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Lived Experiences with Abortion by Young Women Attended at United Bulawayo Hospitals

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ABSTRACT

In Zimbabwe, it is estimated that ten to fifteen thousand abortions occur annually. Abortion is one of the top five cause of maternal mortality in Zimbabwe and is rated to be at number four. The purpose of this study was to explore the experience of young women with abortion. An interpretive phenomenological qualitative design was used in this study. The study was carried out at United Bulawayo Hospitals in Bulawayo province. A purposive sampling method was used to recruit twelve participants for the study. In depth interviews were conducted on twelve young women using open ended questions. Data was analyzed using manual thematic analysis. Four major themes emerged and these are awareness of pregnancy, perceptions and experiences of unexpected painful reality, post abortion events and quality of care. Findings of the study showed that young women are struggling with this unique experience of abortion. There are low levels of support for them and poor service provision at the hospital and this has negatively impacted on them. The findings provide a context within which young women with abortion can receive quality care and appropriate support for them through counselling and formation of support groups and training of health workers.

Keywords: *Abortion, experiences, pregnancy, post abortion, young women*

INTRODUCTION

Abortion is the expulsion of the conceptus before 24 completed weeks of gestation, or a fetus weighing less than 500g [1]. Abortion is a sensitive and frequently stigmatized topic, both politically and socially. The issue is frequently surrounded by secrecy, shame and misconceptions, which can lead to negative health and social consequences [2]. Abortion may occur spontaneously or intentionally. Types of abortion are spontaneous, threatened, inevitable, complete, incomplete, missed, recurrent, and induced [3].

Literature Review

Each year, an estimated 210 million women throughout the world become

pregnant and about one in five of the pregnancy end up aborted [4]. The prevalence of abortion is still high in developing countries than in the developed countries [5]. It also is higher in countries where abortion is illegal. There is higher rate of abortion among younger age groups compared to the older women [6]. Young women's pregnancy remains a major challenge and contributor to maternal and child mortality. About 2.2 to 4 million young women worldwide undergo an abortion per year; 14% of these procedures are unsafe [1, 5]. Scholars have also singled Zimbabwe as among Sub- Saharan African countries characterized by increasing cases of safe and unsafe abortions [8]. Abortion laws influence access to care by women worldwide. Induced abortion is illegal in Zimbabwe, but is available under limited circumstances.

The causes of spontaneous abortion are unknown. Fifteen to twenty percent (15−20%) of spontaneous abortion are thought to be caused by abnormal genes or chromosomes. There are several risk factors that may predispose women to abortion and maternal age is one risk factor [9]. Lifestyles of women like smoking, alcohol and illicit drugs can also predispose women to abortion [10].

Women may experience a range of complications following any type of abortion and this may affect their quality of life and wellbeing. Abortion (especially unsafe) may have serious health consequences and cause complications such as haemorrhage, sepsis and uterine perforation [11]. Fifteen to twenty percent of women who abort suffer complications like retained products of conception (incomplete abortion) and long term health problems like chronic pelvic pain, tubal blockage, secondary infertility, depression and anaemia [12]. Management of abortion (spontaneous and induced abortion) involves both medical and surgical management. Management also depends on the gestational age and classification of abortion.

Much variation exists within the literature on the subject of women's experiences of abortion, but many clinical studies document the safety and efficacy of abortion procedures and importance to reduce unsafe abortions [13]. Abortion studies have focused on issues of epidemiological prevalence, the characteristics of abortion seekers, the reasons for abortion and their medical complications most of these studies have employed quantitative methods using medical records of women seeking care in public health facilities following complications of abortion [12]. These statistics do not capture experiences of abortion for women and their social contexts and this means public health issue of abortion has been presented in a statistical form with the women's voices and their contexts lacking [12].

Women often constitute a vulnerable group in society. To help women, nurses and midwives must have a better understanding of the ideas, perceptions and influences that are involved in the experience with abortion. There is a need to understand the experience faced by young women with abortion as this is an important contribution to the health profession and for clinical and policy reasons.

Methods and Methods

An interpretative phenomenological analysis (IPA) was undertaken in this study to explore the experiences of young women with abortion. The phenomenological analysis requires the researcher to understand and 'give voice' to the participants, whilst the interpretative analysis requires the researcher to contextualize and 'make sense' of this information [14]. The study was conducted at United Bulawayo Hospitals located in

the second largest town in Zimbabwe. The target population were women aged 15 to 24 years who had an abortion and are being seen at the Hospital.

Twelve participants were used in this study. Purposive sampling was used in order to identify participants that met the specific requirements or criteria for the study by the researcher. Data collection was done on a one to one basis using semi-structured interview guide. Data was captured through the use of audio tapes and writing. Data was analyzed using the thematic framework, this method was used to identify, analyze and report information in themes and sub themes within the data that was collected.

Thematic analysis was done in phases so as to create established meaningful patterns within the context of data on lived experiences of young women with abortion. Thematic analysis can be done in six phases which are familiarization with the data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes and finally producing the final report [15].

RESULTS

Ten participants (83, 3%) had spontaneous abortion and two (16, 7%) had self-induced abortion. The age range of the participants was 15 to 24 years giving a mean age of 21, 6%. Five participants (41, 6%) were single and seven (58, 4%) were married. Eight (66, 6%) had completed secondary school, two (16, 7%) had achieved the level of primary school, and two (16, 7%) tertiary levels. Eleven (92%) participants lived in the urban area of Bulawayo and one (8%) in the peri urban. Ten (83%) participants were unemployed, and one (17%) participant worked and one was self-employed.

Table 1: *Socio demographic data.*

Client number	Age	Marital status	Educational level	Employment status	Place of residence	Salary	Type of abortion	Number of abortions
1	17	Married	Primary level	employment	urban	Below 200	Spontaneous abortion	2
10	18	Single	Secondary level	Not employed	urban	N/A	Induced abortion	1
12	20	Single	Secondary level	Not employed	urban	N/A	Induced abortion	1
4	21	Single	Secondary level	Not employed	urban	N/A	Spontaneous abortion	1
11	21	married	Primary level	Not employed	Peri urban	N/A	Spontaneous abortion	1
3	22	married	Secondary level	Not employed	urban	N/A	Spontaneous abortion	1
5	23	married	Secondary level	Not Employed	urban	N/A	Spontaneous abortion	1
7	23	married	Tertiary level	Not employed	urban	N/A	Spontaneous abortion	1
9	23	married	Tertiary level	Not employed	urban	N/A	Spontaneous abortion	1
2	24	Single	Secondary level	Not employed	urban	N/A	Spontaneous abortion	1
6	24	Single	Secondary level	Not employment	urban	N/A	Spontaneous abortion	1
8	24	married	Secondary level	Self employed	urban	N/A	Spontaneous abortion	4

Table 2: *Themes and subthemes*

Theme	Subtheme	Frequency
Awareness of pregnancy	Discovering the pregnancy	9
	Reactions to the pregnancy	12
	Partner expectations	12
Perceptions and experiences of unexpected and painful reality	Cause of abortion	12
	Decision to terminate pregnancy	2
	Physical experience	9
	Emotions at the time of event	12
	Meaning of abortion	4
	Changes in their lives due to abortion	8
Post abortion events	Perceived support	12
	Presence of other pregnant women and young children	7
	Implications for future pregnancy	12
Quality of care	Perceptions of care given	12
	Counselling	5
	Support groups	5
	Pain management	8
	Post abortion family planning	11

Four major themes came out of the study with seventeen subthemes

First major theme: Awareness of pregnancy

Discovering the pregnancy: Majority of the participants (10) said they did a pregnancy test to confirm their pregnancy. Each of the participants had their own expectation when they did the pregnancy test.

Reactions to the pregnancy: Reactions of participants on learning that there are pregnant varied and depended on the meanings attached to the pregnancy and women's circumstances surrounding conception. There was anticipation and excitement of upcoming motherhood. Seven women reacted with a positive response to learning about their pregnancy. Having an unplanned pregnancy was another reason some of the women were not happy when they discovered they are pregnant.

Partner and Family Expectations: Majority of the partners were happy while a few were not pleased. Pregnancy also brought disappointment to the family and lead to forced marriage to the young women. Women who are pregnant out of wedlock were forced into early marriage. Very few were able to escape the arranged marriage which occurred because of the unplanned pregnancy.

Second major theme: Perception and Experiences of Unexpected and Painful Reality

Cause of Abortion: Majority of the women felt the cause of abortion was stress. Majority of the participants said the stress came from worrying that they are pregnant and also from pressure of their relationships and also from the family. They believed that this stress lead to them having their abortion. Some participants noted other things to be causing their abortions like abnormalities with the uterus, vaginal growths while some participants interpreted the abortion as a form of punishment from God. Two participants self-induced their abortion.

Decision to Terminate Pregnancy: The two participants terminated their pregnancy. One participant described in detail how hard it was for her to inset the tablets in her vagina. They knew it was a wrong decision and felt guilt about it. Both

women terminated their pregnancy through the use of tablets accessed from nurses for a price.

Physical Experience: Majority of participants talked about bleeding and expulsion of clots as the most recognized key signs noted. These symptoms or signs brought revelation that they were losing their pregnancy. Some participants with the onset of abortion symptoms did not come early to the hospital.

Emotions at the Time of Event: The common reactions to pregnancy loss included shock, sadness, pain and confusion. There was loss of hopes and dreams. This left them with intense emotional pain. Abortion was seen as an actual loss or symbolic loss to some of the participants.

Meaning of Abortion: Only four participants were able to put meaning to the abortion they went through. Abortion meant loss of hope and dreams, to some it meant that they killed their child, for some it meant punishment from God while to others it was a dead end of their lives.

Changes in their Lives due to Abortion: Most women felt the experience changed their lives in a positive and to some in a negative way and it was something they didn't want to go through again.

Third major theme: Post Abortion Events

Perceived Support: Participants acknowledged the importance of having emotional support within the relationship during this experience. Those who had support from relatives and partners copied better with the experience. A supportive partner acted as both a source of support but in some cases as a stressor for some of the women. The abortion experience led to intimate partner violence for some women and faced physical and emotional violence from the partner.

Presence of other Pregnant Women and Young Children: Confrontation with the presence of other pregnant women and young children triggered feelings of envy and brought pain to the participants and it also brought feelings of lost hope and dreams. Sharing the ward with other pregnant women and newborns was a traumatic and painful experience for some participants.

Implications for Future Pregnancy: Some participants said the experience made them want to wait to get pregnant while some participants did not wait for long before getting pregnant again. Those who did not wait long wanted to bring back the joy they felt when they were pregnant and some wanted to please their partners. The experience of pain and suffering and abortion made some participants insecure about their chances of becoming pregnant in the future. Myths and misconceptions in the community lead women to believe that they won't be able to carry to full term again.

Fourth major theme: Quality of care

Perceptions of Care Given: There were a number of shortcomings with the care given and some of the participants were not happy with the services rendered by health care workers. Health care workers attitudes were mentioned to be prohibitive of quality post abortion care. Waiting time was highlighted as a challenge by some participants. Delay in the emergency department was seen as a barrier to post abortion care. Other barriers to care were in terms of access to ultra sound scan (USS) which was needed before they got any help at the hospital. Some women had difficulties accessing the resources needed to pay for the care given. Poor communication was also noted to be a challenge between healthcare workers and patients and some of the participants were not pleased with how the health care workers talked to them. Lack of

management of women with threatening abortion or with abortion at local clinic where women were attended to first was highlighted.

Pain Management: Lack of pain management during MVA was highlighted by most participants. They said the procedure was very painful and no sedation was given during the procedure.

Post Abortion Family Planning: Post abortion family planning has been noted not to be done in majority of the clients. Education on family planning was about selected methods only and participants felt they had been given basic advice.

Counselling: Lack of counselling by health professionals was highlighted by most women after abortion they found it in other sources not at the hospital. The participants thought it will help them deal with what has happened and help them move on.

Support Groups: Participants highlighted the need for formation of support groups for women who have aborted. They felt there was a need for them to share their experience with other women and help them move on in life.

DISCUSSION

Young women's experience with abortion was a painful and life-altering event. When confronted by the news of their abortion, women experienced shock, numbness, pain and disbelief as they struggled to grasp the series of events that were unfolding to them. The experience of abortion was more complex, and comprised of many losses. Regardless of the type of abortion (spontaneous or induced), the women spoke of their loss as the loss of a child. Findings of this study revealed that most women thought stress was the cause of their abortion, this might be true as supported by a study which found that stress and emotional changes increased the risk of early spontaneous abortions [13].

The women spoke of positive growth as an outcome of their experience while some said this experience brought negative issues in their lives. For some women this process with abortion led to domestic violence. Health workers play a significant role in the provision of care of abortion and also to detect issues of domestic violence. Poor partner support was the most highlighted issue in this study. The findings are similar to a study which revealed lack of support from the partners for women who had undergone abortion and this impacted negatively on the women [16].

There were mixed levels of satisfaction within the health care sector. Communication is integral to effective care, and poor communication can negatively impact on the recovery process of women who have undergone abortion. This can be a barrier to post abortion care and can lead to women not accessing the services which might save their lives. Poor perception of care was also rooted in the hospital design and infrastructures where women had to share a ward with women with babies when they had just lost theirs. This leads to poor post abortion care. Deciding on the right time to try again following abortion is complicated by the provision of contradictory advice from healthcare providers and the women's own families' views. Women might get pregnant to early and this can lead to recurrent abortions or they might get ill and increase the rates of maternal morbidity.

There should be appropriate referral mechanism for young women with abortion. Transportation for referred cases should be provided from Primary Health Care (PHC) centers to higher level of care.

In the study women were referred to higher levels from PHC late or told to go the following day. This predisposed them to complications of abortions because of late referral. There was lack of technical competence in the skill of doing the MVA procedure, infection prevention and pain management with the participants. WHO said the most important factor for a successful MVA procedure is appropriate pain management [17, 18]. In this study majority of the women complained of pain during MVA and their concerns were not addressed. WHO goes on to say pain during MVA varies and is mostly caused by cervical dilatation, anxiety and uterine evacuation and manipulation [1].

Post abortion contraception services should be availed before women are discharged to help women avoid future unwanted and unplanned pregnancy. Weeks et al, in their study revealed that PAC services should improve treatment and link women to FP and other reproductive services [18]. Few families accepted the young women's pregnancies, but did not deal with them with understanding and affection which would have helped them. Most parents imposed marriage on the young women because of the pregnancy. Even when they did not want to get married this forced them to give up their own desires and expectations. This worsened the situation and lead to issue of domestic violence and abuse within these early marriages enforced on them. Forced marriages constitute serious and recurrent violations of human rights and the rights of the young women under the cloak of respect for the culture and traditions because a young woman got pregnant outside marriage. Women value an opportunity to be counselled, more so in the case of a life changing event. Counselling should respond to this need or to be referred if necessary as highlighted in this study.

CONCLUSION

Abortion is a reality and a unique experience. It is a painful and life altering event. Regardless of type of abortion all women spoke of loss of a child. There is need to help young women to prevent occurrence of abortion and support them through the process with abortion. There is need to remove barriers to PAC like poor communication, domestic abuse and poor support systems. There is need to remove culture and traditions which violate young women's rights and increase maternal mortality.

RECOMMENDATIONS

Activities should shift from being service centered to more client focused and allow health care workers to identify problems and develop solutions. There is need for empowerment of young women on the use of FP to prevent unwanted pregnancy. Provide community education activities to inform people about dangers of early pregnancy, domestic violence and importance of support on women who have had an abortion.

There is need for comprehensive documentation of midwifery practice to demonstrate the impact of abortion on women's health and lives. The hospital needs to strengthen post abortion counselling and follow up counselling for the first three months post abortion. There is need for provision of analgesics during MVA procedure. Provision of post abortion contraceptive services and follow-up should be strengthened with the inclusion of partners in the counselling.

REFERENCES

1. World Health Organization (2006), "Pregnant adolescents: Delivering on global promises of hope",
2. Kumar A, Hessini L, Mitchell EM (2009), "Conceptualising abortion stigma", *Cult Health Sex*, Volume 11, pp. 625–639.

3. Solo J (2000), "Easing the pain: pain management in the treatment of in-complete abortion", *Reproductive Health Matters*, Volume 8, pp. 45–51.
4. World Health Organization (2011), "Unsafe abortion Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008",
5. Sundaram A, Juarez F, Bankole A et al. (2012), "Factors associated with abortion-seeking and obtaining a safe abortion in Ghana", *Family Planning*, Volume 43, Issue 4, pp. 273–286.
6. Maina BW, Mutua MM, Sidze EM (2015), "Factors associated with repeat induced abortion in Kenya", *BMC Public Health*, Volume 15, Issue 1048.
7. Denberu B, Alemseged F, Segni H (2017), "Determinants of Abortion among Youth Seeking Reproductive Health Care in Selected Health Facilities, in Addis Ababa, Ethiopia", *Global Journal of Reproductive Medicine*, Volume 1, Issue 2,
8. Ngwena C (2013), "Access to Safe Abortion as a Human Right in the African Region", *South African Journal on Human Rights*, Volume 29, Issue 2, pp. 399–428.
9. Nybo Andersena AM (2014), "Risk factors for miscarriage from a prevention perspective: a nationwide follow-up study", *Royal College of Obstetricians and Gynaecologists*, DOI: 10.1111/1471-0528.12694.
10. Andersen AM, Andersen PK, Olsen J, Gronbaek M et al. (2012), "Moderate alcohol intake during pregnancy and risk of fetal death", *International Journal Epidemiology*, Volume 41, pp. 405–413.
11. Diedrich J, Steinauer J (2009), "Complications of surgical abortion", *Clinical Obstetrics and Gynaecology Journal*, Volume 52, Issue 2, pp. 205–212.
12. Broen A, Moum T, Sejersted A et al. (2005), "The course of mental health after miscarriage and induced abortion: a longitudinal, five-year follow-up study", *BMC Medicine*, Volume 3, Issue 18,
13. Lie M, Robson SC, May C (2008), "Experience of Abortion; A narrative review of qualitative studies", *BMC Health service research*, Volume 8, Issue 150,
14. Patton MQ (2002), "Qualitative research and evaluation methods (3rd ed.)", Thousand Oaks, CA: Sage.
15. Creswell JW (2009), "Research Design: Qualitative, Quantitative, and Mixed Methods Approaches (3rd edition)", Thousand Oaks, CA: Sage.
16. Alex L, Hammarstorm A (2004), "Women's experience in connection with induced abortion- a feminist perspective", *Scandinavian Journal of caring Sciences*, Volume 18, Issue 2, pp. 160–180.
17. World Health Organization (2003), "Safe abortion: Technical and policy guidance for health systems", Geneva: WHO.
18. Weeks A, Alia G, Blum J et al. (2005), "A randomized trial of misoprostol compared with manual vacuum aspiration for incomplete abortion", *Obstet Gynecol*, Volume 106, pp. 540–547.