ORIGINAL RESEARCH ARTICLE

Who Cares? Pre and Post Abortion Experiences among Young Females in Cape Coast Metropolis, Ghana

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Abstract

Issues of abortion are critical in Ghana largely due to its consequences on sexual and reproductive health. The negative perception society attaches to it makes it difficult for young females to access services and share their experiences. This paper examines the pre and post abortion experiences of young females; a subject scarcely researched in the country. Twenty-one clients of Planned Parenthood Association of Ghana (PPAG) clinic at Cape Coast were interviewed. Guided by the bio-psychosocial model, the study revealed that fear of societal stigma, shame, and rejection by partners, as well as self-imposed stigma constituted some of the pre and post abortion experiences the respondents. Other experiences reported were bleeding, severe abdominal pain and psychological pain. The Ghana Health Services (GHS) and other service providers should partner the PPAG clinic to integrate psychosocial treatment in its abortion services while intensifying behaviour change communication and community-based stigma-reduction education in the Metropolis. *(Afr J Reprod Health 2015; 19[2]: 43-51).*

Keywords: Ghana abortion; young people; experiences.

Résumé

Les questions de l'avortement sont essentielles au Ghana en grande partie due à ses conséquences sur la santé sexuelle et de reproduction. La perception négative que la société attache à elle, le rend difficile pour les jeunes d'accéder au service et de partager leurs expériences. Cet article examine les expériences d'avant et d'après avortement des jeunes gens, un sujet à peine étudié dans le pays. Vingt-et-un des clients de la clinique de Planned Parenthood Association de Ghana (PPAG) à Cape Coast ont été interrogées. A l'aide du modèle bio-psycho social, l'étude a révélé que la peur de la stigmatisation sociale, la honte et la perte de partenaires, ainsi que la stigmatisation auto-imposé constituaient. L'expérience d'avant et d'après avortement des interrogées rencontrées. L'hémorragie, les douleurs abdominales intenses et de la douleur psychologique ont également été signalées. Les services de santé du Ghana (GHS) et d'autres fournisseurs de services devraient collaborer avec la Clinique du PPAG d'intégrer le traitement psychosocial dans leurs services d'avortement tout en intensifiant la communication sur le changement de comportement et l'éducation à base communautaire destinée à la réduction de la stigmatisation dans la métropole. *(Afr J Reprod Health 2015; 19[2]: 43-51).*

Mots-clés:avortement, jeunes, expériences

Introduction

Since the adoption of declarations from the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women (FWCW) in Beijing in 1995, issues about sexual and reproductive health in general and abortion in particular have gained currency globally. The interests in abortion issues have increased over the recent decades particularly due to the consequences associated with maternal mortality[1-3] and women's rights[4]. For instance, an estimated 529,000 adolescent girls and women die from pregnancy-related causes each year, almost all of them in Africa, However, 13% of these deaths are due to unsafe abortion[5-7].

Say et. al.,[8] estimated that about 8%of all maternal deaths in the world between 2003 and 2009 were as a result of abortion. Estimates for sub-Saharan Africa was about 10% while that of North Africa was less than 3%. Of the 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions[6,9].

Although abortion is a criminal offence regulated by Act 29, section 58 of the Criminal code of 1960, amended by PNDCL 102 of 1985 in Ghana, the country's abortion law is considered to be fairly liberal[10]. The law permits qualified medical practitioners to undertake abortion if the pregnancy is a result of rape, incest or defilement of a 'female idiot'; if the continuation of the pregnancy could result in risk of the life of the woman or threaten her physical or mental health; or if it is a risk to the life of the unborn child. This notwithstanding, unsafe abortion is not uncommon in the country contributing about 11% to maternal mortality[11-16]. The incidence of abortion with its consequences is considered to be highest (25%) among women aged 20-24 years[15], with a reported rate of 34 per 1000 among women in urban areas[17-20].

Societal perception and religious doctrines surrounding abortion make it difficult for young people to access abortion services in the country and also share their pre and post abortion experiences. The study therefore examines the pre and post abortion experiences among young females in Cape Coast Metropolis.

Conceptual, policy and empirical issues

The concept and definition of health have well been espoused by world governing bodies and institutions such as the World Health Organization (WHO) as a state of complete physical, mental and social well-being. For instance, the health governing body defines reproductive health as '*Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.* By extension, the definition provides a condition for every young female to decide and terminate a pregnancy if she is unstable and mentally unhealthy as a result of the pregnancy. In fact, the ICPD in 1994 and FWCW in 1995 affirmed the human rights of women in this area of health[18].

The above conceptualization especially within the framework of human health and rights still heightens the pro-choice and pro-life debate. The proponents of pro-choice argue that laws against abortion rather kill women and discriminate against low income women who cannot travel to access safe abortion service elsewhere. Thus, laws per se do not prevent abortion but rather allow the service to be accessed secretly and practiced illegally with obvious consequences. On the other hand, the pro-life debate centres on the premise that personhood begins immediately after conception and that the termination of a fetus is murderous and defeats the practice of human rights[20].

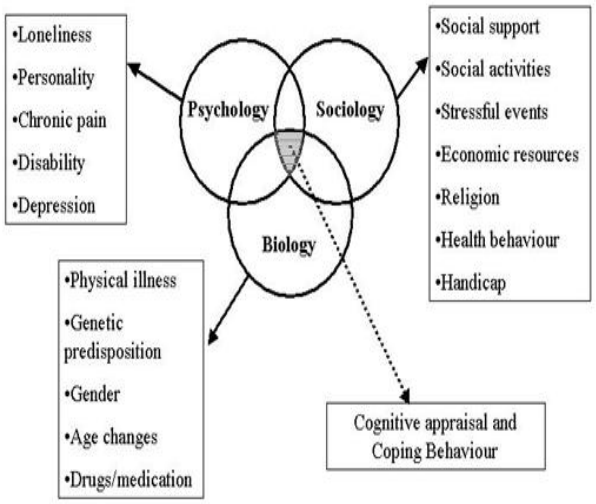
From a policy perspective, abortion was only integrated into the national reproductive health policy in 2003 with comprehensive abortion care (CAC) becoming a reproductive health service in 2006 when the Ghana Health Service introduced the new standards and protocols for safe abortion services Nevertheless, the law still tends to be interpreted as prohibiting abortion making it difficult especially for young people to access services[21].

Existing evidence shows that abortion is highest among the youngest cohorts of women. While sixteen per cent of pregnancies among women age less than twenty years end Abortion, almost fifty per cent of young unmarried women in Greater Accra and Eastern Regions of Ghana who had ever been pregnant had terminated a pregnancy[12,21,22]. In a comprehensive study by the Ghana Health Services known as the Ghana Maternal Health Survey (GMHS), among women reporting on their most recent abortion in the five years before the Survey in 2007 reveals that, 16% terminated their pregnancy with tablets young people go through various related experiences not only to access service, but first coping with the pregnancy result, deciding to abort and coping with post-abortion experience. Literature available indicates that reasons such as poverty, fear of education discontinuity, stigma and shame are among the main reasons young people abort[21-23]. These reasons continue to put psychosocial stress on many a young people; more so because abortion among young female is secretive. The Ghanaian society also does not approve of pre-marital sex and abhors every decision to abort, hence, the difficulty of this group sharing their

experiences.

Consequently, research has not focused much on their pre and post experiences due in part to the societal perception about the subject and young people's difficulty in sharing their abortion experiences[24]. The present study adopted the bio-psychosocial model to examine these experiences (Figure 1). The model explains that biological, psychological and social factors collectively play vital roles in human functioning such as cognitive appraisal and coping behaviour in the context of health[24]. Health is best understood in terms of these factors, a view also held by the WHO[18].

Figure 1: The biopsycho-social model



*Source: Based on White and Grenyer[24]

The study facility

The Planned Parenthood Association of Ghana (PPAG), established in March 1967 became a member of the International Planned Parenthood Federation (IPPF) in 1969. IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. The IPPF has its global headquarters in London, UK. The structure of the PPAG consists of volunteers and staff. The volunteers are the members who volunteer resources, including time and expertise for the promotion and achievement of the Association's objectives[25]. The PPAG has over the years, implemented a number of programmes and projects that target abortion services to the whole populace especially young people. These include the Global Comprehensive Abortion Care Initiative (GCACI), and the SALIN+ project. With the GCACI, some of the objectives were to increase access to comprehensive abortion care services resulting in a total of 405 clients being attended to by the end of 2012 and to increase access to treatment for incomplete abortion services resulting in a total of 117 clients served by the end of 2012. As an achievement under this project, 881 females had been provided with Comprehensive Abortion Care (CAC) at the time of the study. These included 176 incomplete abortions and 613 Post abortions Family Planning services. From January to December 2010, a total of 42 abortions were carried out at the Cape Coast clinic. Moreover, between January and March 2011, 24 clients were provided with abortion services while 74 abortions were also conducted from July to September 2011[26].

The PPAG clinic was selected as the study facility because it provides youth friendly sexual and reproductive health care including Comprehensive Abortion Care (CAC). The clinic provided a sample frame of all young people who had had abortion over the last three years. Available at the clinic are three methods of abortion: medical abortion (MA), manual vacuum aspiration (MVA) and diagnostic dilation curettage (DD&C). However, the first two methods are the options presented to its clients. The MA procedure involves administration of *medabon* tablets orally while the MVA is surgically conducted.

Methods

To explore the pre and post experiences of young people (aged 12 to 24) who had their abortion three months prior to the study, in-depth interviews were conducted among them using an in-depth interview guide, which was developed for the study. The guide was pre-tested in a private facility in Cape Coast to test for validity.

The appointment technique was adopted. With this, clients who came for post-abortion review were contacted and the purpose and objectives of the study were explained to them in the language (local: Fante and Twi; and English)

they best understood. An Appointment, comprising the date, time, place of interview, and who to interview were scheduled for the in-depth interviews (IDIs) as determined by each respondent. Most of the interviews were conducted at the clinic. Two of the interviews were conducted at the clinic in the evening and three were interviewed by a female. The bias in the sampling was that only those who came for post-abortion review during the data collection period were targeted.

In all, twenty-one (21) respondents were interviewed out of 27 clients contacted. Additionally, the Coordinator of the clinic was also interviewed to understand the methods and abortion services provided at the facility. Consent was sought to use a digital tape recorder to record the interviews. Names of respondents were avoided during the interview to ensure anonymity. Post-interview phone calls were made to five (5) of the respondents to seek clarity of issues which were not captured during the main interviews or were considered inconsistent. On the average each interview took about an hour to complete. The recorded interviews were transcribed and manually analysed thematically.

Ethical considerations

Informed consent was obtained from each young person, who signed a consent form, after a detailed explanation about the purpose of the study had been given and the importance of their views as service users. Respondents were also given information sheets that had details about the purpose of the study. Respondents were assured of privacy and confidentially. Participants were informed of their right to refuse to participate in the study or withdraw from the discussion at any time. Approval for the study was sought from the Head Office of the Planned Parenthood Association of Ghana (PPAG).

Results

Socio-Demographic characteristics of respondents

The ages of the respondents were between thirteen and twenty-four years. The youngest respondent was aged 13 years while the oldest was aged 24 years. Six were under apprenticeship training while one was out of school and also unemployed. The rest were in school. Three were at the tertiary level while seven and four were in the senior high school (SHS) and junior high school (JHS) respectively (Table 1). All the respondents were Christians who lived with their parents or guardians except one who was cohabiting with her partner. Apart from the cohabiting, the rest were single but had regular sexual partners. The minimum and maximum ages at first sex reported were 11 years and 21 years.

Table 1: Socio-Demographic Characteristics of Respondents

Code name	Age at first sex	Educational attainment	Occupation
R1	11	JHS	Student
R2	15	SHS	Student
R3	17	None	Unemployed
R4	17	SHS	Student
R5	16	Tertiary	Student
R6	16	SHS	Student
R7	16	SHS completed	Student
R8	13	Tertiary	Student
R9	20	SHS	Student
R10	21	JHS completed	Dressmaking apprentice
R11	16	JHS	Student
R12	16	JHS	Hairdressing apprentice
R13	15	JHS completed	Sales attendant
R14	20	Tertiary	Student
R15	17	SHS completed	Dressmaking apprentice
R16	16	JHS completed	Hairdressing apprentice
R17	15	JHS Completed	Hairdressing apprentice
R18	18	SHS	Student
R19	16	SHS	Student
R20	15	JHS	Student
R21	16	JHS	Student

***Source: Fieldwork, 2013.**

Most of the respondents lived in and around Cape Coast with few residing at distant villages (see table 1).

Pre-abortion experiences

Decisions to abort were mostly taken with the

sexual partners. With the perception that abortion was illegal, 'murderous' and sinful, the respondents generally found it difficult to take the decision even though to them, there was no other option available. Some reported that their sexual partners were against the abortion and therefore threatened a break-up of the relationship if the pregnancy was terminated. The cost implication was also an issue. These psychological stressors were increased with information about abortion complications such as infertility and death some of the respondents had these to say.

> *My boyfriend told me not to abort. He said it is a bad thing to abort. ... He threatened to break-up with me if I realised I aborted the pregnancy.* [R15, Apprentice]

> *When I told him [boyfriend] that I was pregnant, he asked me to if I had money to abort because he did not have.... The money issue became an argument and I left his house.* [R4, Student]

> *I was scared because, I thought I would die when abortion became the only option for me because I had heard and witnessed people die as a result of abortion in my village….* [R9, Student]

Other pre-abortion experiences and stressors reported by most of the respondents included the rationale and decision to abort, choice of facility and the method(s) of abortion to opt for, as well as the expectation of potential pain and possible complications.

Reasons and decision to abort

Reasons given for young females' decision to abort abortion are consistent with literature. Principally, inability to care for the babies owing to household poverty fear of dropping out of school, societal/community stigma and shame were mentioned (see quotes below).

> *My parents are divorced and my mother is the only person taking care of my three siblings and myself...therefore took the decision to have an abortion when I realized I was pregnant.* [R10, Apprentice];

> *I am a small girl, who is still in JHS. If I should give birth now, what will happen to my schooling?* [R1, Pupil]

> *I am a very shy and quiet person among my peers and everywhere I go to the extent that people around me would never think I have a boyfriend and even engage in sexual intercourse, let alone becoming pregnant. [Laughs]* [R21, Pupil]

Respondents further indicated that one of the challenging life-decisions ever to be taken was the decision to abort. Some indicated that it took them more than a week to even inform their partners about the pregnancy. Others did not inform their partners about the pregnancy at all. For instance, two of the respondents said that their partners always spoke against abortion so they decided not inform them (partners) about the pregnancy.

> *"My boyfriend is totally against abortion. He told me to make sure I don't abort if I get pregnant. How can I then inform him about this [pregnancy]. I decided to keep it to myself and abort secretly. [R14, student]"*

> *"He [boyfriend] is a 'serious' catholic. He would have 'killed' me would have killed me if he got to know that I was pregnant and I wanted to abort it. For me, to keep this relationship going, I had to keep the pregnancy to myself and abort it without his knowledge. [R8, Student]"*

Choice of facility for abortion

The respondents were aware of both public and private health facilities where abortion services are provided. However, apart from being a youth

friendly centre, the choice of the PPAG clinic was based on other reasons. Firstly, cost of abortion is comparatively cheaper. Secondly, the location of the facility is convenient in that it does not attract many potential 'gatekeepers' and gossips. Thirdly, the attitude of staff is youth friendly and compassionate. This attitude is what has described as sympathetic attitude[22]. The youngest respondent shared her experience at the facility.

> *The cost of abortion here [PPAG clinic] is cheaper. When I got pregnant for the first time I paid an equivalent of $45 to abort it at a clinic at Aboom [a suburb of Cape Coast]. But this is my second abortion in two years and it cost less compared to the cost of the first one...It is an equivalent of $31. This is far cheaper.* [R14, Student]

> *A friend of mine advised me to come to PPAG clinic because it is affordable. .... I paid an equivalent of $31 for it [abortion].* [R17, Apprentice]

> *.... I could have gone to a hospital but you are likely to see someone you know who would ask you so many questions. PPAG clinic is cool...not many people come here....* [R8, Student]

The abortion process: methods and cost

There are safe and unsafe methods used to abort. All the respondents indicated that they preferred to have abortion at recognised facilities and by recognised practitioners so as to make it safe. With the safe methods two main techniques are adopted at the PPAG clinic. One is the medical or medication abortion (MA). It involves the use of *medabon* comprising *misoprostol* and *misoprostol* tablets. Most of the respondents opted for the MA because perceptually, it is less frightening. As a result, sixteen of the respondents opted for this method. The second method is the manual vacuum aspiration (MVA), which involves the application of surgical techniques to remove the fetus. Locally, this method is referred to by young females as *kafu-kafu* (pump and remove) or *gyina-hɔ-gye* (do it on the spot).

some of the respondents also self-aborted. These respondents, mostly those in the Universities bought *misoprostol* from the Pharmacy shops to administer in a process commonly known as *two up, two down* (two tablets taken orally, and two tablets inserted into the vagina).

> *As for me, I go to the drug store to buy my cytotec (misoprostol) whenever I realised that I am pregnant. I have used this method to abort two of my pregnancies.* [R8, Student]

The cost of abortion was considered affordable by the respondents. Comparing the cost at the PPAG Clinic to other facilities elsewhere, they indicated that the former was economical. The cost of aborting a pregnancy in its first trimester ranged between $30-$40 accordingly. The cost was higher (an equivalent of $175) if the pregnancy is in its second trimester. In most cases, the male partners or both partners contributed to pay for the abortion services. Those whose partners were not in favour of abortion bore the cost. Few others bore the cost because their partners refused to contribute under the 'pretence' that they did not have money. The Coordinator of the facility indicated that the facility usually provides free services to young people who genuinely did not have money to pay for the services received. The Coordinator had this to say:

> *The facility absorbs the cost of abortion services particularly young people who genuinely cannot pay particular CAC services. We carefully interview such clients to be fully convinced that they could not pay for such services.*

Post-abortion experiences

The study identified three main experiences post-abortion - biological, psychological and social. Irrespective of age, all the respondents went through physical pains after abortion. Some of the

respondents experienced severe abdominal pains and bleeding. Usually, the respondents came back to the facility for further treatments whenever the pains became severe. This affected regular attendance to school, class or lectures as well as apprenticeship training.

> *I have had abortion twice.* [R5, Student]

Psychologically, the respondents were worried about the fact that an 'illegality', a 'crime' and sin had been committed against humanity and God. This guilt led to self-imposed stigma, which was usually reinforced by sermons and talks about abortion at the Church, in the media and no other social platforms.

> *Sometimes I think about it and feel bad for the number of abortions I have had. At times, I feel I will not be able to make babies in future...* [R20, Student]

Other factors that increased respondents' emotional stress were social factors. For instance, some of the partners who threatened to break-up the relationship really actualised the threat when they realised that the pregnancy has been aborted. One of the respondents shared her experience:

> *When I informed him (boyfriend) about the pregnancy, he asked me to keep the pregnancy. But I could not because I was not ready for a baby. He insisted and threatened to break up with me if I aborted...he now does not pick my phone calls, but sent a text message to me that he is no longer in any relationship with me.* [R10, Apprentice]

Sharing of abortion experiences

keeping abortion, experiences as a secret is common with young people. To the respondents, it is better to be secretive with such information given the negative perception the society, religious and social groups hold about abortion. As one put it:

> *Who cares about my experiences? None! The moment you share such an experience, you become the sermon topic at church, No one cares.* [R13, Apprentice]

Discussion

The recent findings by the Ghana Demographic Health Survey (GDHS) (2008) indicate that young people become sexuality active from the early teens. With a high unmet need for family planning of about 66%[27] abortions, therefore, becomes an immediate option to those who for varied reasons do not wish to carry it to full term.

Young females' vulnerability within the economic and social spheres of life makes them more dependent on their male partners. Previous research shows that household poverty and inability to negotiate for safer sexual practices contribute immensely to unintended pregnancies among young people especially teenagers[1, 5, 28]. The need to dispel misinterpretation of the abortion law and negative perceptions societies/communities hold about the subject is not only critical but imperative. It is, therefore, not surprising that the respondents considered abortion as 'sinful', 'murderous' and thus, an abominable act. Given the statistics of abortion and its related consequences in the country, the present study theoretically supports the pro-choice argument which gives females the right to take control over their own reproductive health including whether to terminate or keep a pregnancy to term.

Young people must, however, take full responsibility of their sexual and reproductive life. It is instructive that young people must consider the health implications of not-using contraceptives. It is true to a large extent that most females in Ghana[14] and broadly developing countries cannot negotiate for safer sex[6] though, the onus lies on the female to consent for (un)safe sex.

Conclusion

Drawing from the bio-psychosocial model, it is evident that young females' abortion experiences

touch on biological, psychological and social health factors. This calls for a comprehensive approach which involves all stakeholders including community gatekeepers, practitioners

and researchers. Common among young people's needs is who to share experiences with without any negative outcomes. It is through sharing of such experiences that appropriate information can be drawn to advance effective behaviour change communication. Undoubtedly, research is crucial. The paper admits the difficulties in conducting abortion-related research. Perhaps, building trust and confidence among researchers and public and private health facilities could serve as a strong platform to share data, have access to clients for research purposes, and share findings to improve access to sexual and reproductive health services.

It is recommended that PPAG partners relevant service providers to integrate psychosocial treatment as a specific component of CAC tailored to meeting the pre and post-abortion needs of young people. Similarly, stakeholders such as the Ghana Health Service, Ghana Education Service and other private service providers must develop specific behaviour change communication to encourage safer sex practices among young people, and community-based stigma reduction programmes to demystify abortion at various levels of the society.

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Conflict of interests

The authors declare none.

Authors' Contribution

KED conceived the study, conducted data analysis and interpretation as well as drafted the first version of the manuscript. KED, HB and HA conducted the initial literature scoping and searches and collected the data. HB and HA transcribed the data. EKMD revised the manuscript for important intellectual content and conducted the final literature searches. All authors have read and approved the final manuscript.

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