive health and rights services positioned as key strategy for youth empowerment”.
- The Programme of Action (PoA) of the International Conference on Population and Development is a global policy that recognises adolescent reproductive health as one of the elements of reproductive health and advocates for their sexual and reproductive rights. Nigeria has developed a national strategic framework for the achievement of the PoA.
- The Beijing Platform of Action of the 4th World Conference on Women is also a global policy that consolidates the experiences of ICPD and builds upon previously agreed language to link reproductive health, reproductive rights, adolescents and other major developmental issues.

- UNFPA's State of the World's Population: Motherhood in Childhood (2013): Focuses on the challenge of adolescent pregnancy across the world.
- USAID's Youth in Development Policy (2012): This policy places strong emphasis on integrating youth considerations as cross-cutting factors in all USAID programming (health, education and economic empowerment).
- PEPFAR's Blueprint for an AIDS-Free Generation (2012): Recognizes that achieving effective HIV prevention with young people requires tailoring interventions to their needs, risks and interests
- Ending Child Marriage and Meeting the Needs of Married Children: Vision for Action (2012): USAID's commitment to preventing and responding to gender-based violence as part of its development and humanitarian assistance mission.
- UNICEF's State of the World's Children: Adolescence, an Age of Opportunity (2011): Advocates for large investments in adolescents, given historical global gains achieved in early and middle childhood since 1990
- Bali Global Youth Forum Declaration(2012): Recognizes young people's rights and explicitly states the need for investments in young people's sexual and reproductive health in order to achieve the Millennium Development Goals

2.3.6. WHO's guidelines for post-abortion care

Immediate post-abortion care is needed by women who experience complications from unsafe abortion. However, in nations where abortion is severely restricted, many women delay seeking care until their symptoms become critical (Ziraba, 2015). Most of the mortality associated with induced abortion can be attributed to treatment delays because the longer they remain untreated, the poorer the outcome (Eschenbach 2015). Recommended standards of post-abortion care integrate the following key elements: immediate treatment of complications, including pain management; provision of contraceptive counselling and services, and STI/HIV care; and mobilization of community partnerships to improve services and spread information about their availability (Post-abortion Care Consortium, 2015)

Consistent with the Cairo Programme of Action, which was agreed to by all countries, even in countries with restrictive abortion laws; the provision of post abortion care is generally accepted by governments and health care providers as part of standard women's health care. As a result, it would be extremely difficult for post abortion care to be denied on the grounds of conscientious objection. Global efforts emphasising the importance of post-abortion care to save lives have led some countries with restrictive abortion laws to issue laws that make provision of post-abortion care mandatory (Singh, et.al, 2018).

National guidelines on post-abortion care have been issued by several countries including Nigeria (Singh, et.al, 2018). Depending on the severity of the woman's symptoms and the stage of pregnancy in which the termination attempt occurred, WHO's guidelines for managing abortion complications vary (Table 2.3). To treat incomplete abortions in the first trimester, WHO recommends either misoprostol or vacuum aspiration, and for the most severe, life-threatening

complications such as: uterine perforation, peritonitis, septic or haemorrhagic shock), women generally need emergency interventions, which could include antibiotics, blood transfusions, intravenous rehydration therapy, antibiotics and surgery. Furthermore, to address critical shortages in highly trained personnel, WHO specify the health workers that are most appropriate for the task. This strategy expands access to life-saving care and simultaneously reduces costs (WHO 2015; WHO 2014)

The quality of post-abortion care falls far short of WHO's guidelines in many countries with extremely restrictive abortion laws. Delaying care for an incomplete abortion can make a mild problem much worse, because doing so can lead to sepsis, shock and even death. Medical personnel's discriminatory attitudes toward women who have had an abortion often obvious in neglect and abuse: For example, in Sudan and Gabon, post-abortion patients experienced excessively long waits significantly longer than all other obstetric patients. (Singh, et.al, 2018) An unknown level of risk is allowed by women who forgo care altogether, which likely occurs most often among those disadvantaged by their lower socioeconomic status. According to surveys of a wide variety of health professionals in 14 countries with recent abortion incidence studies, abandoning needed care is expected to be far more common among rural poor women than among urban rich women. Although, on average, an estimated 49% of rural poor women who need care from abortion complications do not get it while only 21% of similar urban women abandon such care (Singh, et.al, 2018)

vacuum aspiration (either manual or electric) and D&C were the procedures recommended for treating incomplete abortion and serious complications, Until relatively recently, when studies demonstrated effectiveness and safety of misoprostol in treating incomplete abortion (Adisso et

al., , 2014; Mayi-Tsonga et al., 2014). Misoprostol can be a good option for women with mild complications who want to avoid surgery (Singh, et.al, 2018) on the other hand, vacuum aspiration takes much less time, which can be an important consideration in resource-poor countries with overcrowded facilities. Moreover, despite WHO's long-standing advice to move away from and replace the invasive technique of D&C for post-abortion care, it continues to be broadly used in some resource-poor countries. For example, D&C was used in roughly four-fifths of post-abortion cases in South Sudan in 2008, two-thirds in Colombia in 2010 and nearly three-fifths in Pakistan in 2012, a proportion that barely changed from the report of 2002 (Singh, et.al, 2018; Darney et al., 2014; Sathar, 2014)

A woman's ability to comprehend can return very soon after an abortion—most often within a few weeks (WHO, 2015; Schreiber et al., 2011). WHO guidelines indicate that all women seeking abortion may initiate contraceptive use immediately following surgical or medication abortion. The full range of methods should be offered, including the most effective reversible methods such as the injectable, the implant, the IUD, each of which can be provided at the site of post-abortion care. For women who have been counselled about all methods, want no more children and freely choose tubal ligation, the immediate post-abortion period is an appropriate time for this procedure. However, in a number of settings, women do not receive adequate post-abortion contraceptive counselling. Obstacles to contraceptive services include shortages of trained staff, method stock-outs and providers' lack of knowledge about how long it takes for fertility to return (Singh, et.al, 2018).

Table 2.3: WHO's guidelines for quality of post-abortion care for health personnel

TASK	HEALTH WORKER TYPE			
	Lay health workers* Pharmacy workers Pharmacists	Auxiliary nurses Auxiliary nurse-midwives	Nurses Midwives Associate/advanced associate clinicians	Nonspecialist doctors Specialist doctors
LEVEL OF RECOMMENDATION FOR TASK (NEVER, IN SPECIFIC CIRCUMSTANCES, ALWAYS)				
Method of first-trimester abortion				
Vacuum aspiration	Never†	In specific circumstances	Always	Always‡
Combination medication and misoprostol only	Never for pharmacy workers; subtasks feasible for lay health workers and pharmacists	Always	Always	Always‡
Method of second-trimester abortion or of postabortion care				
Dilation and evacuation	Never†	Never§	Nurses/midwives:** never All others: more research needed	Always††
Medication	Never†	Never	In specific circumstances	Always††
Method of management of uncomplicated incomplete abortion				
Vacuum aspiration	Never†	In specific circumstances	Always	Always‡
Misoprostol	Pharmacists/pharmacy workers: never All others: more research needed	Always	Always	Always‡
Type of non-life-threatening complication for initial management				
Postabortion infection	Never†	Always	Always	Always‡
Postabortion hemorrhage	Never†	Always	Always	Always‡
Postabortion contraceptive method provision				
IUD	Never	ANMs: always All others: more research needed	Always‡‡	Always‡
Implant	Pharmacists/pharmacy workers: never All others: more research needed	In specific circumstances	Always‡‡	Always‡
Injectable	Pharmacists: always All others: in specific circumstances	Always	Always‡‡,§§	Always‡
Tubal ligation	Never†	Never	Associate/advanced associate clinicians:‡‡ always All others: more research needed	Always‡

(Singh, et.al, 2018)

2.4. Empirical review

Empirical review of literature in this study focus on previous research result findings from both quantitative and qualitative studies relating to abortion and post abortion care

2.4.1 Perceptions and trend of abortion in adolescents

The perceptions of abortion by adolescents are pertinent, as this may inform better approaches to abortion and post-abortion care in adolescents. Paluku, Kalisoke, Wandabwa and Kiondo (2013) in a study to describe the knowledge and attitudes of young women about the medical complications of induced abortions, recruited 319 youths aged 15 to 24 years who were attending Naguru's Information and Health Centre. The respondents' socio-demographic characteristics, knowledge and attitudes about induced abortions and its complications were obtained using an interviewer-administered questionnaire. Knowledge was assessed using a scoring system and attitude using a Likert scale. In addition, four focus group discussions were conducted using an interview guide. The results revealed that most (93.1%) of the young women knew of at least one medical complication of an induced abortion and that the majority of them cited death (91.3%) as the most common complication. Few (16%) participants would encourage their colleagues to procure an abortion, while 83.7% would counsel others about the perceived dangers of induced abortions. Participants who were aware of at least one complication were more likely to counsel their colleagues about the dangers of an induced abortion. Thus, knowledge of complications of induced abortions was high among female youths attending Naguru Teenage Information and Health Centre.

In Blantyre, Malawi, a descriptive study by Chamanga, Kazembe, Maluwa, Chirwa and Chimango (2012) found that adolescents admitted to the gynecological ward of Queen Elizabeth Central Hospital experienced psychological distress before, during and after unsafe induced

abortion. Before and during unsafe abortion, the adolescents were worried that their pregnancies would disrupt their education, they would lose family support and perhaps get arrested. In addition, they were angry and disappointed because of the lack of support from their male partners. After abortion, the adolescents felt guilty, regretted having lost their babies, and grieved for their children.

In yet another study, Ratlabala Makofane & Makofane (2007) examined the adolescents' perceptions of factors influencing their Choice on Termination of Pregnancy (CTOP) and the constraints in accessing TOP services. The major findings indicated that most adolescents were uninformed about CTOP. This is attributed to the lack of coordination among health professionals and educators in the dissemination of information. The overwhelming majority of the respondents expressed discomfort at receiving termination of pregnancy services from the local public clinics and hospitals, as they regarded such facilities as unfriendly to young people. In Ouagadougou in Burkina Faso, Iboudo, Greco, Sundby and Torsvik (2014) estimated the costs and consequences of abortions to women and their households through a cross-sectional study and found that women who had induced abortions were often single or never married, that they were younger, better educated and more likely to have had earlier pregnancies than women who had spontaneous abortions. They also tended to be more often under their parents' guardianship compared with women who had spontaneous abortions. Women who had opted for induced abortion paid much more money to obtain abortions and treatment of the resulting complications, compared with women who had spontaneous abortions.

A number of studies have been carried out in Nigeria to examine the perceptions and patterns of abortion as practised by adolescents. One such study was done by Olaitan (2010), who investigated the perceptions about unwanted pregnancy among university students in South-West

Nigeria, and found that university students have well-developed perceptions of the causes, consequences and prevention of unwanted pregnancy. This knowledge was, however, not translated into action, as most of them, though knowledgeable, still engage in activities that eventually end in unwanted pregnancy and subsequently abortion. A similar scenario was observed by Mustafa (2015) in a research study to determine the rate of abortion and contraceptive use among women seeking repeat induced abortion in Western Nigeria. He too found adequate knowledge and awareness in the sample population. This awareness, he found, did not translate into contraceptive use, with the end-result being very low contraceptive prevalence in Nigeria, a finding that correlates with high levels of unplanned pregnancies and abortions, leading to increases in the maternal mortality ratios, especially in the rural regions of Nigeria.

Oyebode, Sagay, Shambe, Ebonyi, Isichei, Toma, Embu, Daru and Ujah (2015) conducted a study to review the contribution of unsafe abortions to gynecological emergencies, patterns of terminations and complications, as well as morbidity and mortality among women in Jos University Teaching Hospital. The findings of the study revealed that morbidity and mortality from unsafe abortion remains high in adolescents and induced abortions contributed 4.8% of the 2,495 gynecological emergencies and 12.64% of the maternal deaths, with the maternal mortality ratio being 891/100,000 live births. The age range was 14-45 years, with the majority, 33% (40), being adolescents. 70.8% (85) of the subjects were unmarried, 26.7% (32) were married, and 2.5% (3) were separated or divorced. The parity range was 0-10, with 66.4% being nulliparous and 21.1% grand-multipara. At presentation, 26 (21.7%) denied termination of pregnancy. Modal gestational age was 13 weeks. Surgical termination occurred in 75 (62.8%) of patients. There were 51 abortions (42.5%) procured at private clinics and 28 (23.1%) at chemists and homes. For

most of the patients 60.8% (73), this was their first such experience. Most of the complications of induced abortion occurred in the first week and were mainly one or more of the following: incomplete abortion, septicemia, uterine perforation, acute renal failure, pelvic abscess and tetanus. Uterine evacuation was done for 47.8%, laparotomy for 17.5% and blood transfusion for 23.3% of the patients. The case fatality rate was 11.2%, with 30.8% of the deaths attributed to the use of herbal concoctions.

Awoyemi and Novignon (2014) embarked on a study to investigate the factors determining the demand for abortion and post-abortion care in Ibadan city of Nigeria. The results showed that 62% of respondents demanded abortion, and that 52.3% of those who demanded abortion received post-abortion care. The findings again showed that income was a significant determinant of abortion and post-abortion care demand. Women in higher income brackets were more likely to demand abortion and post-abortion care. Married women were found to be less likely to demand abortion and post-abortion care. Older women were significantly less likely to demand abortion and post-abortion care. Mothers' education was only statistically significant in determining abortion demand but not post-abortion care demand.

In Ilorin metropolis, Alade (2013) examined the attitudes of adolescents to abortion and found that the majority of adolescent students have a negative attitude towards abortion. From the findings, it was revealed that neither male nor female adolescents supported abortion. Their perceptions and attitudes may be informed by religious ideology; it was noted that the inhabitants of Ilorin township are mostly Muslim.

Atere, Ayodele and Omololu (2012) examined the influence of abortion on the lives of pregnant teenage girls in Lagos. The study adopted an exploratory and descriptive research design. Findings of the study indicated that adolescent girls are hesitant to discuss their past exposure to

abortion, have divergent perceptions of abortion and display inadequate though varying knowledge of the implications of abortion for their future reproductive health. Moreover, the study found evidence of cultural and religious inhibitions that discourage girls from public discussion of their sexual behaviour. Scared by the disgrace that such an act might cause, most girls determine that they will not access abortion services from specialists. The researchers strongly recommended that the government legalizes abortion to enable experts to handle the abortion and post-abortion needs of adolescent girls. This, they added, will save the lives of many innocent babies and girls who might be involved in unsafe abortion.

Ikeako, Onoh, Ezegwui and Ezeonu (2014) assessed the pattern of unsafe abortion and the extent to which unsafe abortion contributes to maternal morbidity and mortality in our setting. They also set out to assess the impact of post-abortion care. A descriptive study was carried out, of patients admitted for complications following induced abortions between January 1, 2001 and December 31, 2008 at the Federal Medical Centre, Abakaliki, in the south-east of Nigeria, with data obtained from case records. Of the 1,562 gynecological admissions, a total of 83 patients presented with complications arising from induced abortion. The age group 20-24 years was most significantly affected and adolescents constituted 32.5% (27/83). Nearly 15.7% (13/83) of these patients died while the remaining 84.3% (70/83) had various complications. These were septicemia 59.0% (49/83), anemia 47.0% (39/83), peritonitis 41.0% (34/83), hemorrhages 34.9% (29/83) and uterine perforation 30.1% (25/83). During the study, there were 38 gynecological deaths and abortion related death accounted for 34.2% (13/38) of these gynecological deaths. 84.3% (70/83) of the patients had no documented evidence of counselling on family planning and 59.0% (49/83) were not aware of the different methods of contraception.

Adjei, Enuameh, Asante, Baiden, Nettey, Abubakari, Mahama, Gyaase and Owusu-Agyei (2015), in a survey on Sexual and Reproductive Health among a representative sample of females aged 15-49, interviewed a total of 3554 women. Of this total, 2197 women reported on the outcomes of 2723 pregnancies that occurred over the period. Unmarried women were more likely to have abortions as compared with married women (aOR = 1.77, 95% CI [1.21-2.58], p = 0.003). Women aged 20-29 were 43% less likely to have abortions than those aged 13-19 (aOR = 0.57, 95% CI [0.34-0.95], p = 0.030). Women with primary, middle/junior high school (JHS) and at least secondary education had higher odds of having abortions than women without formal education. Compared with poor women, wealthier women were thrice as likely to have abortions. Unmarried women had higher odds of having induced abortions than married women (aOR = 7.73, 95% CI [2.79-21.44], p < 0.001). Women aged 20-29, 30-39 and 40-49 were less likely to have induced abortion than those in the 13-19 age group.

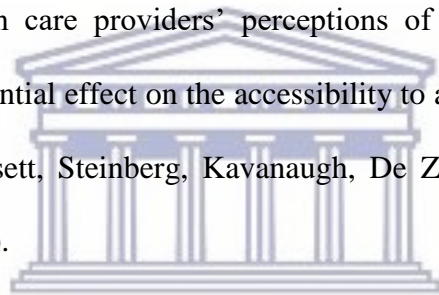
2.4.2 Perceptions of abortion by health care providers and other stakeholders

The way health care providers and major stakeholders view abortion is critical in providing the needed PAC services to adolescents with abortion complications. Health care providers and leaders in a study in Colombia (Rao, 2011) mentioned adolescent stage, poverty, poor education, inadequate access to contraception and local culture as determinants of reckless sexual practices that lead to unwanted pregnancy and subsequently abortion. Moreover, decision-making for managing an unwanted pregnancy was influenced by families and partners, financial considerations, age and cultural or religious disapproval of abortion. Respondents commonly opposed abortion and its legalization on moral grounds, while they objected to emergency contraception (EC) based on fears of complications from long-term use. Their perceptions of irresponsible sexual behaviors led them to oppose EC and abortion.

One study attempted to describe the management and implementation of care for women hospitalized due to abortion, from the perspective of nursing professionals. Strefling, Filho, Kerber, Soares and Ribeiro (2015) found ambivalent views in relation to abortion among the respondents. Their various statements implicitly suggested the interference of discriminatory behaviour and little professional interaction with the women. On the other hand, in other categories, some of the nurses recognized the importance of providing dignified, humane treatment, regardless of the etiology of abortion, and pointed to some humanized aspects such as listening, psychological support and the provision of a unique therapeutic environment separated from other patients in order to improve care. In Addis Ababa, Ethiopia, Abdi and Gebremariam (2011) assessed the perceptions of health care providers towards safe abortion provision at selected health facilities. The researchers found that although the overwhelming majority of the respondents believed that unsafe abortion was a serious health problem, only a quarter of them were actually willing to participate in pregnancy termination. In addition, actual clinical practice and knowledge about the law governing abortion were significant factors associated with the mean attitude score.

Prabhat, Maya, Harper, Darney and Henderson (2012), in a study to examine health care providers' views on abortion legalization found that these providers were generally positive about the implications of legalizing abortion. However, some were concerned about continued unsafe abortion practices. A systematic review of the literature by Rehnström, et al. (2015), indicated that religious convictions, beliefs about professional roles and ethics, and feelings of unpreparedness frequently give rise to dilemmas among health care providers responsible for the

provision of abortion care in sub-Saharan Africa. Furthermore, Rehnström, et al. (2015) stated that health care providers in sub-Saharan Africa have moral, social and gender-based reservations that influence their attitudes towards induced abortions. These reservations, they found, affect the relationship between the health care provider and the woman who wishes to have an abortion. In many societies, abortion is a highly controversial topic. Those who opt for abortion are stigmatized, and health care providers offering these services suffer discrimination in and outside of the workplace. The discrimination may result in a lack of willingness and commitment among health care providers to deliver timely, thoughtful and supportive abortion care, and this may directly or indirectly contribute to maternal mortality due to unsafe abortions. Therefore, it is important to understand health care providers' perceptions of and attitudes towards induced abortions, as they have a substantial effect on the accessibility to abortion services and the quality of these services (Norris, Bessett, Steinberg, Kavanaugh, De Zordo & Becker, 2011; Harries, Cooper, Stebel & Colvin, 2014).



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In Anambra, Nigeria, Ubajaka, Adogu, Ilika and Ilika (2014) investigated the perceptions around abortion and the relevant laws on the part of lawyers. All the respondents knew about abortion, recognized the health hazards associated with it and mentioned infertility (53%) as the major complication of abortion, followed by death (52.5%) and bleeding (42.5%). About 80% of respondents said abortion should be allowed in cases of danger to the mother's life, rape or incest. Eighty-five percent of the lawyers were aware of the existing abortion law in Nigeria and 76.5% of these knew that abortion is legal only in cases where the mother's life is in danger. Only 26% were in support of the legalization of abortion.

Mustafa (2015) in his research work explored the factors that determine health care providers' involvement in or disengagement from abortion services in selected private health care facilities in Ogun State, Nigeria. Findings revealed that a mix of factors among service providers seemed to influence their decisions to become involved in one way or the other with abortion provision. The major factors identified were abortion laws and policies that restrict or prevent access to safe abortion services. Others included a combination of personal interest and circumstance. Religious and moral beliefs and fears of being stigmatized and ostracized played an important role in decisions not to be involved in abortion provision. However, despite misgivings about being involved in abortion provision, non-providers were concerned about the many difficulties women in Nigeria faced in seeking an abortion. They were concerned too about the need for improved contraceptive provision and counselling.

2.4.3 Health Care Providers' Perspective of PAC Services

Perceived negative attitudes of health care providers can be a major deterrent for those seeking care (Beltman et al., 2013; Majrooh et al., 2014; Ibrahim et al., 2014; Moyer et al., 2014). The availability of knowledgeable health care providers in health facilities is the key to ensuring that women with complications from abortion get the kind of response that will save their lives and drastically reduce morbidity. How much health care providers know about post-abortion care and of course how they manage such patients is paramount. In a study that examined the knowledge, attitudes and practices of private medical practitioners in Calabar on abortion, post-abortion care and post-abortion family planning, forty-eight private practitioners were interviewed using a structured questionnaire. The doctors involved in the study were proprietors of private clinics in the city. Only 18.2% of them used standard procedures such as manual vacuum aspiration

(MVA) for the management of patients who had had an abortion or who had abortion complications (Etuk, Ebong & Okonofua, 2003). Indeed, some of the factors contributing to the risks to health of women suffering complications from unsafe abortions were related to retained products of conception. These cases were being managed with MVA without, for instance, simple analgesia. There was also a lack of adequate training and a relative absence of the requisite skills among providers (Etuk, Ebong & Okonofua, 2003). This study recruited only medical practitioners who are not the only providers involved in post-abortion care. The point needs to be made that these medical practitioners, who are also proprietors of their clinics, may be preoccupied with managerial activities, and this could be the reason for the perceived inadequacies.

A study was carried out to investigate knowledge and practice in post-abortion care (PAC) services among health care professionals in the Anambra State of South-Eastern Nigeria (Adinma, Ikeako, Adinma, Ezeama & Ugboaja, 2010). 60 health facilities with 450 participants were selected using multi-stage sampling technique. The respondents comprised of general practitioners (214, 49.0%), nurses (161, 36.8%), specialist doctors (56, 12.8%), and resident doctors (5, 1.1%). Findings revealed that 350 respondents (75.5%) were aware of PAC services. 27 (6.2%) and 28 (6.4%) respondents were aware of community partnership and family planning services respectively, as elements of PAC. In the study, the majority of respondents 302 (69.1%) treated abortion complications, but only 155 (35.5%) used a manual vacuum aspirator. 328 (88.8%) offered counselling services, and 248 (56.8%) provided referrals to other reproductive health services (Adinma, Ikeako, Adinma, Ezeama & Ugboaja, 2010).

Ikeako, Onoh, Ezegwui and Ezeonu (2014) examined the pattern of unsafe abortion and the extent to which unsafe abortion contributes to maternal morbidity and mortality in our setting.

They also set out to assess the impact of post-abortion care. Of the 1,562 gynecological admissions, a total of 83 patients presented with the complications arising from induced abortion. Young people were most affected and adolescents constituted 32.5% (27/83). Nearly 15.7% (13/83) of these patients died while the remaining 84.3% (70/83) had various complications, which were mainly septicemia 59.0% (49/83), anemia 47.0% (39/83), peritonitis 41.0% (34/83), hemorrhages 34.9% (29/83) and uterine perforation 30.1% (25/83). During the study, there were 38 gynecological deaths, and abortion related deaths accounted for 34.2% (13/38) of these gynecological deaths. 84.3% (70/83) of the patients had no documented evidence of counselling on family planning and 59.0% (49/83) were not aware of the different methods of contraception.

Mandira, Gemzell-Danielsson, Kiggundu, Namugenyi and Klingberg-Allvin (2014) undertook a study that aimed to explore physicians' and midwives' perceptions of post-abortion care with regard to professional competences, methods, contraceptive counselling and task shifting and sharing in post-abortion care, in the Central Region of Uganda. Post-abortion care was perceived as necessary, albeit controversial and sometimes difficult to provide, as revealed by the findings of the study. Together with poor conditions post-abortion care provoked frustration especially among midwives, and midwives were identified as the main providers, although they rarely had the proper training in post-abortion care. Further to this, midwives were sometimes forced to provide services outside their defined task areas, due to the absence of doctors. Different uterine evacuation skills were recognized, although few providers knew of misoprostol as a method for post-abortion care.

Hassan (2014) in a study to assess the post-abortion care (PAC) services provided in 18 randomly selected public health facilities in Bauchi, Nigeria found that awareness of PAC was

found to be quite high among doctors and nurses/midwives at 100% and 98% respectively. It was obvious from the findings that the use of MVA by health workers in the management of incomplete abortion is 11% which was quite low in the PHCs where they are most needed. Oral contraceptive pills and injectables, the study found, were the most common methods of contraception available in the health centers.

Adinma et al., (2010) conducted a cross-sectional questionnaire-based survey to determine the practice of post-abortion care (PAC) counselling among healthcare professionals in South-Eastern Nigeria. A total of 431 health professionals were questioned, 270 (62.6%) medical doctors and 161 (37.4%) nurses. Of the 302 (70.1%) respondents who reported practising PAC counselling, only 173 (40.1%) had received formal training in PAC counselling. PAC counselling was most commonly practised by health professionals working in the University Teaching Hospital (90.5%). It was also more commonly practised by nurses in rural areas (75, 67.6%) compared with nurses working in urban areas (24, 48.0%).

2.4.4 Challenges and Barriers to Effective and Efficient PAC Services

Adolescents with abortion complications seeking post-abortion care often encounter challenges or/and barriers and these barriers in no little way influence the nature of care they receive and subsequently their treatment outcomes. Rasch's (2011) review of PAC has shown that the main barriers reported in many low income settings were government restrictions on procurement, high cost of equipment, limited access to MVA-training, and difficulty obtaining MVA equipment. In addition, a study conducted in Nigeria challenged the assumptions according to which MVA is considered more cost-effective than surgical curettage (Rasch, 2011). Mutua, Maina, Achia and Izugbara (2015) in their study looked at factors associated with delays in seeking post-abortion care among women in Kenya. Their findings established that women with unintended pregnancies

were at higher risk of experiencing longer delays in seeking care for abortion complications, which exposed them to increased complications and hence higher risk of maternal mortality. Delay in seeking care was associated with women's age, education level, contraceptive history, fertility plans and referral status. Yet another study in Kenya's Central and Nairobi provinces, to examine receipt of PAC services by client age, client satisfaction and provider attitudes, Evens, Otieno-Masaba, Eichleay, Mccarraher, Hainsworth, Lane, Makumi and Onduso (2013) found that delivery of PAC treatment, pain management, HIV and STI services, as well as violence screening did not vary by age of respondents. However, fewer youths between the ages of 15 and 24 received a contraceptive method compared with adult clients (35% versus 48%). Forty-nine per cent of the youths reported not using a family planning method due to fear of infertility, side-effects, or from lack of knowledge, compared with 22% of adults.

Melkamu, Betre and Tesfaye (2010) assessed the factors which influence decisions for utilization of abortion related services at community level. Most respondents said that they prefer public health facilities. According to the respondents, the reasons why women do not visit health facilities for PAC services included lack of community support, unavailability of services, high cost of services, distance to facilities and lack of means of transportation. From the multivariate analysis it appears that public health facilities are preferred by younger respondents, those with no education, those with no history of unwanted pregnancy and those in higher income brackets. The qualitative study indicated that women do not go to health facilities for PAC mainly because of inappropriate treatment by providers at the health facilities.

Further to these findings, Arambepola, Rajapaksa and Galwaduge (2014) conducted a study in Sri Lanka to assess the PAC services given to women following an unsafe abortion, compared to the routine hospital care following spontaneous abortion (SA) or unintended pregnancy carried to

term. They found care following unsafe abortion to be deficient in post-abortion counselling, education and family planning services. Engagement of public-health staff for follow-up care was inadequate and respondents were dissatisfied with their overall care during their hospital stay, predominantly due to verbal harassment of health care providers on their abortion status (57.9% versus 19.3% SA-controls, $p < 0.05$).

In a similar study in Nigeria, Kalu, Umeora and Adeoye (2012) reviewed the implementation of post-abortion care and effective linkage to other post-abortion services in Ebonyi State University Teaching Hospital, Abakaliki. Data on PAC over a five-year period (July 2004 to June 2009) were analyzed and a standardized questionnaire was administered to 45 direct PAC service providers. Abortion complications constituted 41.4% of all gynecological admissions. Maternal mortality from complications of abortion was 11.5% of all the maternal mortality cases at the centre. Women aged 19 years and younger accounted for 37(7.1%), and single women (132), constituted 25.3% of all cases. About 31% of the PAC care providers had formal training for the implementation of PAC services. Fifteen percent of the care givers were satisfied with the linkage between PAC and the family planning services.

Findings of a research study carried out in Ibadan city of Nigeria, with the aim of investigating the factors determining the demand for abortion and post-abortion care, revealed that 62% of respondents demanded abortion while 52.3% of those that demanded abortion received post-abortion care. The findings again showed that income was a significant determinant of abortion and post-abortion care demand. Women who earned better were more likely to demand abortion and post-abortion care. Married women were found to be less likely to demand abortion and post-abortion care. Older women were significantly less likely to demand abortion and post-abortion

care. Mothers' education was only statistically significant in determining abortion demand but not post-abortion care demand (Awoyemi & Novignon, 2014).

2.5. Conceptual framework

The conceptual framework of the study is derived from the patient-centred care and Donabedian's model. A multidimensional conceptualization of patient-centred care shows how clinical, structural, and interpersonal attributes can collectively influence the patient's experience. The reason for using these models is because they have served as foundations for other models of quality and focused on the patient. The proposed framework is designed to identify barriers and challenges to adolescents' PAC and ways in which care could be more patient-centred.

2.5.1. Patient centred care

The concept of patient-centred care has received increased attention in recent years and is now considered an essential aspiration of high-quality health care systems. The framework is about a collaborative and respectful partnership between the service provider and the recipient of care (Pizzi, 2015; McCormack, 2003) with the term "adolescent-centred care" more overtly reflecting the application of the model to the study. The literature reflects the use of related terms with a similar underlying notion: person-centred care, client-centred care, family-centred care, and relationship-centred care. (Drach-Zahavy, 2009; Leap, 2009; McCormack, Dewing, Breslin, Tobin et al., 2010).

Person-centred care is an approach to practice that is established through the formation and fostering of therapeutic relationships among all care providers, patients, and others significant to them. Person-centred care is underpinned by values of respect for persons, individual right to self-determination, mutual respect, and understanding (McCormack, Dewing, Breslin, Toin et al., 2010).

Adolescent patient-centred care' focuses on the adolescent's individual needs, aspirations and expectations, rather than the needs of the institution or professionals because the adolescent population is considered an integral component of healthcare decision-making and delivery processes. Berwick (2009) has asserted that adolescent patient-centred care is a dimension of quality in which care is individualized and customized to adolescents and in which they, not clinicians, have control over healthcare decisions. The essence of this care is to shift the adolescent patients from having a passive role in the health care they receive to becoming actively involved in decisions about their care. It moves away from an emphasis on disease to a model that integrates the biological, psychological and social dimensions of illness (Dewi, Evans, Bradley, & Ullrich , 2014; Wolf , Lehman , Quinlin, Zullo , Hofman ,2008).

According to Conway et al. (2006), the core concepts of patient- centered care are:

- 1. Dignity and Respect:** This is the capacity of health care practitioners to listen to and honour adolescents' perspectives and choices. Adolescents' knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- 2. Information Sharing:** This includes health care practitioners' willingness and capacity to communicate with adolescents, and share complete and unbiased reproductive health information with them in ways that are affirming and useful. Adolescents should receive timely, complete and accurate information on PAC services in order to effectively participate in care and decision-making.
- 3. Participation:** Patients are encouraged and supported to participate in care and decision-making at the level they choose. There are therefore efforts to ensure proper identification of barriers and challenges of adolescent PAC, as well as shared decision-making on the basis of best available evidence coupled with adolescent preferences.

4. Collaboration: Patients, health care practitioners, and hospital leaders collaborate in policy and programme development, implementation and evaluation. They play a role also in health care facility design, and in professional education, as well as in the delivery of adolescent PAC services.

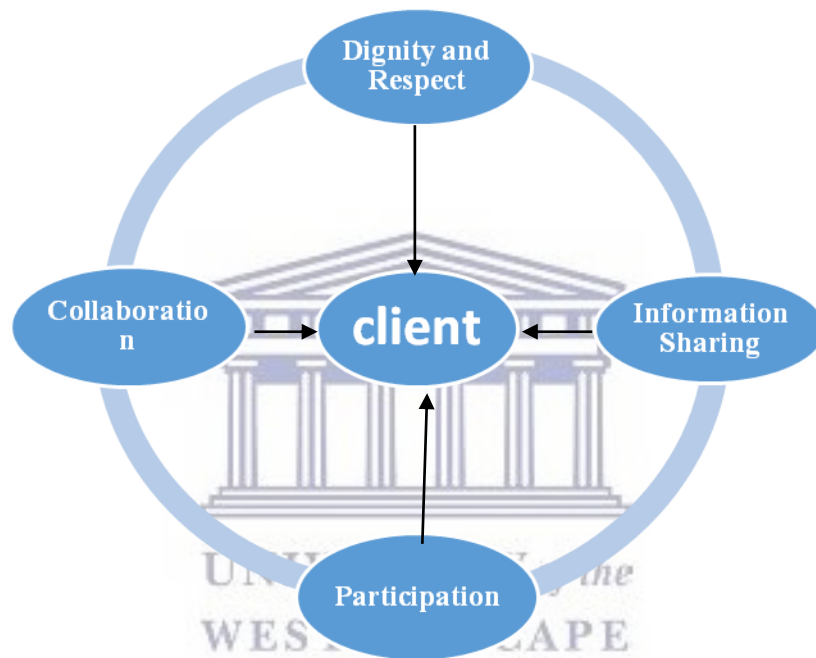
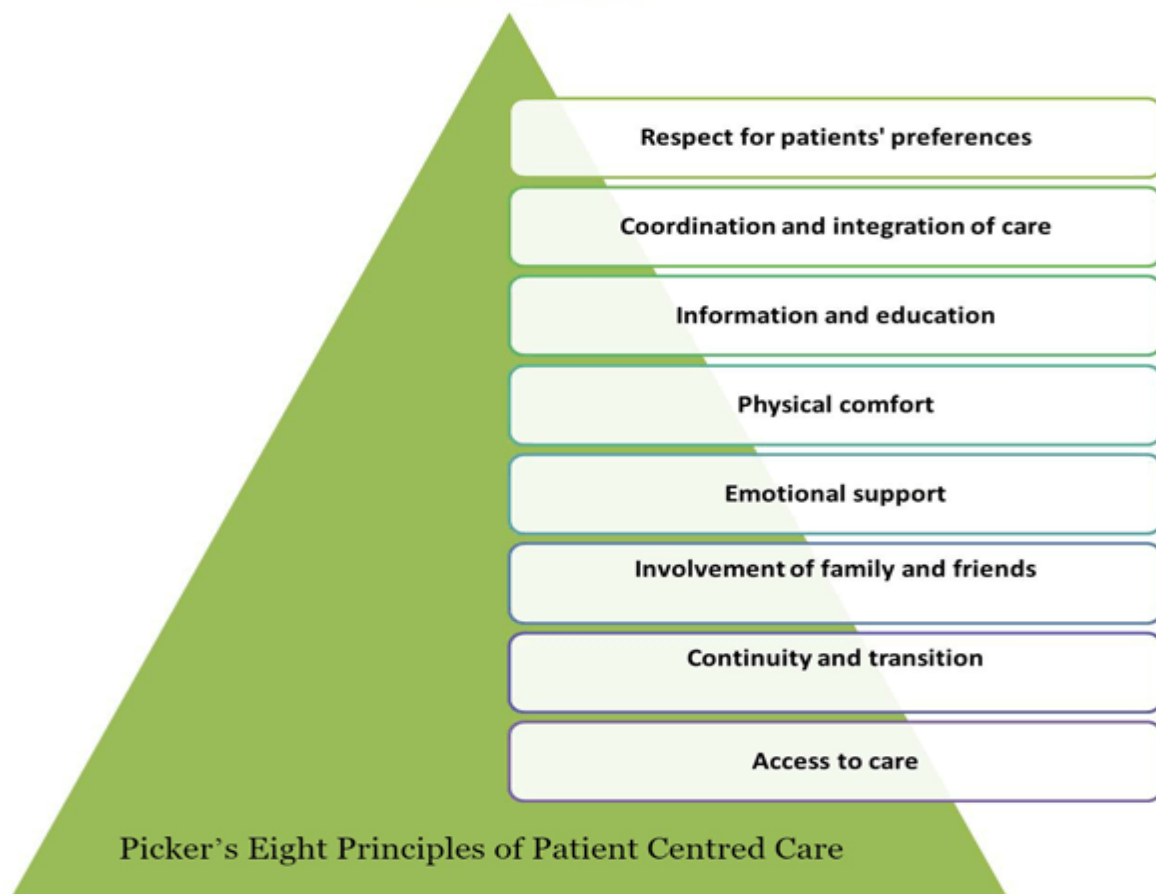


Figure 2.1: Core concept of patient centered care

2.5.1.1 Dimensions of patient-centered care

Patient-centred concepts of care have gained increasing prominence as goals of healthcare systems and various dimensions of patient-centred have been offered. Some authors have attempted to describe these dimensions; particularly, Gerteis et al. (1993) who proposed seven dimensions of patient-centered approach; Stewart, Brown, Donner, McWhinney, Oates, & Jordan (2000) incorporated six interactive components of patient-centered concepts. Little et al. (2001) raised five main domains of patient-centered care, while Mead and Bower (2002) developed five

key dimensions of patient-centeredness. However, contemporary views of PCC are based largely on research conducted by the Picker Institute. The Picker Institute identified eight dimensions of PCC also known as the Eight Picker Principles of patient-centred care: (a) respect for patient preferences, values and expressed needs; (b) information, education and communication; (c) coordination and integration of care and services; (d) emotional support; (e) physical comfort; (f) involvement of family and friends; (g) continuity and transition; and (h) access to care and services. There is growing recognition that patient-centered care is associated with quality of care and can increase patients' satisfaction and impact on patient's health outcomes, this may in turn reduce the overall cost of care (McMillan, Kendall, Sav, King, Whitty, Kelly et al, 2013).

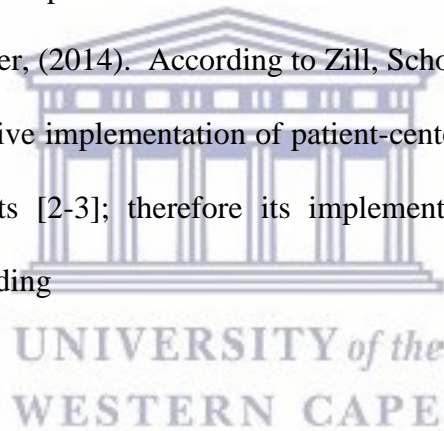


Source: Picker Institute (2017)

Figure 2.2: Dimension of Patient centered care

2.5.1.2 Researchers' Critique of the patient-centred care's model

PCC is one of the essential dimensions of health care and as such is an important indicator of health-care quality. However, there is no global consensus regarding its definition and no conceptualization has been established yet. To buttress this, Van Dulmen (2003) states that it is a “fuzzy concept”, which lead to more confusion than clarity. Moreover, Epstein and colleagues (2005) outline it as a “multifaceted construct, like intelligence”, and Hobbs (2009) describes patient-centeredness as a “poorly conceptualized phenomenon”. Similar results about the ambiguity of the German term for patient-centeredness were found in a pilot study conducted by Scholl, Zill, Härter, and Dirmaier, (2014). According to Zill, Scholl, Härter, and Dirmaier, (2015) one of the barriers to the effective implementation of patient-centered care is the ambiguity of its definition and key components [2-3]; therefore its implementation internationally might be impeded by a lack of understanding



2.5.2. Donabedian's Model

This quality of care framework was developed by Avedis Donabedian in 1966 in order to assess quality of care in clinical practice. The model is made up of three domains, namely, structure, process, and outcome. These domains represent three types of information that may be collected in order to draw inferences about quality of care in a given system. Donabedian notes that each of the three domains has advantages and disadvantages. This necessitates that researchers draw connections between them in order to create a chain of causation that is conceptually useful for understanding systems as well as designing an intervention (Donabedian, 2003). Furthermore, Donabedian stated that these categories should not be mistaken for attributes of quality, but rather

that they are the classifications for the types of information that can be obtained in order to infer whether the quality of care is poor, fair, or good (Donabedian, 2003). He was of the view that the structure of care affects the processes of care and that both, in turn, affect the outcomes of care. Therefore, data were collected on nursing structure, and process and outcome indicators, which provides a comprehensive approach to evaluating quality of PAC services and related reproductive health services available which in turn helps to identify the challenges and barriers to PAC.

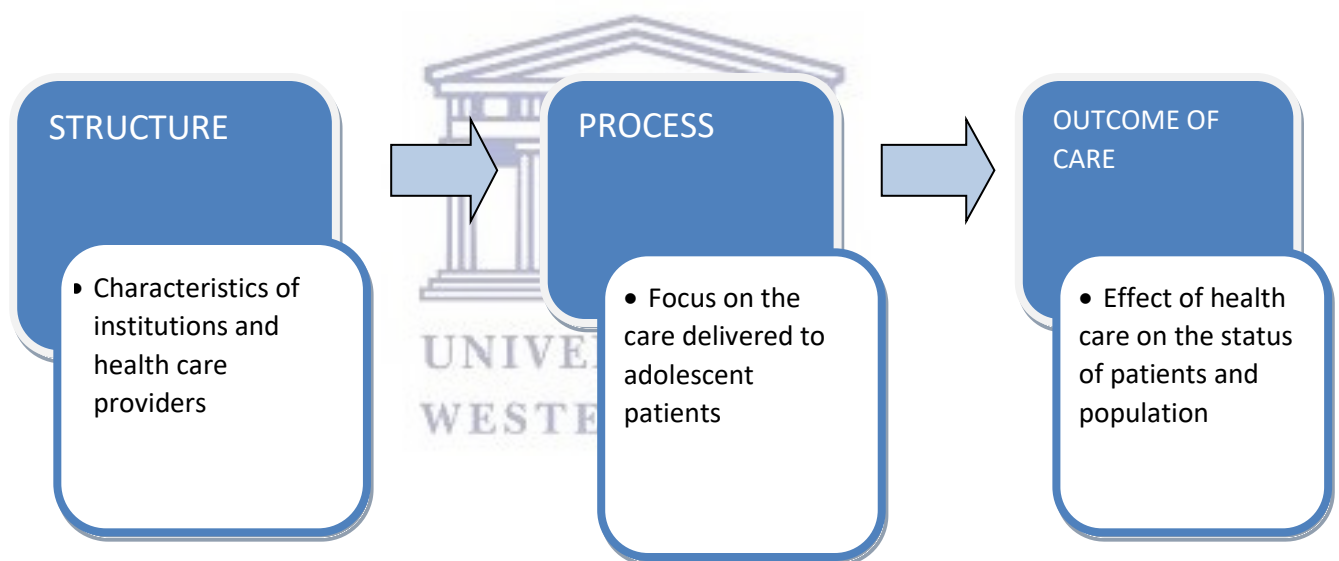


Figure 2.3: Donabedian's quality of care model

2.5.2.1 Dimensions of care

The model is most often represented by a chain of three boxes containing structure, process, and outcome connected by unidirectional arrows in that order (Figure 2.3). These boxes represent three types of information that may be collected in order to draw inferences about quality of care

in a given system (Donabedian, 2003). A Donabedian model assumes the existence of three essential dimensions in assessing quality. These include; structure, process, and outcome and possibly a causal relationship between them.

1. Structure: This includes all the factors that affect the context in which PAC services are delivered. This includes the physical facilities, equipment, and human resources, as well as organizational characteristics and structures such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system. Structure is often easy to observe and measure and it may be the upstream cause of problems identified in process (Donabedian, 2003).

2. Process: This is the sum of all actions that make up PAC services. These commonly include diagnosis and treatment of post-abortion complications, preventive care including contraceptive use and counselling, as well as actions taken by the adolescents and their families to access PAC services. The process can be further classified into two sub-processes, namely the **technical process** which focuses on how care is delivered, and the **interpersonal process** which encompasses the manner in which care is delivered (Donabedian, 2003).

3. Outcome: This contains all the effects of PAC services on the adolescent population, including changes to health status, behaviour, or knowledge as well as adolescents' satisfaction and health-related quality of life. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare. Outcomes, the central component of the framework, are the results of effective, person-centred nursing and include satisfaction with care, involvement in care, feeling of wellbeing, and creating a therapeutic environment.

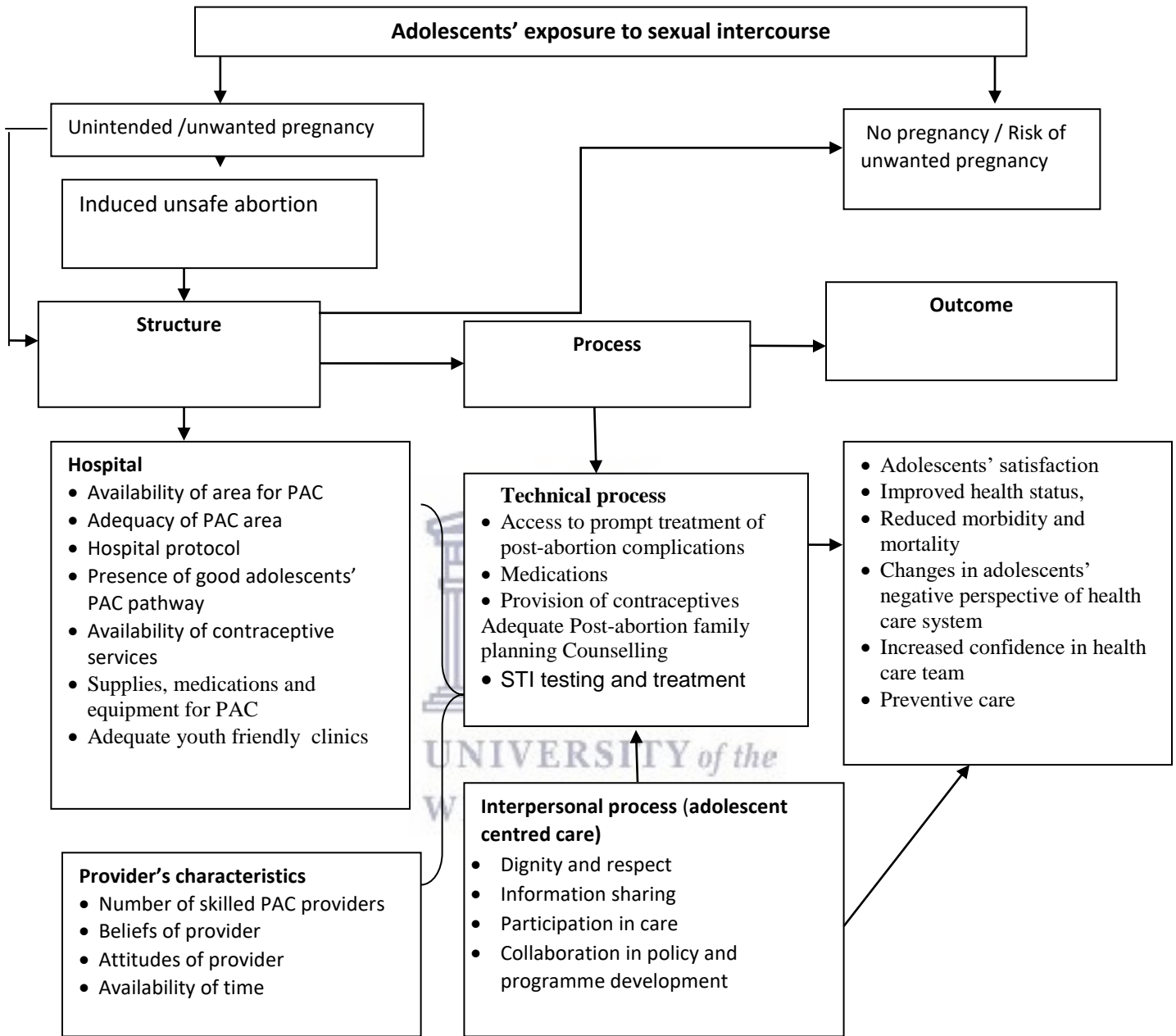


Figure 2.5: The relationship between the constructs of the Framework (created by onasoga,2018)

2.6. Summary of literature review

The review of literature was done in three categories, namely, conceptual discourse, empirical review and theoretical framework. Basic concepts such as adolescent, unwanted pregnancy,

abortion, and unsafe abortion were discussed. An overview was given of wanted pregnancy and unsafe sexual behaviour among adolescents, and abortion law as applicable to the Nigerian situation, the perceptions about abortion by health care providers and other significant stakeholders, health care providers' perspectives of PAC services, as well as barriers to effective and efficient PAC services.

The empirical aspect reviewed studies on abortion, abortion complications and PAC services. Most of the literature indicated that adolescents were fully aware of the inherent dangers or complications associated with abortion and mentioned death as the most common of all the complications. This knowledge, however, did not translate into action and this was evident in the numbers of adolescents who still opt for abortion as a solution. The review found abortion was more common among adolescents and youths who were unmarried and had some level of formal education. Poverty, delay in child bearing and the desire to continue education were the most common reasons for seeking abortions.

Health care providers had mixed feelings about abortion, the majority of them disapproving of abortion owing to their religious views. Some studies revealed that the health care providers see unsafe abortion as a serious health problem but were also mindful of the consequences of legalizing abortion.

Most of the studies revealed that health care providers were aware of PAC services and what such services entail and have treated one abortion complication or the other. The attitudes of health care providers to adolescents seeking PAC services were guided by restrictive laws regulating abortion, and also by religion, gender, profession and work experience.

Knowledge gap

Most of the studies examined the perceptions of adolescents and health care providers around abortion and PAC, but no study, particularly in Nigeria, has been done to explore the challenges or barriers adolescents face in procuring PAC services. The findings of this study will thus go a long way in filling this gap and also add to a body of existing literature on PAC, with the aim of informing policy on post-abortion care in Nigeria, Africa and the world at large.



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CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

The research methodology section forms an integral part of the research process and is one of the basic aspects of any scientific study (Polit & Beck, 2018). A study of challenges and barriers facing adolescents in obtaining post-abortion services is a technically distinctive undertaking that needs a comprehensive research strategy. With this in mind, various methodological approaches were selected by the researcher in order to achieve the purpose and objectives of this study.

This chapter provides a detailed description of the research design, population and settings, sample and sampling strategy, data collection methods and data analysis procedures. Aspects pertaining to reliability and validity, including academic rigor and trustworthiness as key principles in a research study using quantitative and qualitative methods, are highlighted in the relevant sections. Key ethical considerations fundamental in nursing research involving participants, as referred to in quantitative studies and informants in the case of qualitative research, were given the necessary attention. Limitations of the study were identified and reported accordingly. An explanation of how the researcher overcame technical difficulties encountered in the research process is outlined in specific areas of the study.

3.2. Research objectives

The objectives of this study were to:

- Assess knowledge of reproductive-health and related post-abortion care services among health care providers in selected secondary and tertiary health facilities in Edo state
- Describe the adolescents' perception of post-abortion care received in Edo State, Nigeria

- Determine the service providers' perspectives on adolescents' post-abortion care challenges and barriers in Edo State, Nigeria
- Analyze the challenges and barriers faced by adolescents in obtaining post-abortion care services
- Explore ways in which the knowledge about challenges and barriers to adolescents' post-abortion care services can be improved in order to inform policy
- Develop policy document and make recommendations or suggestions in key areas to improved PAC services in Nigeria as part of working towards improving reproductive health

3.3. Research setting

This study was conducted in Edo State, Nigeria. Nigeria is the most populous country in Africa, and the 7th largest country in the world (National Population Commission [NPC] and ICF International, 2014; Nigerian Demographic Profile, 2016). It is a Federal constitutional republic comprising 36 states and its Federal Capital Territory, Abuja. The country is located in the West African sub-region with an area of 923,768 square kilometres, including about 13,000 square kilometres of water. Nigeria shares borders with Cameroon (1,690 kilometres) in the east, Chad (87 kilometres) in the north-east, Niger (1,497 kilometres) in the north, and Benin (773 kilometres) in the west. There are over 500 ethnic groups in Nigeria, of which the three largest are the Hausa, Igbo and Yoruba (Nigerian Demographic Profile, 2016; Federal Ministry of Information, 2011). According to the Nigerian Demographic Profile (2016) the population of Nigeria is estimated to be 186,053,386, distributed as 52.2% rural and 47.8% urban, with a population density of 167.5 people per square kilometer (CIA World Factbook, 2016).

Nigeria can be divided into two regions, namely the Northern and Southern parts and is

subdivided into six geo-political zones. These are: **North Central** which comprises of: Kogi, Niger, Benue, Kwara, Plateau, Nassarawa and the Federal Capital Territory, **North-Eastern** which comprises Taraba, Borno, Bauchi, Adamawa, Gombe and Yobe State, **North-Western** which comprises Kaduna, Kebbi, Zamfara, Sokoto, Kano, Jigawa and Katsina State, **South-Eastern** which comprises Ebonyi, Enugu, Imo, Abia and Anambra State, **South-Western** which comprises Ekiti, Oyo, Ogun, Lagos, Ondo and Osun State and **South-Southern** which comprises Akwa-Ibom, Bayelsa, Cross River, Rivers, Delta and **Edo** States.

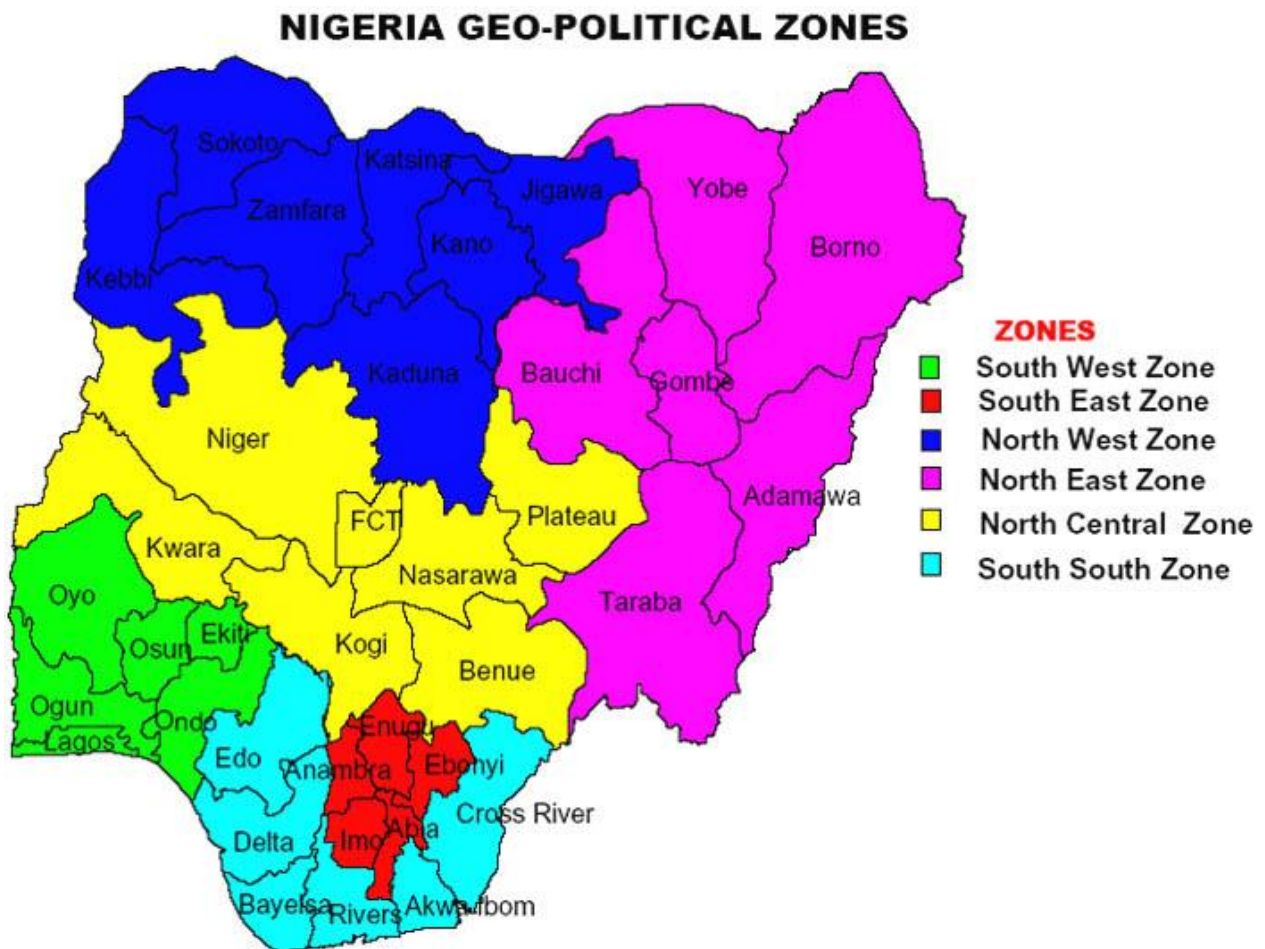


Figure 01: A map of Nigeria showing the six geo-political zones (Source: Nigerian Muse, 2010)

Setting Profile

Edo State, which is the setting for this study, is an inland state in central southern Nigeria. The state was created on August 27, 1991 and is located in the South-South Geo-Political Zone of Nigeria. Its capital is Benin City and consists of 18 Local Government Areas. It is bounded in the north and east by Kogi State, in the south by Delta State and in the west by Ondo State. The main ethnic groups in Edo State are Edos, Afemais, Esans, Owans and Akoko Edos. The state has a rich cultural heritage and is famous for its unique bronze, brass and ivory works of art. The principal mineral resources include crude oil, natural gas, clay chalk, marbles and limestone. Edo state has an estimated population of about 3.2 million, with 1.3 million females and 356,247 female adolescents between 15 and 24 years of age (Nigerian National Population Census, 2006). The researcher decided to conduct the research study in this setting because the state has some of the country's highest rates of commercial sex, international sex trafficking and risky sexual behaviour with few adolescent friendly reproductive health facilities, and its adolescents face several reproductive health (RH) vulnerabilities including abortion complications. Edo state has four tertiary health institutions and 33 secondary health facilities distributed over the three senatorial districts and there are many primary health care facilities in the local government areas of the state (Edo State Ministry of Health, 2010).

3.3.1. The Organization of the health system in Nigeria

The provision of health care in Nigeria remains the functions of the three tiers of government: the federal, state, and local government. The private sector also plays a big role in the provision of medical services in Nigeria. All three tiers of government share responsibility for providing health services and programmes in Nigeria. The Federal Ministry of Health (FMOH) provides policy

guidance and technical assistance to the 36 States and the Capital Territory (Abuja), co-ordinates State efforts in working towards the goals set by the national health policy; it is establishing a management information system designed to improve both national and state-level planning. The FMOH also monitors and evaluates the implementation of the national health policy. In addition to this, FMOH bears direct operational responsibility for training professionals, operating teaching hospitals, and running Federal Medical Centres and psychiatric and orthopaedic hospitals.

At the state level, responsibility for health programmes is shared by the State Ministry of Health (SMOH), the Hospital Management Board (HMB), and the Local Government Authorities (LGAs). The SMOH is headed by the State Commissioner of Health, who is responsible to the State Executive Council and is assisted by the Director General in the SMOH. Its responsibilities include planning and coordinating the state health systems operating and maintaining secondary and non-specialized tertiary hospitals and some primary health facilities, implementing public health programmes, training nurses, mid-wives and health technicians, and assisting the LGAs with the management and operation of some primary health facilities. Each State has at least one health training institution. However, declining infrastructure, lack of teaching equipment, poorly trained staff, and low morale seriously undermine the quality of training and trainees (African Development Fund, 2002). The HMB administers the State hospitals and, in some cases, health centres and urban clinics. Its main responsibility is personnel administration and the financing and management of logistical support systems, including drugs, supplies, equipment and maintenance. The HMB is headed by a chairman, who in some states, reports to the State Commissioner of Health and in others to an independent board. The SMOH establishes the policy under which the HMB functions whilst maintaining overall responsibility for the state health programme. Each of

the 774 LGAs in Nigeria is responsible for operating primary health facilities within their geographical area, including the provision of basic out-patient, community health, hygiene and sanitation services. The SMOH coordinates these activities and provides technical support. Health service delivery in each LGA is the responsibility of the Health and Social Welfare Counsellor. However, many LGAs lack the capacity to effectively carry out their mandate.

In Nigeria, the health sector is financed through different sources and mechanisms which include out-of-pocket payments (OOPs), indirect and direct taxes, donor funding and health insurance. The difference in the proportionate contribution from these stated sources determines the extent to which the health sector will succeed in achieving an adequate health care financing system. Unfortunately, in Nigeria, achieving the correct blend of these sources remains a challenge (Uzochukwu, Ughasoro, Etiaba, Okwuosa, Envuladu & Onwujekwe, 2015).

The Nigerian health care system is poorly developed and has suffered several setbacks, especially at the Local Government level. Current health care delivery in Nigeria is plagued with persistently low funding at all levels. Nigeria spends less than US\$ 4 per person per year on health care, which is well below the recommended levels of US\$ 12 in developing countries (African Development Fund, 2002). Nigerian's health sector is characterized by poor quality and inefficiencies in the provision of public sector health services, resulting in poor health outcomes. According to the 2009 communiqué of the Nigerian national health conference, the health care system remains weak, as evidenced by lack of coordination, fragmentation of services, dearth of resources (including drugs and supplies), inadequate and decaying infrastructure, inequity in resource distribution, and access to care coupled with deplorable quality of care. The communiqué further points out that the lack of clarity of roles and responsibilities among the

different levels of government has compounded the situation (Nigerian National Health Conference Communiqué, 2009).

3.3.2. Selection of Hospitals for Study

Benin City, the capital of Edo State, which was the study area, has four government owned hospital, two federal and two state, two main missionary hospitals and several primary health centres and private clinics. All the hospitals provide post-abortion care in varying degrees. The researcher selected three hospitals (one tertiary and two secondary hospitals) in Benin City, Edo State using the purposive sampling technique based on phenomenon of interest (Creswell & Plano Clark 2017). These hospitals include:

3.3.2.1. Tertiary hospital

The tertiary hospital is owned by the federal government. The hospital is a 600-bed tertiary health institution that renders specialist care to its host community and environs. It serves as a referral center offering services to a large population of nearly 2 million people from the mid-western part of Nigeria. It also serves as a training institution for all cadres of health care professional and enjoys the patronage of large numbers of clients.

3.3.2.2. Secondary Hospital

One of secondary health care facility is owned by the state government. The hospital is situated in the central area of the Benin City, Nigeria. It is a 432-bed hospital and has a staff of 502, cutting across all cadres of health care workers. The hospital renders preventive, promotive, ameliorative and rehabilitative health care services to the local population. It also serves as a training institution for medical and nursing students, as well as other health professionals and has large numbers of clients using its services.

3.3.2.3. Missionary Hospital

This is a secondary health care facility that was established by catholic missionaries in the year 1941. The hospital renders mainly obstetric care and serves as a referral center for other primary health care centres. It also serves as a training institution for midwives, nurses and medical students as well as other health professionals. It attracts a multitude of clients because it is a missionary hospital whose work has been trusted upon for over 70 years.

Criteria for selecting the of hospitals

These hospitals receive referrals from health centres and private hospitals in the area. They were purposively selected due to their catchment area, patient load, scope and coverage of post-abortion care services.

Inclusion criteria:

- All secondary and tertiary hospital offering post abortion care services
- All hospital serving as a referral hospital for abortion complications
- Provide 24hours PAC services and have large number of PAC patients

Exclusion criteria:

- All secondary or tertiary hospital out Edo State
- All primary health care centres in Edo State.
- Any hospital that did not meet the inclusion criteria were excluded from the study.

3.3.3. Gaining entry and access to the setting

In order to gain access to the three health care institutions the researcher applied to the management boards. Approval was granted to access the tertiary institution after the proposal was screened by the Ethics and Research Committee of the hospital (Appendix II). Permission was

also granted by the secondary health institutions through the federal ministry of health after the proposal had been passed by the Ethics and Research Committee (Appendix III and IV).

Once approvals to health facilities were granted, copies of the letter of approval from the Ethical Review Committee were presented to the heads of nursing services in the various facilities, along with a brief introduction to the researcher and the purpose of the study. The heads of nursing services introduced me to the ward managers of the various wards, who assisted in identifying participants to be recruited for the individual and focus group interviews. The ward managers requested that they cooperate and render assistance where necessary. They also introduced me to their nurses who in turn introduced me to the patients. The researcher was called upon by the nurses when they had adolescents with abortion complications in the wards. The researcher was then able to establish a rapport with the patients and significant others, and subsequently interview patients when they were well and about to be discharged.

3.4 Research design

Research design is the overall plan for obtaining answers to the questions being studied. It guides the researcher in planning and implementing the study in such a way that is most likely to achieve the desired goal (Creswell & Plano-Clark, 2017). The study employed a mixed-methods approach, using both quantitative and qualitative research designs. This involved collecting, analyzing and integrating quantitative and then qualitative data in two consecutive phases within one study. This is because neither quantitative nor qualitative methods are sufficient to capture the trends and details of a situation. When both quantitative and qualitative designs are used, they complement each other and allow for a more robust analysis, taking advantage of the strengths of each (Creswell & Plano Clark, 2017). Consequently, the study was designed to be carried out in two phases.

3.4.1 Phases of Research Process

There were two phases of the research process, namely Phase One which was the assessment Phase and Phase Two which was the Interactive Phase. Each phase was discussed in detail showing the steps and approaches used in the study.

Phase One: Assessment Phase: This phase employed both quantitative and qualitative designs. The quantitative design was used to examine the facility, its infrastructure, inventory of services provided and PAC-related service statistics in each service-delivery point, as well as technical skills and training level of staff involved in post-abortion care. This gave background information on PAC services in these centres. The qualitative design was also used to explore the adolescents' feelings and thoughts regarding abortion and post-abortion care received, as well as the service providers' perspectives about adolescents' abortions, the challenges and barriers to adolescents' post-abortion care and suggestions for the way forward.

Phase 2: Interactive Phase: This phase employed quantitative design using the policy Delphi method to evaluate and discuss challenges and barriers faced by adolescents in obtaining post-abortion care services. They made use of the findings generated from an analysis of all data collected on the reproductive-health and related post-abortion care services in the selected secondary and tertiary health facilities. These were adolescents' perceptions of PAC received, service providers' and key persons' perspectives of challenges and barriers to adolescents' post-abortion care services in the assessment phase of their evaluation, discussion and suggestions formulated with a view to improving PAC services that are capable of meeting adolescent reproductive health needs.

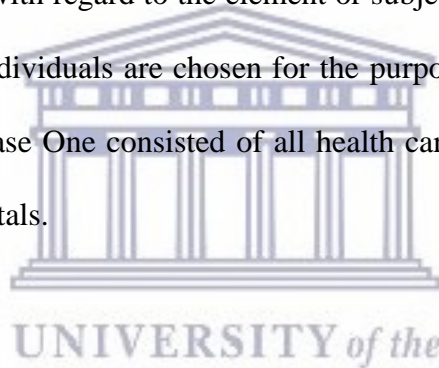
3.4.2 Quantitative Part of the Phase 1(Assessment Phase)

3.4.2.1 Research Design

A descriptive cross-sectional research design was adopted to examine reproductive health and related post-abortion care services in selected secondary and tertiary health facilities in Edo state, Nigeria.

3.4.2.2 Population

A population is the entire group of persons or objects that are of interest to the researcher, in other words, those that meet the criteria which the researcher the researcher is interested in studying (Grove, Gray & Burns, 2015; Polit & Beck, 2018). Furthermore, Polit & Beck (2018) describes the term as setting boundaries with regard to the element or subjects. A population, therefore, is a group of people from which individuals are chosen for the purpose of the study. The population for this quantitative part of Phase One consisted of all health care providers (doctors and nurse-midwives) in the selected hospitals.



3.4.2.3 Sample

Polit & Beck (2018) defines a sample as a small portion of the total set of objects, events and persons which together comprise the subject of the study. Sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Creswell & Plano-Clark, 2017; Grove, Gray & Burns, 2015). It is the process of selecting units (e.g. people, organizations) from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen, since it is not always possible to study all the members of the population or to make every possible observation of them. Therefore, the researcher selected a sample from the population; sample units consist of health care providers,

generally nurse-midwives and doctors working in the selected hospitals. They provided information on type and quality of post-abortion services available, technical skills and training level of staff involved in post-abortion care.

3.4.2.4 Sample Size (Sample Size Calculation)

The sample size (SS) was obtained by applying the standard sample size calculating formula by Kish (1965)

$$n = \frac{Z^2 Pq}{d^2}$$

Where: n =sample size

Z = Z value (e.g. 1.96 for 95% confidence level)

P = Prevalence of outcome of interest=75.5% (0.755) (Adinma et al., 2010)

q = 1-P (1- 0.755)=0.245

d=0.05

Substituting in the above formula, one obtains the following sample size;

$$n = \frac{1.96^2 \times 0.755 \times 0.245}{(0.05)^2}$$

$$n = \frac{0.71059996}{0.0025} = 284$$

However, to ensure that the number needed remains after expected loss of study subjects' non response, a rate of 10% is added to the sample size.

$$\text{Non response rate of 10\%} \left(\frac{1- 10}{100} \right) = 0.9$$

$$= \frac{284}{0.9}$$

$$= 315.$$

=315.

Therefore, a sample size of 315 was used

3.4.2.5 Sampling Techniques and Approaches

Purposive sampling technique

The purposive sampling technique was employed for the assessment phase, to ensure that the appropriate individuals, who were well-informed about or have experience with the phenomenon of interest, were identified and selected (Creswell and Plano-Clark, 2017). The purposive sampling technique is a non-probability sampling method which involves the conscious selection of certain subjects to be included in the study. These sampling methods provide the most extensive information about the phenomenon being studied (Burns & Grove, 2017). It is a technique widely used in both quantitative and qualitative research for the identification and selection of information-rich cases, for the most effective use of limited resources (Patton, 2002). This sampling technique involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or have experience of a phenomenon of interest (Creswell & Plano-Clark, 2017). Thus, purposive sampling technique was used to select a sample size of 315 health care providers (nurses and doctors).

Inclusion criteria: All registered nurse-midwives and doctors who were working in the selected hospitals at the time of the study, who had worked for at least 6 months in the maternity units or obstetrics and gynaecological units (ANC, Labour, gynaecology, O&G emergency and FP, section of the facility) and were willing to participate in the study.

Exclusion criteria: Registered nurse-midwives and doctors who did not meet the inclusion criteria were excluded.

Table 3.1: Summary of Method of participant recruitment for the quantitative part of the assessment phase

Type of Hospital Facility	NURSES			DOCTORS			Total
	Population	Percentage of Nurses	Sample	Population	Percentage of Doctors	Sample	
Tertiary health care	699	699/1343= 52%	164	210	210/1343= 15.6%	49	213
Secondary health care owned by state government	246	246/1343= 18.3%	58	98	98/1343= 7.3%	23	81
Secondary health care owned by missionary government	65	65/1343= 4.8%	15	25	25/1343= 1.9%	6	21
Total	1343		237			78	315

3.4.2.6 Techniques and Instruments for Data Collection

The instrument for data collection was a self-administered questionnaire. The questionnaire offers the possibility of complete anonymity, which may be crucial in obtaining information about embarrassing personal details. It also ensures that there will be no biases reflecting the respondent's reaction to the interviewer but rather than to the questions themselves (Polit & Beck, 2017).

The questionnaire was used as a tool to collect information on the structure and process of PAC in the study setting. The questionnaire was adapted from USAID Post-Abortion Care (PAC) Assessment Tool and Pathfinder International Youth-Friendly PAC assessment tool to examine the facility, its infrastructure, inventory of services provided and PAC-related service statistics in each service-delivery point. The data also included information regarding the type and quality of post-abortion clinical services, availability of necessary supplies, adequacy and privacy of areas where post-abortion care is provided, technical skills and training level of staff involved in post-

abortion care, availability of contraceptive services and types of contraceptive items present in the facilities, in order to give adequate background information on PAC services in these centres. The questionnaire consisted of 3 sections with a total of 35 items. Section A was designed to provide general information about the facility, as well as status and field of study of respondents, Section B was designed to elicit information about the availability and range of services provided. Finally, Section C was designed to collect information about the technical skills and training level of staff involved in PAC. The researcher and one health worker each from the selected hospitals served as research assistant. A total of three research assistants were trained and used for the data collection. The researcher and the research assistants distributed the questionnaires directly to the respondents who met the inclusion criteria by hand. The respondents were given two days to complete the questionnaires and the filled copies were retrieved by hand. The collected data were checked for completeness, accuracy and consistency by the researcher. The data collection was done in November 2014 and the process lasted for 5 weeks.

3.4.2.7 Validity of instrument

Validity refers to the degree to which an instrument measures what it is intended to measure (Polit & Beck, 2018; Maree & Pietersen, 2011). *Content validity* focuses on the degree to which the items in an instrument adequately represent the entire concept being measured while *Face Validity* involves subjective judgments by experts about the degree to which the instrument appears to measure the relevant variable. Hence, to ensure content and face validity, the literature was reviewed, to ensure that the instrument covers the full content of a construct that it sets out to measure. Also the views of the project supervisor, experts and senior colleagues in the field of study were sought in order to assess the content in relationship to the research objectives, and the instrument was modified according to their recommendations. However, the questionnaire was

adapted from two validated questionnaires that had been used in similar studies, namely USAID Post-Abortion Care (PAC) Assessment Tool and Pathfinder International Youth-Friendly PAC assessment tool.

3.4.2.8 Reliability of instrument

Reliability is the degree of consistency or dependability or repeatability of an instrument with which an instrument measures something (Polit & Beck, 2017; Maree & Pietersen, 2011). In order to ensure the reliability of the research instrument, the questionnaire was tested twice within a three-week interval. First, the researcher conducted a pilot study to pre-test the questionnaire using ten (10) respondents from the study population who were not part of the actual study. It intended to test the understanding of participants concerning the questions and to ascertain whether their answers validate the type and format of questions asked. It took the respondents an average of 10 minutes to complete the questionnaire, and issues relating to typographical errors, and suggested additions to the questionnaire were raised. The revised instrument was later sent to the researcher supervisor for final evaluation and approval. The approval to proceed was granted by the researcher supervisor with no further modification of the instrument. The revised instrument required was retested on the ten (10) respondents and the reliability coefficient (Crobach Alpha) was 0.89, which showed that the instrument was reliable. The data from the pilot studies were not included in the main study

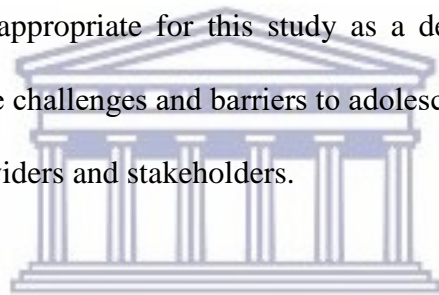
3.4.2.9 Data analysis

A Statistical Product Service Solutions (SPSS) version 21 was used to analyze the data collected. Descriptive statistics in the form of frequency distribution tables, percentage and bar charts were used.

3.4.3 Qualitative Part of the Phase One (Assessment Phase)

3.4.3.1 Research Design

A descriptive design using the qualitative approach was used to describe the adolescents' perception of post-abortion care received, as well as the service providers' and stakeholders' perspectives about challenges and barriers to adolescents' post-abortion care services. According to Creswell and Plano-Clark (2017) a descriptive research is designed to provide a complete and accurate description of a particular situation, social setting or relationship. An accurate description of the phenomenon is given by asking the "how" and "why" questions. The purpose of descriptive research is to provide a picture of a situation as it naturally happens (Burns & Grove, 2017). The design was therefore deemed appropriate for this study as a description, and deeper meaning could be extracted regarding the challenges and barriers to adolescents' post-abortion as perceived by adolescents, health care providers and stakeholders.



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3.4.3.2 Population

The population for the qualitative section of the study comprised of three different groups, namely:

- All adolescents with post-abortion complications admitted to the selected hospitals
- Health care providers (doctors and nurse-midwives)
- Stakeholders

3.4.3.3 Sample

The sample size for each of the above sample sets was determined on the basis of data saturation for the qualitative data (Polit & Beck, 2018), at a point where new information was no longer

forthcoming. Data saturation was achieved for a wide representation of data from the key informants regarding various components of the study. The decision was then made by the researcher when no new information could be gleaned by further data collection on the study questions.

A total of twenty (20) adolescents with abortion complications were enlisted to provide data on their experiences about abortion and post-abortion care services received in order to describe the adolescents' perspectives of post-abortion care received as well as the challenges and barriers they faced in obtaining these services.

On the part of the health care provider, the key informants were nurse-midwives and doctors working in maternity/obstetrics and gynaecology units of the selected hospitals. They provided information on the type and quality of post-abortion services available, technical skills and training level of staff involved in post-abortion care. They also recommended possible solutions to the identified challenges and barriers faced by adolescents in obtaining post-abortion care services. A total of thirty-two (32) health care providers were interviewed. Furthermore, seven (7) stakeholders were also interviewed to identify and evaluate the challenges and barriers faced by adolescents in obtaining post-abortion care services. On the part of the other stakeholders, the key informants were religious leaders, teachers, peer educators, youth counsellors, and representatives of an NGO working with adolescents.

3.4.3.4 Sampling Techniques and Approaches

A purposive, non-probability sampling procedure was used, in order to allow for reflection of the differences in the study population, and a selection of strategic informants capable of providing

useful, comprehensive and articulate information relevant to the study. This approach was used to select the participants for the qualitative part of the assessment phase.

Purposive sampling is a type of non-probability sampling which is based on the judgment of the researcher to select a sample that contains the most characteristic, representative attributes of the population that serves the study population best (Grinnell & Unrau, 2008). The use of purposive sampling allowed the researcher to use her knowledge and expertise regarding the study population, and to select participants who yielded insights and rich information about the purpose of the study (Creswell & Plano-Clark, 2017). The choice of such a sampling method is consistent with the exploratory nature of the study.

Inclusion criteria:

- Adolescents admitted with post-abortion complications in the selected hospitals and who are willing to participate in the study
- Health care professionals who had worked for at least six (6) months in an obstetrics and gynaecology unit and had managed a patient with abortion complications
- Stakeholders who had worked with adolescents or adolescent-related issues for at least 6 months and were still working with adolescents or adolescent-related issues during the period of data collection

Exclusion criteria:

- Adolescent patients who are not willing to sign the consent form to participate in the study.
- Health care professionals not involved in direct care of hospitalized patients with abortion complications.

3.4.3.5 Techniques and Instruments for Data Collection

3.4.3.5.1 Triangulation of Data Sources

Triangulation is defined as “the use of multiple sources or referents to draw conclusions about what constitutes the truth” (Polit & Beck, 2017). Data triangulation refers to the use of a variety of data sources in a study to validate results, increase credibility and gain a more detailed understanding of findings (Donoghue & Punch, 2003). Gerrish & Lacey (2006) further explained that data triangulation involves the use of a number of different data sources that can shed light on a particular phenomenon. Employing the different methods of data collection will not only compensate for the specific limitations in the different methods chosen (Mouton, 2004) but will further add value to data required for a study of this nature. Therefore, in order to overcome these weaknesses, the researcher used triangulation as a method of data collection in which questionnaires, individual in-depth interviews, and focus group discussions were employed.

A combination of data collection methods were used. These comprised the in-depth interview for adolescents, and focus group discussions for health care providers and stakeholders, for the purpose of obtaining the relevant research data. The various data collection methods used are discussed below

3.4.3.5.2 In-depth interview (IDI).

In-depth interviews were used for the adolescents with complications from abortion because the participants were not comfortable talking about abortion openly in a group, as suggested by several authors. IDIs provide more depth on issues raised, as participants have the chance to share

thoughts that they may not feel comfortable sharing in the presence of other participants, in the context of focus groups (Boyce & Neale, 2006; Silverman, 2005).

The researcher employed the use of in-depth interviews as they provide much more detailed information than what is available through other data collection methods. These are especially useful when detailed information about a person's thoughts and behaviours are explored, or where the researcher needs information about new issues, and in greater depth (Boyce & Neale, 2006).

The in-depth interview is a qualitative research tool that involves conducting intensive individual interviews with a small number of respondents with the aim of exploring their perspectives on a particular idea, programme, or situation. Hence, a total of 20 adolescents from the selected hospitals were interviewed using a semi structured interview guide. The information elicited from the adolescent participants include: their age, occupation and experiences on the following (i.) abortion procurement (ii.) post-abortion care received (iii.) challenges or barriers encountered during post-abortion care (iv.) expectation during post abortion care (Appendix XII IDI Guide for adolescents).

The researcher visited the selected hospitals weekly to find out if there were adolescent patients who had been admitted with abortion complications in the hospitals, and sometimes the researcher was called upon by the nurses when there were patients in the wards who had abortion complications. The researcher was then able to establish a rapport with the patients and their significant others. The interview was conducted as soon as each patient became more stable and was able to sign a consent form. The interview venue was a side room in the ward of the selected hospital, one that had been selected for the purpose by the participants, ward leader and the researcher. The setting was most appropriate because it was convenient, comfortable and conducive for discussion. The duration of the interview was 25-40 minutes.

3.4.3.5.3 Focus group discussion:

The main characteristics of a focus group discussion are the interaction between the moderator and the group, and the interaction between group members. The aim of a focus group discussion is to give the researcher an understanding of the participants' perspectives on the specific topic of discussion (Liamputtong, 2009; Wong, 2008). Focus groups allow multiple lines of communication and may offer “a safe environment where people can share ideas, beliefs, and attitudes in the company of others with the same socioeconomic, ethnic, and gender backgrounds” (Kruger & Casey, 2015).

Focus groups are also exceptionally effective for the study of sensitive issues as well as ones that are difficult to access, such as the vexed question of abortion in Nigeria. FGDs can also be used to gain insights into people's experiences of ill health and health services and explore the attitudes and needs of healthcare providers. Kruger & Casey (2015) points out that there may be reasons to have either smaller or larger groups for the FGD. However, small groups of 5-8 participants constituted the focus group in each of the hospitals selected. This size of focus group was preferred because the participants had intense and personal experiences to share about the topic and the researcher wanted participation from each subject (Kruger & Casey, 2015).

Two separate interview guides were developed by the researcher for the FGDs, one was directed at health care providers and the other was for the other stakeholders involved in the study. Each of the instruments contained information formulated around key issues, directed at the research questions and the study objectives. One (1) round of focus group discussion involving the health care providers was conducted in each of the hospitals selected and the FGDs (FGDs 1-3) were held at the selected hospitals, since participants were health care providers working in the clinical

setting at the time of the study, and permission to use the venue had been obtained from the hospital managers, with the time and date fixed and agreed upon by the participants.

Another one (1) round involving the stakeholders was also conducted (FGDs 4). A total of four sessions were conducted and participants were recruited on the basis of their experience and involvement in matters raised by the research topic, participants in whose opinions the researcher was interested. A focus group confidentiality binding form was signed by participants after a counselling session and participants who were emotionally affected by the study were referred to a therapist (clinical psychologist) at the hospital. Focus group interviews did not exceed one hour and were conducted during November 2014 and March of 2015.

3.4.3.6 Trustworthiness and Rigor of the study (validity of qualitative research)

The trustworthiness of qualitative research is often questioned by positivists because their concepts of validity and reliability cannot be addressed in the same way as naturalistic work (Shenton, 2004). The researchers who work within the interpretivist/constructivist paradigm have adopted the concept of trustworthiness as an alternative term for validity, reliability and generalizability for their qualitative work (Loh, 2013). The issue of validity in qualitative research should not be captured under truth or value as obtained among positivists (Shenton, 2004). The term “trustworthiness” is preferred by many naturalistic researchers. Trustworthiness is a term used in qualitative research to describe and evaluate the efforts made by a researcher to ensure that the research process is described accurately (Lincoln & Guba, 1985). Lincoln and Guba in Shenton, (2004) suggested four criteria for ensuring the trustworthiness of the findings of qualitative research: credibility, transferability, dependability and confirmability. These four criteria of trustworthiness were followed in this study.

3.4.3.6.1 Credibility

This criterion seeks to ensure that the study measures what it has set out to measure. It corresponds with internal validity as used by the positivist researcher (Houghton, Casey, Shaw & Murphy, 2013). Credibility in qualitative study raises the issue of congruence of the findings with reality. It is one of the most important means of ensuring trustworthiness. The techniques for achieving credibility include the following:

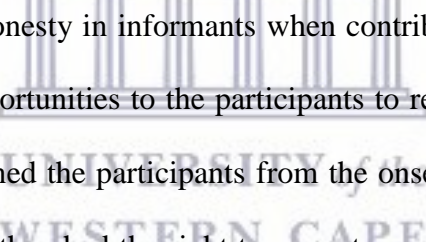
- a) Adoption of research methods well established both in qualitative investigation and information science. The data collection and analysis strategies, and information seeking process should derive from the approaches that have been used successfully by others in previous, comparable projects. The researcher adopted the mixed-methods design which has been successfully used by many researchers and PhD students in developing frameworks, intervention programmes, documents, guidelines, and models (Joel, 2015; Ibitoye, 2017). The research approach used by these researchers in their respective studies is the mixed method approach and this guided them in their data collection and data analysis. In the same note, this researcher used mixed-methods design in collecting and analysing the data. The findings were interpreted from two philosophical perspectives (quantitative and qualitative methods), as one complements the weakness in the other method used.
- b) Development of an early familiarity with the context of the proposed study through appropriate documents and preliminary visits. This involves prolonged engagement between both the participants and researcher. This researcher had interactive sessions with the gatekeepers in order to acquaint them with her research intent, and enlist their cooperation. The researcher had earlier developed a rapport with the adolescent patients and their relatives in the selected wards before formally seeking their consent to participate in the research.

Furthermore the researcher also had interactive sessions with the health care providers and other participants in order for them to gain adequate understanding of research intent and to establish relationship based on trust. The level of familiarity was modest so as to avoid whittling down the motive of the visit. The interaction enabled a good understanding of the research purpose by the participants and the researcher gaining their trust.

c) Triangulation of the sources and methods of the data was also utilised by the researcher to ensure trustworthiness. Triangulation is a powerful strategy that strengthen the validity of data obtained from research by using different research methods and sources (Yeasmin & Rahman, 2012; Carter, Bryant-Lukosius, Dicenso, Blythe & Neville, 2014). The following types of triangulation can be present in a qualitative research study: data triangulation; investigator triangulation; methodological triangulation and theory triangulation (Pattson, 1999). In this study the researcher used both data and methodological triangulation.

- Data triangulation refers to the use of different data sources, including person, place and time. The data were collected from adolescent patients from the selected hospitals; health care providers from the selected hospitals, and other stakeholders such as religious leaders, teachers, peer educators, youth counsellors, and representatives of an NGO working with adolescents.
- Methodological triangulation entails using more than one kind of method to understand a phenomenon. There are two types of methodological triangulation, within a method and across methods (Bekhet & Zauszniewski, 2012). The researcher used triangulation within methods, which is the use of different data collection methods within research. In this study, the data collection methods used were interviews and focus groups. The interview was audiotaped, and this was complemented with field notes which

documented some of the verbal responses and nonverbal cues. There was post-interview discussion in order to review what was discussed between the researcher and the assistants on the one hand, and between the research team and the participants on the other hand. Information on the experiences of abortion procurement and challenges and barriers to PAC received was not only sourced from the adolescents with abortion complications but also from the health care providers and other stakeholders such as religious leaders, teachers, peer educators, youth counsellors, and representatives of NGOs working with adolescents. This allowed the researcher to compare information obtained from the different sources and also verify information supplied by the participants, thus enhancing the quality of the research study (Shenton, 2004; Krefting, 1991).

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- d) Tactics to help ensure honesty in informants when contributing data was achieved by the researcher by given opportunities to the participants to refuse to participate in the study. The researcher enlightened the participants from the onset that participation in the study was voluntary, and that they had the right to agree to participate or to decline, as well as withdraw from the study at any given time. This is to ensure that the data collection sessions involve only those who are genuinely willing to take part and prepared to offer data freely (Shenton, 2004). Furthermore, the researcher informed participants that the information supplied would not jeopardize their interests and that they would remain anonymous. Therefore, participants were encouraged to be frank about the information they would give from the outset.
- e) Iterative questioning was also incorporated to ensure credibility of the study and this was achieved through probing and rephrasing the questions asked on different occasions

during the course of the interview process. The researcher often went back after an interval of one or two questions to the previous one to revalidate what the participant had said earlier. Where contradictions occurred, the researcher discarded the suspect data or asked for possible explanations (Shenton, 2004).

- f) The researcher regularly debriefed with her supervisor in order to discharge her personal feelings related to the study and ensure credibility. The researcher's supervisor corrected the questions that were to be asked during the interview sessions and misconceptions were cleared and further clarification and insight were provided to the researcher. The transcribed data were also subject to the supervisor's scrutiny and comment, and a second opinion was obtained on the data analysis.
- g) Peer scrutiny is the process a researcher utilizes by working with one or more colleague to help clear misconceptions, clarify ideas and to ensure an impartial judgment concerning the research work (Creswell & Plano Clark, 2017; Onwuegbuzie, Leech, & Collins, 2008). In this study, the researcher had discussions with trusted senior colleagues and fellow PhD students, who had also, use similar forms of data collection methods in the past, to gain their input. Samples of the transcripts were read by trusted colleagues who had previously had their work transcribed and analyzed to ensure that the researcher was on the right track.
- h) The process of member checks requires the researcher to return to the participants and discuss the interpretation of the collected data (Rolfe, 2006; Creswell, 2014; Lincoln & Guba, 1985). One of the purposes for conducting member checking was to give the participants the opportunity to correct errors and challenge interpretations, as well as provide additional information they had not made during the interviews (Lincoln & Guba

1985). However, Shenton (2004) argues that checks relating to the accuracy of the data can take place immediately where the data were collected in the course, and also in end of data collection discussions. The researcher checked with the some of the experts as to whether there was any correlation between the words used and what they had actually intended. The themes generated were taken back to them to give them the opportunity of providing alternative interpretations. Their suggestions were built into the data analysis and data presentation.

3.4.3.6.2 Transferability

Another criterion that Lincoln and Guba (1985) emphasise in ensuring trustworthiness is transferability. Transferability is an alternative construct for external validity in positivist research and it refers to the extent in which the findings from one study can be applied or transferred to another research setting or participants with similar characteristics (Lincoln & Guba, 1985) Shenton (2004) stated that it is impossible to demonstrate that the findings and conclusions of a qualitative study are applicable to other situations and populations because of the small sample size which is not a representative of the study population (Shenton, 2004). Furthermore, the work of Cole and Gardner, Marchionini and Teague, and Pitts in Shenton (2004) highlights the importance of the researcher's conveying to the reader the boundaries of the study and following information should be given at the outset before any attempts at transference are made:

- a) The number of organisations taking part in the study and where they are based;
- b) Any restrictions in the type of people who contributed data;
- c) The number of participants involved in the fieldwork;
- d) The data collection methods that were employed;
- e) The number and length of the data collection sessions;

f) The time period over which the data were collected.

In order to achieve transferability, the researcher has provided a thick description of the nature of the study participants, their reported experiences, the study settings and research methodology (Stommel & Celia, 2004). The researcher has identified and described sufficient data and compiled the report such that it became easier for the consumers to evaluate the applicability of the data to other settings/contexts (Polit & Beck, 2017).

3.4.3.6.3 Dependability

The third criterion that Lincoln and Guba (1985) emphasize is dependability. From the positivist point of view, dependability is reliability of data over a period of time and conditions, i.e. assessing whether the findings of the study can be replicated using in the same context, with the same methods and with the same participants in the same or similar setting. Dependability is necessary for credibility of a research project (Polit & Beck, 2017; Shenton, 2004). Dependability is necessary for credibility of a research study and it indicates the repeatability of the methods and procedures used in arriving at the conclusions (Polit & Beck, 2017; Shenton, 2004). In addition, Lincoln and Guba (1985) corroborate the close relationship between credibility and dependability, and argued that, credibility ensures dependability, which may be achieved through the use of “overlapping methods”, such as the focus group and individual interview. In order to enhance the reliability of qualitative research, the research design and methods used in data collection and analysis were fully described in the study. The details of data gathering activities were also provided.

3.4.3.6.4 Confirmability

The fourth criterion that needs to be met to ascertain trustworthiness according to Lincoln and Guba (1985) is confirmability. The concept of confirmability is similar to objectivity in positivist's language. Triangulation plays an important role in maintaining confirmability in qualitative study. Triangulation as applied to credibility was observed to ensure that the investigator's bias was reduced. The researcher also indicated her own prejudices and how these were kept in check in order to lessen its effect on the data collection process and analysis outcome. The researcher provided a detailed methodological description of the study. Confirmability was equally achieved through the presentation of representative quotations from the transcribed text to show a connection between data and results (Elo, Karriainen, Kanste, Polkki, Utriainen, & Kyngas, 2014). The researcher used an audit trail by representing the research process diagrammatically, which shows how the data collected and analysed led to the basis of the intervention programme development for school. To achieve confirmability the researcher used audit trails in which the approaches to data collection, decisions about data to collect and about the interpretations of data were carefully documented so that another knowledgeable researcher could have arrived at the same conclusions about the data as the primary researcher (Stommel & Celia 2004). The researcher ensured that the findings reflected the participants voices and the condition of inquiry, and not the biases, motivations or perspectives of the researcher (Polit & Beck 2017). The researcher also ensured that there had been an internal agreement between the researcher's interpretation and the actual evidence (Creswell & Plano-Clark, 2017). There was consensus between the researcher, the participants, and the co-coder on data collected. Confirmability was also tested through the involvement of experienced and erudite

supervisors who, as independent reviewers, critiqued the proposal and the entire thesis and attested to the evidence of academic rigour that was given to the study.

3.4.3.6.5 Data analysis

Qualitative data analysis and interpretation is the process of assigning meaning to the collected information and determining the conclusions. It is conducted by organizing the data into common themes or categories. Qualitative data analysis is aimed at generating themes and making sense out of the data. In this regard content analysis was employed to analyze the data. Thematic analysis is used for exploratory or explanatory research, but most often in descriptive research (Neuman, 2003). The process of analysis consists of moving from the reading and note-taking into describing, classifying and interpreting (Creswell, 2014). The tape-recorded data were transcribed verbatim, and then cleaned and prepared for the analysis. The huge volume of data had to be condensed, categorized and pared down to a manageable size. Meticulous readings were conducted to filter and clean the data. The individual interviews and FGDs with caregivers and stakeholders were analyzed separately. Interviews were conducted in English for all groups and this meant that it was not necessary to translate the interviews. The transcribing and analysis were done concurrently with the data collection process. This enabled the researcher to identify gaps in the interview or to see if some relevant points were missing, so that the gaps could be filled in the following interviews.

In this study, thematic analysis of issues recurring in each interview was done and themes emerging from the various categories of data were conceptualized into meaningful themes on the basis of regularities and convergence in the data. Data were analyzed according to the five stages of data analysis described in the Framework approach by Ritchie and Spencer (1994) as outlined by Gerrish and Lacey (2006).

1. **Familiarization:** This step was achieved through immersion in the data to get an initial feel for the key ideas and recurrent themes. The researcher immersed herself in the details of the data, and in this way developed insight into the whole sense of the data, learnt more about it and then formulated an overview that encompassed all of the ideas contained in the data. In order to do this, the researcher first read and reread all the information to obtain a sense of a general overview of all the transcribed information by jotting down notes and reflective notes in the margin of the text and/or highlighting text with different colours. Then the researcher started to look closely at the words used by participants in the study. Development of the themes was done by immersion in the data to understand and seek further explanation needed for generating the themes. A code was assigned to individual text items and line numbering was allocated to text, which enabled the researcher to trace back from which text the data were extracted.
2. **Identifying a thematic framework:** This is the stage of identifying key issues, concepts and themes and the setting up of an index or framework. This stage was achieved by writing memos in the margins of the text in the form of short phrases, ideas or concepts arising from the texts. Categories were developed which formed the key issues, concepts and themes that were expressed by the participants; these were used to filter and classify the data.
3. **Indexing:** In this stage, the researcher identified portions or sections of the data that corresponded to a particular theme. This process involved sifting the data, highlighting and sorting out quotes and making comparisons both within and between cases. For the sake of convenience a numerical system NVivo was used for the indexing references and annotated in the margin beside the text.

4. **Charting:** In this stage, quotes were “lifted” from their original context and re-arranged according to themes under the subheadings that were drawn in the thematic framework, in the manner that is perceived to be the best way to report the research (Ritchie & Spencer, 1994). The themes were presented in chart form and separate charts were used for each major subject or theme.
5. **Mapping and interpretation:** This involves the analysis of the key characteristics as set out in the charts. This analysis provides a schematic diagram of the event/phenomenon, thus guiding the researcher in her interpretation of the data set. It is at this point that the researcher is cognizant of the objectives of qualitative analysis, which are: “defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies” (Ritchie & Spencer, 1994). Therefore, the charts were used to define concepts, map the range and nature of the phenomena, create typologies, and find associations between themes in order to provide explanations for the findings. This process was guided by the original research questions as well as the themes and relationships emerging from the data.

Finally, the researcher, the supervisors and the independent coder reviewed the data to make judgments and interpretations of the content and meaning of the material (Patton, 2002). Clarification of the data were done according to agreement between the researcher, independent coder and the supervisor of the study

3.4.4 Phase 2: Interactive Phase:

In this phase of the research design and development, objectives five and six of the study were addressed: to explore ways in which the knowledge about challenges and barriers to adolescents’ post-abortion care services can be improved as well as, develop policy document in key areas to

improved PAC services in Nigeria as part of working towards improving adolescents' reproductive health services.

3.4.4.1 Research Design

This phase employed quantitative design using the policy Delphi method to evaluate and discuss challenges and barriers faced by adolescents in obtaining post-abortion care services and develop policy document in key areas to improved PAC services in Nigeria. The Delphi was a method used to obtain the most reliable consensus of opinion of a group of experts by a series of intensive questionnaires interspersed with controlled feedback (Keeney, Hasson, & McKenna, 2011). Delphi method is a flexible approach that can be modified to achieve the purpose of the research and is based on the premise that “pooled intelligence” enhances individual judgment and captures the collective opinion of experts (De Villiers, De Villiers & Kent, 2005). It also provides an opportunity for experts to communicate their opinions and knowledge anonymously about a complex problem or a topic of interest, to see how their evaluation of the issue aligns with that of others, and to change their opinion, if desired, after reconsideration of the findings of the group's work (Kennedy, 2004).

In this phase, the survey was conducted by means of a series of questionnaires that were completed anonymously by individuals on the expert committee. It is a process of group communication without the group ever meeting face to face. The responses from each set of questionnaires were analyzed, summarized and then sent back to the participants until optimum consensus was reached on the area of interest (Keeney, Hasson, & McKenna, 2011).

3.4.4.2 Data collection instruments

The data collection instrument for expert panellist in the study was a self-completion structured questionnaire. Two (2) questionnaires were formulated. The In-depth interviews and focus group

discussions in the phase one of the study informed the development of the content and concepts of the questions in the first questionnaire while the second questionnaire was formulated using the data generated from the experts in round one. The questionnaires were partly structured and partly semi-structured, containing mainly closed ended and few open-ended questions. It contains four sections, sections A, B, C and D. Section A contains questions on the demographic data of the respondents, section B contains questions on experts' opinion on abortion and post abortion care (PAC). Section C contains questions on experts' opinion on challenges and barriers to adolescents' post abortion care services. Section D also contains questions on possible resolution of barriers and challenges to post abortion care (PAC). The instrument contains 5point Likert-scales of "strongly agree" "agree", "undecided", and "disagree" "strongly disagree" options which was used evaluating the expert panellists views (see appendix XV).

3.4.4.3 Number of Rounds

The Delphi technique employs a number of rounds in which questionnaires are sent out and are used until consensus is reached (Beretta, 1996; Green et al., 1999). According to Hsu and Sandford (2007), one of the characteristics of a Delphi method is the feedback process that allows the participants to re-assess their initial judgments, and thus the process of different rounds is encouraged. In this study, the Delphi method employed was conducted over a period of two months and only two rounds were done because consensus was reached by the panel of experts at the end of the second round. In the first round, the questionnaire consisted of demographic questions, open-ended and closed questions developed from the information gained from the in-depth interview and focus group discussion. In the second round, the questionnaire consisted of closed questions developed from the structured information gained from the panellists in the first

round, to re-evaluate their opinion and recommendations about the challenges and barriers to adolescents' post-abortion care in Nigeria.

The initial measurement of opinions (the first round) was followed by data analysis, and a new questionnaire was designed. The second measurement of opinions (the second round) was done and consensus was reached, or saturation of opinion occurred at the completion of Round 2, with all the questions posed in the questionnaires during Round 1 and 2 obtaining a score of 70% and higher.

3.4.4.4 Panel of Experts and Panel Size

The panel of experts refers to “someone who has knowledge about a specific subject” or “informed individual or advocates” (Keeney, Hasson, & McKenna, 2011). Adler and Ziglio (1996) outlined four requirements for expertise. These are: knowledge of and experience with the issues under investigation, capacity and willingness to participate, sufficient time to participate, and effective communication skills. The eligibility of the panel of experts for this study was based on the criteria.

Panel size refers to the number of expert panellists to be included in the study (Polit & Beck, 2017). There are no clear guidelines for the number to be included in studies applying the Delphi survey because the sample is purposively selected; it also depends on the problem being investigated (Keeney et.al, 2011). The purposive sampling technique was used to select 50 experts to participate in the Delphi study. The researcher decided to use this sampling method because the goal was to include eligible participants who would make useful contributions to the discussions and whose participation would be of benefit to the study. The experts invited included five university lecturers, five school teachers, four doctors, six nurses, ten religious scholars, two youth counsellors, four lawyers, two peer educators, two politicians, two youth representatives,

two women representatives, two men representatives, two youth counsellors and one motivational speaker. They were chosen because they already had an interest in and clinical background to the problem. They explored the social, economic and political challenges and barriers to PAC, thus providing direction and focus to the development of informed policy and legislation for adolescent PAC.

Table 3.2: Sampling Framework of Panel of Experts

Organizations Represented	Category	Total number
Health care	Doctors (O&G consultant)	4
	Nurses	6
	Social workers	2
Education	University lecturers	5
	School teachers	5
	Peer educators /Health educators	2
Legislation	Lawyers	4
	Politicians	2
Religion	Islamic scholars	5
	Pastors	5
Community representatives	Community leaders	1
	Youth representatives	2
	Women representatives	2
	Men representatives	2
	Youth counsellors	2
Non-governmental organization	Youth motivational speaker	1
TOTAL		50

3.4.4.5 Process

All experts on the panel were informed by telephone that a questionnaire related to the study was on the way and they were informed that the need for their assistance as an expert on the panel would be appreciated. A letter of invitation, consent form and questionnaire were sent to the participants either by e-mail addresses for those with functional e-mail or hardcopies of the questionnaire were given personally by hand or sent by courier service for those who do not have functional e-mail or found it difficult to complete it online (see Appendix XV). The experts were asked to read the information carefully and indicate consent to participate before completing the

questionnaire; this was done by all participants. On completion, the participants were requested to send back the consent forms and questionnaires.

All expert panellists made use of cell phones; therefore, they were called to follow up, as regards to the filling of the questionnaire. A total of four emails were sent including the initial email with the questionnaire, the 1st reminder, the 2nd reminder and the final reminder. A three days interval phone call reminder was made to each participant to remind them and to find out from those with hardcopies if the questionnaire was ready for collection; when it was available, the researcher informed the courier service to fetch the questionnaires back to her based on the prior arrangement of the researcher with the courier agent. Once the completed questionnaire was received from a participant, no further reminder was sent.

A key characteristic of the Delphi survey is anonymity, which in this context serves four fundamental purposes: it assures the expert panellists' ethical rights, obviates "group think", prevents dominance by influential or high profile individuals, and encourages independent decision-making (Sharkey & Sharples, 2001). The Delphi survey is a group communication process whereby the participants never meet each other with regard to the process (Rowe & Wright, 1999). There is the guarantee of anonymity of participants' individual responses and these are never known to one another (McKenna, 1994). Aggregate group views are communicated as group summaries for individuals to review against their own opinions and ideas (Keeney, Hasson & McKenna, 2011).

3.4.5 Data Analysis

In the Delphi method, data collected included both qualitative and quantitative items. The quantitative data from the first and second rounds were analysed using a computer software package SPSS (Statistical Package for Social Sciences) version 21. According to the literature, the

major statistics used in Delphi studies using quantitative data are measures of central tendency (mean, median, and mode) and level of dispersion (standard deviation and inter-quartile range), in order to present information concerning the collective judgments of respondents (Keeney, et.al 2011). Ascertaining the group’s collective opinion required the use of descriptive statistics, which was carried out in this study in consultation with a statistician (Keeney et al., 2011).

Table 3.3: Summary of the Research methodology

The table below shows the summary of the methodology used in this study

Phase 1	Design	Data source	Instrument	Sample and sampling techniques	Methods of data analysis
Objective 1	Quantitative	Health care providers (nurses and doctors)	Questionnaire	315 respondents Purposive sampling	Descriptive statistics
Objective 2	Qualitative	Adolescents with abortion complications	Individual in-depth interviews	Purposive sampling	Thematic analysis: All the raw data gathered were sifted, charted and sorted in accordance with key issues and themes
Objective 3	Qualitative	Health care providers (nurses and doctors)	Focus group discussions		
Objective 4	Qualitative	Other stakeholders working or involved with adolescents	Focus group discussions		
Phase 2 Objectives 5 and 6	Policy Delphi Survey	Panel of experts on adolescens’ reproductive health issues	Questionnaire (Two rounds)	50 participants Purposive sampling	

3.5 Ethical considerations

The fundamental ethical principles that focus on the protection of human beings and the rights of the participants were recognized and protected in this study. The following ethical issues were noted and observed throughout all phases of the research and form part of the information included in the information sheet and consent form provided to the key persons and participants:

3.5.1 Permission

The proposal was presented to a review committee within the School of Nursing before it was recommended for submission to the Higher Degrees Ethical Committee of the university. Ethical clearance of the proposal was obtained from the Higher Degrees Ethical Committee of the University of the Western Cape (see Appendix I for the ethical clearance document). Also, written permission to use the health facilities for study purposes was obtained from the various authorities in charge of the hospital facilities after scrutinizing the research proposal (see Appendices II-IV). A copy of the ethical approval and permission letter was provided to each facility manager in order for the researcher to use the facility. The researcher also negotiated with each health facility manager on how to contact the participants to arrange a convenient time to meet with them without interrupting normal activities.

3.5.2 Informed consent

Participants within the selected health institution were given participant information sheets (see Appendix VI) and informed consent forms (see Appendix VII). These were prepared by the researcher to sign after all participants were fully informed about the purpose of the study and the implications of participation in the study. They were encouraged to ask questions where they were not clear and all questions and doubts were clarified such as. Adolescents below the age of consent (under the age of 18) are regarded as a vulnerable age group in research studies (Gerrish

& Lacey, 2006). In the case of these adolescents, a parental consent form was included, requesting the permission of the parent or guardian to allow his/her child to participate in the study (see Appendix X). The parental consent forms were duly signed for participants under 18 by the guardian or parent, and informed assent forms were duly signed by these adolescent minors. Participants were informed of the use of a moderator and the audiotape. The consent form and information sheets were written in English because most people in the area speak and read English, and English was the only means of communication for the researcher to communicate with the participants.

3.5.3 Beneficence and Non Maleficence

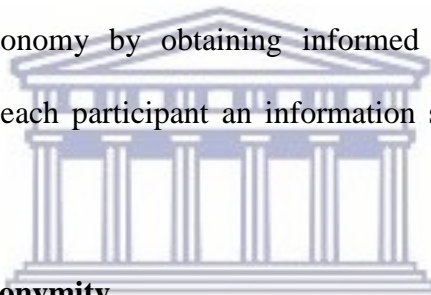
This is the principle that compels a researcher not to inflict harm intentionally or unintentionally. All participants have a right to be protected from discomfort and harm (Beauchamp & Childress, 2012). The researcher ensured that the participants were not harmed in any way, either physically, psychologically, emotionally, socially or otherwise. To ensure this, arrangements was made for a clinical psychologist to be on a standby during the interviews, for prompt management of any participant who experienced psychological discomfort due to the study. The researcher observed the participants for signs of distress; some of the adolescents in the study did indeed appear distressed, as many personal issues emerged during the interviews. The researcher then spent time with the participants after the interview to listen to them and then referred them to the clinical psychologist, which they declined. However, they were counselled before and after the in-depth interviews and they claimed that they felt better. Furthermore, the adolescent patients were involved in the study only when their general health conditions were stable and they were waiting to be discharged.

3.5.4 Veracity

Participants were given detailed information about the study without the researcher or anyone acting on her behalf withholding information or giving false information concerning the study.

3.5.5 Respect for autonomy

The participants' right to take part in the research study without external control, coercion exploitation or persuasion was respected. Participation was completely voluntary. Participants were informed that participation in the study was voluntary, and that they had the right to agree to participate or to decline, as well as withdraw from the study at any given time. The researcher also achieved respect for autonomy by obtaining informed consent from the participants (Appendix VII), and by given each participant an information sheet informing them about the research (Appendix VI).



3.5.6 Confidentiality and Anonymity

The confidentiality and anonymity of participants were maintained. Information entrusted to the researcher was used purely for research purposes and was not revealed to others who were not directly involved in the study. Codes and pseudo initials were used on the relevant documents during data collection instead of names, and participants were interviewed in a quiet place within the hospital to ensure privacy and confidentiality. All tapes and instruments used during the study were kept under lock and key, to which the researcher and her supervisor will have sole access for a period of five years. Focus group discussion (FGD) confidentiality binding forms were given to the participants in the focus group to sign (see Appendix) after a full explanation of what the study was all about and what was expected of them. However, participants were informed that the researcher had no control over information that was discussed outside the group. Audacity

software was used to disguise participants' voices on the audiotapes, so that the resulting data could not be linked in any way to the identity of any individual.

3.6 Summary of the Chapter

This chapter explained the research methodology used for the study. The nature and methodology of this research was indicated. Both quantitative and qualitative methods were employed through the use of surveys, focus group discussions with health care providers and other stakeholders, and individual interviews. The Delphi method was employed to evaluate challenges and barriers faced by adolescents in obtaining post-abortion care services, in order to highlight implications and make recommendations and suggestions in key areas in order to inform policy for improving adolescents' reproductive health. The reason for using exploratory mixed methods to conduct the study was also discussed. The data analysis process, ethical considerations and limitations of this study were outlined. The next chapter gives a comprehensive description of the data analysis and findings from the quantitative study.



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CHAPTER FOUR

DATA ANALYSIS FOR QUANTITATIVE PHASE

4.1 Introduction

This chapter presents the analysis and interpretation of data collected on the quantitative component of the study. The chapter focuses on findings from examined facilities and inventory of PAC-related services provided, as well as on the technical skills and training levels of staff who were involved in post-abortion care, in order to identify barriers and challenges to adolescents' PAC. Of the 315 questionnaires administered, only 301 were retrieved and analyzed. Thus, the response rate was 95.6%.

4.2 Demographic characteristics of respondents

The table 4.1 below shows respondents' field of study and designation with 224 (74.4%) and 77 (25.6%) of them as nurses and doctors respectively. Of these nurses, 26 (8.6%) were CNO, 32 (10.6%) ACNO, 34 (11.3%) SNO, 40 (13.3%) PNO, 49 (16.3%) NOI and 43 (14.3%) NOII, Senior registrars accounted for 19 (6.3%) of the respondents, junior registrars 30 (10.0), MO 10 (3.3%) and HO 18 (6.0).



Table 4.1: Demographic characteristics of respondents (n=301)

ITEMS		Frequency	Percent
Field of study	Nursing	224	74.4
	Medicine	77	25.6
Rank	ACNO	32	10.6
	CNO	26	8.6
	PNO	40	13.3
	SNO	34	11.3
	NO I	49	16.3
	NO II	43	14.3
	Senior Registrar	19	6.3
	Junior Registrar	30	10.0
	MO	10	3.3
	HO	18	6.0
	Total	301	100.0

4.3 Reproductive-health and related post-abortion care services

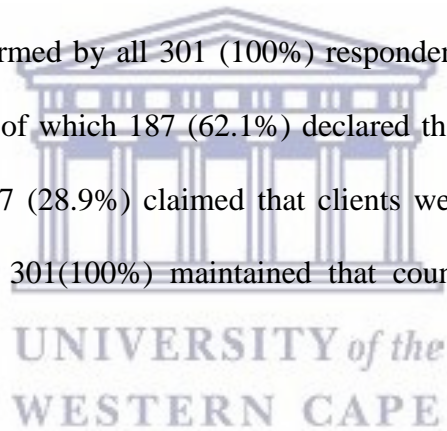
The reproductive-health and related post-abortion care services of the health facilities are displayed in tables 4.2 to 4.4 and figure 4.1 to 4.5.

Table 4.2: Availability and range of PAC Services provided (n=301)

ITEMS	Yes	No
	Freq (%)	Freq (%)
Provision of PAC in facility 24 hours a day	301 (100)	0 (0.0)
Availability of free PAC services	0 (0.0)	301 (100)
Availability of adequate equipment and materials needed for PAC services	301 (100)	0 (0.0)
Availability of Emergency Gynecologic Care for post-abortion complications	165(54.8)	136(45.2)
Availability of supplies, medications and equipment necessary to ensure safety and efficacy of post-abortion services	237 (78.7))	64(21.3)
Availability of staffing to meet PAC client needs	159(52.8)	142(47.2)
Availability of family planning services in the immediate PAC period	251(83.4)	50(16.6)
Availability of contraceptive services	301 (100)	0 (0.0)
Types of contraceptive services provided	301 (100)	0 (0.0)
Counselling	249(82.7)	52(17.3)
Provision of contraceptives		
Source of supply of contraceptives for referred clients		
Site within facility	187(62.1)	114(37.9)
Site outside of facility	87(28.9)	214(71.1)
Agreed contraceptive referral arrangement	0 (0.0)	0 (0.0)

All of the respondents (100%) agreed that their facilities provide 24-hour post-abortion care and that these services were not free. All the respondents affirmed that their various facilities have a convenient place for uterine evacuation as well as an adequately equipped operating room to provide timely emergency care to abortion patients in case of abortion complications.

A majority, 273 (78.7%) of the respondents maintained that medications, equipment and other supplies necessary to ensure safety and efficacy of post-abortion services are readily available; 159 (52.8%) agreed that staffing was adequate to meet clients' needs. 251 (83.4%) of the respondents affirmed that their hospitals officially offer family planning services in the immediate post-abortion period as part of its comprehensive PAC programme, and the availability of contraceptive services was affirmed by all 301 (100%) respondents. Provision of contraceptives was affirmed by 249 (82.7%), of which 187 (62.1%) declared that clients were referred to sites inside the facilities, whereas 87 (28.9%) claimed that clients were referred to sites outside the facilities. All the respondents 301(100%) maintained that counselling was available in their facilities.



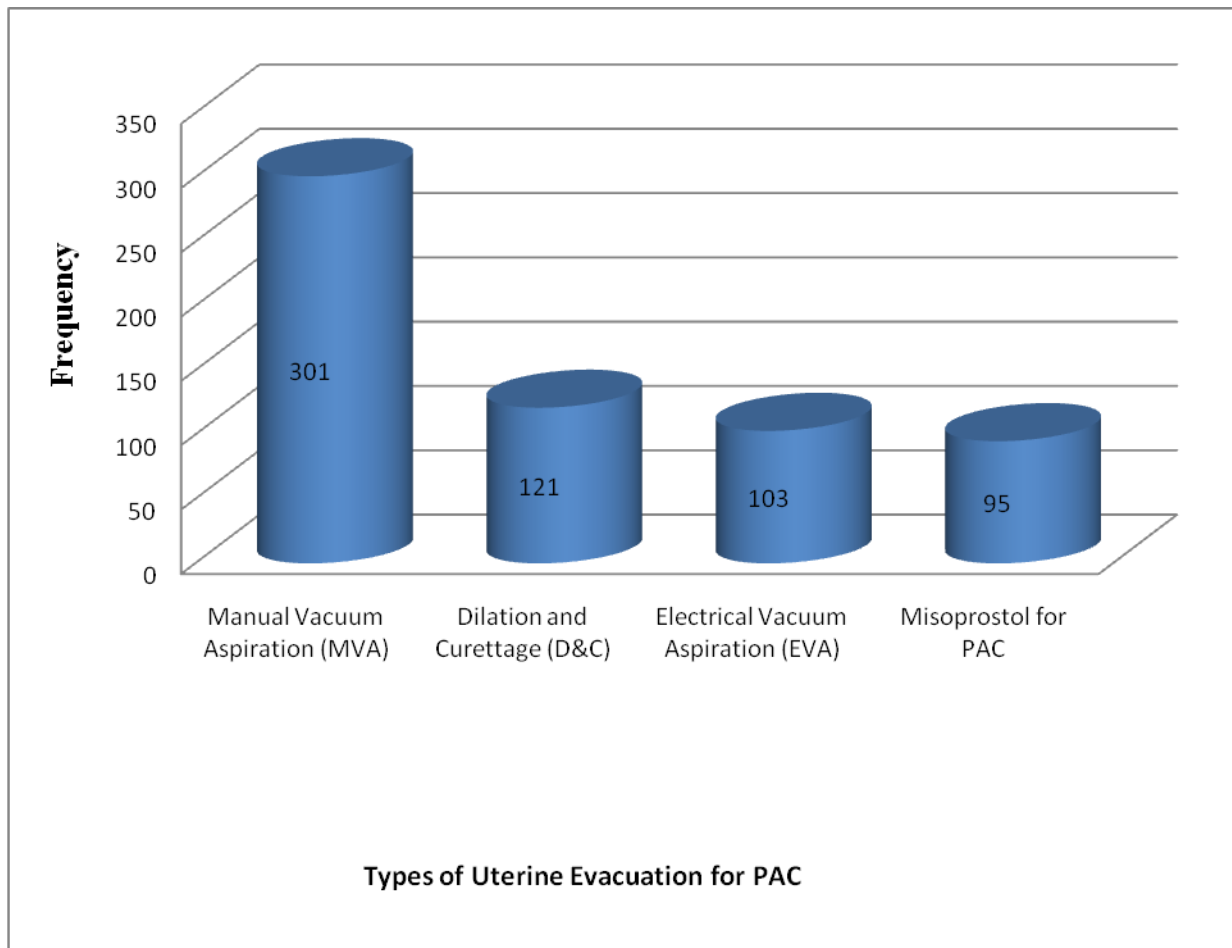
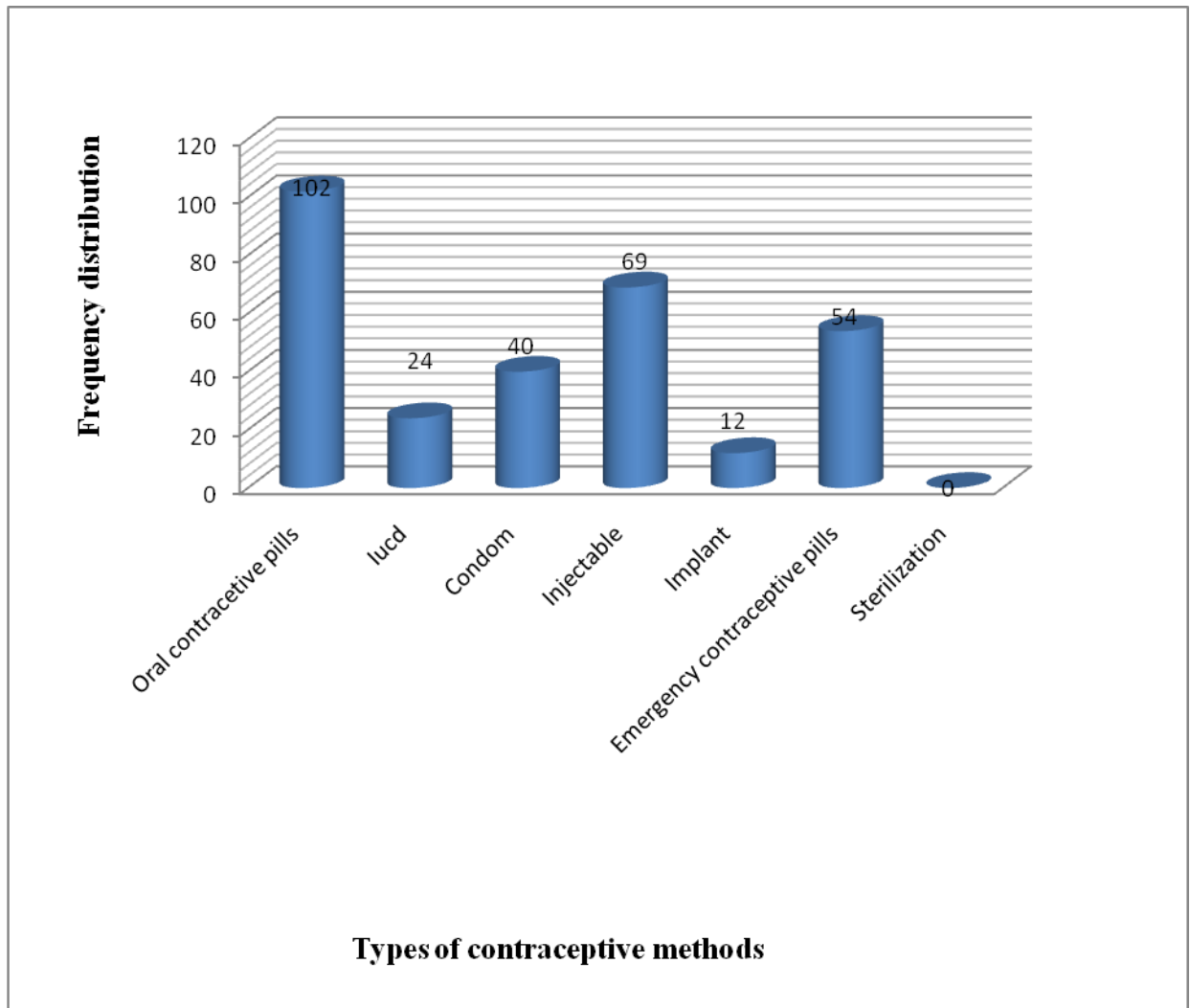


Figure 4.1: Type of Uterine Evacuation for PAC (n=301)

All the participants noted that MVA was used for PAC in their facilities, 121 (40.2%) of the respondents said that D&C was also used in their facilities. 103(65.8%) also confirmed the use of EVA, while only 95 (31.5%) agreed that misoprostol is being used for PAC in their facilities.



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Figure 4.2: Types and distribution of contraceptive methods (n=301)

Figure 4.2 shows the types of contraceptive methods available and distribution of methods used, with oral contraceptive pills 102 (34.0%) constituting the most commonly used type of contraceptive, followed by injectable 69 (23.3%), then emergency contraceptive pills 54 (18.0%) and condom 40 (13.0%). The methods least used were IUCD 24(8.0%), implant 12 (4.0%) and sterilization method 0 (0.0%).

Table 4.3: Technical Skills and Training Levels of Staff Involved in PAC (n=301)

ITEMS	Yes Freq (%)	No Freq (%)
Does the hospital have competent providers for PAC services at any time of the day?	190 (63.1)	111 (36.9)
Is there a coordinator/supervisor in charge of post-abortion care services?	243(80.7)	58(19.3)
What kinds of staff provide post-abortion services?		
Doctors only	0 (0.0)	301 (100.0)
Midwives only	0 (0.0)	301 (100.0)
Midwives and Doctors	301(100)	0 (0.0)
Have you been trained to administer post-abortion services?	159(52.8)	142(47.2)
Is there any staff trained to administer post-abortion services?	301 (100)	0 (0.0)
What kinds of staff have received training in post-abortion care?		
Doctors only	0 (0.0)	301(100)
Midwives only	0 (0.0)	301(100)
Midwives and Doctors	301(100)	0 (0.0)
Does the hospital have providers trained in Manual Vacuum Aspiration (MVA)?	301(100)	0 (0.0)
Have you ever been trained in Manual Vacuum Aspiration (MVA)?	140(46.5)	161(53.5)
Have you ever used Manual Vacuum Aspiration (MVA)?	140(46.5)	161(53.5)
What kinds of staff provide Manual Vacuum Aspiration (MVA)?		
Doctors only	301(100)	0 (0.0)
Midwives only	0 (0.0)	301 (100)
Midwives and Doctors	0 (0.0)	301 (100)
What kinds of staff counsel post-abortion clients for contraceptives?		
Doctors only	0 (0.0)	301 (100.0)
Midwives only	143 (47.5)	158 (52.5)
Midwives and Doctors	158 (52.5)	143 (47.5)
Have you ever counselled post-abortion clients for contraceptives?	213(70.8)	88(29.2)

Table 4.3 shows that 190 (63.1%) said their facilities have competent providers for PAC services at any time of the day while 111 (36.9%) felt that this was lacking. The majority, 243 (80.7%) of the respondents agreed that there is a coordinator/supervisor in charge of abortion care services and 58 (19.3%) maintained there are none at their facilities. All of the respondents maintained that medical doctors and midwives provide post-abortion services in their various facilities. 159 (52.8%) of respondents agreed that they have received training in post-abortion services whereas

142 (47.2%) said they have never received any training in post-abortion services. All of the respondents 301 (100.0%) affirmed that there are staff trained in post-abortion services and that midwives and doctors are the only staff who receive such training.

All of the respondents 301 (100.0%) maintained that the hospitals have providers trained in Manual Vacuum Aspiration (MVA) and only 140 (46.5%) agreed that they have been trained and have used MVA. They did however claim that only doctors carry out the procedures at their facilities. More than half 158 (52.5%) of the respondents said that both doctors and midwives offer contraceptives counselling to post-abortion clients while 143 (47.5%) said it is done by only midwives. 213 (70.8%) stated that they have counselled post-abortion clients for contraceptive services while 88 (29.2%) admitted that they had never counselled post-abortion clients.

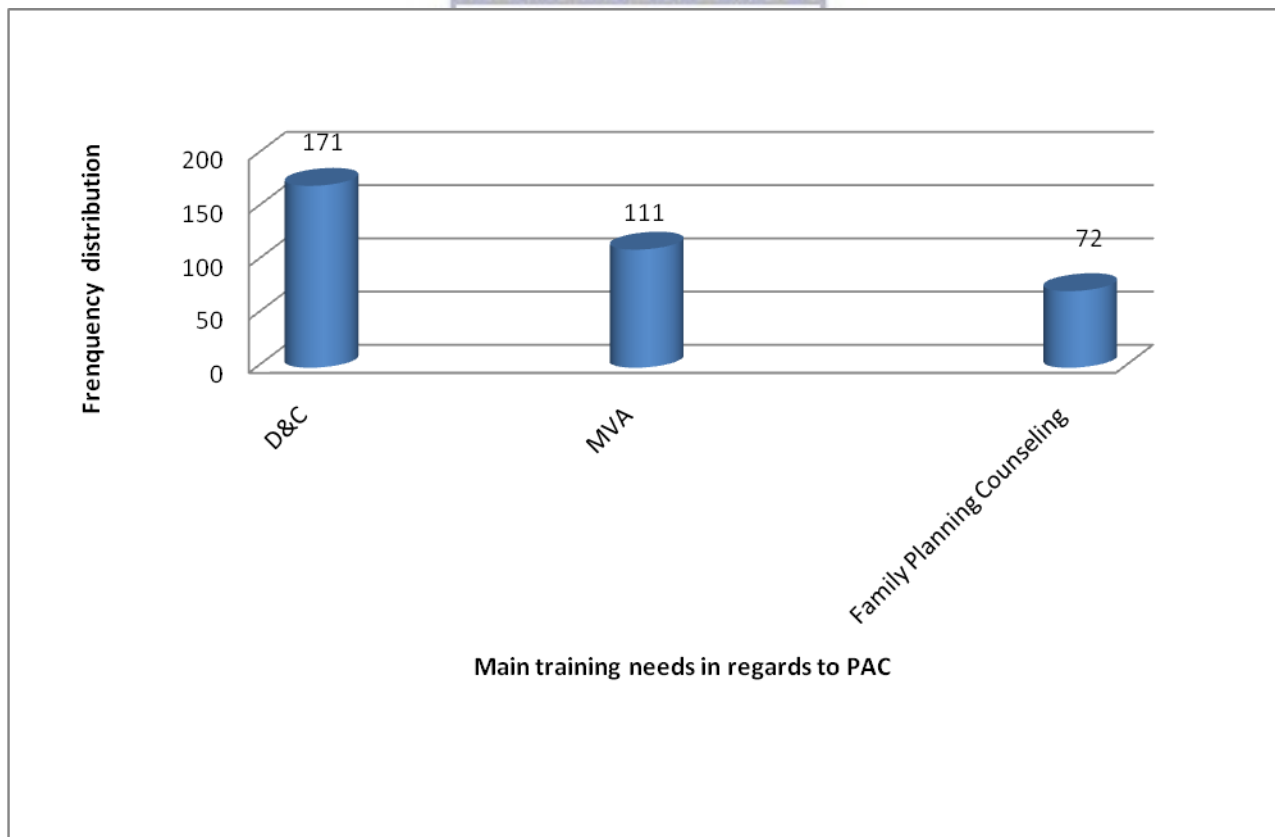
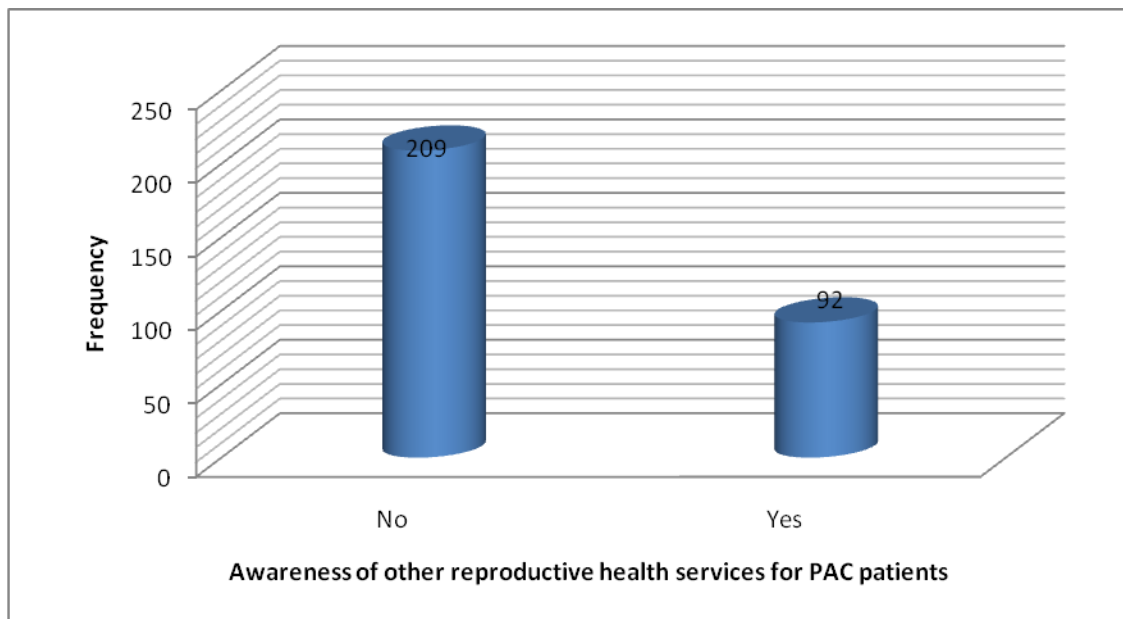


Figure 4.3: Main training needs in regard to PAC in the various facilities

**Some of the respondents chose more than one training need in their facilities.

Figure 4.3 depicts the main training needs in respect to PAC, 171(56.8%) of the respondents identified the need for D&C training in their facilities, 111 (36.9%) identified an MVA training need and 72 (23.9%) identified the need for PAC family planning counselling training.



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Figure 4.4: Awareness of reproductive health services for PAC adolescents

Figure 4.4 clearly illustrates that more than two thirds 209 (69.4%) of the respondents showed ignorance of any other reproductive health services to which adolescents can be referred for PAC services, while 92 (30.6%) claimed knowledge of these.

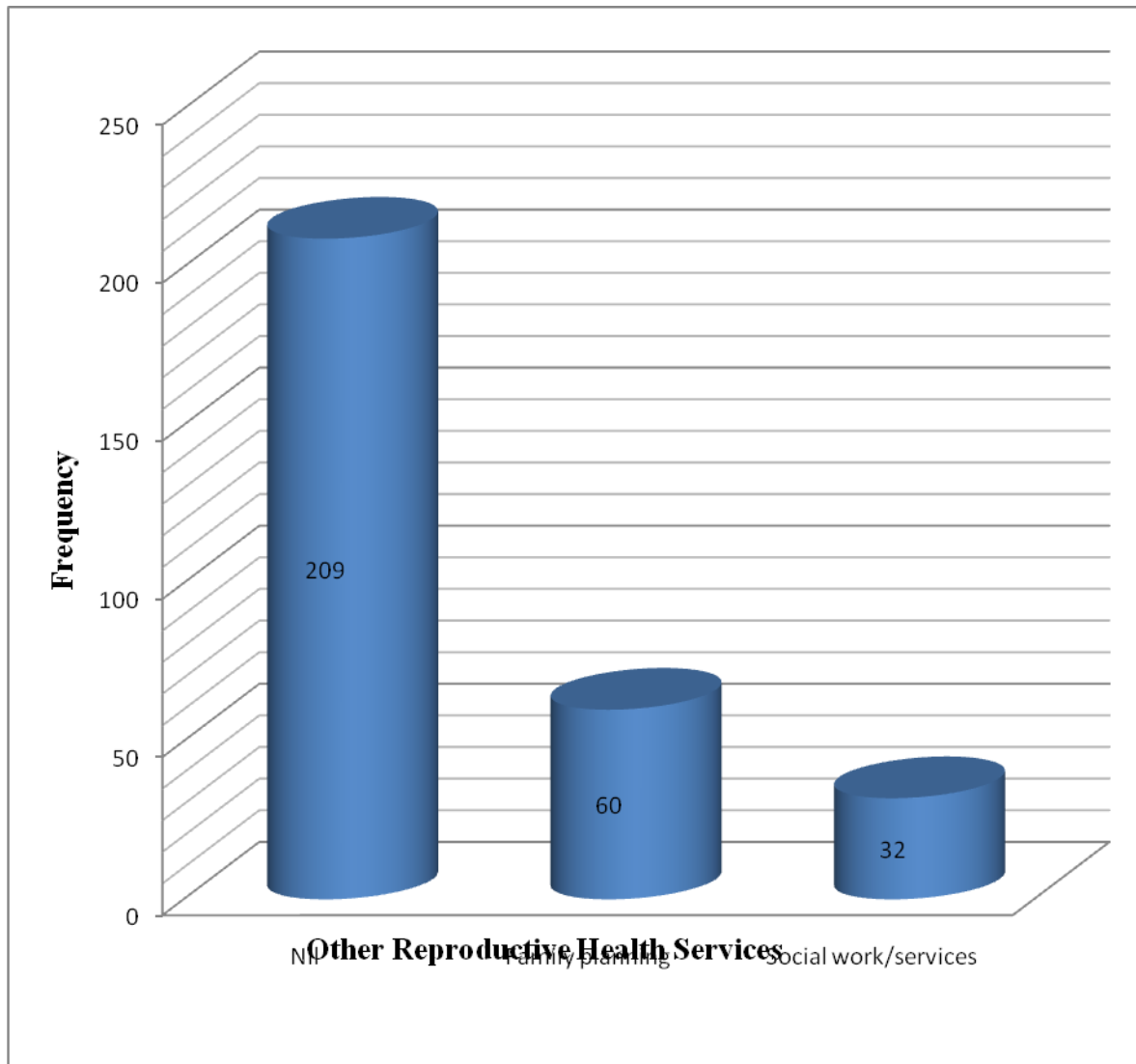


Figure 4.5: List of other reproductive health services where adolescents can be referred for PAC services

Figure 4.5 indicates that a significant number of the respondents, 209 (69.1%) were unable to mention a reproductive health service where adolescent patients can be referred, while 60 (19.9%) mentioned family planning and 33 (11.0%) mentioned social work services.

Table 4.4:: Major obstacles to providing PAC services to adolescents (n=301)

ITEMS	Yes	No
	Freq (%)	Freq (%)
Staff not adequately trained in contraceptive services	45 (15.0)	256 (85.0)
Staff do not have time to counsel abortion clients	237(78.7)	64(21.3)
Contraceptive methods are not available at all times for abortion clients	187(62.2)	114(37.9)
Problems with storage of family planning supplies	251 (83.4)	50 (16.6)
Lack of private space for counselling	237(78.7)	64(21.3)
Clients not interested in discussing contraceptive services	162(53.8)	139(46.2)
Lack of commitment by administration, head of department, providers of care	149(49.5)	152(50.5)

A majority of the respondents, 256 (85.0%) maintained that staff were adequately trained for contraceptive use and 45 (15.0%) of them had a contrary view. A good number, 237 (78.7%) of the respondents said staff do not have time to counsel abortion clients on contraception while 64 (21.3%) of them think staff have time for this service.

On the availability or otherwise of contraceptive methods as a major obstacle, 187 (62.2%) of the respondents confirmed that these methods are not available at all times for abortion clients, and 114 (37.9%) of them said that these methods are readily available for abortion clients.

While 251 (83.4%) of the respondents think there are problems with storage of family planning supplies, 50 (16.6%) maintained that the storage of family planning inputs is efficient. Most of the respondents, 237 (78.7%) opined that their facilities lack private space for counselling while 64 (21.3%) said their facilities have private space for counselling.

On whether or not clients are interested in discussing contraceptive services, 139 (46.2%) said clients are interested and 162 (53.8%) said clients are not interested in discussing these services. 152 (50.5%) said that a lack of commitment by administration or head of department was not experienced in their facilities while 149 (49.5%) of them felt that there was a lack of commitment on the part of senior staff and the administration.

4.3 Discussion of findings

The findings of the study showed that a majority of the respondents were nurses. This is not surprising as nurses form the largest population of health care providers across the globe. All respondents maintained that their health care facilities run PAC services round the clock but these services, they added, were not free. From this standpoint, it is obvious that most hospitals in Nigeria offer 24-hour PAC services to meet the needs of women, especially adolescents, seeking such services. According to Hassan (2014) emergency abortion care should be 24 hours a day in order to be effective in treating post-abortion complications and preventing mortality.

All facilities offer contraceptive services in the form of counselling or contraceptive commodities or both. However, the majority of the facilities provide contraceptive commodities with oral contraception and injectables being the most common methods used. This finding was in line with Hassan (2014), who found that the most common contraceptives in use were the oral contraceptive pills and injectables.

The most frequently used types of uterine evacuation for post-abortion care in these facilities were Manual Vacuum Aspiration, and D&C. The MVA is recommended in the management of abortion complications because it is less painful and easy to use (Sathar et al., 2013; Graff and Amoyaw, 2009). This finding contradicted the study done in Bauchi State, Nigeria by Hassan in 2014, which showed that the technique of D&C was the most common type of procedures used to

provide first trimester abortion in both public and private facilities, in hospitals and clinics due to unavailability of MVA equipment and the lack of training in its usage at such facilities. Despite WHO's long-standing recommendation to replace the invasive technique of D&C for post-abortion care, it continues to be broadly used in some resource-poor countries such as Colombia, Pakistan, South Sudan and Nigeria (Singh, et.al, 2018; Darney et al., 2014; Sathar, 2014).

All the respondents maintained that their hospitals have trained staff for the provision of PAC and MVA but less than half (46.5%) agreed that they have been trained for PAC services and MVA. This contradicts Kalu et al., (2012) who in a study found that more than half of the respondents had formal training on PAC services. Furthermore, all the respondents maintained that only doctors carry out MVA procedures. Despite the fact that both doctors and nurse midwives had received training for PAC services and MVA in particular, nurses were not allowed to carry out the procedure, thus making the skills of these nurses in MVA a waste. This may serve as a barrier to effective PAC services, as affirmed by Mandira et al., (2014), that midwives who are the main providers of PAC services lack the necessary skills needed for these services since there is no room to enhance the acquired skills and ensure quality skill performance. Etuk, Ebong and Okonofua, (2003) also pointed to inadequate training and/or skills of providers as one of the factors militating against the provision of PAC services. It is assumed that there must have been some improvement over the years in respect of staff training in the needed skills for PAC services (Mandira et al., 2014; Etuk, Ebong & Okonofua, 2003). Still, a contrasting view was discovered by Rasch (2011) in his study, where limited access to MVA-training was mentioned as one of the factors militating against effective implementation of PAC services.

Most of the respondents demonstrated ignorance of any other reproductive health services to which adolescents can be referred for PAC services, only a few mentioned family planning and

social work services as an alternative reproductive health service. Furthermore, most of the respondents identified D&C, MVA and the need for PAC family planning counselling as the key training needs for effective PAC services. Approximately three-quarter (78.7%) of the respondents maintained that staff did not have time to counsel abortion clients on contraception. This is similar to the findings of Ikeako et al., (2014) who found no records of counselling on contraception as a component of PAC services in his study. It was also observed that adolescents are often unwilling to talk freely about contraceptive services. This is based largely on the premise that the culture does not support pre-marital sexual activity (Saka et al., 2012). Atere, Ayodele and Omololu (2012) also found adolescent girls to be hesitant in discussing their past exposure to abortion and post-abortion care.

4.4 Conclusion

It has been observed and established that the hospitals have the necessary facilities and trained staff needed for PAC services. Nurses who make up the bulk of the health care provider population available for PAC services, have the needed skills for PAC, but these skills are not translated into practice as a result of the confined role of nurses in Nigerian government hospitals. Generally, staffs were observed to have demonstrated little or no sense of commitment to PAC family planning counselling. However, there was an observed training need for healthcare providers particularly in D&C, MVA and family planning counselling for effective PAC services. The next chapter gives a comprehensive description of the data analysis and findings from the interviews with the twenty (20) adolescents, thirty-two (32) health care providers and seven (7) other stakeholders.

CHAPTER FIVE

DATA ANALYSIS FOR QUALITATIVE STRAND

5.1 Introduction

This chapter presents the findings generated from interview analysis; the findings are presented in three sections. The first section presents the findings from individual interviews with the adolescents with abortion complications, on their experiences regarding the abortion done, and the care they received as well as the challenges and barriers in obtaining these services. This section also explored their views and recommendations on abortion and post-abortion care.

The second section presents the findings from the FGDs with caregivers. This section shows the caregivers' points of view about abortion, challenges and barriers to adolescents' PAC and the way forward. The third section presents the findings from individual interviews with the other stakeholders in the community (religious leaders, parents, key persons working with adolescents, and teachers). The emerging themes are presented in tabular form and then followed by the narration of each theme. The main emphasis here was to obtain more detailed information based on the participants' perspectives of the challenges and barriers to adolescents' post-abortion care, as well as their recommendations. The analysis was conducted based on the research questions of the study; this enabled the researcher to group the results based on the objectives of the study.

5.2 RESULTS

5.2.1 Demographic data of the participants

The adolescents with abortion complications who participated in this study were between 15 and 21 years of age. The age range of these adolescents is similar to those in the study conducted by Paluku et al. (2013), who observed that PAC services were mostly sought by adolescents between the ages of 15 and 24. Most of them were students in either secondary schools or tertiary

institutions, as noted by other researchers (Adjei et al., 2015; Awoyemi & Novignon, 2014; Iboudo et al., 2014). Focus group discussions were held with purposively selected health care providers (doctors and nurses) who had between 5 and 25 years' working experience in the care of adolescents with abortion issues. Also, in-depth interviews were held for other stakeholders (religious leaders, teachers, representatives of NGOs, parents) who are working with adolescents on a daily basis and who have had at least five years of experience in the field.

Table 5.1 indicates the themes and sub-themes that emerged from adolescents' in-depth interviews.

Table 5.1: Themes and sub-themes that emerged from adolescents' in-depth interviews.

THEMES-(Adolescents)	CATEGORIES
1A. Experiences with abortion procurement	Fear of unpleasant reaction from their parents and others, such as rejection, abandonment or stigmatization
	Inability to access abortion service from government hospitals
2A. Experiences of adolescents while obtaining PAC services at the hospital	Unfriendly and judgmental attitude of health workers
	Rigid admissions procedure in the hospitals and prolonged waiting period
	Lack of parental support
3A. Barriers/challenges encountered	Financial challenges
	Lack of privacy by health care personnel
	Stigmatization and Discrimination
	Lack of landmarks in the hospital environment
	Lack of support system
	Lack or shortage of the necessary supplies
4A. Suggestions made by the adolescents	Need of health care providers to change their attitude
	Equality in treatment irrespective of condition(s) treated for
	Legalization of abortion
	Free/reduced cost of health services including provision of drugs
	Free education
	Adolescent friendly Clinics
	Need for use of contraceptives

5.2.2 Experiences of adolescents on post-abortion care received

The findings from in-depth interviews with adolescents with abortion complications, were clustered into themes and sub-themes clearly indicated in the discussion below. The themes elicited were related to the adolescents' experiences in procuring abortion, post-abortion care received, challenges and barriers encountered and suggestions made by the adolescents, on what provisions should be put in place for post-abortion care services. These are discussed below.

5.2.2.1 Experience of adolescents on abortion procurement

1. Fear of unpleasant reactions from parents and stigmatization

The experiences of adolescents about the abortion done were painful and unpleasant. The adolescents were observed to be helpless, confused and afraid to discuss issues of pregnancy/abortion with their parents or guardians, because of unpleasant reactions from parents. Adolescents had encountered condemnation, rejection, stigmatization and even being disowned by the parents or guardians. Furthermore, some could not tell their parents, because of the shame of getting pregnant out of wedlock. This meant that they could only disclose to or confide in their friends or the boyfriends who had impregnated them. A 17-year-old adolescent shared her ordeal (in the quote below) when she disclosed her being pregnant:

“hummmm...when I didn't see my period for two months, so ...I didn't want to tell my parents about it, because my parents will beat me, and almost kill me, so I decide to ask my friend for help.”

Another adolescent, 19 years of age, who dreaded revealing her unwanted pregnancy to her parents bluntly said:

“... I can't tell my parents of something like this, because I am too ashamed to tell them, I am even afraid to tell them.”

Sometimes, some adolescents were confused about whom to tell when they fell pregnant unexpectedly. During the interview, a girl of 16 years expressed her experience thus:

“In fact, the experience was very painful, when I discovered that I was pregnant, I didn't know who to tell because I can't tell my aunty am staying with, so I told my boyfriend, the person that impregnated me and he gave me some drugs, but I didn't know the name of the drugs, to take with hot (alcohol) mixed with lemon and salt....”

Sometimes, adolescent girls dread the anticipated maltreatment they are likely to suffer should their parents get to know that they are pregnant. One of the girls interviewed expressed the fear of possibly being killed by her parents if they ever get to know about her unwanted pregnancy.

Hence, she said:

“...knowing my family background, there is no way I will go home and come out alive, so I had no option, I had to go for an abortion, a friend who had done it before took me to a private clinic”

The fear of unpleasant reactions from parents and the need to continue their education often makes adolescents deal with unwanted pregnancies by obtaining clandestine abortions. In an attempt to have such abortions, they either used traditional medicine in the form of native concoction (herbs mixture) or orthodox drugs, or a combination of both drugs and concoctions. These substances had commonly proved harmful to their health. Some of the respondents employed the help of medical practitioners in private settings to procure these abortions. A 19-year-old girl narrated how she was led to a private hospital where she had an abortion performed on her:

“The experience was very painful, when I discovered that I was pregnant, I confided in my friend and asked for help to get rid of it, she took me to a private clinic where I had it done”

Another girl, aged 16, narrated how she attempted to effect an abortion in a clinic for a token amount. She said:

“...I didn't really want my parents to know, so, I decided to go to a chemist (Pharmacy), and then the owner of the chemist gave me some drugs and collected some money from me.”

2. Inability of the adolescents to access abortion services

The difficulties experienced by adolescents in trying to access abortion services were commented on by all the respondents. The initial option was to procure abortion in government hospitals where they were sure of expert management. However, they later discovered that there are restrictions in these hospitals that caused them to opt for private clinics or for self-induction by using over-the-counter drugs and traditional medicines. This was captured in a statement by an 18-year-old girl:

“... well coming to the hospital was actually my first choice, when I came I was told that such services were not rendered in the hospital, it was a really painful thing, it was a blow to me because if the hospital had helped me out in the first place, I wouldn't be here.”

The inaccessibility of abortion services contributed to the adolescents' patronage of different informal centres. A 19-year-old girl described how it came about that she sought help at a pharmacy after her bid to terminate the unwanted pregnancy was turned down at a public hospital:

“.....when I went to the government hospital and was turn down, so I told one of my friend, so she took me to one pharmacy, where we brought drugs to terminate it”

One of the girls (aged 16) told how her decision to have her unwanted pregnancy terminated was opposed by a nurse:

“...so I went to a nurse who I know she usually work at general hospital, so... she said that she won't do the um.... abortion for me that I should go and call my parents, and talk to them....”

From the above comments, it can be deduced that most adolescents experienced challenges and barriers in seeking abortion and its care in government health care facilities or hospitals. They therefore decided to use private hospitals, patent medicine stores and traditional medicine men, or prepared herbal concoctions themselves. According to a study conducted in Nigeria about the knowledge and practice of public health practitioner towards abortion, reported that most of the abortions in Nigeria are carried out by private health practitioners. The same study also concluded that the abortion by those private practitioners can be considered as “unsafe” (Tsegay, 2011)

5.2.2.2 Perception of adolescents on post-abortion care received

The adolescents expressed their views about the services they receive and highlighted the following as challenges and barriers they face when they seek PAC services.

1. Unfriendly and judgmental attitude of health care providers

Most of the adolescents complained about the attitudes of the health worker(s) as being judgmental and unfriendly. One of the IDI participants described both verbal and non-verbal

attitudes of some health workers towards her when she visited hospital for post-abortion treatment:

“...the nurses here....it is as if they are looking at me with bad eyes, they look at me with pity, some even look at me with anger....”(18-year-old participant)

Some of the participants viewed the attitude of some health workers towards girls who had attempted or performed abortions as being insulting and judgmental. The quote below captures the judgmental attitude of some health workers towards them:

“.....is not only the insults from the nurses, and even when I came to, they didn't attend to me in time.” (17-year-old participant)

“Most of them were judging when they find out that I try to abort the baby, they started behaving in a strange....” (19-year-old participant)

“Some behave to me as if I am a harlot” (17-year-old participant)

“Most of them (doctor and nurses) are usually very rude when talking to me or my mother.....em. They pass comment that makes one more depressed” (21-year-old participant)

However, the views of some of the adolescents about post-abortion care received in the health facilities were positive. An adolescent had this to say about the care she received in a particular health facility:

“...the care I have received since have been good because all the nurses, ... all the nurses took care of me really well, and all the doctors, they showed that they really care, maybe it was good.” (16-year-old participant)

The sentiments in the above statement were further borne out by another girl, aged 19, when she described her own experience:

“...my experience so far in this hospital is good, the nurses received me very well, and also the doctors too, they treated me, although we don't have money, they are really trying to help me....”

Another girl explained how she was counselled and advised by a nurse whom she described below as “kind”:

“Some of the nurses are kind and understanding as mothers, like one of the nurses here knew that, as a girl, I made a mistake and she gave me some advice, she counsels me....”

Most of the respondents commented on the positive attitudes of the nurses. This opinion was expressed by a 16-year-old adolescent:

“.... Nurses are the ones that are usually in the ward with me, you know doctors just come around to evaluate my condition and they go, but nurses are the main one with me and know what is going on with me....”

2. Rigid admissions procedure in the hospitals and prolonged waiting period

Some of the adolescents condemned the long waiting time to see the doctor and the tiring bureaucracy that characterized hospital admission. Some of the adolescent girls, while describing their experience said:

“....they were just sending us from one place to the other, go and get card, go and get forms, go and queue somewhere and the experience was not palatable at all....” (17-year-old participant)

“When I came they didn't attend to me in time, I had to go and open folder, buy everything and stuff like that before they attended to me....”(18-year-old participant)

“... the waiting time was so long, that i was almost fainting before I actually got a doctor to attend to me....”(19-year-old participant)

“....when I got here, I was weak, I was in pain but then I was told to go and get card somewhere, I was told to go and pay somewhere, I was told to queue, wait for my turn, before I will be admitted, it was too long for me in my situation”(21-year-old participant)

The delay in getting treatment was not limited to the hospital or clinic visits but also experienced by those admitted on the ward. The statement below describes the experience of an adolescent patient, while receiving care on the ward:

“Sometimes when am having some complains that I need to see the doctors and I tell the nurses, they will tell me that I should wait till the doctor comes and sometimes the doctors doesn't come, or show up till God knows when, sometimes when they show up, they don't even take time to hear my complains.” (17-year-old participant)

The prolong waiting time resulted in delayed treatment as demonstrated in the statements above concurs with the findings of a study in Ethiopia indicated that long waiting time was one of the causes of dissatisfaction reported by the users of PAC services (Mcharo, 2016; Kumbi et al., 2008). Similarly, Wariki et al., (2015), affirmed that public (government) facilities have been characterised by long queues and long waiting hours which is a barrier to utilization of PAC services.

5.2.2.3 Adolescents' views on challenges and barriers encountered in receiving post-abortion care

The major challenges and barriers identified by the adolescents were finance, high cost of treatment, lack of privacy, non-legalization of abortion, stigmatization, lengthy waiting period, lack of land marks in the hospital and lack of available support system following post-abortion care, as well as unavailability of prescribed drugs in the hospital environment, as discussed below.

1. Financial constraints

Virtually all the adolescents interviewed identified finance as a major barrier encountered in the course of seeking post-abortion care, as most of the hospitals only attend to them upon payment of the stipulated bills. This may be due to the fact that these adolescents conceal these abortions and their subsequent complications from their parents and significant others who are in a better position to settle the bills for services rendered. Often, the adolescents confide in their friends who are themselves dependant and cannot assist with anything but advice, which is misleading at the best of times. This is clearly illustrated in the quotation below:

“...the only challenge is about money; we don't have money and is only my mother that is trying to get money to help me in the hospital....” (18-year-old participant)

A 16-year- old girl interviewed expressed her financial constraints due to the refusal of the father to pay the hospital bills:

“....my dad wasn't involved in my care in the hospital at all, so I had financial challenges, mostly in buying my drugs and paying the hospital bills....”

“I have not been able to settle the hospital bills if not I would have been discharged since yesterday now....”

Financial constraints have been indicated as one of the challenges women face in accessing PAC services (Sathar et al., 2013). Similarly, research study conducted in Pakistan found that utilization of PAC services was hindered by lack of finance to pay for PAC services (Azmat et al.,

2012). Further, adolescents often lack the financial and other resources to seek appropriate care from well-equipped clinics, and hence, resort to poorly equipped low-cost facilities or self-induced abortion (Ushi, Izugbara¹, Mutua, & Kabiru, 2018).

2. Lack of privacy

Most of the adolescents were of the view that the health care providers were not discreet in the way they discussed the adolescent patients' condition freely in the ward and sometimes referred to their condition while admonishing their friends. This was embarrassing to them since the society is quick to pass judgments and tag one as being promiscuous or immoral following an abortion. This was the reflected view of a girl, aged 19:

"The doctors, when they are doing their.... rounds, they just say people diagnosis openly without caring whether people around are listening or not...."

Two of the informants elaborated on the lack of privacy

"...and even the embarrassment is becoming too much, like everybody in the ward knows why I was brought to the hospital, everybody knows what is wrong with me...." (17-year-old participant)

"... when some of my friends came from my schools to visit me, the nurses were telling them not to be like me, that they should stop jumping from bed, that they should face their book and it was so embarrassing that I don't even know if I would be able to go back to school again...."(16-year-old participant)

Privacy is one of the key factors of quality PAC and maintained that women in need of PAC services would prefer facilities that can guarantee their privacy in setting where abortion is stigmatized and criminalized (Payne et al., 2013; Iboudo, 2014)

3. Stigmatization and Discrimination

Another challenge identified was stigmatization and discrimination as pointed out by some of the respondents. This they think was responsible for the poor attention paid to them when they presented with cases of abortion complications at the health facilities. An adolescent has this to say:

“...they treat me differently from the others patients in the ward because of the condition that brought me here....”

The statement quoted below describes the experience of some adolescent patients, while receiving care on the ward:

“... they don't really give me the adequate attention and treatment as when needed.”

“Sometimes, they might not be busy but will not answer when I call them, they said that they are not the one that sent me to go and abort”

4. Inadequate land marks in the hospital environment

Another challenge was the lack of adequate land marks in the hospital environment. The landmark usually provides directions to different places in the hospital. However, some of the respondents claimed that the landmarks were not adequate to find the places they needed to get to.

The statement by one of the participants in the quote below describes the inadequacy of landmarks in hospitals:

“I did not know the hospital very well, people were not too helpful describing it, took me some time to locate where I was going.” (18-year-old participant)

The inadequacy of landmarks in hospitals was also found in study conducted by Demtsu et al., (2014) in Ethiopia where inability of users of PAC services to locate PAC services was a source of their dissatisfaction with the care.

5. Lack of support system

All the adolescents were in agreement that they lacked a support system or a confidante to advise them during their pregnancy and that this had led to their poor decisions. These adolescents, through fear of unpleasant parental reactions would prefer to confide in others, but do not have around them the kinds of people who are able to offer them useful advice to remedy their problems. This is evident in the statements below:

“The real problem was before the hospital when I was still pregnant, I didn’t ...I didn’t really have any body to talk....” (17-year-old participant)

“My daddy has disowned me that I must not come back home, he hasn't even called.” (17-year-old participant)

Another 15-year-old adolescent illustrated her ordeal saying:

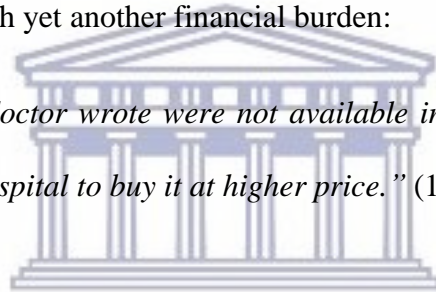
“...I was raped, but, there was no way i could tell my parents because they are strict people, and because of that now am in this mess.”

This lack of support as demonstrated in the statements above concurs with the findings of Melkamu et al., (2010) who also discovered a lack of community support as a challenge the adolescents face in receiving post-abortion care.

6. Lack or shortage of the necessary supplies

Some of the adolescents identified a shortage of prescribed drugs in the hospital pharmacy; their relatives had to go outside of the hospital environment to buy these drugs. This often caused a delay in the service they received as well as an increased physical and financial burden on their significant others. The fact that they have to move outside the hospital environment in search of such drugs often faces them with yet another financial burden:

“Some drugs that the doctor wrote were not available in the pharmacy, and my mother had to go outside the hospital to buy it at higher price.” (16-year-old adolescent)



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5.2.2.4 Suggestions that the adolescents feel should be put in place

1. Change of attitude by health care providers

A good number of the adolescents encouraged health care providers to treat all patients equally irrespective of what has brought the patient to the hospital. They feel they are being unfairly disadvantaged in the process of obtaining care, as less attention is being offered them as compared with other patients. They maintained that a change of attitude by health care providers will go a long way in improving the quality of care being rendered to adolescents seeking post-abortion care. This is reflected in the statements below:

“The nurses and doctors should treat all patients equally, they shouldn't prefer one patients over the other because this one came here for abortion, this one came here for other condition....”

(19-year-old participant)

“We all came to the hospital to receive care, so they should treat us all equally”(15-year-old participant)

“There is need for the health workers to change their attitude positively to people with abortion problem to ensure quality care.” (21-year-old participant)

2. Provision of financial assistance by government

Some of the respondents think the government should offer financial assistance to the adolescents in the form of subsidies and even free services to those seeking PAC services, as the majority of them often do not have the wherewithal to pay for such services. This is evident in the quotes of the 17- and 19-year-old adolescents below:

“... the government should try and provide money for the hospital, so that they can take care of the poor people.” (17-year-old participant)

“Government should provide free services for people like me so that money will not be a barrier from coming to the hospital” (19-year-old participant)

3. Legalization of abortion

Some were of the opinion that government should legalize abortion so as to reduce the stigma attached to it. This they think will also make post-abortion services more readily available to those seeking such services. Some of the adolescents showed disapproval of the restrictive abortion laws:

“... I think first of all, I think abortion should be legalized, I don't know whatever reasons the government has for not legalizing it.”

“It is my health, every man has a right to health and choice, but then the government has taken this right away from me by not legalizing abortion.”

“They make legalization of abortion seem like the worst sin on earth, especially religious fanatics, but giving birth to a child you can’t cater for is even far worst.”

4. Provision of adequate post-abortion equipment and supplies

Another suggestion was for the government to supply the needed drugs to the hospital pharmacy so that patients do not have to suffer the extra burden of going outside the hospital environment to get them. This they think will reduce their waiting time and the extra financial burden placed on them. An adolescent has this to say:

“...I would advise the governments to provide necessary drugs, necessary injections to the pharmacist so that, that one would not be another, another journey, someone should go and buy drugs in another place.....” (17-year-old participant)

5. Free education for adolescents

Some of the adolescents suggested free education as a means to curb unwanted pregnancy as well as abortion and its accompanying complications. This is because they blamed their involvement in such acts on lack of access to formal education, as a result of poverty. Some of them were of the view that if they were in school, they would not be employed in the menial jobs that make them prone to abuse by men. One of the adolescents has this to say:

“er..... government should try to create school funds, so that person like me, will not be at home, but in school, if I am in school now, I will not work for the person that impregnate me, so they should please help us to go school too....”

6. Provision of adolescent friendly services

Some of the adolescents think that the government can do better by providing an enabling environment where they can be listened to and assisted as necessary. This is evident in the statements below:

“...I want the government to provide facility whereby we can actually have somebody to talk to, about our...about what to do, that will advise us on what to doand not be so judgmental about it.” (17-year-old participant)

“.....if they actually have a centre that one can go just solely for the purpose of sex and births control issue, I think it will be good, where you can go and you know that ok, you can get contraceptives there without anybody passing any judgment on you, I think it will be nice...” (19-year-old participant)

Indeed, these adolescents were of the view that an increase in health awareness campaigns in form of sex education, and that easy access to contraceptives such as condoms, oral pills, etc. will go a long way in curbing abortion and its complications in that unwanted pregnancies can be prevented in the first place through the use of contraceptives. One of them commented thus:

“...enough publicity about birth control will be good, if they can go to schools and er... actually, if they can even give out contraceptives.” (16-year-old participant)

In summary, a fair number of the respondents suggested change of attitudes by health care providers and equality in treatment irrespective of condition, availability of support service(s), legalization of abortion, free/reduced cost of health services, provision of drugs, free education, sex education and provision of contraceptives were seen as necessary for enhancing post-abortion care services.

5.2.3 Service providers' perspective on challenges and barriers to adolescents' post-abortion care

The findings from focus group discussions with thirty-two health care providers were clustered into themes and sub-themes clearly indicated in the discussion below. The themes elicited related to the providers' experiences in caring for adolescents with abortion complications, barriers and challenges encountered and suggestions to improve care.

Table 5.2: Themes and sub-themes that emerged from focus group discussions with health care providers

THEMES: Health care providers	SUB-THEMES
1. Health care provider experience(s) with caring for post-abortion complications	Challenging and tough
	Inability of the adolescent to confide in service providers
2. General outcome of post-abortion complications cases	Long term disabilities: hysterectomy, tubal blockage, infertility
	Psychological problems such as depression
	Death
3. Challenges and barrier(s) experienced by adolescents in obtaining PAC services	Financial challenges
	Late presentation at the hospital
	Rejection /discrimination and stigmatization
	Attitudes of health care provider
	Lack of post-abortion counselling
	Lack of cooperation from adolescent patients and relatives
4. Existing support services in place for adolescent(s)	Lack of support(s) system
	Nil support services in place Social work
5 Suggestion(s) for resolution of challenges and barriers	Treatment subsidy / Free medical care
	Training and retraining of service providers
	Provision of effective support system
	Legalization of abortion
	Enact laws and policies that favour adolescents with abortion complications
Parental bond and guidance	

	Sex education/counselling
	Introduction of stipends for the students by government and scholarship opportunity
	Youth empowerment
	The need for use of contraceptives/family planning

5.2.3.1 Experiences of service providers rendering post-abortion care to adolescents

Challenging and tough experience

Health care providers were asked to share their experiences in caring for adolescents with post-abortion complications. They described their experiences as “challenging and tough”, explaining that dealing with the adolescents requires a lot of skill, understanding, patience and wisdom. Below are examples of some care givers describing their experiences, while rendering post-abortion care to adolescents:

“...caring for adolescents with abortion complications require a lot of skills, and it takes a lot from the carer.” (Participant 3, FGD 1)

“Hum....I will say caring for adolescents with abortion complications is a bit tough, some of them are minority group and you need to involve their parents and most time you find out that they want to hide some of these things from their parents....” (Participant 7, FGD 1)

“Caring for the adolescent with abortion is a very serious and tedious job.” (Participant 1, FGD 1)

“....it's require a lots of skills, sometimes you need to apply wisdom because most of these patients, being adolescents they are either alone or with their mothers most of the time,

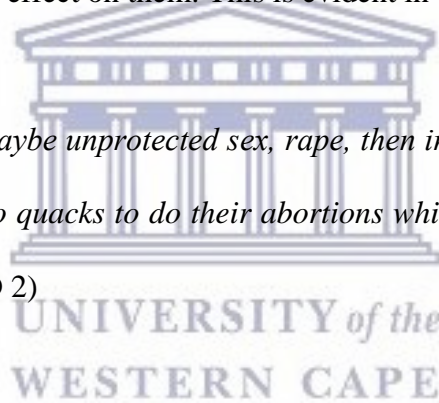
because their father will not be.....will not want to be identified with such because it is criminal in the first place.” (Participant 11, FGD 2)

Another informant described her experience saying:

“..... it has been a challenge anyway, it has not been very easy because er...adolescents with abortion most times, they present with haemorrhage and shock and to revive them back, we had to battle ...” (Participant 23, FGD 3)

In addition, some of the health care providers hinted that some adolescents suffer sexual abuse that resulted in unwanted pregnancy and later abortion. These adolescents are likely to present with psychological problems as the devastating experience of rape together with abortion complications has a devastating effect on them. This is evident in the experience shared below:

“Most of them are victims of maybe unprotected sex, rape, then incest so, in the process of trying to cover their shame, they go to quacks to do their abortions which now end up in complications for them.” (Participant 18, FGD 2)



Two of the informants narrated their experienced with patients who fell pregnant as a result of rape and had abortions with complications:

“.... I could remember the experience I had, she was raped, and she did abortion, when she presented to the hospital with complication i.e. ruptured uterus, she had like fifteen pines of blood and upon that, she later died.” (Participant 3, FGD 1)

“She was rape by a family friend, which later led to pregnancy and abortion that was not properly done. She was rush to the theater and had hysterectomy done that is removal of the uterus, she too wasn't balance, she later came up with psychological problem, so it wasn't

easy job caring for patients with abortion complications as a result of rape.” (Participant 15, FGD 2)

Some of the care givers testified that most cases of abortion complications usually involve adolescents and they are moved emotionally seeing these children involved in acts that will threaten their fertility in later years. Managing these adolescents, they added, makes them think of their female children and try to imagine what the experience will be like if their own children are the ones involved. This is illustrated in the quotations below:

“My own experience is that.... most time when there are abortion complications, it usually involves young people.” (Participant 17, FGD 2)

“... the first time I managed a case of criminal abortion, the reason why I call it criminal is that you know we have therapeutic and there was this thirteen years old girl, came up with bleeding, because bleeding is the usual sign that they presented with, this is a girl of thirteen years old, with two gestational sacs one in the uterus, the other in the fallopian tube, the one in the uterus was evacuated, meanwhile the other one was in the fallopian tube, so she was rushed to the theatre and the removal of the fallopian tube was done , so the story was pathetic, not easy, especially when a mother seeing a girl, a teenager in that condition, the first thing you think of is your baby girl at home...”(Participant 4, FGD 1)

Another stated that:

“There are cases of spontaneous abortion which occur naturally on its own but this is more common among the older or middle aged married women but the induced ones are common among adolescents.” (Participant 28, FGD 3)

5.2.3.2 Experiences of the outcome of abortion cases managed by health care providers

1. Short and long term disabilities

Care givers pointed out that the outcome depends on the severity of the condition and how early patients reported to the health care facility. Most of the outcomes were good but some end up with long term disabilities while others die as a result of the abortion. This is illustrated in the following statements:

“...their outcome usually depends on the severity of the condition before they were brought into the hospital, most of them good, but some of them were not too good.” (Participant 13, FGD 2)

“.....ok, from my experience, some have septic abortion that lead to infertility, some even lead to total hysterectomy, that is, they will have to remove their uterus due to the complication they had.” (Participant 27, FGD 3)

The care givers described the prognosis of the cases presented early as good and said that those who presented late with severe complications were not easily managed. Hemorrhage, septicemia, ruptured uterus, tubal damage, disseminated intravascular coagulopathy, anofistula, infertility, pelvic inflammatory disease, and death were identified as possible complications of abortion if the abortions were not performed properly:

“.....anyway, the outcome was good, but we have several, let me say few casualties among them, sometimes they come to the hospital with some serious complications that cannot be managed that will lead to death...” (Participant 7, FGD 1)

“..... some came in with sepsis, I have managed several with septicemia, as a result of abortion complication, some came in with ruptured uterus.... and they will have to remove their uterus where repair is not possible.” (Participant 22, FGD 2)

A respondent described her experienced saying:

“I have managed several with septicemia, as a result of abortion complication, some came in with ruptured uterus, the uterus would have been traumatized that they will require to go in for surgery, even here in the past 2 months, I have seen one that have gone in for hysterectomy, as a result of complication arising from abortion, last week we discharge one, HIV+, it was noticed when she came in, she was counselled and was encouraged to go to heart to heart clinic, to receive best care, so it exposes them to a lot of problems here.” (Participant 14, FGD 2)

5.2.3.3 Service providers’ perspectives on challenges and barriers to adolescents’ post-abortion care

1. Financial challenge

Many of the service providers identified some challenges as affecting the care they rendered to adolescents seeking post-abortion care. Finance was identified as a major challenge faced by adolescents receiving post-abortion care. The care givers testified that these adolescents lack parental support as most of the abortions are hidden from parents and often done on the advice of friends who are themselves dependant and cannot help with the bills. Even the boyfriends responsible for the pregnancy often distance themselves from the situation and even if they are willing to assist, may not have the financial capacity to do so as they are themselves dependant on their parents.

This assertion is revealed in the quotations below:

“...first and foremost, there is the issue of money, the financial aspect of it, most times, they are underage, they are unemployed, they are dependent on their parents, even the.....partner is not the responsible type, he too may be dependent on the parent.”

(Participant 18, FGD 2)

“The major challenge they usually face is finance, because they may not have money to get the necessary medication that will be needed for their treatment.” (Participant 5, FGD 1)

“These adolescents often don’t have money to settle bills, settlements of the bills is usually a challenge....” (Participant 3, FGD 1)

“...majority of them they are in the school, secondary school to be precise, they are dependant, they don't have any means of saving they can fall back to, and so um...finance comes in as barrier or problem.” (Participant 15, FGD 2)

2. Late presentation at the hospital

Most of the service providers testified that these adolescents presented late at the hospital, when they are almost impossible to handle and this affects their treatment outcomes as the condition generally has deteriorated before presentation at the hospital. Some informants noted:

“.....em there is the issue of late presentation too, they don't actually present early to the hospital until the complication is serious.” (Participant 26, FGD 3)

“.....Abortion complications usually occur among the adolescents, like the elderly, they come out early, they complaint early....but the adolescence you know is hidden and they are usually shy, so they don’t usually come out early, they usually come with serious complications, in the post-abortion care, usually they go outside to do the abortion, maybe with quack or not quack, but by the time the complication comes, they usually come to the hospital late.” (Participant 9, FGD 1)

Similarly, another nurse expressed her opinion saying:

“...by the time they come to the hospital, they are almost unmanageable because they would have gone to several other places....” (Participant 16, FGD 2)

Various studies have shown that adolescents will not only delay the request for termination but also use the options that are within their reach while maintaining secrecy to reduce the number of people who become aware that they have had an abortion to forestall stigmatization (Ushie, Izugbara, Mutua, & Kabiru, 2018; Izugbara, et. al, 2015; Mutua, et al, 2015)

3. Rejection, Discrimination and Stigmatization

The majority of the care givers pointed out that these adolescents suffer discrimination and stigmatization from the society, and that they may even be rejected or abandoned by their parents, loved ones and significant others because of their condition. Nigerian society often considers such adolescents as wayward or promiscuous, a shame and label which often is extended to the parents who may be seen as failing in fulfilling their parental role to these children. Some of these adolescents are denied love and care by their parents and significant others. This has a devastating effect on adolescents' psychological wellbeing and by extension their response to treatment. This was expressed in the remarks of some of the health care providers:

“...first and foremost is rejection, they are being rejected, by the family, society, peer group, even by their so called fiancé or husband...” (Participant 2, FGD 1)

“...most of the time, the family members will abandon them for us to take care.”
(Participant 11, FGD 2)

“...like I said before, the first one will be social stigmatization, especially in the area that the adolescent was living before the incidence, so there will be social stigmatization, people will just tagged her a prostitute or wayward, so been socially stigmatized, the adolescent will be depressed, then, number two, the family will abandon her, the family will not want to

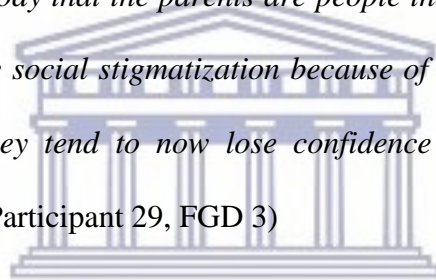
care for the patient, so been abandon as well, it will worsen the emotional state.”

(Participant 3, FGD 1)

“Due to the area we find ourselves, there is this cultural believe that once you engage in sex and you are pregnant and you even go to that extent of aborting it, there is this stigma, people tend to believe that you are promiscuous, they don't want to know how the pregnancy came into being.” (Participant 32, FGD 3)

One of the health care providers pointed out that this stigmatization may even extend to the parents, especially if they are prominent persons in the society:

“The child maybe somebody that the parents are people that much are expected of them in the society, they now face social stigmatization because of the er.....people getting to know about their condition, they tend to now lose confidence in er..them and they now see themselves as outcast.” (Participant 29, FGD 3)



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4. Attitudes of health care provider

Some of the care givers stated that certain of their colleagues tend to allow their belief system and ideas about morality to cloud their judgment, and that this influences the kind of care rendered to the adolescents negatively, as illustrated in the following statement:

“Sometimes when these people(adolescents) come in, the carer might be judgmental in caring for them and these patients can read meaning into this things.” (Participant 1, FGD 1)

“Some of us professionals tend to insult these adolescents.” (Participant 23, FGD 3)

“You know we are all humans, of course when you see a child, or an adolescent with abortion, of course, you will raise an eye brow towards it because cultural believe doesn't

support it, spiritual believe doesn't support it, and in all wise it doesn't support it especially in this settings.” (Participant 10, FGD 1)

“...er... care giver need to be enlightened on giving care that is not biased, care that is not judgmental, so that our care would be....would be standardized.” (Participant 18, FGD 2)

5. Lack of post-abortion counselling

The lack of post-abortion counselling was raised as a barrier by some of the health care providers who said that professionals do not counsel on contraceptives following post-abortion care. This, they say, may have led to an increase in the rate of abortion and abortion complications. Furthermore, some of them said that most of the adolescents have had more than one abortion before the complicated one, so if they had been properly counselled the likelihood of further abortions would have been less. Concerning this issue, some of the service providers remarked:

“They (health care provider) are too busy to discuss contraceptive with this adolescents after the post-abortion care.” (Participant 20, FGD 2)

You see....these teenagers have more than one complicated abortions in a life time which I think is due to inadequate comprehensive family planning counselling for this adolescents.” (Participant 6, FGD 1)

“Most healthcare professionals think when they discuss contraceptive with adolescents; they are encouraging them to have sex, so they shy away from it.” (Participant 25, FGD 3)

“Frankly speaking, the post-abortion care... comprehensive post-abortion care is not functional anywhere in Nigeria, because it suppose to encompass treatment, family planning, counselling, integrating the adolescent back into the society but apart from treatment the others are not done adequately.” (Participant 9, FGD 1)

Another service provider reported that referral to the family planning unit was usually done after some counselling but that most adolescents will not utilize these services:

“We may not discuss contraception with them in detail but we counsel them a little before discharged and refer them to family planning unit but they won’t go.” (Participant 14, FGD 2)

6. Lack of cooperation from adolescent patients and relatives

Some of the service providers narrated their difficulty in providing these services to the adolescents due to lack of cooperation on the part of the patients and relatives, as shown below:

“Dealing with these people have been so stressful, because majority of them were proving too secretive, they were not ready to tell the truth about their case.” (Participant 3, FGD 1)

“.....well, in managing this patients, part of the challenges I am facing is that the relatives of the patients are not cooperating, because they do not want the patients to disclose what really happened to them, so that you won’t blame them...” (Participant 19, FGD 2)

“We couldn't manage majority of them well, because most of the parents were not aware of what really happen and what brought the children to the hospital.” (Participant 7, FGD 1)

7. Lack of support system

The lack of support system was also identified as a barrier to these adolescents seeking post-abortion care. Most of the respondents affirmed that there are few or no existing support services put in place for these adolescents:

“...presently in Nigeria, I am not aware of any existing support services for these groups of adolescents....” (Participant 5, FGD 1)

“... there is none that is er... that is available for the adolescents, the only one available is meant for all patients generally and is the issue of social works and they have a limited service that they can render, is not all the need of the patients that they can equally assist, they have a limited number of assistance that they can give, so this is what is even causing more problem to the care of the patients in the hospital...” (Participant 30, FGD 3)

Another respondent also maintained that there are support services available for these adolescents:

“.....we have a supporting services, the social worker, if we get one, we call them.”

“There is a support system which is social welfare but it is not effective because their funding is limited.” (Participant 12, FGD 2)

5.2.3.4 Solutions to the challenges and barriers identified, as suggested by care givers

The healthcare providers, having identified some challenges faced by adolescents in the course of receiving post-abortion care service, suggested ways out or possible solutions to the identified challenges and barriers:

1. Treatment subsidy/free medical treatment

On the issue of finance, some of the respondents suggested that the government should subsidize or even make available free treatment in government hospitals, as this will go a long way in assisting these adolescents. Two nurses commented thus:

“.... the government has a part to play, free medical care for all, would be a good one, that you can come in into Nigerian hospital, take treatment and you go without paying bills...”

(Participant 6, FGD 1)

“When they got abortion done in the town, if health care is subsidized, at least when there are early signs of complications in town or home, they can easily come to the hospital to receive care on time.” (Participant 4, FGD 1)

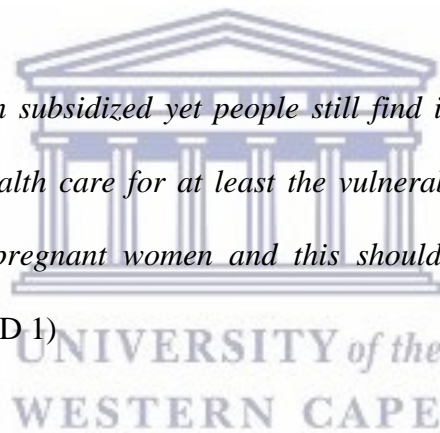
One of the informants stated that there is no way health care can be free but that it should be subsidized:

“Health care cannot be free, but it can be subsidized, at least when it is subsidized people can easily come to the hospital to receive the right care, instead of patronizing the quack.”

(Participant 9, FGD 1)

Another had a contrary view:

“Health care has already been subsidized yet people still find it difficult to afford so what we need in this country is free health care for at least the vulnerable group such as the children, adolescents, elderly and the pregnant women and this should reflect in terms of budgetary provisions.” (Participant 1, FGD 1)



2. Training and retraining of service providers

Providers suggested that there is a need for training and retraining of staff in the hospitals on value clarification and attitude transformation. A nurse who has been trained by IPAS on post-abortion care has this to say:

“Nurses and doctors need to be trained not to judge the patient but to understand with her and give holistic care. During IPAS training we were taught not to allow our religious or moral

grounds to cloud our professional judgments, so I think they need to be train on value clarification and attitude transformation.” (Participant 6, FGD 1)

3. Provision of effective support system

Some of the respondents suggested that effective and efficient support systems be put in place where these adolescents can have someone to talk to, and where someone can listen to them and offer useful advice that will remedy their situation. This was captured in the statement below:

“The government should provide a kind of adolescent friendly unit in each hospital where adolescents can go for any kind of advice or counselling.” (Participant 24, FGD 3)

“Hospital should provide an effective referral where these adolescents can be referred for further management and integration into the society without making similar mistake.”

(Participant 8, FGD 1)

“Provision of special fund for social welfare services of the hospital by the government and nongovernmental organization (NGO) to assist these adolescents...” (Participant 11, FGD 2)

4. Legalization of abortion

The legalization of abortion was suggested as a way to improve the adolescent post-abortion care service in Nigeria. However, health care providers had conflicting opinions on this. Some of the care givers suggested the legalization of abortion as they think this can reduce to the barest minimum the complications associated with abortion. Most of these abortions, the care givers opined, were being carried out by the adolescents themselves through the use of drugs or in private clinics by quacks or amateurs because the adolescents cannot present themselves at government hospitals to receive quality care. Legalization of abortion, they feel, will curb this

menace where abortion services are provided clandestinely, sometimes by untrained personnel and in unsafe environments. This is demonstrated in the statements below:

“... there is no harm if the government can legalize it.” (Participant 4, FGD 1)

“...er.... I will say er...they should legalize abortion in this country so that adolescents can go to a health care facility and get it done in the right way, the complications will be lessened and then infection will be lessened because prior to the surgery or the abortion, the patients will be placed on antibiotics and after the abortion, so the rate of sepsis will be reduced, then secondly, why I said it should be legalize, is that, we talk about perforation of the uterus, it can reduced the incidence of uterine perforation and also hum...infertility, to a certain level.” (Participant 26, FGD 3)

“...this issue of law that stated that abortion is not allowed, fine it is good, it is to restrain criminal abortions but at the same time, that same law is affecting the health of the women in this country, most women, most adolescents, once they discover that they are pregnant like this, they would not even go to any hospital instead they induce it by themselves, which is detrimental to their health, so I think governments and policy makers should revisit the abortion laws”(Participant 10, FGD 1)

“They should legalize it, em....you that your faith is against it should not do abortion but those in need of it should have access to quality abortion services ‘shike na’(finish).”
(Participant 3, FGD 1)

However, some of the care givers had a different view on the legalization of abortion because of their religious and moral beliefs. They considered abortion an immoral, murderous and sinful act:

“Legalization is not an option because it is sin against God and man.” (Participant 2, FGD 1)

“Abortion is killing.” (Participant 23, FGD 3)

“My faith is not in support of abortion, so I can never support legalizing it.” (Participant 13, FGD 2)

One of the health care providers has mixed feelings on legalization as a solution:

“er...I am skeptical about saying legalizing abortion, but if we want to be a little bit objective, I will say let’s legalize it, but looking at this from my own faith, I don’t think I would want to talk about legalizing abortion, because from our faith, we say we are not permitted to take life, further the physiologist will tell you how do you know that this cloth of blood have life, so is a give and take so, be that as it is may, it is left for the government to decide whether they are legalizing abortion, from my own perspective I will say no.”

(Participant 29, FGD 3)

Two of the informants expressed the fear of that there may be an increase in the rate abortion if it is legalized:

“...me personally I don't support legalizing abortion, because if you dare legalize abortion in this country, the rate at which abortion will go up, it would be rampant, me I don't support that, all...” (Participant 22, FGD 2)

“If you dare legalize abortion, is not even the specialist that will be doing it, every dick and harry will be doing abortion on the street, and you will even have a worst case at hand than this.” (Participant 18, FGD 2)

Another health care provider disagreed with this view, saying:

“Legalizing it does not mean everybody will be doing it, it simply means people can access quality abortion services if the need arises without putting their lives in danger.”

(Participant 3, FGD 1)

5. Parental bond and guidance

Care givers think that unwanted pregnancies and consequently abortions can be reduced if parents relate better and more closely with their children. This is because these adolescents will be able to communicate freely and more openly with their parents instead of confiding in their friends, who often mislead them when faced with such difficult situations as unwanted pregnancy. Parents are also advised to live up to their expectations in the training of these children, and also provide for their needs. Parents should spend quality time with children so that they are able to monitor the activities these adolescents involve themselves in. Some parents are too busy for their children and this makes room for excesses such as unwanted pregnancy and subsequently abortion. The following sentiments of the health care providers corroborated this view:

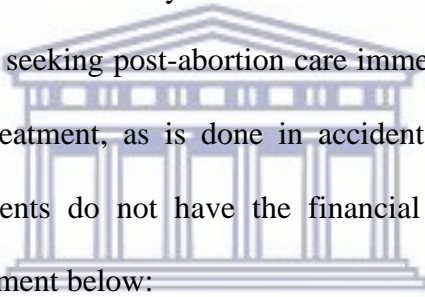
“... the problem start majorly from the home, because if the home.....if the parents of the adolescents are very, very interested in what their children are doing, and how they get about with whatever they need, the problem of adolescent pregnancy may not arise in the first place before the abortion.” (Participant 1, FGD 1)

“Parents are too busy to even noticed what is going on with their children, I think they should spend more time with their children to know what is really going on in their lives, and should try their best to see that they tutor these children, that they teach them some moral too...” (Participant 22, FGD 2)

“The problem we are having these days is that parents are far away from their children and the world in particular, are close to the children, so what you are shying away from telling them, the world is telling them the opposite thing and by the time they are now trying to explore what the world is giving to them, the repercussion will now fall on you whether you like it or not, it is your child, even if she died, you have lost a child, even if something happen to her, you have lost....” (Participant 13, FGD 2)

6. Enact laws and policies that favour adolescents with abortion complications

Some of the care givers think that the government should enact laws and policies that favour adolescents with abortion complications. They feel that there should be a law that compels health workers to attend to adolescents seeking post-abortion care immediately on presentation, without requesting payment for such treatment, as is done in accident and emergency cases. This is because most of these adolescents do not have the financial means to foot the bills. This suggestion is evident in the statement below:



“..... maybe there should be a law, as in the case of accidental and emergency, I mean any accident cases that is been brought into the hospital are given care without asking of money, so for this teenagers or adolescents with abortion complications, there should also be that kind of provision by government, to ensure that they are properly managed without asking of money from anybody.” (Participant 19, FGD 2)

Other informants stated that there should be laws and policies that allow trained nurse-midwives to do evacuation and manage adolescents who present with retained product of conception, using MVA, since the majority of the adolescents in question usually come to the hospital with this problem. This will help to prevent delay and ensure prompt management of these adolescents:

“I think there should be law or hospital policy that allowed trained nurse-midwife to do evacuation of retained product of conception because they are trained.” (Participant 4, FGD 1)

“Trained nurse midwives should be allowed to do evacuation and stop bleeding and pain instead of waiting for doctor to come while the patient and relative will be seeing the nurses as uncaring or wicked.” (Participant 16, FGD 2)

7. Sex education and counselling

Some of the care givers suggested sex education as a solution to unwanted pregnancy and abortion. This sex education, they insisted, should begin with the parents, extend to schools by introduction into the school curriculum and then through the electronic and print media in the form of awareness programmes. Two respondents have this to say about incorporating sex education into school curriculum:

“...sex education should be introduced right from primary schools, if they know what it entails; of course they will re-frame from those acts.” (Participant 30, FGD 3)

“Sex education is very, very important and should be emphasized in the schools to reduce unwanted pregnancy and abortion ...” (Participant 4, FGD 1)

A nurse clinician elaborated the need for parents to counsel and tell their adolescents the rules:

“.....they need to know, if you don't tell them, they browse, technology will tell them, some of us pretends as if we are trying to counsel ... no they know more than us, in terms of this sex education because the internet is there for them 24 hrs, the phone, they access it on the phone and everywhere, so we parents need to actually tell them the rules, don't chose a foreign words over a particular thing, if it is penis, call it a penis, if it is vagina, call it

vagina, tell them what is involve so that they don't make mistakes, and we should bring our girls and boys children closer to us, let us come to their level and discuss intimately with them.” (Participant 6, FGD 1)

A medical practitioner said:

“They need a lot of counselling; both the parents and the adolescents need to be counselled.” (Participant 11, FGD 2)

Similarly, a nurse clinician expressed her opinion:

“... as an health worker, it is our own responsibility to even educate these parents that this is their civic responsibility to their children that when they make them to know... that when they know right from wrong, they will not go the way we don't want them to go, like if you educate a child, maybe at theinception of the adolescents signs, I mean puberty, attaining the age of puberty, what they are expected to see, the changes in their body, their menstrual time, what they are to do, and then as they attain the menstrual er...thing, they should watch what their relationship should be, with the male counterpart, I think the issue of unwanted pregnancy that will lead to these complication will be averted...” (Participant 16, FGD 2)

Another informant interviewed expressed the need for mass media for educating the adolescents on sex education:

“ ...health education should be done, maybe in the media, and even newspaper and on the television about sex and reproductive organ, how it works, especially menstrual cycle, ovulation time, if they know everything about it they will know how to protect themselves from getting pregnancy.” (Participant 23, FGD 3)

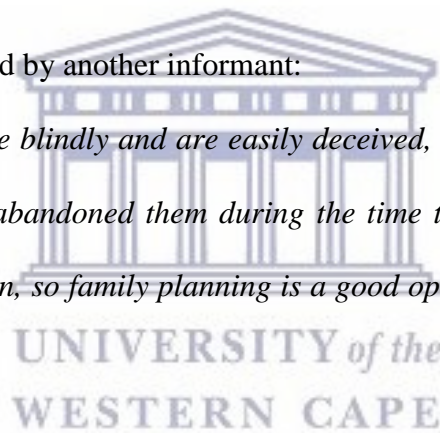
8. Provision of contraceptives/family planning services for adolescents

Some care givers thought that the involvement of these adolescents in family planning programmes is a solution to the challenges and barriers to post-abortion care as well as to unwanted pregnancy. They were of the opinion that once the adolescents have been introduced to sexual intercourse, they will continue to have sex irrespective of the consequences:

“Once these girls have indulged in sexual intercourse, they will continue therefore they should be introduced to family planning following post-abortion care.” (Participant 11, FGD 2)

The above statement was echoed by another informant:

“These teenager girls love blindly and are easily deceived, once they are well, you see that it is the same boys who abandoned them during the time they were hospitalized that they will be sleeping with again, so family planning is a good option for them after discharged.” (Participant 4, FGD 1)



Some of the health care providers stated that those adolescents that have an interest in sexual intercourse should be introduced to family planning. Two of the informants expressed their feelings on this:

“I think the best thing is to introduce them to family planning clinic, every adolescents because some of them at the age of twelve, you will just see them sleeping with men around, so when you sit them down, tell them that if you know you have interest in this thing, go to the family planning clinic and explain different kind of method of family planning to them...and help them to make informed choices” (Participant 17, FGD 2)

“If a lady knows that she cannot er....curb herself and must indulge in having sexual intercourse then she should go for family planning, there should be family planning services available for them.” (Participant 31, FGD 3)

9. Introduction of government stipends and scholarship opportunities

Some of the informants were of the view that the government should assist these adolescents in their educational pursuits and that this could be done through stipends, scholarships or even free education. They added that the government should empower these youths who have dropped out of school or who have not had much formal education, and those who have finished school but are unemployed. This, they believed, will stop these adolescents, especially females from engaging in sexual immorality in the name of seeking financial support for their education. This is illustrated in the statements below:

“..... the government should put up scholarships to help the poor, in their education or in empowering them to learn some trade or handwork, that will also be helpful...” (Participant 13, FGD 2)

“...in those days, while we were in school, school of nursing then, they paid us salary while schooling to encourage not to go about with men, but now, those services are longer there, so this children now because of the globalised way of life now, some of them will want to go for these big IPad, big handset, all those things, they would be forced to mess around with those men, that would want to entice them with money but if the government can assist in maybe in giving them some stipend, maybe that will go a long way to help the students....”
(Participant 29, FGD 3)

5.2.4 Other Stakeholders' experiences with adolescents

Table 5.3: Themes and sub-themes that emerged from focus group discussion with stakeholders

THEMES	SUB-THEMES
1. Perceptions of abortion and post-abortion	<ul style="list-style-type: none"> • Societal influence(s) • Single parenting/low socio-economic status • Family background • Reasons for abortion
2. General outcome of cases seen	<ul style="list-style-type: none"> • Depression • Removal of womb • Infertility • Death
3. Experience(s) with adolescents' post-abortion care services	<ul style="list-style-type: none"> • Delayed hospital involvement • Procedure carried out by medical doctor(s) • Abortion done by patent medicine store • Post-abortion complication(s) • Need for counselling
4. Support services	<ul style="list-style-type: none"> • Family planning service(s) • Unavailability of any support service(s)
5. Challenges and barrier(s) encountered	<ul style="list-style-type: none"> • Stigmatization • Lack of counselling/counsellors • Lack of sex education • Financial constraints • Lack of underground law against abortion • Nonchalant attitude of the patient(s)
6. Solutions to challenges and suggestions	<ul style="list-style-type: none"> • Parental support/guidance • Provision of counselling unit • Free health services

5.2.4.1 Perceptions of other stakeholders of abortion and abortion complications

1. Societal influence(s)

Most of the stakeholders interviewed were of the opinion that our current society is becoming morally bankrupt as each day passes, all in the name of civilization, and that this has a significant influence on unwanted pregnancy and subsequently abortion. Most of the adolescents watch pornographic videos and in an attempt to practise what they see in such videos, end up with unwanted pregnancy leading to abortion. One of the male informants interviewed had this to say:

“.....we have been taking note that pornography is one of the causes of unwanted pregnancy, then from the pornography, you will discover that these adolescents start to practise it and when pregnancy occur they shy away from the responsibility resulting in abortion.”(Pastor)

Adults who should set a good example for these adolescents and encourage them to live a decent life are the ones involved in corrupting these adolescents. They lure them into all kinds of indecent acts with the promise of financial security, which is often bait for these hungry and insecure adolescents. A clergyman lamented:

“.....we discover that the rich grown up members of the society, the ‘Aristoles’, The aristole are men that have money to squander on little girls and they will lavish these money on these girls and when these girls see such money, they cannot resist them, and they go into promiscuity with these children ...”(Pastor)

One of the respondents attributed abortion to a means of escape from unwanted pregnancy for the adolescents:

“My experience with them over the years has shown that majority of them look at abortion as a way of escaping from unwanted pregnancy and keep on enjoying their own lives.”
(Female Teacher)

The issue of abortion and post-abortion care among adolescents was associated with a decline in social norms and values. This opinion was expressed in the quote below:

“The societal norms and value too has gone down and this has brought about increase in teenage pregnancies and abortions.”(Parent)

2. Single parenting and low socio-economic status

Single parenting and low socio-economic status was also seen as having a significant influence on unwanted pregnancy and therefore on abortion. It was noted that children raised by single parents lack proper training as well as parental guidance and may get involved in acts that will cause unwanted pregnancy. Poverty may also push some of these adolescents to involve themselves in sexual activity in an attempt to get their needs met as quickly as possible. In the process pregnancy may ensue, leading to abortion as illustrated in the statement of the informant:

“.....most of the children that we see go into this abortion, most of these children comes from single parent, they come from the low income family or people that are in poverty and most of them, their parents are uneducated and majority of them is the kind of background are lure into sex which may result unto unwanted pregnancy.....”(Lawyer)

Another informant held a similar view, that the parents were to blame, especially the mothers who usually support their daughters by hiding the pregnancy from the fathers, and also assist them in procuring the abortion sometimes. This opinion was expressed by a teacher:

“....in many cases we have seen adolescents having abortion in schools precisely my school where I am teaching, but when we look into the causes of these cases we will find out that most of those little girls that are having abortion, the problem arise from their parents especially their mothers who will be backing them, although the mothers don't use to support them before the pregnancy but once they reach the pregnancy stage the mothers have no choice but to support them because they are their children, to find a way to get rid of that pregnancy to the extent that they will hide it from the teachers and the father of the child.” (Male Teacher)

3. Adolescents' reason to opt for abortion

One of the stakeholders stated that the decision of the adolescents to have an abortion is due to shame, as expressed below:

“...you know, in the process of trying to enjoy and have fun, they end up with unwanted pregnancy, so they feel that abortion is the only and easiest way out of this because majority of them would not want to bear the shame of keeping the pregnancy till delivery while they are not yet married.”(Islamic cleric)

A similar view was held by another informant:

“.....another thing is the fear of bringing shame to their family or been mocked by the society couple with the belief that any unmarried teenage girl with a child is wayward and will not be able to get a good husband may prompt these girls into doing abortion, which is usually done in secret and no evidence except when there are complications.” (Lawyer)

Two of the informants attested that pregnant adolescents become confused, nervous and gullible, and that this makes them susceptible to any advice that will remedy the situation. This was captured in the statements below:

“... number one, there is confusion, there is embarrassment, because many of them don't even know what to do with the pregnancy and as a result whatever they think is the solution, whoever think have solution, they will follow.” (Female Teacher)

“Some of them they don't even know that they are pregnant and when they know that they are pregnant with the African custom, you cannot tell your parents when you are not of age that you are pregnant and because of this fear, they tried anything that their friends tell them on how to get rid of that baby.” (Pastor)

5.2.4.2 General outcome of cases of abortion seen by stakeholders

The other stakeholders described the deleterious outcomes in cases of backstreet abortion, where the adolescents had tried to induce the abortion themselves or sought the assistance of charlatans. They went on to say that they had seen cases that ended in depression from guilt, infertility, removal of the womb (hysterectomy) and death. This was illustrated in the following statements:

“You just see them dozing in class, and what happen next? Suddenly you will see them collapse, you rush them out to the hospital and call their parents, then the doctor may say she's having this, she is having that. She is having complications due to so-so abortion, because they don't use to go to standard hospital to do those kind of abortions. They will just go to one...maybe chemist shop or unregistered clinic to go and do the abortion which is not good enough.” (Female Teacher)

A clergyman narrated how he watched a girl die from abortion complications, and could do nothing to help her:

“Really most of the one I have heard in the past, they lost their lives because one is only aware after the complication is severe, just when there is no hope or help that can be given to them....to the person concern and definitely you watch them die, the hospital too can do nothing,..... and can you imagine a girl that was asked to take... er...battery water (acid inside battery) to help her commit the abortion, so her colour just change and the skin was peeling, that is how we watch her die...”(Pastor)

5.2.4.3 Other stakeholders’ views on Support services

Unavailability of any support service(s)

Some of stakeholders acknowledged the lack of support system to assist these adolescents. According to them, there are no plans put in place by the Nigerian government to provide better healthcare / more accessible healthcare and social support for these pregnant adolescents to help those who have suffered post-abortion complications. This is demonstrated in the statement below:

“.... er.....most of the blame sometimes I put it on the government, when these children have challenges hum....and as compared to the developed countries hum...at least I remember in Dallas area, there is a place called "HOPE COTTAGE MINISTRY" is meant for teenage girls, adolescents who are pregnant, where they just help the children go through those kind of pregnancy and when they have the baby, if they chose to take care of the baby, they leave the baby for them if they have the means and where they don't have the means, they have a

way of asking the government to take care of those children and that is not put in place here in Nigeria....” (Male Teacher)

“I don't know of any, I don't know of any either in the hospital or in the church or any organisation, or any NGO” (Pastor)

5.2.4.4 Other stakeholders’ perspectives on challenges and barriers to adolescents’ post-abortion care

The stakeholders identified some challenges and barriers these adolescents face when they seek post-abortion care.

1. Stigmatization

Society stigmatizes women who have had an abortion, and this experience is often traumatic and devastating, and if care is not taken, may cause psychological trauma for these adolescents. All these factors drive them to abortion. A clergyman commented thus:

“After they are already in this situation, the society stigmatize them, they do away with them, they see them as an outcast, and as a result the adolescent feel stigmatized and traumatized and... even some take their lives. ” (Pastor)

“Em....because of the religious belief and custom that abortion is a sin and a sinner must be punish we tend to stigmatized these adolescents, for example, parents will forbid their kids from associating with such adolescent so that she will not corrupt them.” (Lecturer)

“you know as a result of how the society see them, so all these are not helping them and it make them to think of how to get rid of the pregnancy instead of thinking of nurturing it, they won't think of nurture, rather they will think of how to terminate it...” (Islamic cleric)

Unfortunately, due to the fear of being stigmatized, adolescents become fearful of going to the hospital because of confidentiality issues. As a result, adolescents will use the options that are within their reach while maintaining secrecy to reduce the number of people who become aware that they have had an abortion to prevent stigmatization (Ushi, Izugbara¹, Mutua, & Kabiru, 2018; Yegon, Kabanya, Echoka, & Osur, 2016)

2. Lack of counselling/ counsellor

Lack of counselling and lack of confidantes were also identified as the challenges these adolescents face when they seek post-abortion care. There are no well trained counsellors around, teachers and parents feel it is inappropriate to counsel the adolescents about sex and contraception. Because these adolescents cannot confide in their parents, they seek solace in their friends who often advise them wrongly, and they end up with abortion complications time without number. Some of these opinions are illustrated below:

“....we don't have good counsellors, where even there is counsellors in the school, to counsel those children, there is no proper sex education and some of them don't even know that they are pregnant and when they know that they are pregnant with the African custom, you cannot tell your parents when you are not of age that you are pregnant and because of fear, they try anything that their friends tell them on how to get rid of that baby.” (Lawyer)

“Parents feel shy discussing sexual activities and education with their wards and this has actually caused a lot of problem over the years.” (Lecturer)

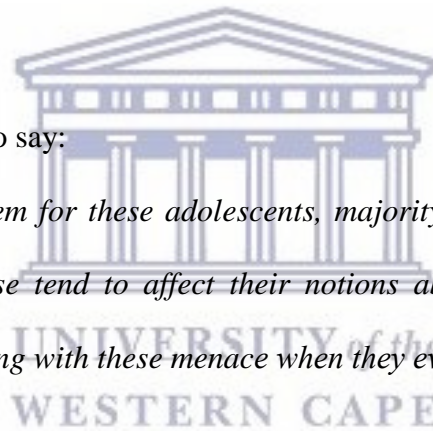
3. Lack of sex education

Lack of sex education was identified as one of the challenges these adolescents face. Most of them, particularly females, have little or no idea of what is happening within their bodies. They may not even know what safe period means during the menstrual cycle. This is because the parents shy away from discussing these issues with their children before they begin to engage in sexual activity. One of the respondents elaborated on this:

“....some parents are shying away from the ...their responsibility to this er....adolescents by not making them to know what sex education is all about, some they even forbid for a child to even talk about anything related to private part, they say that type of a child is becoming promiscuous or is wayward.” (Pastor)

A university lecturer had this to say:

“This has been a major problem for these adolescents, majority of them do not have access to proper sex education and these tend to affect their notions about things like pregnancy and abortion and even ways of coping with these menace when they eventually find themselves in it.”



4. Financial constraints

Money was identified as a major constraint to post-abortion care, as expressed by some of the informants:

“When we rush them to the hospital, at the end of the day they will say before you can rescue this lady you will have to do this, go and get blood, we have to transfuse blood because she has lost some blood during the abortion and we will start running for blood and money which may not be available at that time and without money hospital will not give

further treatment. So therefore that is the challenge we have noticed in them.” (Islamic cleric)

“Some of this adolescents when they are in the hospital they have problem paying bills because the father who is the breadwinner may refuse to pay, leaving the mother to carry the burden alone and sometime she is a full house wife, em...making her situation worse financially.” (Male Teacher)

“Of course, these adolescents are not working, so there is financial problem.” (Lawyer)

5. Non enforcement of law guiding prescription of drugs and abortion by unlicensed practitioners

Generally, stakeholders acknowledged that despite the various laws guiding the control of drugs and abortion, the adolescents still patronize “quacks” that assist them in procuring abortions. This is illustrated in their statements below:

“...the patent drug stores, those who are there, who don't have either any medical training, they try to see how they put different kinds of drugs into the hand of the child to see whether it can force them into labour.” (Female Teacher)

“....we have some quack doctors who specialized in just helping children, those teenagers girls to commit abortion and since even those who are caught are not been punished, fake continue but if government have enforced the law and people have been punished for doing abortion without been licensed, then I feel the children will fall into safe hands.” (Pastor)

“Helping a young girl to procure abortion when you don’t have the knowledge, skills and the means to ensure safe abortion is criminal, and government need to enforce the penalty.”

(Lawyer)

6 Attitudes of the health care provider

Some of the stakeholders reported that the health care professionals in public hospital were sometimes unfriendly, rude, and abusive. These negative attitudes influence the decisions of the adolescents whether to come to the hospital or not. This was captured in a statement of a school proprietor:

“I went to see someone with abortion complication at the government hospital and the people there were not friendly, they were just shouting at us and they were not attending to the young girl very well.” (Male Teacher)

A teacher also elaborated by sharing her experience as a mother:

“As a mother I have witness the way a young girl with abortion complications was treated in government hospital and I can tell you categorically that it is not a pleasant experience.”

(Female Teacher)

This was further corroborated by other informants:

“I think that is why some adolescents with abortion complication will prefer to manage it at home first or try private hospital, because they dread the hostile environment created by the behaviour of some of the hospital workers.” (Lecturer)

“Those health worker need to be trained on manners because majority of them have bad manners and talk to people em.....without regard.” (Islamic cleric)

Another informant commented on the inability of the care provider to manage information:

“When I was younger, I went to a family planning clinic and one of the staff of the hospital who knew my mother saw me and reported, my parent nearly killing me, it was the worse experience of my childhood.” (Female Teacher)

5.2.4.5 Solutions to the challenges identified as suggested by stakeholders

The stakeholders identified possible ways of addressing some of the challenges and barriers adolescents encounter in seeking post-abortion care.

1 Parental support/guidance

They are of the opinion that parents, especially mothers, have a significant role to play in supplying their children with the necessary information for them to be morally upright and avoid such practices that will destroy their future, like unwanted pregnancy and abortion. A clergyman has this to say:

“.....everything start from home, mothers should be able to talk to their children, both male and female that there is time for everything and there are many things that before you have a baby there are some things that must come first and hun.....which even the two major religion that we have in Nigeria,....they didn't say you can have a child without a husband, you must be prepared and you must have a husband before you can have a baby and is something right for you to do that, you will make the family to be proud and even people around you because you went the right way and majority of the work is for the parents and more also for the mothers to train their children which way they should go, so that at the end none of them will regret...”(Islamic cleric)

Abortion is strongly being condemned on all platforms by clergymen; they believe children are a gift from God and that therefore these lives should not be taken for any reason. This is illustrated in the statements below:

*“....I strongly go against abortion if the person is pregnant.....she should have the baby
(Pastor)*

*“I am not in support of abortion, children are gift from God; you can't get it because you
have money or because you, you are in position....” (Teacher)*

*“Anybody that is pregnant should have the baby it is a big sin to abort, so I am really
against abortion”(Lawyer)*

However, one of the Muslim clergy said that it is permissible only if the pregnancy poses a threat to the life of the mother:

*“Abortion can only be done if the life of the mother is at stake apart from that it is criminal
and is a sin.” (Islamic cleric)*

Provision of counselling unit

There is a need for hospitals to establish functional counselling units to advise these adolescents about pregnancy and all that comes with it, as well as leading a healthy lifestyle before and after pregnancy:

*“....the hospital are the people to first discover and the hospital should have a counselling
unit in the hospital where both the teenage girl and the parent are counselled, so that they
quickly find ways that is not going to cost any further problem for the child....”(Female
teacher)*

Provision of free health care/ subsidies

The government can lessen the burden of these adolescents by providing subsidies for the care they receive. Some stakeholders suggested financing of adolescents' post-abortion care by government and nongovernmental organization. This was captured in the statement of a legal practitioner:

“There is need for government and non-governmental organizations to assist in providing funds for the care of these adolescents.” (Lawyer)

“There is need to subsidise cost of treatment for these adolescents to lessen the financial burden.” (Lecturer)

5.3 Triangulation of results from various participant groups

An organized basic approach of enhancing trustworthiness of data were used to elicit information using three approaches of semi-structured interviews, and focus group discussions during data collection from participants. Data were analyzed and various themes and categories emerged from the data that would serve as main conclusions (see Table 5.4). These conclusions assisted in presenting the discussion and the development of the Delphi survey.

Table 5.4: Summary of vertical themes relating to participants and concluding statements

Conclusion Statement	Adolescents' Group	Health Care Providers' Group	Stakeholders' Group	Conclusion Statement Based On Horizontal Themes
VERTICAL THEMES AND RELATED CATEGORIES				
Experience(s)	<ul style="list-style-type: none"> Adolescents cannot discuss issue of 	<ul style="list-style-type: none"> Abortion complications usually involve 	<ul style="list-style-type: none"> Abortion is mainly among adolescents 	<ul style="list-style-type: none"> Adolescents experienced inability to access

	<p>pregnancy/abortion with the parent or guardian due to fear of stigmatization or rejection</p> <ul style="list-style-type: none"> • Inability of the adolescents to access safe abortion service led to patronage of private clinics or pharmacy • Use of concoction to induce abortion • Family shame and disappointment influenced the decision to opt for abortion 	<p>adolescents</p> <ul style="list-style-type: none"> • Adolescents patronize quacks in the process of trying to cover their shame • The outcome of abortion depends on the severity of the complication and early presentation to the health care facility. 	<ul style="list-style-type: none"> • Society lures adolescent into all kinds of indecent acts with a promise of financial security • Abortion is a way of escaping from shame of unwanted pregnancy out of wedlock 	<p>safe abortion services which influenced their decision on the place and method of abortion</p> <ul style="list-style-type: none"> • Fear of stigmatization and rejection prompt the adolescent to procure abortion
Perceptions of post-abortion care	<ul style="list-style-type: none"> • Adolescents perceived negligence of care which was influenced by the unfriendly and judgmental attitude of the health care worker • Rigid admission procedure and 	<ul style="list-style-type: none"> • Late presentation of adolescents to hospital for care • Difficulty in management due to inability of the adolescent to confide in the service providers • Private clinic 	<ul style="list-style-type: none"> • Delayed hospital involvement • Procedure carried out by quacks or untrained persons. 	<ul style="list-style-type: none"> • Adolescents perceived negligence of care which was influenced by unfriendly and judgmental attitude of the health care worker • Inability of the adolescent to

	delay in getting treatment	and patent medicine store performed abortion		confide in the service providers also affected the post-abortion care rendered by the health care providers <ul style="list-style-type: none"> • Abortion is mainly performed by private clinic either by skilled or unskilled personnel under unhygienic conditions
Outcome of post-abortion complications cases		Long term disabilities Psychological problems such as depression Majority died due to self-induced abortion	Poor outcome due to late presentation to hospital Majority died due to self-induced abortion by crude means such as the use of herbal mixture of lime, salt, potash and alcohol; insertion of metal rod or wire, drinking of fluid from car battery (acid)	<ul style="list-style-type: none"> • Prognosis is usually good with early intervention • Long term disabilities and deaths are common with late presentation
Challenges/	• Unfriendly and	• Financial	Financial difficulty	• Government

<p>barrier(s) experienced by adolescents in obtaining PAC services</p>	<p>judgmental attitude of health workers</p> <ul style="list-style-type: none"> • Delay in treatment • Non availability of prescribed drug in the hospital pharmacy • Financial challenges • Lack of landmarks in the hospital • Non-legalization of abortion • Stigmatization • Lack of privacy by the health care personnel • Nil availability of support system • Lack of proper PAC counselling 	<p>challenges</p> <ul style="list-style-type: none"> • Attitude of health care provider • Late presentation to the hospital • Rejection /discrimination and stigmatization • Lack of post-abortion counselling • Lack of cooperation from adolescent patients and relatives • Lack of support system 	<ul style="list-style-type: none"> •lack of utility of contraceptive/sex education •Nonchalant attitude of the patient(s) •Lack of underground law against abortion •Lack of communication •Poor decision making •Lack of parental support/care •Lack of counsellors •Stigmatization 	<p>policy on abortion is a major barrier to provision of abortion service and it is believed that liberal laws on abortion reduced to the barest minimum the complications and deaths from abortions, as well as regularized and standardized abortion services</p> <ul style="list-style-type: none"> • Financial constraints occur due to lack of parental and societal support as well as high cost of treatment • Stigmatization and discrimination occur due to moral and religious beliefs • Lack of privacy
<p>Suggestion(s) on challenges</p>	<ul style="list-style-type: none"> • Need for health 	<ul style="list-style-type: none"> • Treatment 	<ul style="list-style-type: none"> • Parental 	<p>There is a need to improve on quality</p>

and barriers	<p>care providers to change their attitudes</p> <ul style="list-style-type: none"> • Equality in treatment irrespective of condition(s) seen • Legalization of abortion • Free/reduced cost of health services • Free education • Adolescent friendly environment <p>Use of contraceptive</p>	<p>subsidy/Free medical care</p> <ul style="list-style-type: none"> • Training and retraining of service providers • Provision of effective support system • Legalization of abortion • laws and policies that favour adolescents • Education/counselling • Stipends /scholarship for the students • Contraceptives/ F/ P use 	<p>support/guidance</p> <ul style="list-style-type: none"> • Provision of counselling unit • Free health services • Legalization of abortion • Sex education in school programme • Job opportunities • Continuing professional development programme <p>Free educational system</p> <p>Counselling unit/guidance center</p>	<p>of PAC services through provision of adequate space and equipment as well as training and retraining of service providers on value clarification and attitude transformation.</p> <p>There is a need to develop youth friendly support programmes for PAC patients strengthening and integration of post-abortion contraceptive counselling into post-abortion care, Review of abortion laws</p>
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5.4 Discussion of findings

5.4.1 Experiences of adolescents, health care providers and stakeholders, of abortion and PAC

In the Nigeria where this study was conducted, abortion is not liberalized and the society views the act of getting rid of the unwanted pregnancy as criminal and a form of moral decadences.

Thus, the adolescents with unwanted pregnancies found it extremely difficult to discuss issues of unwanted pregnancy and possible option of abortion with their parents or guardians due to fear of stigmatization or rejection. This corroborates the finding of Streffling *et al.*, (2015) where inability of the adolescents to discuss freely on the issues of unwanted pregnancy and abortion with their respective parents and guardians was observed.

Report from this study indicates that adolescents with unwanted pregnancy boycott formal (government) hospitals and find their way to informal places to terminate the unwanted pregnancies due to the inability of adolescents to access safe abortion services. This inability to access safe abortion care services led them to private clinics or pharmacies. Sometimes, they used self-prepared concoctions such as mixture of lime, salt, potash and alcohol to induce abortions. The fact that formal (government) health facilities are known for treatment of only complications of unsafe abortions made the adolescents to embark on the various unsafe abortion practices as the first option. This further stimulates the emergence of unqualified and opportunistic operators setting up shops and charging exorbitant amounts of money to help these adolescents get rid of the unwanted pregnancies, so they can spare themselves and their families the shame and the wrath of the community (Akangbe, 2015). Unfortunately, some government hospitals are not well equipped to handle the situation and this group of adolescents are sometimes treated with contempt. The resultant effect though, is that many lives, especially that of young girls (adolescents) are lost due to unsafe abortion. Donabedian stressed that both the structure and process influences the outcome of care. Although, in this study PAC constitutes one of the elements of the **structure** in most formal health facilities, the **process** which constitutes the care received had been described deficient and unsatisfactory by the adolescents. Consequently, the **outcome** was negatively affected.

The health care providers recognized the fact that abortion and its resultant complications are common among adolescents who all too often patronize unskilled abortion service providers in an attempt to escape societal criticism, stigmatization and rejection (Tunde, 2013). Thus, most adolescents seek abortion and its care in private hospitals, patent medicine stores and from traditional medicine men or prepare herbal concoctions themselves, while avoiding government (public) hospitals where presumably they know they can get the best care. Most adolescents just as pointed out by Ratlabala et al., (2007) expressed discomfort at receiving PAC services from the public clinics or hospitals because these facilities are seen as unfriendly. In addition, the other stakeholders were of the view that societal influence lures adolescents into sexual practices with the promise of financial security, and that such acts consequently result in pregnancy, with abortion as the only way of escaping from the shame of unwanted pregnancy out of wedlock. According to Abbas (2014), material gain is another reason that pushes young girls to become pregnant, because of absolute poverty especially in the rural areas. A study conducted in Anambra State Nigeria reveals that, over 98% of teenagers had sex or became pregnant because of material gratification. In addition, various studies in Nigeria have shown that restrictive abortion law, religious and moral belief about abortion and pre-marital sex in the country makes PAC services less accessible, particularly to young unmarried adolescents. (Olaitan, 2017; Mcharo, 2016; Mustafa, 2015; Hassan, 2014; Ubajaka et al., 2014),

5.4.2 Perceptions of adolescents, health care providers and stakeholders of abortion and PAC

The adolescents perceived negligence of care which reflected in the unfriendly and judgmental attitudes of health care workers and this, they pointed out, has affected significantly the PAC services they received. This corroborates WHO (2015) and Singh, et.al, (2018) statement that medical personnel's discriminatory attitudes toward women who have had an abortion often

manifest in neglect and mistreatment. Most of the adolescents affirmed that the health care providers were unfriendly and judgmental while providing PAC services to them. Some health care providers interviewed actually confirmed the judgmental and unfriendly attitude of some of the health care providers toward PAC patients. It is possible that these care givers were actually unfriendly and less caring than they should be, but nurses were particularly mentioned, maybe because they, unlike other health care providers, spend more time with the patients and it is just common to lay the blame on whoever is available at any given time. However, Payne et al., (2013) stated the nurses and midwives seemed to withdraw from abortion patients and ignored their responsibilities as caregivers. Studies have found that nurses and midwives disliked being involved with abortion services, and they commonly reported hesitance in providing these services (Harries et al., 2009; Klingberg-Allvin et al., 2007; Mokgethi et al., 2006). For instance Klingberg-Allvin et al., (2007) found that among midwifery students in Vietnam the main reason for choosing midwifery as a profession was to care for women in labour and delivery, and hardly any of the students wanted to work in the area of abortion services.

Additionally, researchers have also reported the unpleasant attitudes of health care providers who often see these adolescents as wayward only because they have fallen pregnant outside of wedlock. Notable among such studies is that of Arambepola, Rajapaksa and Galwaduge (2014) who found that respondents were dissatisfied with the overall care received during their hospital stay, predominantly due to verbal harassment and breach of confidentiality of information by health care providers about their abortion status. Similar, the judgmental or negative attitude of the providers on induced abortion may lead to women receiving poor quality services which may put women at risk of maternal mortality (Singh et al., 2018; Melkamu et al., 2010). Furthermore, this judgmental attitude as observed by the adolescents may also be explained by the moral

principles held by these care givers, that abortion means taking someone's life as can be observed in a study by Rehnström et al., (2015) who found that providers have moral-, social- and gender-based reservations about induced abortion which subsequently influence their attitudes towards induced abortions, and affect the relationship between the health care providers and women seeking such services. Strefling et al., (2015) also found discriminatory behaviour among health care practitioners, and little or no professional interaction with the women seeking care, which exposed them to unsafe abortion and its devastating consequences of death and disability.

On the other hand, some of the adolescents gave a positive view on health care providers' attitudes towards them. This is similar to a study conducted by Harries et al. (2012) where positive view on nurses' and midwives' attitudes towards abortion was noted and early termination of pregnancy was more accepted among health care providers than second-trimester abortions (Harries et al. 2012).

The health care providers on the other hand maintained that the inability of the adolescents to open up on issues concerning pregnancy and abortion as well as their reluctance to confide in the service providers, affect the PAC services these adolescents seek and receive from the health care providers. This may be due to the fact that adolescents were nursed in the same ward with other obstetric and gynecological cases and are wary of sharing information with the health care providers whom they perceived were not discreet with information on their ward rounds. In addition, the health care providers and stakeholders maintained that adolescents with post-abortion complications delay seeking post-abortion care. This is often because they have exhausted all possible options, namely patent medicine stores and traditional medicine men, among others, before seeking proper care at the health care facilities (Ushie, Izugbara, Mutua, & Kabiru, 2018; Izugbara, et. al, 2015; Mutua, et al, 2015). This late presentation usually worsens

the adolescents' condition and when it is not properly managed, can result in permanent deformities, such as loss of uterus, infertility or even death. According to Ushie et.al, (2018) young women presenting late were more likely to have severe complications. In addition, WHO (2015) and Singh et.al, (2018) stated that delaying care for an incomplete abortion can make a minor problem much worse, leading to long term disabilities and deaths

Furthermore, both care givers and other stakeholders maintained that the outcomes of post-abortion care are dependent on the severity of the complication and time of presentation at the health care facilities; they noted that early presentation accompanied by efficient and timely treatment resulted in good outcomes. This finding is corroborated by previous studies which state that the severity of complications resulting from abortion among young women can be reduced if appropriate abortion care is sought in time. Ushie, Izugbara, Mutua, & Kabiru, 2018; Izugbara, et. al, 2015; Mutua, et al, 2015)

5.4.3 Challenges and barrier(s) experienced by adolescents in obtaining PAC services

The adolescents, health care providers, and other stakeholders identified finance as a major constraint the adolescents encountered in an attempt to secure PAC services. This may be due to the fact that they do not have any means of livelihood, coupled with the lack of support from parents and significant others, as well as the high cost of medical treatment. This finding agrees with that of Melkamu, et al., (2010) who found high cost of treatment as a barrier to effective PAC by adolescents. Awoyemi and Novignon (2014) also found income to be a significant determinant of abortion and PAC demand.

All respondents noted restrictive legislation on abortion and government policy in Nigeria as one of the challenges these adolescents face in securing PAC services, but others were worried about the implications of legalizing abortion. For instance, Ubajaka et al. (2015) examined lawyers'

views on abortion and found that the majority of them were against the legalization of abortion in Nigeria. In many sub-Saharan African countries, including Nigeria, many women are unable to access safe abortion services for unwanted pregnancies on account of the abortion laws among other factors. Despite this, there is widely accepted evidence that restrictive abortion laws do not reduce the incidence of unsafe abortions, but rather drive it underground, and increase morbidity and mortality (Henshaw, Adewole, Singh, Bankole, Oye-Adeniran & Rubina Hussain, 2011). That is to say, the consequences of the law seem to overwhelm the intent, and this is why there is the need to re-examine the legislation on abortion.

Also mentioned as a barrier and challenge to PAC services by all respondents was the delay in treatment occasioned by unnecessary and avoidable bureaucratic procedures in Nigerian hospitals. This is quite detrimental, as most of these adolescents with abortion complications delay seeking health care services and may present with complex complications that must be handled as an emergency until proven otherwise (Singh, et.al, 2018).

All the informants identified unfriendly and judgmental attitudes of health workers, particularly nurses, as a major challenge and barrier standing in the way of adolescents' access to effective PAC services. However, some of the health care providers argued that the hospital policies that prevent midlevel providers like nurses from using MVA and prescribing drugs for PAC patients handicapped nurses and created the impression that they were uncaring and did not want to attend to the PAC patients. Notwithstanding these factors, the adolescents see the care givers as unapproachable and are skeptical of the care giver/patient interaction and communication. Care givers on the other hand think these adolescents are not sufficiently cooperative as they are unwilling to provide the information that care providers need to make important decisions about their care. In addition, adolescents and health care providers lamented on the lack of post-abortion

counselling, and noted that these adolescents keep coming back with the same problem. One would expect that if they are properly counselled while receiving PAC services, they will refrain from unprotected sexual intercourse or take measures that will prevent unwanted pregnancy and abortion. The fact that they keep coming back showed that these adolescents are not properly counselled on issues relating to unwanted pregnancy, abortion and contraceptives. This is consistent with the finding of Arambepola, Rajapaksa and Galwaduge (2014) who noted deficiencies in care with regard to provision of post-abortion counselling, education and family planning services among women seeking hospital care following unsafe abortion. Similarly, Mustafa (2015) reported that poor contraceptive uptake amongst post-abortion clients in a relatively well-resourced area of Nigeria is worrisome. This is due to lack of post-abortion contraceptive counselling, which is a missed opportunity for contraceptive initiation for these adolescents with post-abortion complications, in order to prevent reoccurrence.

Non availability of prescribed drugs and supplies in pharmacies within the facilities was another challenge the adolescents felt affected their access to PAC services. This is because the absence of the necessary drugs in the hospital owned pharmacies place an extra burden on the patients, relatives and friends of these adolescents who may have to go distant places in search of these drugs and supplies at a higher cost than they would incur in government hospitals.

The health care givers and other stakeholders added that these adolescents face rejection from their parents and significant others who have the capacity to pay for the treatment of these adolescents, thus leaving them to the mercy of their friends who have nothing more than unhelpful advice to offer. This supports the contention of Melkamu et al., (2010), who also found the lack of community support to be a challenge the adolescents face in receiving post-abortion care. Discrimination and stigmatization from the society and lack of a support system was

observed by all the respondents to dampen the spirit of these adolescents as they seek PAC services. Ganatra et.al, (2017) affirmed that abortion-related stigma, which cuts across all contexts, continues to negatively affect women's health and well-being. As long as such stigma persists, so will unsafe procedures, because fear of being recognized by family and friends moves women to avoid trained providers in formal medical settings for both abortion and post-abortion care. Stigma is also an important reason why data on induced abortion are so scarce and unreliable (Sedgh, et.al, 2016). The fear of being stigmatized also extends to health personnel for providing abortions or PAC services (Singh, et.al, 2018). This may likely hinder health care providers from providing quality PAC services.

Despite the mixed opinion on abortion, the majority of the health care providers and other stakeholders viewed restrictive laws on abortion as a major barrier to the provision of abortion services and it is believed that liberal laws on abortion will reduce to the barest minimum the complications and deaths from abortions, as well as regularized and standardized post abortion care services; because legal restrictions on abortion strongly reinforce stigma (Bearak et al., 2018; Ganatra et.al, 2017).

5.4.4 Suggestions for the resolution of challenges and barriers, as made by adolescents, health care providers and stakeholders

All categories of respondents in this study gave various suggestions that are capable of improving the three components of Donabedian's model of quality care (the structure, the process, and the outcome).

Suggestions capable of improving the structure:

The respondents were also of the view that legalizing abortion will enhance access to PAC services and reduce the stigmatization from the society and also make the care givers less

judgmental and discriminative in dealing with the adolescents. In addition to this, the care providers suggested that government enact laws and policies that favour adolescents with abortion complications. A similar view was that of Arambepola, Rajapaksa and Galwaduge (2014) who insisted that legalization of abortion is a pragmatic public health approach for further reduction in maternal mortality rates among adolescents. Also, the respondents noted that establishing non-threatening physical environments within wards will encourage the adolescents to access PAC service.

Suggestions capable of improving the process:

All the respondents suggested free or reduced cost of treatment for adolescents seeking PAC services. This, they think is necessary as most of these adolescents present at the facilities with serious complications, and without the necessary financial resources to foot their bills. Making these services free or reduced to a reasonable level will make these services readily available to the adolescents in cases where there are abortion complications.

Furthermore, the adolescents stressed the need for health care providers to change their attitudes and provide adolescents a friendly environment for effective PAC services. Arambepola, Rajapaksa and Galwaduge (2014). Improving positive attitudes of all PAC-providers is necessary for effective PAC service provision. Besides, Dorayi (2012) suggested PAC training for nurses and doctors as this will update their knowledge and skills for enhanced PAC service provision.

They also urged health care providers to give every patient equal treatment irrespective of their diagnosis. On the other hand, the care givers pointed out that training and retraining of staff involved with PAC services is necessary for improved patient outcomes. The care givers and the other stakeholders also recommended that counselling as well as health education be strengthened in order to curb the reoccurrence of unwanted pregnancy that often leads to abortion and

subsequently abortion complications. The stakeholders added that this health education should begin at home with the parents and extend to schools and even mass media. In addition, the stakeholders suggested the introduction of sex education in the school programme. To achieve these, there is need for health care providers to embark on public awareness campaign programmes as shown in the framework which guided this study.

All the respondents stressed the need for a continuing professional development programme to change the orientation of health care professionals for improved PAC services to adolescents seeking such services. This could be fostered by purposeful continuing education programmes for health workers. The respondents also advocated for support for adolescents suffering from abortion complications. This support can come from health care providers, social workers, parents, teachers, religious leaders and other concerned individuals within the community. Support such as this, they maintained, will go a long way in alleviating the suffering of adolescents in need of PAC services. There is therefore a need for community involvement and participation in order to address the abortion stigma and provide support for adolescents with unwanted pregnancy as well as PAC patients.

The respondents also maintained that improved access to education by way of free education and provision of scholarships as well as youth empowerment by way of job creation, the establishment of skills acquisition programmes and other project will keep these adolescents away from sexual involvement aimed at financial gain to meet certain needs that these adolescents and their parents are unable to meet.

The respondents also stressed the need for increased awareness on contraceptive use among the adolescents. Effective contraceptive counselling and incorporation of other health care services, it

was suggested by Akinola, Fabamo and Adetokunbo (2010), will go a long way in improving the overall health of adolescents.

Potential improvement on outcome

All the above suggestions if effectively adopted and imbibed by respective stakeholders will engender favourable outcome. Thus, the adolescents needing PAC will be encouraged to access the service in formal health facilities with adequate and appropriate equipment, and skilled health care providers. Subsequently, it will bring about reduction in cases of complications resorting from unsafe abortions that frequently perpetrated by non-physician abortionists.

5.5 Conclusion

This chapter dealt with the analysis and discussion of the qualitative component of the research. The opinions and views of the adolescents, their health care providers and some other stakeholders regarding adolescents' PAC, challenges and barriers to PAC, as well as solutions were explored. The findings from this chapter were given to a group of experts in order to provide them with an opportunity to communicate their opinions and knowledge anonymously so as to gather "the most reliable consensus of opinion of a group of experts that can be used to develop document to inform policy. The next chapter gives a comprehensive description of the data analysis and findings from the experts who were selected on the nature and status of their professional and community credentials.

CHAPTER SIX

RESULTS OF DELPHI ROUNDS

6.1 Introduction

This chapter presents the results and discussion from the Delphi survey with a group of expert panellists in two iterative rounds. Results from the qualitative study from adolescents, health care providers and stakeholders on the challenges and barriers to adolescents' PAC were presented under the three main sections for the expert views in order to generate a policy document that could inform reproductive health policy, as well as highlight recommendations.

6.2 Results of Delphi Round 1

6.2.1 Demographic data of the participants

In Round 1, the number of expert panellists contacted were 50, of whom 43 responded. The same 43 were used for the study. The response rate for this round is 86%. This indicates level of interest and commitment of the expert panellists in the study.

Table 6.1: Socio-demographic Profile of the Experts (n-43)

	Variables	Frequency	Percentage	Minimum	Maximum	Mean	Std. Deviation
Age	30-39	5	11.6	32	68	42.5	9.392
	40-49	15	34.9				
	50-59	19	44.2				
	60-69	4	9.3				
Gender	Male	12	27.9				
	Female	31	72.1				
Highest level of education	Diploma	4	9.3				
	Bachelor's Degree	16	37.2				
	Master's Degree	20	46.5				
	Doctoral Degree	3	7.0				
Work Experience in Years	5-10	3	7.0	6	35	13.9	9.652
	11-15	2	4.7				
	16-20	7	16.3				
	21-25	10	23.2				
	30 and above	21	48.8				

Occupation	Lecturing	5	11.6				
	Teaching	5	11.6				
	Social work	2	4.7				
	Medicine	4	9.3				
	Nursing	6	14.0				
	Law	4	9.3				
	Politics	1	2.3				
	Guardian /counselling	1	2.3				
	Christian Clergy	4	9.3				
	Islamic Clergy	4	9.3				
	Business	7	16.3				
Capacity of dealing with adolescent	Teacher	5	11.6				
	Health care provider	10	23.3				
	Motivational speaker	4	9.3				
	Youth counsellor	3	7.0				
	Peer educator/facilitator	4	9.3				
	Mentoring	4	9.3				
	Youth representative leadership and life-skills training	1	2.3				
	Youth development Programme	4	9.3				
	implementation involving adolescents	1	2.3				
	Research	2	4.7				
		5	11.6				

The table above shows that most 31 (72.1%) of the experts interviewed were females and 19 (44.2%) of the experts were within the age range of 50-59 years. The mean age was 42.6 years with a standard deviation of 9.392. Almost half of the experts 20 (46.5%) had at least a master's degree. 21(48.8%), which was the majority of the expert panel members reported over 30 years of working experience, 10 (23.2%) had 21-25 years, 7 (11.6%) had 16-20 years, 2 (4.7%) had 11-15 years and only 3 (7.0%) had 5-10 years of experience. The mean number of years of working experience was 13.88, with a standard deviation of 9.652.

Of the experts interviewed, 4 (9.3%) were doctors, 6 (14.0%) nurses, 2 (4.7%) social workers, 5 (11.6%) university lecturers, 5 (11.6%) school teachers, 4 (9.3%) lawyers, 1 (2.3%) politician, 1 (2.3%) counsellor, 4 (9.3%) pastors, 4 (9.3%) Islamic scholars and 7 (16.3%) were businessmen. All the panellists have worked with the adolescents in various capacities as shown in the table above.

6.2.2 Experts' opinion on abortion and post abortion care

Table 6.2: Opinions of Experts on Abortion and Post-Abortion Care (n=43)

Opinions	Agree F (%)	Undecided F (%)	Disagree F (%)
Abortion is rampant among adolescents	43 (100)	0 (0.0)	0 (0.0)
Family background is a major contributor to abortion	30 (69.8)	6 (14.0)	7 (16.2)
Poverty influences adolescents' early sexual involvement	40 (93.0)	0 (0.0)	3 (7.0)
Society influences abortion and post-abortion care (PAC)	38 (88.3)	2 (4.7)	3 (7.0)
Easy access to pornography by adolescents increases rate of unwanted pregnancies and rate of abortions	37 (86.0)	0 (0.0)	6 (14.0)
Peer influence has been implicated in adolescents' sexual involvement and procurement of abortion	43 (100)	0 (0.00)	0 (0.0)
Adolescents have limited understanding of their bodies and conception; this increases rate of unwanted pregnancies and abortion	37 (86.0)	2 (4.7)	4 (9.3)
Single parenting is a contributory factor to the high rate of unwanted pregnancies and abortion	31 (72.1)	4 (9.30)	8 (18.6)
Adolescents should have the right to choose whether or not they want to have an abortion	30 (69.8)	3 (7.0)	10 (23.2)
Not legalizing abortion is a contributory factor to increase in morbidity and mortality rates	30 (69.8)	3 (7.0)	10 (23.2)
Adolescents are physically, emotionally and economically unprepared to care for pregnancy and childbearing/rearing	40 (93.0)	3 (7.0)	0 (0.0)
Overwhelming poverty predisposes adolescents to high risk sexual behaviours	41 (95.3)	2 (4.7)	0 (0.0)
Beliefs, values, and attitudes of healthcare providers have an influence on the quality of PAC services provided	40 (93.0)	3 (7.0)	0 (0.0)

All the experts affirmed that abortion was rampant among adolescents which, according to IPAS, (2003), have been described as a schoolgirl's problem in Nigeria, where 80% of patients admitted to hospitals with unsafe abortion-related complications are adolescent girls. 30 (69.8%) agreed to the fact that family background was a major contributor to abortion, 6 (14.0%) were undecided on this and 7 (16.2%) disagreed.

On whether poverty influences adolescents' early sexual involvement, the majority of the respondents, (40, 93.0%) agreed while just 3 (7.0%) of the respondents disagreed. Most of the respondents, 38 (88.3%) maintained that society influences abortion and PAC, 4 (4.7%) were undecided and 3 (7.0%) disagreed. Easy access to pornography by adolescents, 37 (86.0%) maintained, increases the rate of unwanted pregnancies and the rate of abortions. 6 (14.0%) had a different view on this. All experts agreed on peer group influence on adolescents' sexual involvement and procurement of abortion. A good number of the respondents, 37 (86.0%) think adolescents have limited understanding of their bodies and conception and that this contributes to the high rate of unwanted pregnancies and abortion. 2 (4.7%) were undecided and 4 (9.3%) disagreed with this view. Many of the experts, 31 (72.1%) felt that single parenting is a contributory factor to the high rate of unwanted pregnancies and abortion, 4 (9.3%) were undecided and 8 (18.6%) disagreed. The majority of the experts, 30 (69.8%) suggested the legalization of abortion, 3 (7.0%) were undecided while 10 (23.2%) disapproved of the legalization of abortion. Even those who agreed that abortion should be legalized had some religious reservations about it.

A majority of the experts, 32 (74.4%) were of the view that adolescents should have the right to choose whether or not they want to have abortion, 3 (7.0%) were undecided on this and 8 (18.6%) disagreed. Not legalizing abortion, 30 (69.8%) of the experts interviewed opined, is a contributory factor to the rate of increase in morbidity and mortality, 3 (7.0%) were undecided and 10 (23.2%) disagreed with this assertion. Most of the experts, (40, 93.0%) agreed that adolescents are physically, emotionally and economically unprepared for pregnancy and childbearing/rearing while 3 (7.0%) refused to take a side on this, and 3 (7.0) disagreed. Almost all the experts, (41, 95.3%) blamed adolescents' high risk sexual behaviours on acute poverty whereas the other 2 (4.7%) experts disagreed that this is a factor. Most of the experts, 40 (93.0%) maintained that beliefs, values, and attitudes of healthcare providers have an influence on the quality of PAC services provided, while 3 (7.0%) declined to take a firm stance on this.

6.2.3 Experts 'opinion on challenges and barriers to adolescents' PAC services

Table 6.3: Opinions of Experts on Challenges and Barriers to Adolescents' PAC Services (n=43)

Variables	Agree F (%)	Undecided F (%)	Disagree F (%)
Unfriendly attitudes of health personnel is a major barrier	40 (90.0)	0 (0.0)	3 (7.0)
Financial challenges	38 (88.4)	2 (4.7)	3 (7.0)
Rejection from parents and others	41 (95.3)	2 (4.7)	0 (0.00)
High cost of treatment	32 (74.4)	8 (18.6)	3 (7.0)
Religion is a major barrier to abortion and PAC services	31 (72.1)	2 (4.7)	10 (23.2)
Non-legalization of abortion is a barrier to adolescent post-abortion care	30 (69.8)	3 (7.0)	10 (23.2)
Lack of privacy provided by health care personnel	31 (72.1)	4 (9.3)	8 (18.6)
Long waiting time	32 (74.4)	8 (18.6)	3 (7.0)
Lack of landmarks in the hospitals	30 (69.8)	3 (7.0)	10 (23.2)
Lack of available support facilities to which adolescents can be referred	37 (86.0)	4 (9.3)	2 (4.7)
Social stigma	43 (100.0)	0 (0.0)	0 (0.0)
Lack of sex education at home and school	38 (88.4)	5 (11.6)	0 (0.0)
Psychological challenges	43 (100.0)	0 (0.0)	0 (0.0)
Late presentation to hospitals for care is one of the challenges to adequate PAC	36 (83.7)	7 (16.3)	0 (0.0)
Lack of access to PAC services	36 (83.7)	2 (4.7)	5 (11.6)
Lack of adolescent friendly family planning services	36 (83.7)	2 (4.7)	5 (11.6)
Lack of utilization of contraceptives	32 (74.4)	6 (14.0)	5 (11.6)
Lack of parental support or care	43 (100.0)	0 (0.0)	0 (0.0)
Lack of counsellors	35 (81.3)	2 (4.7)	6 (14.0)
Cultural and religious sensitivities surrounding abortion is a barrier to PAC services	40 (93.0)	0 (0.0)	3 (7.0)

Lack of inclusion in budget, of the cost of adolescents' sexual reproductive health needs	31 (72.1)	10 (23.2)	2 (4.7)
Little knowledge of available services and their location	39 (90.7)	4 (9.3)	0 (0.0)
Shame or embarrassment at needing or wanting services especially if the unwanted pregnancy/abortion follows sexual coercion or abuse	41 (95.3)	0 (0.0)	2 (4.7)

The table 6.3 below revealed the opinions of the experts on the challenges to adolescents' PAC services. The major challenge identified was finance, as asserted by 38 (88.4%) of the experts; 2 (4.7%) of them were undecided and 3 (7.0%) had a contrary view. Many of the experts, 40 (93.0%) identified the unfriendly attitudes of health care providers as a major barrier to PAC, where 7 (3.0%) think otherwise. Rejection from parents and others was identified by 41 (95.3%) of the experts as a barrier to PAC, and 2 (4.7%) of them were undecided on this. High cost of treatment was also noted by 32 (74.4%) of the experts as a challenge to PAC. On this matter, 8 (18.6%) were undecided and 3 (7.0%) disagreed with the majority. Many of the respondents, 31 (72.1%) agreed that religion is a major barrier to abortion and PAC services, but 10 (23.2%) disagreed. While 30 (69.8%) of them were of the view that non-legalization of abortion is a barrier to adolescent PAC, 3 (7.0%) were undecided and 10 (23.2%) had a contrary view. Lack of privacy was declared by 31 (72.1%) of the experts as a barrier to PAC; 4 (9.3%) undecided on this and 8 (18.6%) had an opposing view. A good number of the experts 32 (74.4%) also identified long waiting time as a barrier, where 8 (18.6%) of them were undecided and 3 disagreed that long waiting time was a factor. Yet another barrier identified by 30 (69.8%) of the experts was the lack of landmarks in the hospital. While 3 (7.0%) were undecided on this, 10 (23.2%) maintained that poor signage in the hospital is not a barrier to PAC. On the lack of an available support network to which adolescents can be referred, 37 (86.0%) agreed that this lack was real, while all the experts identified social stigmatization, psychological problems and lack of parental support as barriers the adolescents face in seeking PAC services.

Almost all the experts, (38, 88.4%) maintained that lack of sex education at home and school is a challenge to PAC. On the question of late presentation to hospitals for care, 36 (83.7%) of the experts agreed that this is one of the challenges to adequate PAC and 7 (16.3%) were undecided. A significant number of the experts 36 (83.7%) noted lack of access to PAC services as a barrier to PAC services, while 5 (11.6%) had a contrary opinion. On the lack of adolescent friendly family planning services, 36 (83.7%) agreed that this is a problem, 32 (74.4%) of the experts also mentioned lack of utilization of contraceptives as a barrier to PAC services. Also identified by 35 (81.3%) of the experts was the lack of counsellors while 40 (93.0%) were of the view that cultural

and religious sensitivities surrounding abortion is a barrier to PAC services. The fact that the cost of adolescents' sexual reproductive health needs is not budgeted for is a barrier to proper PAC provision, the majority of respondents 31 (72.1%) insisted. As many as 39 (90.7%) of the experts agreed that inadequate knowledge of available services and their locations is a barrier to PAC, while Shame or embarrassment at needing or wanting services especially if the unwanted pregnancy/abortion follows sexual coercion or abuse was thought by 41 (95.3%) of the experts to be a barrier to PAC.(see table 6.3)



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6.2.4 Possible solution to barriers and challenges to post- abortion care (PAC)

Table 6.4: Possible solutions on Challenges and Barriers to Post-Abortion Care (PAC) n=43

Variables	Agree F (%)	Undecided F (%)	Disagree F (%)
Free PAC services	41 (95.3)	0 (0.0)	2 (4.7)
PAC services should be freely accessible to women seeking them	41 (95.3)	2 (4.7)	0 (0.0)
Legalization of abortion	30 (69.8)	3 (7.0)	10 (23.2)
Provision of adequate information through the media on various reproductive issues of the adolescent	43 (100)	0 (0.00)	0 (0.0)
Provision of sexual and reproductive health education	41 (95.3)	0 (0.0)	2 (4.7)
Provision of adolescent friendly counselling unit/guidance	43 (100)	0 (0.0)	0 (0.0)
Training of health personnel in treatment equalization among patients	41 (95.3)	2 (4.7)	0 (0.0)
Parental support/guidance	41 (95.3)	2 (4.7)	0 (0.0)
Continuing professional development programme	43 (100)	0 (0.0)	0 (0.0)
Introduction of stipends for the students by the government	35 (81.4)	2 (4.7)	6 (14.0)
Scholarship / empowerment opportunities for adolescents	43 (100)	0 (0.0)	0 (0.0)
Equality in treatment irrespective of condition(s)	41 (95.3)	2 (4.7)	0 (0.0)
Follow-up programmes for adolescents with abortion complications	43 (100)	0 (0.0)	0 (0.0)
Provision of funds and resources to equip hospitals to provide adequate PAC for adolescents	40 (93.0)	3 (7.0)	0 (0.0)
Provision of adolescent friendly clinics where adolescents with issues regarding unwanted pregnancy, rape, contraceptives, STIs, etc. can go for advice or information	43 (100)	0 (0.0)	0 (0.0)
Training of qualified health practitioners on emergency post-abortion care	43 (100)	0 (0.0)	0 (0.0)
Government policy should allow midlevel providers (nurses) to provide post-abortion care, including independent use of MVA	41 (95.3)	0 (0.0)	2 (4.7)
Public enlightenment programmes on attitude transformation on abortion and post-abortion care	38 (88.4)	5 (11.6)	0 (0.0)
There should be adequate referral services following post-abortion care	43 (100.0)	0 (0.0)	0 (0.0)

Table above shows suggestions to overcome the identified challenges and barriers to adolescents' PAC by experts. The majority 41 (95.3%) of the experts interviewed were of the view that PAC services should be free and made more accessible to adolescents, and also suggested the provision of adequate information through the media on various reproductive issues of the adolescent. They felt that attention should be given to training health personnel in treatment equalization among patients, and that parental support and guidance needs official attention. This group of experts also maintained that equality in treatment irrespective of the condition for which the patient is being treated, should be encouraged. Government policy that allows midlevel providers (nurses) to offer post-abortion care, including the independent use of MVA, will go a long way in improving PAC services.

30 (69.8%) of the experts agreed that abortion should be legalized. They added that public service programmes on attitude transformation on abortion and post-abortion care are necessary for effective PAC services. Regarding the introduction of state stipends for students, 35 (81.4%) agreed, will help to effectively address the issue of unwanted pregnancy and abortion. As many as 40 (93.0%) of the experts maintained that hospitals should be given funds and resources so that they will be equipped to provide adequate PAC for adolescents. All the experts maintained that there should be media features which can provide the public with information on various reproductive issues affecting adolescents. They also felt that there should be adolescent friendly counselling units, continuing professional development programmes, and scholarships and other empowerment opportunities for adolescents. All these provisions would help to foster the delivery of effective PAC services. Also suggested by all experts was the need to train social workers specifically for adolescent issues, to run follow-up programmes for adolescents with abortion complications, and to provide adolescent friendly clinics where adolescents with issues regarding unwanted pregnancy, rape, contraceptive, STIs can go for advice or information. There was also a need to enhance the training of qualified health practitioners on emergency post-abortion care and to establish adequate referral services following post-abortion care.

6.3 Measures of central tendency from Round 1 and 2 Delphi Scoring

Table 6.5: Opinions of Experts on Abortion and Post-abortion Care (PAC)

Opinions	Round I (n=43)		Round 2(n=37)		Remark
	Agree %	Mean	Agree %	Mean	
Abortion is rampant among adolescents	43 (100)	3.00	37 (100)	1.00	Consensus achieved
Family background is a major contributor to abortion	30 (69.8)	2.53	37 (100)	1.00	Consensus achieved
Poverty influences adolescents' early sexual involvement	40 (93.0)	2.86	34 (91.9)	1.16	Consensus achieved
Society influences abortion and post-abortion care (PAC)	38 (88.3)	2.87	35 94.6	1.05	Consensus achieved
Easy accessibility to pornography by adolescents increases rates of unwanted pregnancy and abortion	37 (86.0)	2.86	34 (91.9)	1.14	Consensus achieved
Peer influence is a factor in adolescents' sexual involvement and procurement of abortion	43 (100)	3.00	43 (100)	1.00	Consensus achieved
Adolescents have limited understanding of their bodies and conception thus increases unwanted pregnancies and abortion	37 (86.0)	2.77	33 (89.2)	1.19	Consensus achieved
Single parenting is a contributory factor to the high rate of unwanted pregnancies and abortion	31 (72.1)	2.16	33 (89.2)	1.22	Consensus achieved
Abortion should be legalized	30 (69.8)	1.91	25 (67.6)	1.46	Consensus not achieved
Adolescents should have the right to choose whether or not they want to have an abortion	32 (74.4)	2.05	29 (78.4)	2.11	Consensus achieved
Not legalizing abortion is a contributory factor to increase in morbidity and mortality	30 (69.8)	2.16	20 (54.1)	1.76	Consensus not achieved
Adolescents are physically, emotionally and economically unprepared for pregnancy and childbearing/rearing	40 (93.0)	2.86	43 (100)	1.00	Consensus achieved
Overwhelming poverty predisposes adolescents to high risk sexual behaviours	41 (95.3)	2.95	33 (89.2)	1.19	Consensus achieved
Beliefs, values, and attitudes of health care providers have an influence on the quality of PAC services provided	40 (93.0)	2.86	43 (100)	1.00	Consensus achieved

Table 6.6: Opinions of Experts on Challenges and Barriers to Adolescents' PAC Services

Variables	Round 1 (n=43)		Round 2 (n=37)		Remark
	Agree F (%)	Mean	Agree F (%)	Mean	
Unfriendly attitudes of health personnel are a major barrier	40 (90.0)	2.86	35 (94.6)	1.05	Consensus achieved
Financial challenges	38 (88.4)	2.81	37 (100)	1.00	Consensus achieved
Rejection from parents and others	41 (95.3)	2.95	37 (100)	1.00	Consensus achieved
High cost of treatment	32 (74.4)	2.51	34 (91.9)	1.14	Consensus achieved
Religion is a major barrier to abortion and PAC services	31 (72.1)	2.49	37 (100)	1.00	Consensus achieved
Non-legalization of abortion is a barrier to adolescent post-abortion care	30 (69.8)	2.33	24 (64.9)	1.54	Consensus not achieved
Lack of privacy provided by health care personnel	31 (72.1)	2.30	26 (70.3)	1.49	Consensus achieved
Lengthy waiting period	32 (74.4)	2.40	31 (83.8)	1.19	Consensus achieved
Lack of landmarks in the hospitals	30 (69.8)	2.44	22 (59.5)	1.59	Consensus not achieved
Lack of available support facilities to which adolescents can be referred	37 (86.0)	2.81	34 (91.9)	1.11	Consensus achieved
Social stigmatization	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Lack of sex education at home and school	38 (88.4)	2.88	34 (91.9)	1.16	Consensus achieved
Psychological challenges	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Late presentation to hospitals for care is one of the challenges to adequate PAC	36 (83.7)	2.84	37 (100)	1.00	Consensus achieved
Lack of access to PAC services	36 (83.7)	2.72	37 (100)	1.00	Consensus achieved
Lack of adolescent friendly family planning services	36 (83.7)	2.72	35 (94.6)	1.08	Consensus achieved
Lack of utilization of contraceptives	32 (74.4)	2.63	33 (89.2)	1.19	Consensus achieved
Lack of parental support or care	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Lack of counsellors	35 (81.3)	2.67	37 (100)	1.00	Consensus achieved
Cultural and religious sensitivities surrounding abortion is a barrier to PAC services	40 (93.0)	2.86	37 (100)	1.00	Consensus achieved

No budgetary provision is made for adolescent's sexual reproductive health needs	31 (72.1)	2.67	32 (86.5)	1.16	Consensus achieved
Little knowledge of available services and their location	39 (90.7)	2.91	37 (100)	1.00	Consensus achieved
Shame or embarrassment at needing or wanting services, especially if the unwanted pregnancy/abortion follows sexual coercion or abuse	41 (95.3)	2.91	37 (100)	1.00	Consensus achieved

Table 6.7: Possible solutions to Barriers and Challenges to Post-Abortion Care (PAC)

Variables	Round I (n=43)		Round 2(n=37)		Remark
	Agree %	Mean	Agree %	Mean	
Free PAC services	41 (95.3)	2.91	37 (100)	1.00	Consensus achieved
PAC services should be freely accessible to women seeking them	41 (95.3)	2.95	37 (100)	1.00	Consensus achieved
Legalization of abortion	30 (69.8)	2.12	24 (64.9)	1.54	Consensus not achieved
Provision of adequate information through the media on various reproductive issues of the adolescent	43 (100.0)	3.00	36 (97.3)	1.03	Consensus achieved
Provision of sexual and reproductive health education	41 (95.3)	2.91	37 (100)	1.00	Consensus achieved
Provision of adolescent friendly counselling unit/guidance	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Training of health personnel in treatment equalization among patients	41 (95.3)	2.95	37 (100)	1.00	Consensus achieved
Parental support/guidance	41 (95.3)	2.95	37 (100)	1.00	Consensus achieved
Continuing professional development programme	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Introduction of stipends for the students by the government	35 (81.4)	2.67	31 (83.8)	1.27	Consensus achieved
Scholarships and other empowerment opportunities for adolescents	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Equality in treatment irrespective of condition(s)	41 (95.3)	2.95	37 (100)	1.00	Consensus achieved
Follow-up programmes for adolescents with abortion complications	43 (100.0)	3.00	37 (100)	1.14	Consensus achieved

Provision of funds and resources to equip hospitals to provide adequate PAC for adolescents	40 (93.0)	2.93	37 (100)	1.00	Consensus achieved
Provision of adolescent friendly clinics where adolescents with issues regarding unwanted pregnancy, rape, contraceptives, STIs, etc. can go for advice or information	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Training of qualified health practitioners on emergency post-abortion care	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved
Government policy should allow midlevel providers (nurses) to provide post-abortion care including independent use of MVA	41 (95.3)	2.91	37 (100)	1.00	Consensus achieved
Public enlightenment programmes on attitude transformation on abortion and post-abortion care	38 (88.4)	2.88	37 (100)	1.00	Consensus achieved
There should be adequate referral services following post-abortion care	43 (100.0)	3.00	37 (100)	1.00	Consensus achieved

6.4 Conclusion

There was a degree of consensus among the expert panellists on challenges and barriers to adolescents' post-abortion care (PAC), as well as the solutions to overcome these. The percentage agreement ranged between 69.8% and 100%, the mean ranged between 1.91 and 3.00. This indicated a convergence of opinion towards agreement for Round 2. However, there was no unilateral agreement related to the issues of family background, lack of landmarks in the hospitals, and legalization of abortion, as challenges and barriers to adolescents' PAC services. This is indicated in Table 6.5.

In Round 2 of the Delphi survey, there was a high degree of consensus among the expert panellists, with the percentage agreement ranging between 70.3% and 100%, while the mean ranged between 1.00 and 2.11. This indicates a convergence of opinion towards agreement, and therefore we can say that consensus was achieved. However, it was suggested by some of the expert that abortion law should be reviewed to accommodate foetal abnormality, rape and incest, together with saving the life of the mother.

CHAPTER SEVEN

POLICY DOCUMENT, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This last chapter of the report presents the development of the policy document, limitation, conclusion and recommendations of the study. The post abortion care document to inform reproductive health policy comprised of the underpinning principles, value and philosophies, broad and specific objectives of the policy document , specific action to be taken, desire outcomes of the specific actions, and performance indicators which were presented in this chapter.

7.2 Post-abortion Care Document to Inform Reproductive Health Policy

The development of this document was informed by the findings of the research study on challenges and barriers adolescents face in an attempt to procure PAC services in Nigerian hospitals. It is expected that hospital authorities and other individuals who bear the responsibility of formulating health policies, particularly those concerned with women's health and more specifically PAC services as relating to adolescents, will find this document useful.

Components

The components of the policy document include the following;

Underpinning principles, values and philosophies

This takes into account the overall health of the adolescent and, specifically, the reproductive health of adolescents

- In all countries, adolescents represent the future of families, communities and nations; as such they benefit from universal human rights that aim to protect and promote freedom and human dignity, which are pre-requisites for health (Pandey, 2007) .

- Reproductive health is a vital component of general health and therefore a prerequisite for social, economic and human development (Haque, Hossain, Rumana-Ahmed, Sultana, Chowdhury, & Akter, 2015). For this reason, all women, including adolescent women, have the right to reproductive health.
- When PAC services are available to adolescents, this will reduce morbidity and mortality resulting from abortion complications. Efficient delivery of these services will go a long way toward saving the lives of adolescents who would have been lost to complications of abortion (Madziyire, Polis, Riley, Sully, Owolabi, & Chipato 2018).

Broad Objective of the Policy Document

The aim of this policy document is to ensure that the challenges and barriers adolescents face while procuring PAC services are eliminated or reduced to the barest minimum so that these adolescents have access to high quality PAC services in all hospitals in Nigeria.

Specific Objectives of the Policy Document

This policy document is intended to improve the quality of PAC services provided by health care facilities, as well as improve access to PAC in Nigeria through:

(a) Establishment of PAC units in all facilities with effective monitoring systems

The government must ensure that PAC units not only exist but are fully functional in all health facilities in Nigeria. A unit head should be appointed and charged with the responsibility of running this unit with the support of the PAC staff.

(b) Training and retraining of PAC staff as well as attitude transformation

Periodic training and retraining of staff on advances in PAC services is inevitable if women seeking PAC services are to be given the quality of care they deserve. To this end, hospital authorities must ensure this continuous training is put in place and that it is sustained for all staff. Middle-level providers should be allowed to put the acquired skills into practice for effective PAC service provision.

(c) Institution of free PAC services for adolescents

There is the need for the government to consider free treatment for adolescents with abortion complications who are seeking PAC services. The justification for this is that most adolescent girls, in an attempt to conceal their sexual activities, hide their condition from their parents, who are better placed than they are to pay for medical services. They also present very late at the facility when their health has already deteriorated, thus requiring immediate intervention. If treatment is free or almost free, this will enable them to get easy access to treatment, even when they do not have the funds for such services.

(d) Review of abortion legislation in Nigeria to include cases of incest and rape

The abortion law in Nigeria permits abortion only when the life of the mother is at risk. The abortion law should be opened for public comment and revised in order that stigmatization is reduced and access to PAC services is increased.

(e) Creating a youth friendly hospital environment for PAC services

PAC staff should create an enabling environment where these youths receive the needed PAC services without discrimination and judgment from care givers. It is equally important to take cognizance of the need for privacy of these adolescents and the fact that they should be accorded the necessary human respect in the course of receiving PAC.

Strategies to achieve the objectives

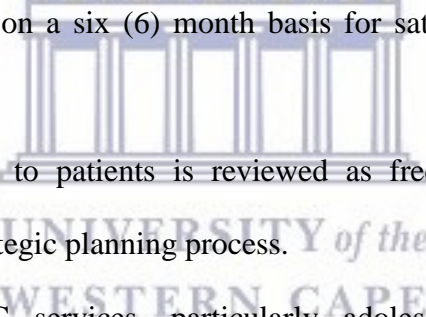
To achieve the above objectives, it is necessary to consider these strategies below;

1. All health care facilities in Nigeria should have a separate unit for the reproductive health of women. A sub-unit of reproductive health should be created for women and particularly adolescents with abortion complications, who are seeking PAC services.
2. Management should identify those health care providers directly involved with the delivery of PAC services, and ensure they have the needed knowledge and skills for PAC. The PAC staff should be required to update their knowledge and skills in accordance with the advances in PAC.
3. There should be professional development opportunities such as workshops and seminars on PAC for the personnel of the various health care facilities.
4. A culture of continuous improvement on the available PAC services should be fostered.
5. All parties should ensure patient satisfaction in the course of rendering PAC services to women and particularly adolescents while eschewing discrimination and judgment of the patient in question.
6. Abortion laws should be opened for public comment and reviewed in order to ensure increase access to PAC services.
7. Implementation of best practice consultation and planning processes should be assured.
8. Government should authorize, through hospital management, free PAC services to adolescents with abortion complications.

9. Evaluation of care received should be done by PAC patients after each service
10. The abortion law should accommodate women, particularly adolescents, whose pregnancy is a result of rape, incest or similar circumstances, to terminate their pregnancy if they choose to do so.
11. PAC staff should perform their duty free of judgment and discrimination against adolescents receiving PAC services. They must treat each patient with respect and dignity irrespective of age and diagnosis.

Specific actions to be taken

The document recommends the following actions:

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- PAC staff are surveyed on a six (6) month basis for satisfaction with programmes and services.
 - The quality of services to patients is reviewed as frequently as possible, as this is necessary part of the strategic planning process.
 - Patients receiving PAC services, particularly adolescents, should be interviewed periodically to examine their views and perceptions about the quality of PAC care they receive. Such feedback should be considered by hospital authorities together with PAC staff with the aim of addressing the issues raised by the patients.
 - There must be provision of the necessary equipment and supplies for PAC services to meet the needs of patients requiring such services.
 - Clinical guidelines for managing complications from unsafe abortions should be available in all Nigerian hospitals and the content of these guidelines should be communicated effectively to staff and update it when needed.

- Ensure that providers are trained and equipped to use the recommended methods of misoprostol and vacuum aspiration.
- Ensure professionals receive sensitivity training in nonjudgmental treatment and are informed of their legal, professional and ethical duty to provide post abortion care without prejudice.

Desired outcomes of specific actions

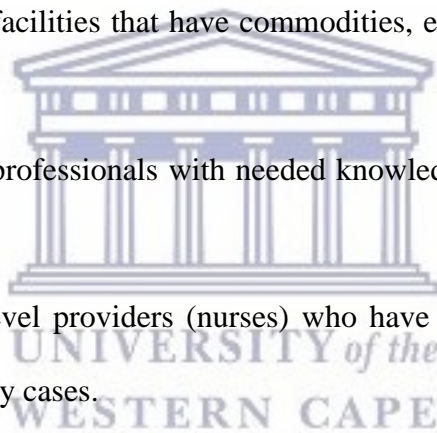
The desired outcomes of this policy document are as follows:

- Improved access to PAC services in all health care facilities in the absence of the identified barriers and challenges.
- Increase contraceptive usage among adolescents following PAC
- An observable increase in patient satisfaction with PAC services in all health care facilities across the Nigeria.
- A demonstrably positive attitude of PAC staff towards patients, particularly adolescents receiving PAC services.
- The availability of needed equipment and supplies for PAC staff to provide care to women with abortion complications.
- Reduced morbidity and mortality from abortion and abortion complications, particularly among adolescents.

Performance indicators

The success of this policy document may be measured in terms of:

- Percentage of adolescents with abortion complications seeking PAC services.
- Of those receiving PAC, percentage of adolescent patients who received family planning counselling prior to leaving the facility.
- Percentage of adolescent PAC patients who received family planning methods prior to leaving the facility.
- Proportion of adolescent patients' satisfaction with PAC services.
- Facility-based case fatality rate for post abortion complications
- Number of health care facilities per 100,000 population with functioning comprehensive PAC services
- Number of health care facilities that have commodities, equipment and transportation for PAC services
- Number of health care professionals with needed knowledge and skills for PAC services.
PAC
- Percentage of middle-level providers (nurses) who have perform basic PAC procedures particularly in emergency cases.



A review program

This policy should be reviewed annually. The review process should include an examination of the performance indicators, consultation with members of the health care team, particularly those concerned with PAC, and a discussion forum involving the management committee and risk management professionals.

7.3 Validating the newly developed policy document on PAC Programme by Experts

The newly developed policy document on post abortion care aimed to inform reproductive health policy presented to Reproductive Health experts was validated using these criteria, namely its representation of reality, accuracy, appropriateness and applicability. The policy document was named as “*New Post Abortion Care Policy Document (PAC policy document)*” because the study participants viewed the document as Reproductive Health-related concepts. This art of labelling of developed policy is in consonance with the guideline provided by McKenna & Slevin (2011), which stated that labelling of developed model (policy document) should agree with the purpose of the model (policy document). Thus this form the basis on which the researcher labelled this new policy document as “*PAC Policy document*”. Empirical knowledge can be authenticated through validation (Chinn & Kramer, 2015).

In order to validate the new policy document; copies of the document and its detailed description was sent to Reproductive Health experts with relevant knowledge of women’s health and adolescents’ health. Therefore, fifteen (15) experts studied and read the contents and the description of the policy documents. Two intellectual scholars in the fields of health profession and academia were reviewed and critiqued the policy documents. Their counsels and recommendations added value to the document.

Thus, the experts tested whether the PAC policy document was adequate, accurate and represented reality for it to be assumed effective in achieving the goal if applied in reproductive and midwifery practice. This is similar to validation of empirical knowledge by noting and sharing convictions about the applicability of the document to the discipline (Jacobs-Kramer &

Chinn, 1988). The composition of the experts who participated in the validation process of the policy document spread across health institutions in Nigeria.

Table 7.1: The rating scores of the PAC policy document by the experts

Rating	Frequency	Percent
100%	4	26.7
70%	1	6.7
75%	3	20.0
80%	6	40.0
90%	1	6.7
Total	15	100.0

The four criteria rated by the experts are: its representation of reality, accuracy, appropriateness and applicability using a 5-point Likert scale. On the Likert scale, the obtainable score was 100%. The maximum rating score was 100%, while the minimum rating score was 70%. Table 7.1 presents the rating of the new post abortion document. Nearly all the experts described the PAC policy document as either “quite” or “very much” representing reality, accurate, appropriate and applicable (Table 7.2). However, the minimum 70% confirmation/validation of the new PAC policy document is unanimously considered as ‘good enough’ by the experts, scholars (research supervisors) and the researcher. All the experts unanimously adopted the label ‘*New PAC policy document*’ for the newly developed document.

Table 7.2: Rating of the new PAC policy document across the four criteria

Rating criteria	Not at all	A little bit	Moderately	Quite	Very much
Representation of reality	-	-	-	40.0	60.0
Accuracy	-	-	-	73.3	26.7
Appropriateness	-	-	-	40.0	60.0
Applicability	-	-	6.7	53.3	40.0

7.4 Limitations

There are a number of limitations in the study. The lack of willingness of the adolescents PAC patients to be interviewed, partly as a result of shame and stigma associated with abortion, as well as the restrictive abortion laws in Nigeria.. However, this problem was relatively overcome by explaining fully the purpose of the study to the respondents, as well as assuring and ensuring high level confidentiality and anonymity regarding information given.

The researcher could not access the adolescents with abortion complications, at the same time. Most of the time, only one or two could be seen and interviewed at the same time. In order to have access to adequate numbers of adolescents to interview, the researcher left her contact (telephone number) and made regular calls to the ward manager prior to each visit. This lengthened the time stipulated for this research study.

The study was restricted to the healthcare facilities in Edo State and therefore may not be generalized or transferred to other sites and settings. Despite these limitations, the findings of this study can be used to inform policy and practice.

7.5 Conclusion

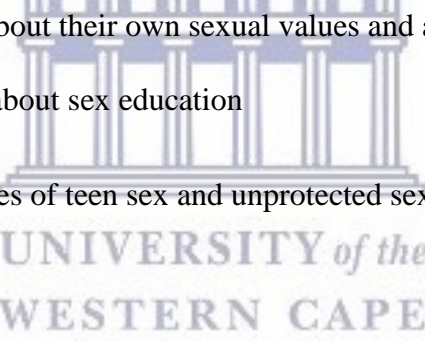
Abortion complication is on the increase among adolescents in Nigeria despite the restrictive laws on abortion. These complications stem from the fact that adolescents, in an attempt to conceal their activities, find backdoor solutions with those unqualified to help them; this often compounds their problems, and hence the need for PAC. The PAC services however, are not effective in meeting the needs of these adolescents, who can barely pay for the services. Poor resources in the facilities, attitudes of PAC providers, lack of support from the community as well as stigmatization from the society and restrictive laws have also compounded the problem.

Counselling and sex education to these adolescents, and a friendlier hospital environment by way of change of attitude from the care givers, can significantly improve PAC services in Nigeria. Legalization, improved access to education and youth empowerment are equally significant in improving PAC care.

7.6 Recommendations

The following recommendations are made for adolescents and families, service provider, policy makers and government and research.

7.6.1 Adolescents and Families

- 
1. Parents should be clear about their own sexual values and attitudes and talk with their children early and often about sex education
 2. The possible consequences of teen sex and unprotected sex should be emphasize for the adolescents.
 3. Parent should build a trusting relationship with the adolescents and encourage them to come to them when there is an issue and help adolescents to feel involved and cared for in the discussion.
 4. Supervision and monitoring of adolescents activities, and helping them learn to use their free time in constructive ways

7.6.2 Service Providers

1. Adolescents are more likely than older adults to delay seeking abortion and treatment for abortion complications should they occur. As a result, by the time they present at the facility

they already have medical complications. Because of this potential for delay and its attendant complications, adolescents presenting with abortion complications should be considered as an emergency until proven otherwise (Singh, et.al, 2018; Guttmacher Institute, 2018). PAC services therefore should be available at as many health care facilities as possible across the country. Basic PAC services can be provided at all levels of health care systems and should be available whenever a health care facility is opened and an appropriate provider is available. Training of more providers may be necessary to make PAC services available wherever they are needed. The training and certification of mid-level abortion service providers such as midwives has been identified as a critical step toward making high quality abortion services accessible to all women in other sub-Saharan countries such as Nigeria. This is the reason why a drastic change in hospital policy is necessary, one which allows registered midwives to use MVA in the management of abortion complications.

2. Both clients and providers cited the need for more respectful, more humane and less judgmental treatment of adolescent PAC clients. Training of providers on how to understand, counsel and work more effectively with adolescents is necessary. Values clarification and attitude transformation workshop attendance by health care providers needs to be encouraged and strengthened.
3. Abortion can be a complicated and difficult physical and emotional experience for any woman, regardless of whether her abortion was spontaneous or induced. Recovery areas for women who have been treated for complications from abortion should provide privacy and these women should be clearly separated from other areas of the maternity ward.

4. Providers and clients alike are aware of the implications of an unhygienic clinic environment and crowded conditions. Creative use of space and resources is required to avoid having hospitalized clients share beds. Training in infection control is also needed.

Women must have access to information in order to make sound and informed decisions concerning their health and lives. Health care providers who are highly educated in their field and have ongoing access to health information need to share this knowledge and efficiently guide women to other sources of information about the topics they seek to understand, including pregnancy, abortion risks, uterine evacuation procedures, family planning options and future fertility. Post procedure complications and a thorough discussion of potential complications, as well as how to address them, is an integral component of PAC. In addition, information about prevention of HIV/AIDS and other STIs is crucial to discuss with every client to assure provider interaction. The clients should be invited and encouraged to ask questions about their health. Even when they do not ask such questions, pertinent information should be provided voluntarily as clients (of any age) are not necessarily aware that there is always more to learn about their health.

7.6.3 Recommendations for Policy-makers/Government

1. The major challenge to abortion care was observed to be finance. The adolescents thought the care givers were unkind by insisting they pay before being attended to. The care givers on the other hand maintained that there is little or nothing they can do for these adolescents if the necessary financial resources are unavailable to sustain the course of treatment. To curb the suffering of adolescents requiring PAC services, the government and policy makers should make treatment for adolescents with complications of abortion

free or reduce charges drastically so as to enable access to these services easily, thus reducing morbidity and mortality resulting from abortion complications.

2. It has been shown in studies that restrictive abortion laws have not reduced the rate of abortion and abortion complications (Singh, et.al, 2018; Guttmacher Institute, 2018). However, abortion laws should be opened for public comment and revised in order that stigmatization is reduced and access to PAC services is increased.
3. There is a need for policy makers, government and non-governmental organizations to develop and strengthen support programmes for adolescent PAC.
4. Lack of access to education as well as unemployment was noted as being responsible for adolescents' involvement in reckless sexual activities that expose them to unwanted pregnancies and abortion. The government should provide free education or provide scholarship schemes to students as well as skills acquisition, which will get these adolescents more engaged and focused. This will reduce the rate of unwanted pregnancies and abortions as it will leave less time for these adolescents to involve themselves in sexual acts that cause unwanted pregnancy.

7.6.4 Further Research Studies

1. Research in the field of abortions and post abortion care presents unique conceptual and methodological challenges. Unlike most other reproductive health matters, abortion research has strong legal and moral implications which make identifying and locating the study population particularly challenging. For this very reason, much of the available data comes from the study of those admitted to a hospital for the treatment of complications. Unfortunately, even the best designed hospital (are not easily generalizable. Innovative

and non-traditional approaches to collecting community-level data, especially those that emphasize the use of mixed methods, need to be developed.

2. The implementation of policy document to eliminate or reduce to the challenges and barriers to adolescents' PAC services is a vital step in addressing the high rate of maternal morbidity and mortality in the Nigeria and other parts of the world. Well-designed evaluation studies should be conducted to modify the document in order to improve implementation success.
3. Information, education, and communication (IEC) efforts should target the entire community including men and the various lay practitioners, chemists, and providers of other types of medical care since throughout the region they play a crucial role in determining the abortion pathway for women especially adolescents. Moreover, future research on policy development process should involve parents and significant others of the adolescents with abortion complications. This will help to build a dialogue and present better understanding of the phenomenon.

7.7 Summary of Chapter

In this final chapter, policy document to eliminate or reduce to the barest minimum the challenges and barriers to adolescents' PAC was developed; which reflected on the purpose of the research studies being achieved. Limitations of the study were mentioned. Recommendations were made for adolescents and families, services providers, policy makers and further research studies

7.8 Dissemination of Results

The results of this study will be disseminated to the participants in the study through presentations and seminars. The research report will be available in the university library and the results will be reported as publications in accredited journals.



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Appendix I :Ethics clearance – Senate Research Committee, UWC



UNIVERSITY of the
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OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

15 April 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms OA Onasoga (School of Nursing)

Research Project: Challenges and barriers to adolescent post abortion care services: Implication for reproductive health policy in Nigeria.

Registration no: 14/3/13

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Patricia Josias'.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
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to action through knowledge

Appendix II: Ethics Approval : UBTH Ethics and Research Committee



UNIVERSITY OF BENIN TEACHING HOSPITAL
P.M.B. 1111 BENIN CITY NIGERIA

Telephone: 052-600418
Telegram: UNITECHOS, BENIN
Telex: 41120 NG
Website: ubth.org

CHAIRMAN:

GEN. A.B. MAMMAN
Mni, OFR, fss, pfc

CHIEF MEDICAL DIRECTOR:

PROF. M.O. IBADIN
MBBS (Benin), FMCP, (Paed) M.S. (IMMUNOLOGY & IMMUNOCHEM)
E-mail: mikobadin@yahoo.com; mikobadin@ubth.org

**AG. CHAIRMAN, MEDICAL
ADVISORY COMMITTEE:**

PROF. O.N. OBUEKWE
BDS, (Benin), FWACS

**AG. DIRECTOR OF
ADMINISTRATION:**

MRS. G.A. IYAYI
B.SC, M.SC, M.PHP

ETHICS AND RESEARCH COMMITTEE CLEARANCE CERTIFICATE

PROTOCOL NUMBER: ADM/E 22/A/VOL. VII/1108

PROJECT TITLE: "CHALLENGES AND BARRIERS TO ADOLESCENT POST ABORTION CARE
SERVICES: IMPLICATION FOR REPRODUCTIVE HEALTH POLICY IN NIGERA".

PRINCIPAL INVESTIGATOR(S) OLAYINKA A. ONASOGA

DEPARTMENT/INSTITUTION: SCHOOL OF NURSING, FACULTY OF COMMUNITY AND HEALTH
SCIENCES, UNIVERSITY OF THE WESTERN CAPE, SOUTH AFRICA

DATE CONSIDERED OCTOBER 23rd, 2014
DECISION OF THE COMMITTEE: APPROVED
REMARK:

CHAIRMAN: PROF. A.N. ONUNU

SIGNATURE & DATE



SUPERVISOR(S): PROF. OLUYINKA ADEJUMO
DECLARATION BY INVESTIGATOR(S):

PROTOCOL NUMBER (please quote in all enquiries)
To be completed in four and three copies returned to the secretary, Ethics and Research committee, Clinical services and
Training Division, University of Benin Teaching Hospital Benin City.

I/We fully understand the conditions under which I am/we are authorized to conduct the above mentioned research
and I/We undertake to resubmit the protocol to the Ethics and Research Committee.

Signature.....

Date.....

Appendix III : Ethics Approval – State Ethical Clearance Committee Edo State

Telegrams: PERM HEALTH

Telephone: 200030



EDO STATE

MINISTRY OF HEALTH

**P.M.B. 1103,
BENIN CITY**

EDO STATE OF NIGERIA

Our Ref: HA.739/30

Your Ref:

Date: 16th October, 2014


**Olayinka Onasoga
Dept. of Nursing Science,
School of Basic Medical Sciences,
University of Benin
Benin City.**

**RE: APPLICATION FOR ETHICAL APPROVAL TO CARRY OUT
RESEARCH ON “CHALLENGES AND BARRIERS TO
ADOLESCENT POST ABORTION CARE SERVICES:
IMPLICATION FOR REPRODUCTIVE HEALTH POLICY IN
NIGERIA.**

I am directed to acknowledge the receipt of your request on the above stated matter. Consequent upon the review of your proposal and recommendations by the State Ethical Clearance Committee, you are hereby given approval by the Honourable Commissioner to conduct the research on **“CHALLENGES AND BARRIERS TO ADOLESCENT POST ABORTION CARE SERVICES: IMPLICATION FOR REPRODUCTIVE HEALTH POLICY IN NIGERIA.**

You are to ensure confidentiality of the respondents and make available to the library of the Ministry of Health, a copy of your research findings.

Accept the assurances of the highest esteem of the Honourable Commissioner.


Dr. (Mrs.) H.I. Eboreime
(Director Medical Services)
for: Honourable Commissioner.

**Appendix IV : Permission to conduct the study in St. Philomena Catholic Hospital,
Benin City, Edo State**



ST. PHILOMENA CATHOLIC HOSPITAL

23, Dawson Road, P. O. Box 2434, Benin City, Nigeria.

18th Sept. 2014

Date: _____

Our Ref SRECC/09/2014-2

Research Ethics/Collaboration Committee (RECC)
ST. Philomena Catholic Hospital (SPCH)
23, Dawson Road
Benin City.

Ms. O.A. Onasoga
Dept of Nursing Science,
School of Basic Medical Sciences,
Niger Delta University,
Amasoma, Bayelsa State
Nigeria.

Re: Request For Permission to Carry Out Research on "The Challenges and Barriers to Adolescent Post-abortion Care Services: Implication For Reproductive Health Policy in Nigeria".


The above request refers.

Your application has been duly considered.

It is hereby approved.

Please, adhere strictly to the research guidelines/protocols.

Yours faithfully,

 18/09/2014

Dr. F.O. Oseji.
Secretary: Research Ethics/Collaboration Committee.
(0805-829-8876)

Cc: Very Rev. Fr. Dr. Michael Oyanoafoh (Hospital Administrator)
Dr. S. Igbarumah



Appendix V: Letter from the Co-coder

Private Bag X17, Bellville, 7535
South Africa

Tel : 0848564343

Email : 3302415@myuwc.ac.za

30th of August, 2015.

To whom it may concern:

This letter serve as a confirmation that i was requested by Mrs Olayinka A. Onasoga to act as co-coder and that i co-coded data collected in the study "Challenges and barriers to Adolescent post abortion care services: Implications for reproductive health policy in Nigeria".

Yours Sincerely

Ms Arowoiya Ayorinde (PHD Candidate)

Tel: 0848564343

A.I.



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Appendix VI: Participant information sheet



UNIVERSITY OF THE WESTERN CAPE
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Tel: +27 21-9593024, Fax: 27 21-9592679
E-mail: yinka_onasoga@yahoo.com

Project Title: Challenges and Barriers to Adolescents' Post-abortion Care Services: Implications for Reproductive Health Policy in Nigeria

What is this study about?

This is a research project being conducted by **Olayinka A. Onasoga** a PhD student of the School of Nursing, Faculty of Community and Health sciences, University of the Western Cape, South Africa. We are inviting you to participate in this research project because you will be able to share your view on challenges and barriers to adolescents' post-abortion care services in Nigeria. The main purpose of the research study is to explore your experiences and knowledge on challenges and barriers to post-abortion care services and suggest the way forward. The information that would be gathered will be used to develop policy document capable of guiding institutional and government policies on adolescent post-abortion care and reproductive health. The broad aim is to bring down to a bearable minimum the high morbidity and mortality rate due to unsafe abortion among adolescent

What will I be asked to do if I agree to participate?

You will be asked to respond to question items in the questionnaire and/or participate in an interactive group discussion, which will involve 6 to 10 people in a group. The filling of the questionnaire will last about 10 to 15 minutes, while discussion session will last 20 to 30 minutes. The questionnaire is to explore baseline information on post-abortion care services from health care providers generally, while the focus group discussion is to identify challenges and barriers to adolescent post-abortion care services and way forward from adolescents, health care providers and stakeholders' perspectives

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, your name and name of the facility you are going to talk about will not be required. Codes will be used instead of name on any of the documents during data collection and participants will be interviewed in a quiet place within the hospital to ensure privacy.

This research project involves making audiotapes/videotapes/photographs of you, if you are participating in FGDs. The purpose of these recording media is to help the researcher to remember all useful information that may be lost, if only writing which may be very slow sometimes is used for documentation. All tapes and instruments used during the study were kept under lock and key in a cabinet in the office, to which the researcher and her supervisor will have sole access for a period of five years. All will be destroyed by burning after five years.

Audiotapes and videotapes will not be played for any other person apart from the researcher who will use it for transcription and reporting.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning neglect or potential harm to you or others

What are the risks of this research?

There may be some psychological or emotional risks or uncomfortable feeling such as fear, guilt, or embarrassment from answering some personal questions during participation in this research study. However, in case of any sign of distress during the interview, it will be discontinued and rescheduled if necessary. Also, if you do not feel comfortable in answering any of the questions, you will not be forced to respond to such questions. The services of clinical psychologist will be made available to participants who may require an intervention due to an emotional episode during the study.

What are the benefits of this research?

There are no direct benefits to participants. However, it is hoped that your participation will help researcher learn more about challenges and barriers to adolescents' post-abortion care services in Nigeria. We hope that, in the future, other people might benefit from this study through improved understanding of adolescents' perspective on challenges and barriers to post-abortion care services in Nigeria in order to inform policy to improve adolescents PAC services. The research will be relevant for planning intervention measures by health care provider and other stakeholders who implement, monitor and evaluate adolescents' post-abortion care programmes. It will also be of immense value to policy makers in government on socio political and economic matters on adolescent reproductive health programme

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

If a participant feels the need for counselling or care, it will be the researcher's responsibility to make an appointment with a relevant counsellor for the participant.

What if I have questions?

This research is being conducted by **Olayinka A. Onasoga**, a Doctoral student of the School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact:

Olayinka A. Onasoga

Faculty of Nursing, Niger Delta University,
Wilberforce Island, Bayelsa State, Nigeria
+2348064967578 Or +2348055216895
yinka_onasoga@yahoo.com or 3176779@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Prof. K. Jooste

University of the Western Cape

Private Bag X17

Bellville 7535

Telephone: **021-959 2274**

E-mail: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: **Prof. J. Frantz**

University of the Western Cape

Private Bag X17

Bellville 7535

Telephone: **021-959 2631/2746**

Fax: +27 (0) 21 959 2755

E-mail: jfrantz@uwc.ac.za



This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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Appendix VII: Participant consent form



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9593024, Fax: 27 21-9592679
E-mail: yinka_onasoga@yahoo.com

CONSENT FORM

Title of Research Project: Challenges and Barriers to Adolescents' Post-abortion Care Services: Implications for Reproductive Health Policy in Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....
Participant's signature.....
Witness.....
Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

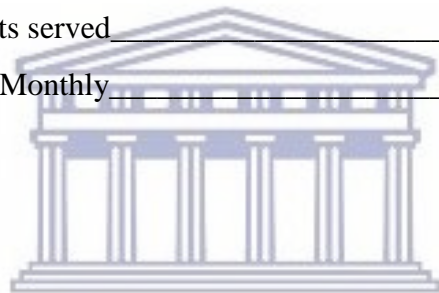
Researcher: Olayinka A. Onasoga.
University of the Western Cape
Private Bag X17, Bellville 7535
Cell: +2348064067578
Fax: (021) 959- 2679
Email: yinka_onasoga@yahoo.com or 3176779@myuwc.ac.za

Appendix VIII: Checklist on general background information of the facility

This section is designed to provide general information about the facility, its size and location, as well as details of the certification process.

1. Serial no _____
2. Date of Visit: _____
3. Name of Facility: _____

4. Type of Facility: Tertiary _____ Secondary _____
5. Service Delivery Statistics
 - Total Admission to Ob/Gyn: _____
 - Number of Cases with Abortion _____
 - No. of adolescent PAC patients served _____
 - Average PAC Clients Served Monthly _____



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Appendix IX: QUESTIONNAIRE

Dear Respondent,

I am a PhD student of the School of Nursing, Faculty of Community and Health sciences, University of the Western Cape, South Africa. I am conducting an academic research study on the topic: **challenges and barriers to adolescents' post-abortion care services: implications for reproductive health policy in Nigeria.**

Kindly complete it by ticking (✓) the options that best express your opinion honestly or fill the appropriate answers. All information will be used purely for the research and treated with utmost confidentiality.

Thanks for your co-operation.

SECTION A: Availability and range of Services provided

- Field of study _____
- Rank _____

S/N	ITEMS	YES	NO
1.	Does the facility provide post-abortion care 24 hours a day?		
2.	Are PAC services free in your facility		
3.	Type of Uterine Evacuation for PAC <ul style="list-style-type: none"> • Manual Vacuum Aspiration (MVA) • Dilation and Curettage (D&C) • Electrical Vacuum Aspiration (EVA) • Misoprostol for PAC 		
4.	Is there an adequate area (clean, private, and equipped with the basic elements needed to ensure the patient's safety) available to perform uterine evacuation?		
5.	Is there separate operating room equipped to provide timely emergency care to abortion patients with complications?		
6.	Are supplies, medications and equipment necessary to ensure safety and efficacy of post-abortion services readily available?		
7.	Are staffing patterns adequate to meet client needs		
8.	Does the hospital officially offer family planning services in the immediate post-abortion period as part of its comprehensive PAC services?		
9.	Are contraceptive services available?		
10.	What types of contraceptive services are provided? <ul style="list-style-type: none"> • Counselling • Provision of contraceptive 		

11.	<p>If the facility offers contraceptive counselling but does not distribute contraceptive methods, specify where clients are referred for provision of contraceptives:</p> <p>a) site within facility b) site outside facility c) agreed contraceptive referral arrangement</p>		
12.	<p>What types of contraceptive methods are available</p> <ul style="list-style-type: none"> • Oral Contraceptive Pills • IUCD • Condom • Injectable • Implants • Emergency Contraceptive Pills (ECP) • Others (specify) 		
13.	<p>Most Popular Method</p> <ul style="list-style-type: none"> • Oral Contraceptive Pills • IUCD • Condom • Injectable • Implants • Emergency Contraceptive Pills (ECP) 		
14.	<p>Other Services for PAC clients only</p> <ul style="list-style-type: none"> • Treatment/counselling on gender-based violence • Sexually Transmitted Infections (STI) and risk assessment counselling • STI testing and treatment • Voluntary Counselling and Testing/HIV test only • Antiretroviral therapy (ART) • Referral for other services • Others (specify) 		
15.	<p>What are the major obstacles to providing PAC services to adolescents?</p> <ul style="list-style-type: none"> • Staff not adequately trained in contraceptive services • Staff do not have time to counsel abortion clients • Contraceptive methods are not available at all times for abortion clients • problems with storage of family planning inputs • Lack of private space for counselling • Clients not interested in discussing contraceptive services • Lack of commitment by administration, head of department, nurses • Other, specify: 		

SECTION B: Technical Skill and Training Level of Staff Involved in PAC

S/N	ITEMS	YES	NO
16.	Is there a coordinator/supervisor in charge of post-abortion care services?		
17.	What kinds of staff provide post-abortion services? a) Doctor b) Midwife c) Others, specify:		
18.	Have you been trained on post-abortion services?		
19.	Is there any staff trained on post-abortion services?		
20.	What kinds of staff received training on post-abortion services? a) Doctor b) Midwife c) Others, specify:		
21.	Does the hospital have providers trained in Manual Vacuum Aspiration (MVA)?		
22.	What kinds of staff provide Manual Vacuum Aspiration (MVA)? a) Doctor only b) Midwife c) Midwife and Doctor d) Others, specify:		
23.	Have you ever been trained Manual Vacuum Aspiration (MVA)?		
24.	What kinds of staff counsel post-abortion clients for contraceptives? a) Doctor b) Midwife c) Others, specify:		
25.	Does the hospital have providers that need training in family planning?		
26.	Does the hospital have competent providers to perform D&C at any time of the day		
27.	What are the main training needs in regards to PAC? • D&C • MVA • PAC Family Planning Counselling • Others, specify:		
28.	Do you know about other reproductive health services to which adolescent patients can be referred refer		

29. Which one do you know-----

Appendix X: Parent consent form



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E-mail: yinka_onasoga@yahoo.com

PARENTAL PERMISSION FORM

Instructions: Parents/legal guardians please read this Parent Consent Form below carefully. If you wish to give consent, please complete and sign the Parent Consent Form

Title: **Challenges and Barriers to Adolescents' Post-abortion Care Programme: Implications for Reproductive Health Policy in Nigeria**

The study has been described to me in language that I understand and I freely and voluntarily agree to allow my child to participate. My questions about the study have been answered. I understand that her identity will not be disclosed and that I may withdraw her from the study without giving a reason at any time and this will not negatively affect me or her in any way.

Participant's name.....

Parent/ Guardian of Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

Researcher: Olayinka A. Onasoga.
University of the Western Cape
Private Bag X17, Bellville 7535
Cell: +23408064067578
Fax: (021) 959- 2679
Email: yinka_onasoga@yahoo.com or 3176779@myuwc.ac.za

Appendix XI: Semi-structured interview confidentiality binding form



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9593024, Fax: 27 21-9592679
E-mail: yinka_onasoga@yahoo.com

Title of Research Project: Challenges and Barriers to Adolescents' Post-abortion Care Programme: Implications for Reproductive Health Policy in Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name.....
Participant's signature.....
Witness's name.....
Witness's signature.....
Date.....



Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

Researcher: Olayinka A. Onasoga.
University of the Western Cape
Private Bag X17, Bellville 7535
Cell: +23408064067578
Fax: (021) 959- 2679
Email: yinka_onasoga@yahoo.com or 3176779@myuwc.ac.za

Appendix XII: Interview Guide for Adolescents

- How old are you?
- What do you do for a living?
- Can you describe your experience about this abortion you had ?
- How do you feel about the post-abortion care you received in this hospital?
- Can you describe your experience for me during your stay in the hospital?
- Did you have any challenges or barriers to the care provided for you?
- What are these challenges and barriers you faced in obtaining post-abortion care ?
- What was your expectation when you were seeking for care
- What will you like the hospital or the government to do for adolescent like you in terms of post-abortion care

Note: Always Probe with: Tell me more about that, what do you mean? , explain more, describe, elaborate, how, why etc

Thank you for your time



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Appendix XIII : Interview Guide for Health care providers

- Introduction: Professional, current position etc.
- How long have you work in maternity unit (obstetrics and gynaecology unit)
- How many cases of abortion complications have you manage
- How many were adolescents
- What was the outcome of the cases
- Can you describe your experiences in caring for these adolescents with post-abortion complication? What is it like to care for these adolescents with abortion complications in your unit
- What are the challenges and barriers faced by these adolescents in obtaining post-abortion care?
- How can these barriers and challenges be removed or how can we overcome them
- What are the existing support services that your institution have in place to support these adolescents after the post-abortion care
- What are your opinions about abortion legalization
- Do you have any suggestion or advice for the provider or the patient or government

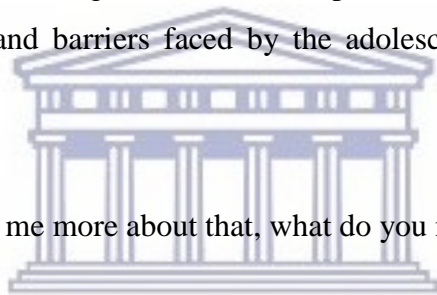
Note: Always Probe with: Tell me more about that, what do you mean? , explain more, describe, elaborate, how, why etc

Thank you for your time

Appendix XIV : Interview Guide for stakeholders

- Introduction: occupation.
- In what capacity have you work with the adolescents
- How long have you being working with them
- What are the issues that you are aware of that adolescent have with abortion and post-abortion care?
- What are the challenges and barriers that you are aware of that adolescent faced when procuring abortion or post-abortion care?
- What are the strategies/ways that you use in assisting adolescents with this problem to cope?
- What are the existing support services that you are aware of, that are available for these adolescents?
- What would you suggest that the government or hospital or the society do or put in place to overcome the challenges and barriers faced by the adolescents in obtaining post-abortion care?

Note: Always Probe with: Tell me more about that, what do you mean? , explain more, describe, elaborate, how, why etc



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Thank you for your time

Appendix XV : Questionnaire for Expert Panellist

Dear Sir/Madam,

Re: Request for Participation to a Study /Letter of Consent

You have been invited to participate in a Delphi study entitled: Challenges and Barriers to Adolescents' Post Abortion Care services: Implications for Reproductive Health Policy in Nigeria. The study is being undertaken in fulfillment of a doctorate degree in Nursing at University of the Western Cape, South Africa. You are identified as an important stakeholder who is able to provide valuable information on the basis of your experience and expertise on this issue. Your participation in this study and input will be highly appreciated and valued towards addressing the challenges and barriers to adolescent post abortion care services in order to inform reproductive health policy in Nigeria. This study may take about two to three rounds or more; therefore, I solicit for your cooperation. Your participation in the study is voluntary. You may withdraw from the study at any point without any retribution. If you decide to participate, please complete the attached questionnaire and return it to me via the e-mail address. Return of the completed questionnaire will be considered as consent to participate in the study. During participation, your input, as a part of an important contribution will be incorporated with the contribution of other stakeholders and will be send back to provide further input on the issues under discussion.

Completion of the questionnaire should take approximately 40 minutes. I would appreciate your response within the next two weeks and I undertake to give you a feedback in three weeks following that.

Throughout the process, your participation is voluntary and anonymous. It is therefore very important that you feel comfortable to share your opinion freely and honestly. The nature of Delphi requires that your address be known to the researcher. Your details will be known to the researcher alone and anonymity will be sustained throughout the study by using codes and symbols.

Thank you



Onasoga Olayinka

Participant Signature _____

Date _____

UNIVERSITY OF THE WESTERN CAPE
Faculty of Community and Health Sciences
Baseline Survey on Challenges and Barriers to Adolescent Post Abortion Care Services
(PACS) in Nigeria

Dear Respondent,

The researcher is a PhD student from the School of Nursing, University of the Western Cape, South Africa conducting a research on the above topic. This questionnaire is designed to obtain information on challenges and barriers to adolescent post abortion care services in Nigeria. Kindly complete it by ticking (✓) the options that best express your opinion honestly or fill the appropriate answers. All information will be used purely for the research and treated with utmost confidentiality.

Thanks for your co-operation.



SECTION A: Demographic Data

1. Age (in years)
2. Gender:
Male
Female
3. Highest level of education
Diploma
Bachelor's degree
Master's degree
Doctoral degree
Specify others
4. Occupation.....
5. Current job position.....
6. Number of years of experience in working with adolescents.....
7. In what capacity have work with the adolescent.....

SECTION B: opinion on abortion and post abortion care (PAC)

S/N	perception of respondents on abortion and post abortion care(PAC)	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments/suggestions
1.	abortion is rampant among adolescents						
2.	Family background is a major contributor to abortion						
3.	Poverty influence adolescents early sexual involvement						
4.	Society influences abortion and post abortion care(PAC)						
5.	Easy accessibility to Pornography by adolescents increases unwanted pregnancy and rate of abortions						
6.	Peer influence has been implicated in adolescents' sexual involvement and procurement of abortion						
7.	Adolescents have limited understanding of their bodies and conception thus increases unwanted pregnancy and abortion						
8.	Single parenting is a contributory factor to the high rate of unwanted pregnancy and abortion						
9.	Adolescents should have a right to choose whether or not that they want to do abortion						
10.	Not legalizing abortion is a contributory factor to increase morbidity and mortality						
11.	Adolescents are physically, emotionally and economically unprepared to care for pregnancy and childbearing/rearing						
12.	Overwhelming poverty predisposes adolescents to high-risk sexual behaviors						
13.	Beliefs, values, and attitudes of health-care providers have an influence on the quality of PAC services provided						

SECTION C: opinion on Challenges and Barriers to Adolescents' Post Abortion Care services

S/ N	Challenges /barriers	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments/ suggestions
1.	Unfriendly attitude of the health personnel(s)is the major barrier						
2.	Financial challenges						
3.	Rejection from parents and others						
4.	High cost of treatment						
5.	Religion is a major barrier to abortion and post abortion care services						
6.	Non-legalization of abortion is a barrier to adolescent post abortion care						
7.	Lack of privacy by the health care personnel(s)						
8.	Increased waiting period affect the						
9.	Lack of land marks in the hospital						
10.	Lack of available support system where the adolescents can be referred						
11.	Social stigmatization						
12.	Lack of sex education at home and school						
13.	Psychological challenges						
14.	Late presentation to hospital for care is one the challenges to adequate PAC						
15.	Inaccessibility to PAC services						
16.	Lack of adolescent friendly family planning services						
17.	lack of utility of contraceptive						
18.	Lack of parental support/care						
19.	Lack of counsellors						
20.	cultural and religious sensitivities surrounding abortion is a barrier to PAC services						
21.	no budgetary provision is made for programming on adolescent's Sexual reproductive health needs						
22.	Little knowledge of available services and their location						

23.	Shame or Embarrassment at needing or wanting services especially if the unwanted pregnancy/abortion follows sexual coercion or abuse						
-----	--	--	--	--	--	--	--

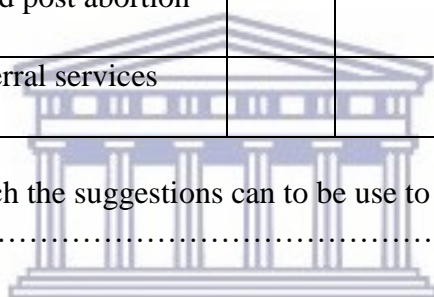
24. In your view, what are the other Challenges /barriers faced by adolescents in obtaining post abortion care in Nigeria.....

SECTION D: Possible resolution of barriers and challenges to post abortion care (PAC)

S/N	Possible resolution of barriers and challenges	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments/suggestions
1.	Free PAC services						
2.	PAC services should be freely assessable to women seeking it in this unit?						
3.	Legalization of abortion						
4.	Provision of adequate information through the Media on various reproductive issue of the adolescents						
5.	Promotion of sexual and reproductive health education						
6.	Provision of adolescents friendly counselling unit/guidance center						
7.	Training of health personnel in treatment equalization among patients						
8.	Free educational system						
9.	Parental support/guidance						
10.	Continuing professional development programme						
11.	Introduction of stipends for the students by the government(s)						
12.	Parents setting time aside for their children especially adolescents						
13.	Scholarship opportunity for adolescents						
14.	Youth empowerment						
15.	Equality in treatment irrespective of condition(s) seen						
16.	There is need for social worker(s) trained						

	specifically for adolescents' issues						
17.	Follow-up programmes for adolescents with abortion complications						
18.	provision of funds and resources to equip hospital to provide adequate PAC for adolescents						
19.	Provision of adolescent friendly clinic where adolescents with issues regarding unwanted pregnancy, rape, contraceptive, STIs etc can go for advice or information						
20.	Training of qualified health practitioners on emergency post abortion care.						
21.	Government policy should allow midlevel provider(nurses) to provider Post abortion care including use of MVA independently						
22.	public enlightenment programmes on attitude transformation on abortion and post abortion care						
23.	There should be adequate referral services following post abortion care						

Kindly recommend way in which the suggestions can to be use to inform policy in Nigeria and make other contributions.....



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Thank you for your time

Appendix XVI : Letter to the PAC policy Experts & Validation Instrument

Project Title: Challenges and barriers to adolescents' post-abortion care services: implications for reproductive health policy in Nigeria

Dear Participant,

Thank you very much for your interest in participating in this study. The study aims at developing a PAC policy document following evaluation of challenges and barriers to adolescents' post-abortion care service in Edo State, Nigeria for the sole purpose of improving adolescent reproductive health through quality PAC services. This is the final stage of the last phase of the study. The first phase in which you actively participated involved collecting information on challenges and barriers to adolescents' post-abortion care services. All the data from the first phase were analysed and a structured PAC policy document was designed.

The last stage of the second phase involves validation of the PAC policy document. To be able to conclude this stage successfully, your expert contribution is very vital and crucial. Therefore, I am requesting your most intelligent contribution as an expert in adolescent health issues. Please, fill free to express your view in order to make PAC services in Nigeria a huge success and a worthwhile programme. Confidentiality and anonymity of your participation are my priority and will be held in high esteem.

Description of the PAC Document to inform adolescent reproductive health policy

The development of this document was informed by the findings of the research study on challenges and barriers adolescents face in an attempt to procure PAC services in Nigerian hospitals. It is expected that hospital authorities and other individuals who bear the responsibility of formulating health policies, particularly those concerned with women's health and more specifically PAC services as relating to adolescents, will find this document useful.

Components

The components of the policy document include the following;

Underpinning principles, values and philosophies

This takes into account the overall health of the adolescent and, specifically, the reproductive health of adolescents

- In all countries, adolescents represent the future of families, communities and nations; as such they benefit from universal human rights that aim to protect and promote freedom and human dignity, which are pre-requisites for health.
- Reproductive health is a vital component of general health and therefore a prerequisite for social, economic and human development. For this reason, all women, including adolescent women, have the right to reproductive health.

- When PAC services are available to adolescents, this will reduce morbidity and mortality resulting from abortion complications. Efficient delivery of these services will go a long way toward saving the lives of adolescents who would have been lost to complications of abortion.

Broad Objective of the Policy Document

The aim of this policy document is to ensure that the challenges and barriers adolescents face while procuring PAC services are eliminated or reduced to the barest minimum so that these adolescents have access to high quality PAC services in all hospitals in Nigeria.

Specific Objectives of the Policy Document

This policy document is intended to improve the quality of PAC services provided by health care facilities, as well as improve access to PAC in Nigeria through:

(a) Establishment of PAC units in all facilities with effective monitoring systems

The government must ensure that PAC units not only exist but are fully functional in all health facilities in Nigeria. A unit head should be appointed and charged with the responsibility of running this unit with the support of the PAC staff.

(b) Training and retraining of PAC staff as well as attitude transformation

Periodic training and retraining of staff on advances in PAC services is inevitable if women seeking PAC services are to be given the quality of care they deserve. To this end, hospital authorities must ensure this continuous training is put in place and that it is sustained for all staff. Middle-level providers should be allowed to put the acquired skills into practice for effective PAC service provision.

(c) Institution of free PAC services for adolescents

There is the need for the government to consider free treatment for adolescents with abortion complications who are seeking PAC services. The justification for this is that most of them, in an attempt to conceal their sexual activities, hide their condition from their parents, who are better placed than they are to pay for medical services. They also present very late at the facility when their health has already deteriorated, thus requiring immediate intervention. If treatment is free or almost free, this will enable them to get easy access to treatment, even when they do not have the funds for such services.

(d) Review of abortion legislation in Nigeria to include cases of incest and rape

The abortion law in Nigeria permits abortion only when the life of the mother is at risk. The abortion law should be opened for public comment and revised in order that stigmatization is reduced and access to PAC services is increased.

(e) Creating a youth friendly hospital environment for PAC services

PAC staff should create an enabling environment where these youths receive the needed PAC services without discrimination and judgment from care givers. It is equally important to take cognizance of the need for privacy of these adolescents and the fact that they should be accorded the necessary human respect in the course of receiving PAC.

Strategies to achieve the objectives

To achieve the above objectives, it is necessary to consider these strategies below;

1. All health care facilities in Nigeria should have a separate unit for the reproductive health of women. A sub-unit of reproductive health should be created for women and particularly adolescents with abortion complications, who are seeking PAC services.
2. Management should identify those health care providers directly involved with the delivery of PAC services, and ensure they have the needed knowledge and skills for PAC. The PAC staff should be required to update their knowledge and skills in accordance with the advances in PAC.
3. There should be professional development opportunities such as workshops and seminars on PAC for the personnel of the various health care facilities.
4. A culture of continuous improvement on the available PAC services should be fostered.
5. All parties should ensure patient satisfaction in the course of rendering PAC services to women and particularly adolescents while eschewing discrimination and judgment of the patient in question.
6. Abortion laws should be opened for public comment and reviewed in order to ensure increase access to PAC services.
7. Implementation of best practice consultation and planning processes should be assured.
8. Government should authorize, through hospital management, free PAC services to adolescents with abortion complications.
9. Evaluation of care received should be done by PAC patients after each service
10. The abortion law should accommodate women, particularly adolescents, whose pregnancy is a result of rape, incest or similar circumstances, to terminate their pregnancy if they choose to do so.
11. PAC staff should perform their duty free of judgment and discrimination against adolescents receiving PAC services. They must treat each patient with respect and dignity irrespective of age and diagnosis.

Specific actions to be taken

The document recommends the following actions:

- PAC staff are surveyed on a six (6) month basis for satisfaction with programmes and services.
- The quality of services to patients is reviewed as frequently as possible, as this is necessary part of the strategic planning process.
- Patients receiving PAC services, particularly adolescents, should be interviewed periodically to examine their views and perceptions about the quality of PAC care they receive. Such feedback should be considered by hospital authorities together with PAC staff with the aim of addressing the issues raised by the patients.
- There must be provision of the necessary equipment and supplies for PAC services to meet the needs of patients requiring such services.
- Clinical guidelines for managing complications from unsafe abortions should be available in all Nigerian hospitals and the content of these guidelines should be communicated effectively to staff and update it when needed.
- Ensure that providers are trained and equipped to use the recommended methods of misoprostol and vacuum aspiration.
- Ensure professionals receive sensitivity training in nonjudgmental treatment and are informed of their legal, professional and ethical duty to provide post abortion care without prejudice.

Desired outcomes of specific actions

The desired outcomes of this policy document are as follows:

- Improved access to PAC services in all health care facilities in the absence of the identified barriers and challenges.
- Increase contraceptive usage among adolescents following PAC
- An observable increase in patient satisfaction with PAC services in all health care facilities across the Nigeria.
- A demonstrably positive attitude of PAC staff towards patients, particularly adolescents receiving PAC services.
- The availability of needed equipment and supplies for PAC staff to provide care to women with abortion complications.
- Reduced morbidity and mortality from abortion and abortion complications, particularly among adolescents.

Performance indicators

The success of this policy document may be measured in terms of:

- Percentage of adolescents with abortion complications seeking PAC services.
- Of those receiving PAC, percentage of adolescent patients who received family planning counselling prior to leaving the facility.
- Percentage of adolescent PAC patients who received family planning methods prior to leaving the facility.
- Proportion of adolescent patients' satisfaction with PAC services.

- Facility-based case fatality rate for post abortion complications
- Number of health care facilities per 100,000 population with functioning comprehensive PAC services
- Number of health care facilities that have commodities, equipment and transportation for PAC services
- Number of health care professionals with needed knowledge and skills for PAC services. PAC
- Percentage of middle-level providers (nurses) who have perform basic PAC procedures particularly in emergency cases.

Validation instrument

INSTRUCTION: Do the criteria describe the items within the components in the above PAC policy document? Choose by ticking [✓] as appropriate from the options ‘YES’ or ‘NO’

Critically study the components of the PAC policy document described above and make your comments:

1. Does the above PAC policy document adequately and accurately contribute to the promotion of adolescent reproductive health? i. Yes [] ii. No []

2. If ‘No’ what do you want to add?

3. Is the MONITORING/SUPERVISION SYSTEM in the PAC policy document adequate and accurate for achieving functional PAC services in all government owned health facilities?

i. Yes [] ii. No []

4. If ‘No’ what do you want to add?

4. Among the components of the PAC policy document, what component(s) do you want to add, remove or move to another component?

a. Components to add:

b. Components to remove:

c. Components to move: i _____ to _____
 ii _____ to _____

5. On establishment of PAC units in all facilities with effective monitoring systems what element(s) do you want to add, remove or move to another component?

a. Elements to add: _____

b. Elements to remove: _____

c. Elements to move: i _____ to _____
 ii _____ to _____

6. On training and retraining of PAC staff and the attitude transformation what element(s) do you want to add, remove or move to another component?

a. Elements to add: _____

b. Elements to remove: _____

c. Elements to move: i _____ to _____
 ii _____ to _____

7. How will you rate the PAC policy document in terms of its adequacy, accuracy, appropriateness and representation of reality if integrated into all Nigerian health facilities?

8. Please, support your answer with comments.

Key: 1 = Not at all; 2 = A little bit; 3 = Moderately; 4 = Quite; 5 = Very much

S/N	Aspects of model to be rated	1	2	3	4	5	Comments
i.	Its representation of reality						
ii.	Its accuracy						
iii.	Its appropriateness						
iv.	Its applicability						

Any additional comment(s):

Thank you

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Appendix XVII : Letter from Editor

Certificate of Editing

This is to certify that the thesis entitled ***CHALLENGES AND BARRIERS TO ADOLESCENTS' POST-ABORTION CARE SERVICES: IMPLICATIONS FOR REPRODUCTIVE HEALTH IN NIGERIA*** to be submitted by Olayinka Abolore Onasoga has been edited for language by me. Neither the content nor the author's meaning was altered or affected in any way during the process.



Lesley Cushman
Editor

16 September 2017

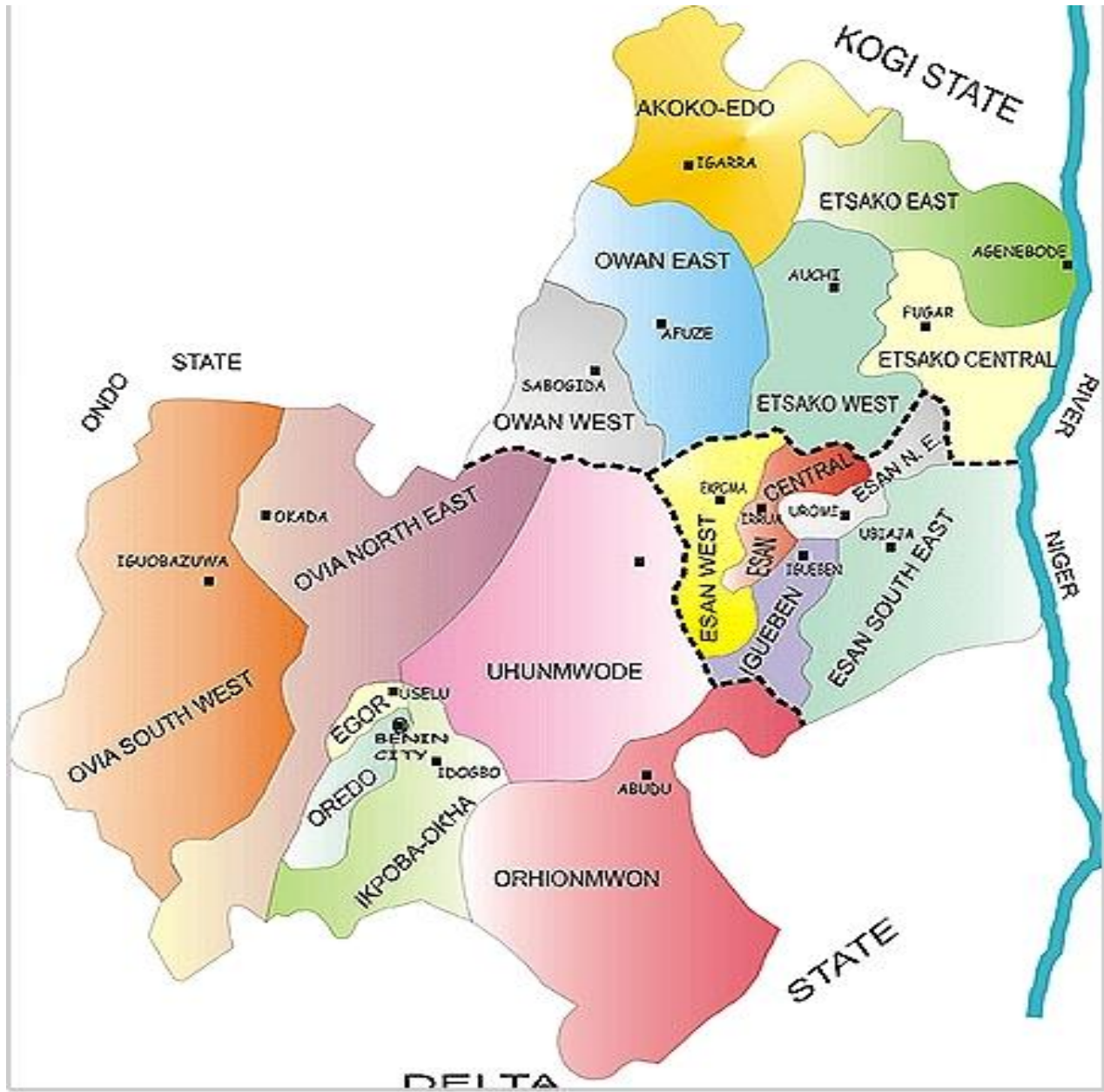
Appendix XVIII:Map of Nigeria



MAP OF NIGERIA(www.channelstv.com, 2014)

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WESTERN CAPE

Appendix XVIX : Map of Edo State



MAP OF EDO STATE

Appendix XX: Professional Cadres in Nursing Services in Nigerian Hospital

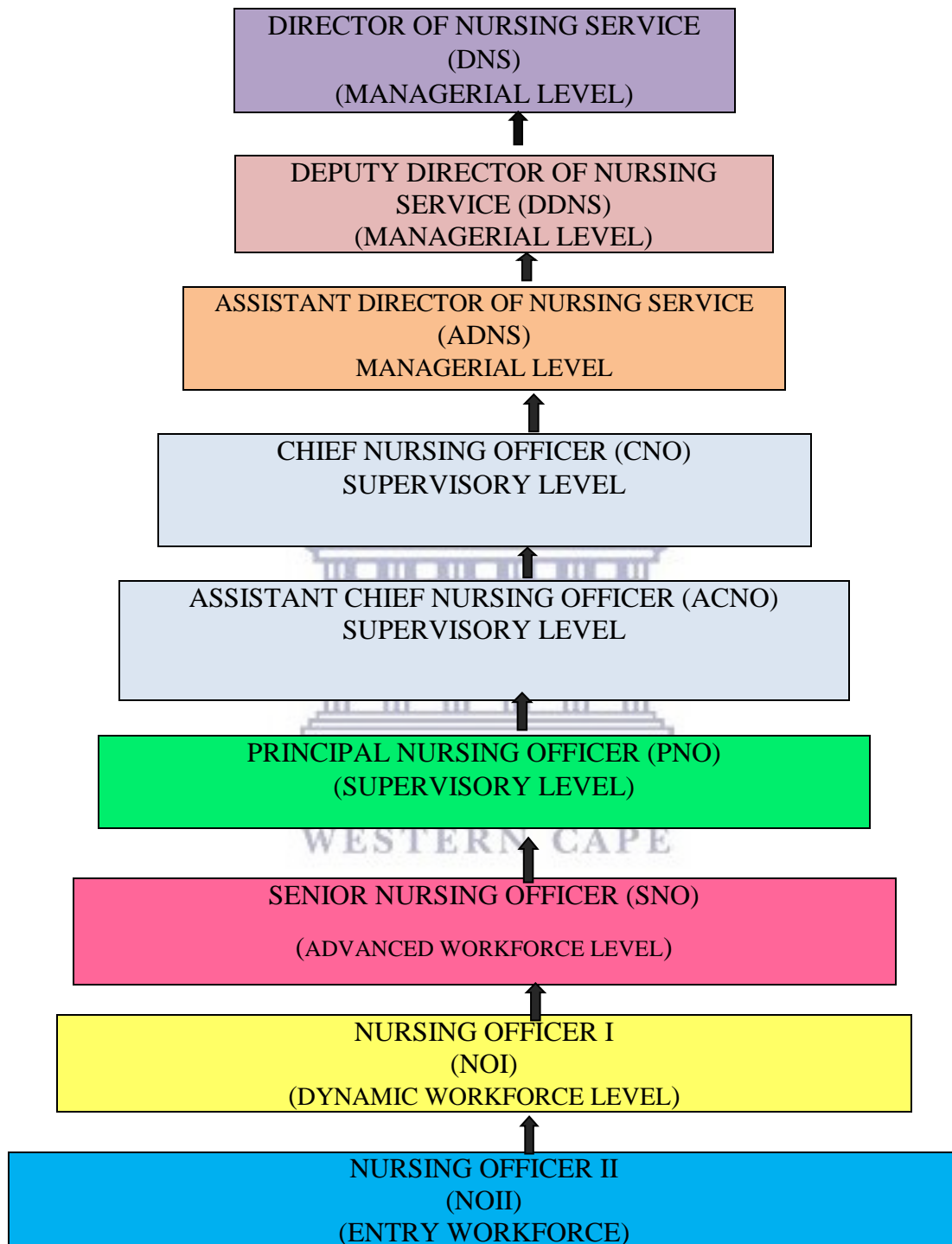


Chart showing Career progression in nursing services from bottom to top. Souce: OAUTHC, Nigeria (2010)