BMC Pregnancy and Childbirth

RESEARCH Open Access

Quality of post-abortion care services in the greater Accra region: connecting the perspectives of service providers and experiences of clients

Kenneth Setorwu Adde[1*], Kobina Esia-Donkoh[1] and Joshua Amo-Adjei[1]

Abstract

Background Access to quality abortion services will not only help to reach SDG Target 3.1 and Goal 3 of Agenda 2063 but will also enhance maternal health in sub-Saharan Africa. Post-abortion care was thus introduced as a key component in managing complications from abortion. However, not much is known about the quality of post-abortion care services and practices. The main objective of this study was to examine the connecting experiences of clients and service providers perspectives on the quality of post-abortion care services.

Methods An in-depth interview technique was used to collect data from 18 purposively selected post-abortion care clients and 13 post-abortion care service providers from selected health facilities in urban Accra. Data were analysed using NVivo 12 software using a quantitative thematic analysis technique.

Results We noted that the providers' perspectives and clients' experiences or narratives about PAC quality converged around interpersonal and technical quality. Apart from the consensus on what quality meant and what clients received, there were subtle divergences or variations in quality perspectives. Specifically, while the clients considered quality communication to be concerned with behaviour and mannerisms, service providers perceived it as patient-centred. Also, while clients considered quality treatment to be the immediate outcome of treatment, service providers perceived it as one with no adverse event. We also found that the quality of PAC services at health facilities could be improved by making consumables readily available and the provision of separate treatment rooms.

Conclusion Although PAC services are generally considered high quality in the Greater Accra region, there is still room for improvement. The private health facility owners, the Ministry of Health and the Ghana Health Services could take pragmatic steps to enhance synchronisation of notions of quality PAC services through sensitisation and education based on existing PAC protocol requirements.

Keywords Post-abortion care, Service providers, Clients, Ghana, Abortion

*Correspondence:
Kenneth Setorwu Adde
kenneth.adde@stu.ucc.edu.gh
[1]Department of Population and Health, College of Humanities and Legal Studies, University of Cape Coast, Cape Coast, Ghana

Background

Access to abortion services continues to be a significant public health concern in developing countries, particularly in the context of affordable quality services to [young people] clients [1, 2]. It has been argued that accessibility to quality abortion services would improve the maternal health of women and girls in sub-Saharan Africa and contribute to the achievements of Sustainable Development Goals (SDG) Target 3.1 and Goal 3 of Agenda 2063 [3, 4]. This has increased the focus on abortion rights, to promote quality abortion services to millions who seek abortion services [5, 6].

One of the efforts to promote safe abortion and, by extension, remediate the effects of unsafe abortions was the introduction of post-abortion care (PAC) services. The concept of PAC was first introduced in 1991 by Ipas and later reiterated as a key component in managing unsafe abortions during the 1994 International Conference on Population and Development (ICPD) [7, 8]. This intervention comprises five essential components; namely, community and service provider partnerships, post-abortion contraceptive counselling and provision, linkages to reproductive and other health services, treatment of adverse health effects or complications aggravating from either spontaneous or induced abortions, and providing counselling services to meet the emotional and physical needs of women who have had an abortion [7, 9]. Since the ICPD, some African countries, e.g., Ghana [10], Burkina Faso, Kenya and Nigeria [11] have integrated PAC into their healthcare delivery system,

Nevertheless, evidence shows challenges associated with PAC provision in many African countries [8], including Ghana [12], with accessibility and quality being a common concern. For instance, the Ghana Maternal Health Survey (GMHS) shows contextual and geographical disparities in PAC service provision [13]. Secondly, the quality of PAC, although presented in previous studies [14–16], situating the concept within the context of providers and clients has been given less attention in the PAC literature in sub-Saharan Africa. It is noteworthy that determining the points of divergence and convergence in the provider and client perspectives on quality PAC are core measures of the quality of PAC services [11, 12]. Our study, therefore, contributes to this dearth of evidence. Jointly studying the perspectives of providers and clients can offer a deeper understanding of the shared vision for PAC service delivery.

The quality of PAC services is focused on the provision of timely measures that reduce the risk of maternal mortality caused by abortion complications, whether induced or spontaneous [17]. In general, the patient, service provider, facility of care, policy, and legal framework for care delivery all contribute to the quality of PAC services [16]. In discussing quality PAC services, the Donabedian quality of care framework provides a valuable lens [16]. This framework encompasses the structure, process and outcome quality [18]. Whereas the structure quality focuses on the settings under which PAC is provided, and process quality focuses on the activities/procedures in the provision of PAC, the outcome quality focuses on the effects of the structure and process quality [18].

In sub-Saharan Africa (SSA), previous studies on the quality of PAC services report significant differences in the utilisation of suitable technology between urban and rural areas, the cadre of service providers, and the type of abortion leading to complications [8, 15]. In the context of Ghana, Esia-Donkoh et al. [19] explored the experiences of young women and girls seeking PAC, Owolabi et al. [12] examined Ghana's healthcare facilities' capacity to provide PAC, Adde, Darteh & Kumi-Kyereme [9], also explored the experiences of women seeking PAC services in a Regional Hospital in Ghana. These studies [9, 12, 19], however, did not explore the connecting synthesis between clients' experiences of quality PAC and providers' view of quality PAC. However, 69,846 PAC cases were treated in Ghana in 2017 [20]. District hospitals handle 36.6%, other hospitals handle 22.6%, and health centres 20.7% [20]. Understanding these gaps, which may trigger policy responses, can advance the attainment of SDG Target 3.1, a precursor to a high maternal mortality rate (MMR) [21]. Our study, therefore, examined this gap in Ghana by exploring the connecting experiences of service providers and clients on the quality of PAC services in urban Accra.

Materials and methods

Study design

We adopted the phenomenological research design to help expatiate the study based on the depth, accuracy, persuasiveness, and realism of the accounts given by the participants [22, 23]. This approach enabled us to gain insights into the opinions and experiences of PAC clients and service providers concerning the quality of PAC services.

Setting

The study was conducted in the Greater Accra Region of Ghana. The Region has the smallest area among Ghana's 16 administrative regions, with a total land surface of 3,245 square kilometres. This represents 1.4% of the total land area of Ghana. However, it is the second most populated region after the Ashanti region. It is also the most urbanised in Ghana, with about 87% of its population living in urban centres [24]. Accra doubles as the capital of Ghana. Greater Accra recorded the highest rate of abortion in Ghana in the latest Maternal Health Survey (14.7%) [13] and a high rate of unmet reproductive health needs (28.3%) [25]. The region has one regional hospital,

eight district hospitals, 99 private hospitals, 14 polyclinics, and 362 health centres/clinics [13]. In Ghana, PAC services are available at all levels of public and private health facilities [12]. However, only 63% of health facilities provide PAC services [20], 100% in teaching hospitals and regional hospitals, and 86–93% among district or university hospitals and polyclinics. PAC provision among health centres, clinics and midwifery/maternity homes was between 41% and 61% [20].

Participants, sampling and recruitment

Participants were recruited from a mix of public and private health facilities. A total of seven health facilities were purposively selected based on the availability of PAC services during the period of the data collection. Each of these facilities recorded a minimum of 200 abortion cases in the year 2019. These facilities comprised a health centre, polyclinic, district hospitals and a regional-level hospital.

The inclusion criteria used to select the providers are those directly working to provide PAC services in the selected facilities. For the clients, the inclusion criterion was all women presenting with incomplete, inevitable, missed, complete or septic abortion during the period of data collection.

The number of participants was not determined before but evolved during the data collection, bearing in mind the concept of saturation [26]. As such, the adequacy of the number was assessed during the data collection period. From Table 1, we conducted 31 interviews comprised of 13 service providers and 18 clients.

Research instrument

The in-depth interview (IDI) guide was used for data collection. The guide was divided into two main parts. The first part comprised questions for the client participants, while the second comprised questions for the provider participants [Supplementary material Appendix 1]. These two main sections comprised sub-sections that covered the participants' background characteristics and perspectives/experiences.

After ethical clearance was secured, the IDI guides were piloted at the Tema General Hospital among three service providers and three PAC clients. The site for the pre-test was chosen from among the seven health facilities that got ethical clearance for this project. This was done under the assumption that it would be helpful for the pre-test to recruit participants from the study population that would be used for the primary research [27]. The suitability of the instruments were determined based on the data analysed from the pre-test. Minor changes were made to the instrument to ensure they had the best potential to continue a quality discourse, which is critical to attaining the study objectives.

Data collection

The director at each of the health facilities was approached with ethical clearance from the Ghana Health Service Ethics Review Committee and an introductory letter from the Greater Accra Regional Health Directorate with the aim and purpose of this research for permission. Afterwards, the research team was introduced to the units in charge of the provision of PAC in each facility, and the study's objectives and data collection process were explained. The lead author (male) and a trained Research Assistant (female) carried out the interview process. The lead author has over five years of experience conducting sensitive interviews before this study. Male and female interviewers were presented to allow clients to choose whom they felt more comfortable to be interviewed by.

We scheduled the provider interviews following an agreement with personnel at these units on venues that ensured privacy and confidentiality and, at times that did not interfere with service delivery. These interviews usually took place in the consulting or changing rooms, at the end of their shifts, and when there were no clients to attend to. The interviews were conducted with the aid of an in-depth interview guide.

Clients at the designated PAC facilities were chosen with the assistance of health specialists. Before the interview starts, the client's psychological and physical preparedness must be approved by the PAC service provider in attendance [10, 28, 29]. Clients were allowed to select a place and time of convenience for the interview to be conducted. We interviewed thirteen (13) of the clients

Table 1 Level of facility, number of clients and providers interviewed

Level of facility	Number of Clients	Number of Providers
Polyclinic	3	3
Health Centre	2	1
District Hospital	1	-
Regional Hospital	2	1
District Hospital	4	3
District Hospital	2	4
District Hospital	4	1
Total	**18**	**13**

at the health facility based on their preferences. Phone interviews were also conducted with five (5) clients who opted for this mode. On average, an interview lasts for about 40–60 min. The data collection was carried out over three months.

Data analysis

The interviews that were conducted in English were transcribed verbatim. Those undertaken in the local languages were translated into English and then transcribed. The transcripts were imported into NVivo 12 software for coding and thematic analysis. The codes were determined deductively using the interview guide. Additionally, codes were developed inductively from the data. To establish trustworthiness, we employed inter-rater coding where the first author and an independent person coded the data. The two coders coded the data separately, and the results were later compared for consistency. The other authors reviewed the codes, and all the authors discussed the codes and the themes that emerged subsequently.

The data was segmented into similar groups to form preliminary codes with corresponding frequencies from the responses of the participants. Codes were then collated and sorted based on their shared pattern to form subthemes and subsequently, main themes. The characteristics of each respondent were also considered for comparative analysis. Finally, a descriptive narrative of the themes together with analytic narratives and data extracts were used to contextualise the analysis based on existing literature [30]. To get a better understanding of the quality of PAC services, the perspectives of service providers and clients were synthesised to determine the similarities and opposing views. This also enabled the study to examine service providers' and clients' understanding of quality PAC services since the outcome indicator encompasses the experiences of the process and structure indicators [18].

Ethical issues

Ethical clearance was received from the Ghana Health Service Ethics Review Committee with reference number GHS/RDD/Admin/App/21/348. Permission was also obtained from the Greater Accra Regional Health Directorate of the Ghana Health Service with reference number GARHD/001/2021. All participants were also provided with a Participant Information Sheet and an Informed Consent Form to sign/thumbprint. The signed/thumb-printed Informed Consent Forms were then obtained from the participants, and a copy was shared with the participants before they were included in the study. This provided the participants with all the relevant information to make an informed decision to take part in the study. To ensure confidentiality, participants were not asked to give any information that could reveal their identity. The identity of participants was also not included in the resulting report from the study. The informed consent was obtained from all the participants.

Results

Background characteristics

Table 2 presents the background characteristics of the client-participants. From Table 2, a higher proportion of the participants (61.1%) were aged 30–39 years. The majority of the women presented at the health facilities with complications from spontaneous abortion (66.7%), were self-employed (61.1%), were married (50%) and reported at a district-level health facility (61.1%) (see Table 2).

Table 3 also presents the demographic characteristics of the providers who participated in the study. From Table 3, a higher proportion of the provider participants were aged 30–39 (38.5%), were Midwives (53.8%), employed for up to 4 years (38.5%), and worked in a District level facility (69.2%).

Perspectives on the quality of PAC services

In our study, the quality of PAC services focused on the outcome indicator of the Donabedian quality of care framework. The outcome in the context of this study was the satisfaction clients derived from utilising PAC services. It also measured the service providers' satisfaction with the status of PAC services.

This was categorised into technical outcome which deals with the physical and functional aspects of care (reduction in disease and absence of complications, among others) and the interpersonal outcome which deals with the satisfaction the patient derives from the care received and the effect it has on the quality of life of the patients from the patients perspective [18].

In view of the above, participants were asked to comment on the quality of PAC services in the selected health facilities from their experience. Regarding the interpersonal outcome, two main themes were deduced deductively from the data (quality of communication, and prompt attention to clients reporting for PAC services (see Fig. 1)). Two main themes were also deduced deductively from the data for the technical outcome (quality of treatment and quality of environment (see Fig. 1)). Aside the interpersonal outcome and technical outcome, one key theme (positive experience but room for improvement) was deduced inductively from the data (see Fig. 1).

Interpersonal outcome

Quality of communication

The client participants identified three indicators that underpinned their perspective of quality communication. These indicators of quality communication are politeness, patience and respect from service providers during communication. This group of clients, irrespective

Table 2 Socio-demographic characteristics of clients

Variable	Frequency	Percentage
Age		
10–19	2	11.1
20–29	5	27.8
30–39	11	61.1
Type of abortion		
Induced	6	33.3
Spontaneous	12	66.7
Occupation		
Civil servant	1	5.6
Self-employed	11	61.1
Student	3	16.7
Unemployed	3	16.7
Facility		
Regional Hospital	2	11.1
District Hospital	11	61.1
Poly Clinic	3	16.7
Health Centre	2	11.1
Marital status		
Married	9	50
Cohabiting	1	5.6
Single	8	44.4

Source: Field data 2021

Table 3 Socio-demographic characteristics of service providers

Variable	Frequency	Percentage
Age		
20–29	4	30.8
30–39	5	38.5
40–49	4	30.8
Designation		
Medical Officer	3	23.1
Obstetrician	1	7.7
Health Assistant	1	7.7
Midwife	7	53.8
Registered Nurse	1	7.7
Years of Employment		
0–4	5	38.5
5–9	4	30.8
10–14	1	7.7
15–19	2	15.4
19+	1	7.7
Facility		
Regional Hospital	1	7.7
District Hospital	9	69.2
Poly Clinic	2	15.4
Health Centre	1	7.7
Marital status		
Married	5	38.5
Single	8	61.5

Source: Field data 2021

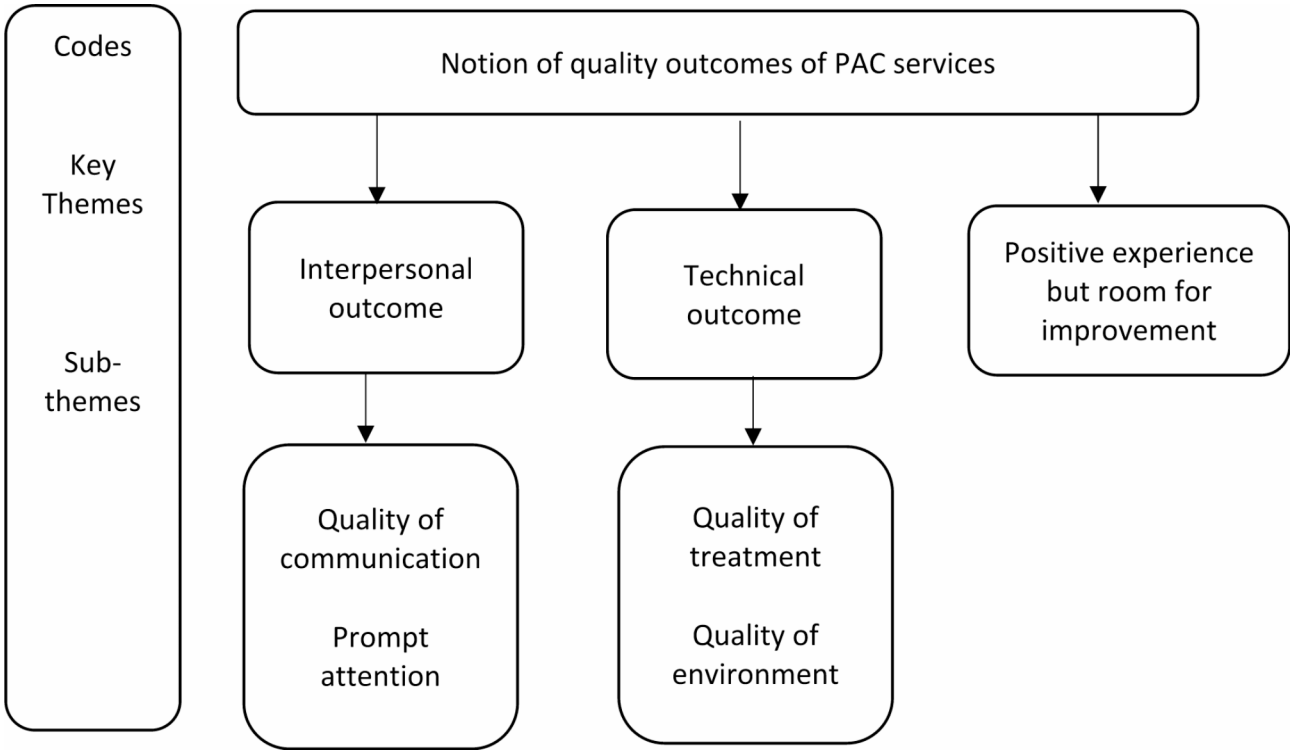

Fig. 1 Codes, key themes and sub-themes from qualitative analysis

of their background characteristics were happy with the behaviour of the service providers and how they spoke to them. To these participants, the way service providers interact with clients greatly affects their health-seeking experience. For instance, a 29-year-old student who presented with an induced abortion remarked "They [service providers] were always polite when talking to me'. Another client had this to say:

> *They were very good and polite towards us. They accorded respect to us anytime they wanted to say something to us (33 years Civil servant, Induced abortion).*
> *… they all talked with me with some kind of respect. They were somehow friendly, especially with my doctor, they often check up on you to check your BP and other stuff, and they ask you how you are (32 Self-employed, Spontaneous abortion).*

Whereas the clients' perspective of quality communication from their experiences was based on the behaviour and the way the service providers spoke to them, the service providers on the other hand perceived quality communication as one that is patient-centred. To them, quality PAC service is achieved if you can educate your client on the process and treatment procedure before the commencement of treatment. To them, the client should be made aware of the options so that they could make an informed choice. Again, they reiterated that clients should be involved in the decision-making process. For instance, the following participant indicated:

> *…Post abortion care to be quality means making sure patients understand what they are going to do, and after it is done, follow up to make sure they don't develop complications and when they are developed you will act quickly and then offer contraceptive care to those who will need them. I think basically if you can do them then I think abortion care should be okay. (District facility Medical Doctor, 26 years)*
> *… Usually, before we start everything, we tell them about what the abortion care is going to involve, both during and after. We don't wait and inform them after because when they don't know what is really going to happen and you start with the procedure, they start getting uncomfortable, hence it is best to educate them before undertaking the process and after that, the medication and everything follows. They need to be aware of what is going to be in their system and how it is going to be in their system for the next pregnancy, especially those who really want to conceive after.… (District facility Midwife, 32 years)*

Prompt attention to clients reporting for PAC services

Our study also showed that another experience that shaped clients' perception of quality PAC service was their experience of prompt attention from the service providers upon arrival at the health facilities. Some were happy with the way service providers were prompt to get the consumables needed to render PAC services. The narratives from the study participants highlighted that regardless of the time (whether day or night) clients presented at the facility with complications from abortion, they received prompt attention. This theme (prompt attention) was evident in both the service providers' and clients' accounts. A client who was happy with the prompt attention had this to say:

> *I will say they are perfect because how they treated me that night was nice, I even thought that when I get there that night, they wouldn't even take care of me, but they did their best.... (28 years Self-employed, Spontaneous abortion)*

A service provider who also indicated that prompt attention reflects quality PAC services had this to say:

> *"The quality of post abortion care is giving prompt and adequate treatment to a woman who needs post-abortion care..." (Polyclinic Midwife, 40 years).*

Technical outcome

Quality of treatment

Quality of treatment was one of the themes under technical outcome. From the views of the participants, what is meant by quality of treatment varied between service providers and clients. Some clients were of the view that the PAC service they received at the facility was quality because of the treatment provided. These clients expressed satisfaction with the outcome of the treatment that they received. Some clients also expressed satisfaction with the treatment by comparing their condition before arriving at the facility and their condition after the treatment.

> *I cannot say anything, but the way I was before I came here, I can only give thanks to God. When I came this was not how I was but now I am better, so I thank God and the doctors because they treated me very well. (32 years Self-employed, Spontaneous abortion)*

The views of other client participants also showed that clients judged the quality of treatment based on how the providers showed care for them throughout the treatment process. Below is the remark of a participant to corroborate this.

> *It is very fine because when somebody does something good for you, you need to acknowledge him or her. At times it is not everywhere you go that they will take care of you like the way they did. (35 years Self-employed, Spontaneous abortion)*

Service providers on the other hand described quality PAC services to be one that records a smaller number of complications after treatment. These providers were of the view that once clients receive treatment and do not return with complications after treatment, then the service provided was quality. Hence the quality of PAC services was measured by the number of complications that are recorded after treatment. This is what some of the service provider participants had to say:

> *I will describe it as quite good because as I said we have not recorded any direct maternal death because of abortion before. It was just one occasion that I remember somebody came and did it and they came back with complaints and pains so we had to admit her and administer antibiotics, and she became okay so the care is quite good. (Polyclinic Obstetrician, 45 years)*
>
> *"We haven't had people coming back with complications, so I think it is very good. Just a few that sometimes come with pelvic inflammatory disease (PID) but it is being treated so I think it is good". (District facility Midwife, 28 years)*

Quality of environment

Quality of environment as a technical outcome was a theme from the client's perspective. Some clients constructed their perceived quality of service based on the physical and enabling environment in which the treatment was provided to them. They were satisfied with the serene and peaceful nature of the environment in which they were treated.

> *"I think if I have to grade between 0 and 10, I will put them on 8. I have not had an experience with this before but generally I feel that I am comfortable here, the environment is quiet and peaceful". (33 years Self-employed, Induced abortion)*

Some also shared the view that they were happy about the hygienic environment in which they received treatment. For instance, a client who expressed she felt comfortable because of the environment had this to say:

> *"The hospital seems to provide quality care as all the Doctors/Nurses I met were up to the task, the place was neatly kept and the patients seem to all be*

responding to treatment" (23 years Student, Spontaneous abortion).

Positive experience but room for improvement

Although all the clients and service providers were generally happy about the quality of PAC services at the various health facilities, a few were of the view that there was room for improvement. For instance, a client was of the view that it would be prudent if the service providers could provide post-abortion counselling services. Remarks were also made for the various units responsible for the provision of PAC services to be near each other. These according to the clients are some of the ways the quality of the service can be improved. The call for improvement was made based on their experience at the facility.

"Everything is perfect, the only problem I had was where they asked me to go for the scan. The place is far if they can bring it closer to the hospital, it will be nice". (28 years Self-employed, Spontaneous abortion)
"... I will give 7 out of 10 for the quality of care. Again, I know they are busy but after the process, they need to give counselling and talk to us for us to feel relaxed because we have been through a lot". (32 years Self-employed, Spontaneous abortion)

A service provider also indicated that there is room for improvement and had this to say:

"... There is a problem with space and then we don't also have all the instruments to carry out the process. Even currently, what the doctor is using is his own personal MVA set... (Polyclinic Midwife, 40 years).

Some service provider participants also shared the view that although they provide privacy and confidentiality to their clients, they sometimes must compromise on privacy. This they attributed to the lack of separate treatment rooms; hence, in times of large number of clients, the room is shared for the clients.

"... We use the same treatment room for SVDs and all that so sometimes when the place is overwhelmed, if you are having an MVA and someone is also examining a client there..." (District Facility Doctor, 26 years).

Discussion

We explored the points of divergence and convergence of clients and service providers on quality PAC services. The results showed that service providers and clients perceive quality PAC as one with quality interpersonal and technical outcomes. These were further explained by quality communication, quality of treatment, prompt attention and the quality of the environment.

Although both clients and service providers highlighted quality communication as a component of quality PAC services, there was a variation in what quality communication meant to each group. Whereas quality communication was concerned with the behaviour and mannerisms component of communication with the clients, the service providers were concerned with client involvement in treatment decision-making. The focus of clients on the behaviour and manners of the service providers affirms the findings of Brown, Alaszewski, Swift and Nordin [31] that the behaviour and body language of service providers help to foster trust in the clients. Brown et al., [31] also argued that whilst verbal communication is important to explain issues to clients, it was the body language that was crucial in validating trust from the clients. Service providers on the other hand were focused on the user-centred perspective of communication to ensure that the clients understood them. Evidence supports a positive association between a client-centred approach by service providers and positive patient outcomes [32, 33]. A plausible explanation for the variation could be that while service providers are trained to adopt a user-centred approach in communicating with their clients, clients on the other hand could be lacking in such information. Hence, clients base their judgement of quality communication on the sociocultural dimension of communication which focuses on behaviour and mannerisms [34]. Notwithstanding the variation in what constitutes quality communication, quality communication helps increase the client's confidence and satisfaction with the treatment given to clients. Galletta et al. [35] argued that clients are likely to adhere to the medications if they have confidence in the treatment given to them as well as actively participate in the decision-making process. Contrary to our findings of effective provider-patient communication, Pasquier et al. [36], reported poor provider-patient communication in Nigeria and Central African Republic from the perspective of PAC clients, which they argued affected the client's satisfaction of care received.

We also found that both the service providers and clients were of the notion that prompt attention is a key measure of quality PAC services. This affirms Donabedian's [18] argument of process quality which measures the technical and interpersonal qualities of the service providers. This encompasses all that is done in the provision of care to the client [18]. The study further shows that denying PAC clients prompt attention could result in worsening conditions for the client. The findings show that there is a chance of delay in health-seeking

decision-making and delay in commuting to the health facility hence there is a need for prompt attention to be provided at health facilities to prevent any further delay. This supports the conclusions of Rominski, Morhe, and Lori [37] and Izugbara et al. [8] that delays in obtaining timely PAC services increase the risk of serious complications and death. Thus, it came as no surprise to us that we saw that PAC clients received early treatment at the health facilities, as reported by both service providers and clients. We think this is an effort on the part of the medical facilities to avoid any more delays that would aggravate the complications of the clients. This affirms the findings of Baynes et al., [38] who also found women reporting short waiting times for PAC services in Senegal.

With regards to quality treatment, we observed that whereas clients consider the quality of treatment as the immediate outcome of the relief they receive as compared to how they arrive at the facility, service providers on the other hand measure quality treatment based on recording no adverse effects after treatment. The disparity in the notion of quality treatment can be attributed to the fact that service providers have been trained and educated on the WHO post-abortion care guidelines [39] that PAC service is only completed after the client receives a check-up two weeks post-treatment [40, 41]. Despite the disparity in the understanding of quality treatment, both service providers and clients expressed satisfaction with the treatment outcomes. The above discussion shows that there is a positive outcome for PAC services in the selected health facilities studied, according to the Donabedian [18] theory.

Donabedian's [18] quality of care model argued that quality healthcare service should be provided in a user-friendly environment by providing convenience, comfort, quiet, and privacy among others that make it easy and attractive to a patient to seek healthcare at the facility. The Optimal Healing Environment framework also argues that serenity and a lovely environment serve as a form of environmental therapy and contribute to healing [42]. The findings of our study showed that PAC clients were generally satisfied with the serene and peaceful nature of the environment in which they received PAC services. This affirms the findings of Zakpa et al., [43] and Baynes et al., [38] who argued that the features of a health facility to provide a comfortable environment are associated with clients' assessment of overall quality of care.

Although both PAC clients and service providers were generally satisfied with the quality of PAC services provided in health facilities in the Greater Accra Region, we found that there is still room for improvement. We found that the availability of consumables for the provision of PAC was not always readily available. We also observed that there is a need for the provision of separate consulting and treatment rooms for PAC services to help promote privacy and confidentiality. Similar observations were made in Kenya and Uganda [44] and Zimbabwe [45]. The findings further showed that PAC clients were of the view that there is a need for the provision of post-abortion counselling services. This affirms the WHO guidelines for the provision of PAC services which recommends the provision of post-abortion counselling [38]. This will help respond to the emotional needs of the clients. We also found that there is a need for the units responsible for the provision of PAC services to be in proximity. This we believe would help provide a more comprehensive and coordinated approach to the provision of quality PAC services.

Strengths and limitations

Despite the important findings from this study, it is imperative to indicate its possible limitations. For instance, the study was delimited to PAC providers and clients from only the Greater Accra Region and a small sample size which limited the study from being generalised to the general Ghanaian society. The sampling strategy adopted could also limit the study to facilities that are more desirable to women seeking comprehensive abortion care services. Facilities which record a smaller number of women seeking comprehensive abortion care services may have different findings to this study. This, however, did not limit the validity and trustworthiness of the study, since the necessary steps were followed to make the instrument valid and trustworthy.

Conclusions

Our results showed that both PAC clients and service providers generally perceive PAC services in urban Accra to be of quality. Although both service providers and clients were of the notion that PAC services were of quality based on communication, treatment, prompt attention and the environment, there were variations in the conceptualisation of these themes. The study also concluded that although PAC services are generally accepted to be quality, there is still room for improvement. To further improve the quality of PAC services in the Greater Accra Region, private health facility owners, the government, the Ministry of Health and the Ghana Health Services should take pragmatic steps to ensure that post-abortion counselling services are provided at the health facilities. Also, the government and policymakers should take deliberate steps to ensure clients are sensitised on quality PAC based on the protocols. Post-abortion counselling services must also be conducted without fail. This will enlighten healthcare seekers and empower them to demand optimum healthcare services. The divergent views on the notion of quality treatment suggest that there is a need for interventions targeted at clients to

encourage women to utilise follow-up services to confirm the completeness of treatment.

Abbreviations

GHS	Ghana Health Service
GSS	Ghana Statistical Services
ICPD	International Conference on Population and Development
LMICs	Lower-and middle-income countries
MMR	Maternal Mortality Rate
PAC	Post-Abortion Care
PID	Pelvic Inflammatory Disease
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
WHO	World Health Organisation

Supplementary information

The online version contains supplementary material available at https://doi.org/10.1186/s12884-025-07502-6.

Supplementary Material 1

Acknowledgements
We appreciate the health facilities (Ashaiman Polyclinic, Marrie Stopes (Kokomlemle), Ga West Municipal Hospital, Ridge Regional Hospital, Lekma Hospital, Achimota Hospital and Tema General Hospital) for their immense assistance. We are also grateful to the post-abortion care clients and the service providers who participated in this research.

Author contributions
KSA conceived the study. KSA performed the analysis, drafted the manuscript. KE and JA reviewed multiple drafts and proposed additions and changes. KSA had the final responsibility to submit. All authors reviewed and approved the final version of the manuscript.

Funding
No funding was received for this study.

Data availability
The datasets used and/or analysed during our study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethical clearance was received from the Ghana Health Service Ethics Review Committee with reference number GHS/RDD/Admin/App/21/348. Permission was also received from the Greater Accra Regional Health Directorate of the Ghana Health Service with reference number GARHD/001/2021. The informed consent was obtained from all the participants.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Received: 27 September 2023 / Accepted: 20 March 2025
Published online: 02 April 2025

References

1. Ameyaw EK, Budu E, Sambah F, Baatiema L, Appiah F, Seidu AA, Ahinkorah BO. Prevalence and determinants of unintended pregnancy in sub-Saharan Africa: A multi-country analysis of demographic and health surveys. PLoS ONE. 2019;14(8):e0220970.
2. Baum SE, Wilkins R, Wachira M, Gupta D, Dupte S, Ngugi P, Makleff S. Abortion quality of care from the client perspective: a qualitative study in India and Kenya. Health Policy Plann. 2021;36(9):1362–70.
3. Ohaja M, Senkyire EK, Ewetan O, Asiedua E, Azuh D. A narrative literature review on media and maternal health in Africa. World Med Health Policy. 2023;15(2):123–47.
4. Amu H, Aboagye RG, Dowou RK, Kongnyuy EJ, Adoma PO, Memiah P, Tarkang EE, Bain LE. Towards achievement of sustainable development goal 3: multilevel analyses of demographic and health survey data on health insurance coverage and maternal healthcare utilisation in sub-Saharan Africa. Int Health. 2023;15(2):134–49.
5. Kim C, Sorhaindo A, Ganatra B. WHO guidelines and the role of the physician in task sharing in safe abortion care. Best Pract Res Clin Obstet Gynecol. 2020;63:56–66.
6. Lynch B, Mallow M, Bodde KE, Castaldi-Micca D, Yanow S, Nádas M. Addressing a crisis in abortion access: a case study in advocacy. Obstet Gynecol. 2022;140(1):110.
7. Cleeve A. *Post abortion care in Uganda: Improving access and quality of care through task sharing and exploring the perspectives of young women and healthcare providers* (Doctoral dissertation, Karolinska Institutet (Sweden)).
8. Izugbara C, Wekesah FM, Sebany M, Echoka E, Amo-Adjei J, Muga W. Availability, accessibility and utilization of post-abortion care in sub-Saharan Africa: a systematic review. Health Care Women Int. 2020;41(7):732–60.
9. Owolabi OO, Biddlecom A, Whitehead HS. Health systems' capacity to provide post-abortion care: A multi-country analysis using signal functions. Lancet Global Health. 2019;7(1):e110–8.
10. Adde KS, Darteh EK, Kumi-Kyereme A. Experiences of women seeking post-abortion care services in a regional hospital in Ghana. PLoS ONE. 2021;16(4):e0248478.
11. Juma K, Ouedraogo R, Amo-Adjei J, Sie A, Ouattara M, Emma-Echiegu N, Eton J, Mutua M, Bangha M. Health systems' preparedness to provide post-abortion care: assessment of health facilities in Burkina Faso, Kenya and Nigeria. BMC Health Serv Res. 2022;22(1):1–3.
12. Owolabi O, Riley T, Otupiri E, Polis CB, Larsen-Reindorf R. The infrastructural capacity of Ghanaian health facilities to provide safe abortion and post-abortion care: a cross-sectional study. BMC Health Serv Res. 2021;21(1):1–0.
13. Ghana Statistical Service (GSS). Ghana Health Service (GHS), ICF. Ghana Maternal Health Survey 2017. Accra: GSS, GHS, and ICF. 2018.
14. Bell SO, Zimmerman L, Choi Y, Hindin MJ. Legal but limited? Abortion service availability and readiness assessment in Nepal. Health Policy Plann. 2018;33(1):99–106.
15. Bell SO, Shankar M, Ahmed S, OlaOlorun F, Omoluabi E, Guiella G, Moreau C. Postabortion care availability, facility readiness and accessibility in Nigeria and Côte D'Ivoire. Health Policy Plann. 2021;36(7):1077–89.
16. Riley T, Madziyire MG, Owolabi O, Sully EA, Chipato T. Evaluating the quality and coverage of post-abortion care in Zimbabwe: a cross-sectional study with a census of health facilities. BMC Health Serv Res. 2020;20(1):1–9.
17. Mutua MM. *Quality of Post-Abortion Care in Health Facilities in Kenya* (Doctoral dissertation, Wits University).
18. Donabedian A. An introduction to quality assurance in health care. Oxford University Press; 2002. Dec 26.
19. Esia-Donkoh K, Darteh EK, Blemano H, Asare H. Who cares? Pre and post abortion experiences among young females in cape Coast metropolis. Ghana Afr J Reproductive Health. 2015;19(2):43–51.
20. Polis CB, Castillo PW, Otupiri E, Keogh SC, Hussain R, Nakua EK, Larsen-Reindorf R, Bell SO. Estimating the incidence of abortion: using the abortion incidence complications methodology in Ghana, 2017. BMJ Global Health. 2020;5(4):e002130.
21. WHO. (2019, February 27). *World Health Organization*. Retrieved November 26, 2019, from Primary Health Care: https://www.who.int/news-room/fact-sheets/detail/primary-health-care
22. Creswell JW. Educational research: planning, conducting and evaluating quantitative and qualitative research. 3rd ed. New Jersey: Prentice Hall; 2007.
23. Yin Z, Liu S, Yan J, Liu J. Motivations for deceased organ donation among volunteers in China: A qualitative research study. Ann Transplant. 2016;21:360–7.
24. Songsore J. The urban transition in Ghana: Urbanization, national development and poverty reduction. University of Ghana, Legon–Accra. 2009 Aug 26.
25. Gss GH, Macro IC. Ghana demographic and health survey 2014. Ghana Statistical Service, Ghana Health Service, and ICF International; 2015.
26. DiCicco-Bloom B, Crabtree BF. The qualitative research interview. Med Educ. 2006;40(4):314–21.

27. Moore CG, Carter RE, Nietert PJ, Stewart PW. Recommendations for planning pilot studies in clinical and translational research. Clin Transl Sci. 2011;4(5):332–7.
28. Kumbi S, Melkamu Y, Yeneneh H. Quality of post-abortion care in public health facilities in Ethiopia. Ethiop J Health Dev. 2008;22(1):26–33.
29. Adde KS, Darteh EK, Kumi-Kyereme A, Amu H. Responsiveness of health professionals to postabortion care at a regional level hospital in Ghana: A qualitative study of patients' self-reports. International journal of reproductive medicine. 2018;2018.
30. Allsop DB, Chelladurai JM, Kimball ER, Marks LD, Hendricks JJ. Qualitative methods with Nvivo software: A practical guide for analyzing qualitative data. Psych. 2022;4(2):142–59.
31. Brown PR, Alaszewski A, Swift T, Nordin A. Actions speak louder than words: the embodiment of trust by healthcare professionals in gynae-oncology. Sociol Health Illn. 2011;33(2):280–95.
32. Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC Nurs. 2021;20(1):1–0.
33. King A, Hoppe RB. Best practice for patient-centred communication: a narrative review. J Graduate Med Educ. 2013;5(3):385–93.
34. Uyanne MC, Oti OJ. The influence of socio-cultural domains on communication. Afr Res Rev. 2012;6(4):234–47.
35. Galletta M, Piazza MF, Meloni SL, Chessa E, Piras I, Arnetz JE, D'Aloja E. Patient Involvement in Shared Decision-Making: Do Patients Rate Physicians and Nurses Differently? International Journal of Environmental Research and Public Health. 2022;19(21):14229.34. Donabedian A. The quality of care: how can it be assessed? Jama. 1988;260(12):1743-8.
36. Pasquier E, Owolabi OO, Powell B, et al. Assessing post-abortion care using the WHO quality of care framework for maternal and newborn health: a cross-sectional study in two African hospitals in humanitarian settings. Reprod Health. 2024;21:114. https://doi.org/10.1186/s12978-024-01835-9.
37. Rominski SD, Morhe ES, Lori J. Post-abortion contraception choices of women in Ghana: a one-year review. Glob Public Health. 2015;10(3):345–53.
38. Baynes C, Diadhiou M, Lusiola G, O'Connell K, Dieng T. Clients' perceptions of the quality of post-abortion care in eight health facilities in Dakar, Senegal. J Biosoc Sci. 2022;54(5):760–75.
39. World Health Organization. Abortion care guideline. 2022.
40. WHO. *World Health Organization*. Retrieved from Health system responsiveness: http://www.who.int/responsiveness/en/. 2015.
41. Barot S. Implementing postabortion care programs in the developing world: ongoing challenges. Guttmacher Policy Rev. 2014;17(1):22–8.
42. Sakallaris BR, MacAllister L, Voss M, Smith K, Jonas WB. Optimal healing environments. Global Adv Health Med. 2015;4(3):40–5. https://doi.org/10.7453/gahmj.2015.043.
43. Zapka JG, Lemon S, Peterson LE, Palmer H, Goldman MB. The silent consumer: women's reports and ratings of abortion services. Med Care. 2001;39(1):50–60.
44. Osur J, Baird TL, Levandowski BA, Jackson E, Murokora D. Implementation of Misoprostol for postabortion care in Kenya and Uganda: a qualitative evaluation. Global Health Action. 2013;6(1):19649.
45. Sully EA, Madziyire MG, Riley T, Moore AM, Crowell M, Nyandoro MT, Madzima B, Chipato T. Abortion in Zimbabwe: a National study of the incidence of induced abortion, unintended pregnancy and post-abortion care in 2016. PLoS ONE. 2018;13(10):e0205239.

Publisher's note