https://rijournals.com/current-research-in-humanities-and-social-sciences/

RESEARCH INVENTION JOURNAL OF CURRENT RESEARCH IN HUMANITIES AND SOCIAL SCIENCES 3(1):8-13, 2024

©RIJCRHSS Publications ISSN 1597-8745

Factors Responsible for Abortions Practices among Adolescents in Africa: Focus on Ghana

Ezek Martins U.

Department of Management Kampala International University Uganda

ABSTRACT

Termination of pregnancy for medical reasons is a complex decision, which may lead to long term complications, both for the woman and for the whole family. A summary of data from the Demographic Health Survey since 2005 shows that in most African countries, sexual activity before age 20 is more prevalent than marriages before that age, with a high adolescent fertility rate and its attendant consequences. It is estimated that about 1.8 million adolescent females give birth yearly, mainly in Low and Medium Income Countries. Additionally, 1 out of every 3 women in developing compared to 1 out of 5 women in developed countries would have given birth by the age of 18. Of these births, about 95% take place in LMICs which are largely beset with poverty, lack of education and high rural populations. As a consequence of these, numerous, sometimes unintended pregnancies, about 3 million, mostly unsafe abortions among adolescents occur yearly, some with fatal and often times long-term complications. This paper therefore examined the religious and socio-economic factors responsible for abortion practices among young people in Ghana. It maintained that, adolescents suffer consequences of abortion, such as haemorrhage, severe anaemia, trauma, foreign body, sepsis, or mortality; hence, the need for alternatives to abortion through expanded and enhanced family planning services, and if unintended pregnancy has already occurred for a woman who qualifies for safe legal abortion, then safety should be guaranteed.

Keywords: Abortion, Adolescents, Ghana, Pregnancy, Factors

INTRODUCTION

Abortion is perceived as a traumatic experience affecting an individual in contact with the healthcare service. According to statistics, it was been estimated that during 2010– 2014, about 56 million induced abortions occurred each year worldwide. The estimated global abortion rate in the same period is 35 per 1,000 for married women and 26 per 1,000 for unmarried women [1]. Apart from medical complications, more and more attention is being paid to psychological consequences associated with abortion, which sometimes occur a long time after the procedure [2]. Termination of pregnancy for medical reasons is a complex decision, which may lead to long term complications, both for the woman and for the whole family. The results of studies on psychological consequences experienced by women after termination are inconclusive. Part of the studies does not confirm an increased prevalence of psychological consequences [3]. A review of the study from 2014 assessing fourteen studies on termination for medical reasons mainly conducted in the US and the UK indicated that termination shakes up the woman's fundamental views, which later need to be reconstructed [4]. For many years, there have been discussions on the subject of medical, social and psychological consequences of deciding to undergo an abortion. There is talk about post-abortion stress syndrome and medical complications linked to the procedure. Sometimes loss of fertility for psychological reasons is also observed [5]. Many women see the experience of termination as abuse, which leads to a decreased sense of security. According to studies, 17% of women who have experienced termination due to fetal defects report signs of post-traumatic stress disorder even two to seven years after the procedure [6]. A survey conducted until the third week, three months after and a year after the procedure on a small group of nineteen patients showed that women see termination as a stigma and loss similar to natural miscarriage [7]. Some women put themselves in the position of a survivor, saying that "they have survived the worst thing in their life" (9). Whereas others say that this experience has made them stronger. They find the strength to rebuild family relations and inner empathy [8, 9]. The United Nations defines young persons (youth) as individuals between the ages of 15 and 24 years [10]. Adolescents, on the hand are defined as young people between 10 and 19 years. This is a period of transition between childhood and independence. Worldwide, it is estimated that there are about 1.8 billion young persons; 90% of whom live in low- and middle-income countries (LMIC) [11]. A summary of data from the Demographic Health Survey since 2005 shows that in most African

countries, sexual activity before age 20 is more prevalent than marriages before that age, with a high adolescent fertility rate and its attendant consequences. It is estimated that about 1.8 million adolescent females give birth yearly, mainly in LMICs [12]. Additionally, 1 out of every 3 women in developing compared to 1 out of 5 women in developed countries would have given birth by the age of 18. Of these births, about 95% take place in LMICs which are largely beset with poverty, lack of education and high rural populations [12]. As a consequence of these numerous, sometimes unintended pregnancies, about 3 million, mostly unsafe abortions among adolescents occur yearly, some with fatal and often times long-term complications [12]. In a global context, adolescent pregnancy is a major contributor to maternal and childhood mortality as well as entrenches the cycle of ill-health and poverty; this paper therefore aims to ascertain factors responsible for abortion practices among young people in Ghana.

Factors responsible for Abortions Practices among Adolescents in Africa

Abortion is generally more prevalent among women in urban centres globally than those in rural areas [13]. However, rural residents in all age groups are more likely to use traditional methods than are urban residents. Unsafe abortions are also common among poorer, younger, and unmarried women with low socio-economic status than those who are married and/or well-off. Although adolescents undergo a substantial fraction of abortions, they are most frequently performed among women aged 20 to 29 years [13]. Nonetheless, women below 20 years constitute more of those hospitalized for complications. Several studies around the world have looked into the factors that influence abortions. Others have scrutinized the determinants of unsafe abortion defined as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both [14]. In South Africa, despite having one of the most liberal laws on abortion, unsafe abortions is reported to be responsible for about 13% of the maternal mortality, with determinants such as poor social support, inadequate contraceptive services and poor health service infrastructure listed [15]. In Nigeria where laws tend to be quite restrictive, a study among adolescents found a perceived threat to fertility by contraceptives made abortion a more acceptable method of controlling fertility [16]. A study conducted by [17] in rural Tanzania also indicated that women who had an unsafe induced abortion were single, primigravida, and younger than 24 years of age. Women who procure unsafe abortions often use clandestine methods aided by unskilled attendants who may be a friend, a close relative or a traditional service provider. A study performed in Cote d'Ivoire in 2017 among high school students indicated that 70% of them first used a self-prescription, and in case it failed, 56.4% proceeded to use traditional service providers and whenever self-prescription and traditional methods were unsuccessful, approximately 85.7% of them consulted skilled health care providers as the last option. The students cited over-the-counter drugs, herbs, roots, beverages, and in some instances, the insertion of sharps in their genital tract as commonly used procedures [18]. The use of pharmaceutical drugs, catheters, and roots has been cited by several other studies. Some girls use battery acid, crushed bottles, pain medication, sedatives, anaesthesia, antibiotics, chlorine, white quinine, cassava-cyanide, aloe vera, castor oil, ashes, ground tobacco, saltwater, sugar solutions, washing powder/soap, and methylated spirits, which are very unsafe [19]. According to [20], the commonly used methods of abortion among adolescents in South Africa are backstreet measures, which is attributable to women's inadequate knowledge of their legal status and eligibility for a safe abortion and a complex decision-making process. Another study on abortion among adolescents in developing countries states the same factors. Additional factors include gender inequality, an unmet need for contraceptive use, sexual education, high cost, and restrictive abortion laws. The issue of stigma is a serious issue, as highlighted by many other studies.

The Case of Ghana

Young people in Ghana (between the ages of 15 – 24) comprise 20% of its about 25 million inhabitants, with young females numbering about 2.5 million (20% of Ghana's female reproductive population) [21]. The age specific fertility rates for the age groups 15-19 years, and 20-24 years have been estimated at 84/1000 and 187/1000 respectively, with corresponding total abortion rates (TAR) of 17/1000 and 25/1000 respectively, the highest across the reproductive age group. In Ghana, where abortion had been largely criminalized until the law was revised in 1985 (and amended in 2003), services are scarcely available. This means that in order to procure abortions, girls and young women expose themselves to unsafe abortions with the attendant risks of uterine perforation, pelvic infections, bleeding, chronic pelvic pain and possible infertility [22]. Additionally, complications which arise from induced abortions have been found to be the second leading cause of maternal mortality in Ghana, accounting for between 12 – 15% of maternal-related deaths. This is in keeping with other studies in Sub-Saharan Africa.

Religion

The social context of adolescents in Ghana has seen a gradual shift of influence from mainly traditional practices and beliefs to those of the two main foreign religions of Christianity and Islam. Both these value systems (traditional and religious) promote the ideals of chastity till marriage [23]. Within the Ghanaian context therefore, religion tends to play a stigmatizing role when confronting behaviour not considered the norm [24].

Addai, in his work states interestingly, that religion appears to be an important predictor of premarital sex, noting that individuals belonging to more liberal religious groups are more likely to engage in premarital sex, than followers of more conservative, orthodox ideologies.

Economic factors

Studies have shown that women in the higher wealth strata of the society have a greater likelihood of procuring a safe abortion. [25] notes that adolescents more often lack economic resources compared to adults. This lack often influences the decision to obtain an abortion, and is a key determinant in its safety [25]. Additionally, lack of resources results in delays at key points in the decision-making process such as seeking help early and using a skilled provider, which may result in complications [25]. According to Baiden, the economic differential tends to stand out where inequities in access to abortion services exist. The resultant desperation accompanied by the 'illegal' nature of such services put them within reach of only those who can afford to the exclusion of those lower down the wealth ladder, who resort to substandard services out of desperation. In the Maternal Health Survey, 21% of respondents stated that they sought abortion due to lack of resources to cater for the child. In like manner, it has also been shown by [26], that abortions are significantly higher in women who are self-employed than those in secondary employment [26]. In the GMHS 2007, 8.5% of respondents stated their desire to continue working as the reason for obtaining an abortion. Welfare assistance and social support differ, and range from support in obtaining healthcare through support for childcare by spouse/ partner and employer. The lack of this support had been identified as one of the determinants of unsafe abortion. Some (2.4%) of the respondents in the survey stated their desire to opt for an abortion was due to lack of support to care for the child. The economic aspirations of individuals hold enormous relevance particularly in Africa, where dropping out of school due to pregnancy significantly reduces one's future prospects. The desire to continue schooling was cited by 11% of those interviewed as the reason for choosing to have their pregnancies terminated.

Social Factors

Most customs in Ghana frown upon pregnancy out of wedlock and consider abortion a taboo that carries profound stigma especially in traditional societies. Abortion-related stigma has been described as a social phenomenon, which is reproduced in local context [27]. For example in some parts of Cameroun, a mistimed entry into motherhood is thought to be more shameful than the act of abortion [27]. Similarly, in certain parts of Ghana where girls are required to perform rites of passage ceremonies to be inducted into womanhood by the society, the shame associated with carrying a pregnancy often forces young girls to seek terminations in order to present themselves as virgins. In several male-dominated societies, the ability for women to exercise sexual and reproductive control in their relationships is limited, as is the decision to opt for an abortion [28]. Studies show that the male partners often influence the decision to abort directly though their insistence and support to procure an abortion or indirectly through denial of the pregnancy or withdrawal of support. The resultant dependence on the male partner in decision-making may sometimes result in delay in seeking care [28]. It has been suggested that partner influence is crucial in deciding whether a woman has a safe abortion or not [28]. A marginally positive association has however been reported between partner neutrality/ support and safe abortion. Partner opposition on the other hand appeared to be associated in delay in seeking care. Common partner-related factors cited in studies as reasons for unsafe abortion by women include: fear of abandonment, denial of pregnancy, partner's insistence, casual relationship, and physical violence. In certain instances, male partner's initiate the process of an abortion by paying for the procedure without revealing the cost to their female counterparts [29]. In the GMHS 2007, 6% of women stated they had an abortion because their partner did not want/denied the pregnancy. In the same vein, parental influence has been enumerated as a factor influencing abortion. This influence may be direct, where parents initiate the process, or indirect in which an abortion is carried out by the woman herself in order to escape family shame or parental backlash. Three per cent of respondents in the survey stated that abortions were undertaken "to avoid shame/fear of parents. Although gender preferences leading to sex-selective abortions have been widely reported in Asia, there is currently no evidence suggesting that the practice if present in Ghana is widespread. In the survey, the respondents make no mention of gender preference as a reason for abortion. The 2007 survey shows higher percentages of induced abortion among respondents who were either married or had been married in the past, compared with their unmarried counterparts. This lends credence to assertions that in the setting of low access to modern contraceptives, couples resort to abortion to achieve their desired family sizes. Union stability in relationships involving young especially unmarried partners has been identified as an influencing role in the decision to opt for an abortion or not [29]. The survey identifies key questions that could be used to extrapolate the stability of a union. Nine (9%) per cent of respondents stated that they "did not love the father/did not want to stay with the father" as reasons for opting for an abortion.

Consequences of Abortion

Almost all ill health and mortality following unsafe abortion is preventable, and adolescents who are mostly in secondary schools are aware of illegal abortion practices and their consequences [30], which range from physical,

psychosocial to economic in nature. The consequences are borne not only by women who acquire unsafe abortion but also by their families and the health care system. Both adolescents and non-adolescents suffer the consequences of abortion, but the impact is greater among adolescents. Adolescents present with morbidities such as haemorrhage, severe anaemia, trauma, foreign body, sepsis, or mortality. These are frequently associated with the procedure used, for instance, women who use herbs to induce abortion are less likely to present with trauma, foreign body, or sepsis than are women who use surgical abortion, roots, or catheters. Similarly, women who use herbs are less likely to obtain blood transfusions than those who use any other method. Haemorrhage is primarily the reason for admission among women who are having or have had an unsafe abortion. In a study by [31] among 111 women who had an unsafe abortion, 75% suffered severe haemorrhage, 11% suffered endometritis, 5% suffered anaemia, and 5% suffered hepatonephritis, while six women died.34 others may suffer from infection and infertility. Other effects are lifelong and devastating, such as psychosocial trauma, permanent disability, and infertility, a condition that upends their lives entirely.

Control Strategies for Abortion

Although adolescents and non-adolescents alike suffer similar abortion complications, adolescent-specific reproductive health policies, and particularly their implementation, are critically desired. Targets should be both in-school and out-of-school adolescents. Additionally, policies concerning the respect and protection of women and other vulnerable groups need to be implemented [32]. Adolescents themselves report the need for adequate information concerning reproductive health issues because in most cases, they are provided with information that is too superficial to help them when confronted with sexual and reproductive health challenges. For example, they have information regarding condom use29 but do not know how to use them correctly and consistently [33]. Adolescents and young adults need varying levels of protection and safety to aid them in making autonomous decisions and to be able to learn and grow. In the case of pregnancy, they need sufficient information, counselling, parental involvement, and contraceptive options. Additionally, identifying key areas of research and advocacy are equally important to control strategies. In conclusion, adolescents are mostly likely to use clandestine methods of abortion, the consequences of which are devastating, lifelong, or even fatal. Awareness and the effective utilization of adolescent- and youth-friendly services would minimize the problem. Social and emotional support in the event of unintended pregnancy is necessary. Awareness of who qualifies for a legal safe abortion and where it can be accessed is still low; hence, it should be included in health education if positive adolescent health outcomes should be realized.

CONCLUSION

As many as 41 African countries have liberalized abortion laws, and three countries have legalized abortion entirely. Still much action is desired to ensure safe abortion and to address the impact of unsafe abortion. There is an urgent need for alternatives to abortion through expanded and enhanced family planning services, and if unintended pregnancy has already occurred for a woman who qualifies for safe legal abortion, then safety should be guaranteed. Additionally, the research agenda needs to be defined and advocacy strategies identified to curb the incidence of unsafe abortion. Abortion, mainly unsafe induced abortion cannot be controlled unless unintended pregnancies are mitigated. This goal is achievable via harmonising contraceptive counselling and uptake, sexuality education, and meeting individual family planning needs. Similarly, better access to safe abortion and post-abortion care is fundamental, especially timely care for plausible complications.

REFERENCES

1. Sedgh G, Bearak J, Singh S, et al. (2018). Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. Lancet; 388: 258-267.
2. Coleman PK. (n.d). Negative abortion experiences: predictors and development of post-abortion psychological and relational adjustment scale. Issues Law Med 33: 133-162.
3. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. (2009). Abortion and mental health: Evaluating the evidence. Am Psychol 2009; 64: 863-890.
4. Lafarge, Caroline & Mitchell, Kathryn & Fox, Pauline. (2014). Termination of pregnancy for fetal abnormality: A meta-ethnography of women's experiences. Reproductive Health Matters. 22. 10.1016/S0968-8080(14)44799-2.
5. Lafarge C, Mitchell K, Fox P. (2014). Termination of pregnancy for fetal abnormality: a metaethnography of women's experiences. Reprod Health Matters; 22: 191-201.
6. Korenromp MJ, Page-Christiaens GC, van den Bout J, et al. (2005). Psychological consequences of termination of pregnancy for fetal anomaly: similarities and differences between partners. Prenat Diagn 2005; 25: 1226-1233.
7. Maguire M, Light A, Kuppermann M, Dalton VK, Steinauer JE, Kerns JL. (2015). Grief after second-trimester termination for fetal anomaly: a qualitative study. Contraception; 91: 234-239.

8. Kotta S, Molangur U, Bipeta R, Ganesh R. (2018). A Cross-Sectional Study of the Psychosocial Problems Following Abortion. Indian journal of psychiatry; 60: 217-223.
9. Sharma R, Radhakrishnan G, Bhatia MS, Gupta R, Mehdiratta A. Satisfaction and psychological after effects of legal abortion at a tertiary care teaching hospital of North India. J Obstet Gynaecol 2018; 38: 836-841.
10. United Nations Educational, Scientific and Cultural Organization (1995). [Internet].[cited 2024 Jan 3]. Available from: http://www.unesco.org/new/en/social-and-humansciences/themes/youth/
11. UNFPA (2012). Adolescents and Youth Demographics: An Overview. New York; p. 2.
12. Media Centre (2012). Adolescent pregnancy [Internet]. Fact sheet No 364. World HealthOrganization:Availablefrom:http://www.who.int/mediacentre/factsheets/fs364/en/index.html
13. Fawcus SR. (2008). Maternal mortality and unsafe abortion. Best practice & research. Clinical obstetrics & gynaecology, 22(3):533–48.
14. WHO (1993). The Prevention and Management of Unsafe Abortion. Geneva; p. 17.
15. Fawcus SR. Maternal mortality and unsafe abortion. Best Pract Res Clin Obstet Gynaecol. 2008 Jun;22(3):533-48. doi: 10.1016/j.bpobgyn.2007.10.006. Epub 2008 Feb 4. PMID: 18249585.
16. Otoide V, Oronsaye F, Okonofua F. (2012). Why Nigerian Adolescents Seek Abortion Rather than Contraception: Evidence from Focus-Group Discussions. Available from: http://www.guttmacher.org/pubs/journals/2707701.html
17. Rasch V, Kipingili R. (2009). Unsafe abortion in urban and rural Tanzania: method, provider and consequences. Tropical Med Int Health, 14(9):1128-1133.
18. Aké-Tano SOP, Kpebo DO, Konan YE, et al. (2017). Abortion practices in high school students in Yamoussoukro, Côte d'Ivoire. Sante Publique, 29(5):711-717.
19. Munakampe NM, Zulu MJ, Michelo C. (2018). Contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries: a systematic review. BMC Health Serv Res.,18(1):909.
20. Varga AC. (2002). Pregnancy termination among South African adolescents. Stud Fam Plan. 33(4):283-298.
21. Ghana Statistical Service (2012). 2010 Population & Housing Census - Summary Report of Final Results. Accra; 2012 p. 119.
22. Lassey AT. (1995). Complications of induced abortions and their preventions in Ghana. East African medical journal, 72(12):774–7.
23. Awusabo-Asare K, Abane A, Kumi-Kyereme A. (2004). Adolescent sexual and reproductive health in Ghana: a synthesis of research evidence.
24. Lithur NO. (2004). Destigmatising abortion: expanding community awareness of abortion a reproductive health issue in Ghana. African journal of reproductive health. Apr;8(1):70–4.
25. Olukoya AA, Kaya A, Ferguson BJ, AbouZahr C. (2001). Unsafe abortion in adolescents. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 75(2):137–47.
26. Ahiadeke C. (2001). Incidence of induced abortion in southern Ghana. International Family Planning Perspectives, 27(2):96–101.
27. Kumar A, Hessini L, Mitchell E. (2009). Conceptualising abortion stigma. Culture, Health & Sexuality, 37–41.
28. Braam T, Hessini L. (2004). The power dynamics perpetuating unsafe abortion in Africa: a feminist perspective. African journal of reproductive health, 8(1):43–51.
29. Dahlbäck E, Maimbolwa M, Kasonka L, Bergström S, Ransjö-Arvidson A-B. (2007). Unsafe induced abortions among adolescent girls in Lusaka. Health care for women international 28(7):654–76.
30. Paluku JL, Maduna P, Mabuza HL, Ndimande VJ. (2010). Knowledge and attitude of schoolgirls about illegal abortions in Goma, Democratic Republic of Congo. African J Prim Health Care Fam Med., 2:1.
31. Ouattara A, Ouédraogo A, Ouédraogo CM, Lankoande J. (2015). Unsafe abortions in countries that restrict legal abortions. Epidemiologic, clinical, and prognostic aspects at the University Hospital Center Yalgado-Ouédraogo of Ouagadougou. Med Sante Trop, 25(2):210-214.
32. Ushie AB, Izugbara OC, Mutua MM, Kabiru WC. (2018). Timing of abortion among adolescent and young women presenting for post-abortion care in Kenya: a cross-sectional analysis of nationally-representative data. BMC Women's Health, 18(1):41.
33. Guttmacher Institute (2013). Documenting the individual- and household-level cost of unsafe abortion in Uganda. Int Perspect Sex Reprod Health, 39(4):174-184.

https://rijournals.com/current-research-in-humanities-and-social-sciences/

CITE AS: Ezek Martins U. (2024). Factors Responsible for Abortions Practices among Adolescents in Africa: Focus on Ghana. RESEARCH INVENTION JOURNAL OF CURRENT RESEARCH IN HUMANITIES AND SOCIAL SCIENCES *3*(1):8-13.