EFFECT OF STIGMA ON THE CHOICE BETWEEN MEDICATION AND SURGICAL ABORTION

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Introduction

Since comprehensive abortion care services, as permitted by law, became a key components of reducing maternal morbidity and mortality objective of the 2007-2011 Ghana Reproductive Health Strategic Plan (GHS 2011***),*** medication abortion (MA) and surgical abortion with the use of manual vacuum aspiration (MVA) have become the major procedures for abortion in health facilities. While in the use of MVA all the process of evacuation of the fetus is completed at the health facility, in the case of MA this process can be completed at home; The woman only needs to follow the instructions given to her by the health provider and some minimal telephonic follow-up. Some studies have even found that follow-up might not be necessary as completion rate between those followed up and those who are not followed up have been found to be the same (Iyengar et al., 2016; Li et al. 2017; Li-Ping et al, 2018). In spite of the fact that both MA and MVA are equally effective and recommended by WHO for uterine evacuation within 12 weeks of gestational age (WHO, 2014), there are marked differences in the choice between these two procedures. In some settings women prefer MVA to the MA while in others MA is a more preferred choice. Demographic and economic background of the clients have been found to be some of the factors associated with the choice between these two approaches in Ghana and elsewhere (Kuffour et al, 2011; Tamang et al, 2012). But in a highly stigmatized environment, a woman's decision to choose either MA or surgical abortion is a function of not only her demographic and economic background, but also facility level nuances and the way she perceives people around her would react to the abortion service she has received. So we hold that a woman would choose method that would minimizes stigma within the environment she finds herself much more than demographic and economic considerations. In other words our aim for this paper is to determine how consideration of stigma affect the choice of abortion procedure method within the given environment.

Method

We interviewed 337 women who had just received comprehensive abortion care from 35 randomly selected public primary, secondary and tertiary health facilities in eight regions of Ghana. We asked series of questions about their level of worries of people's reaction to the abortion service when found out in a four-point Likert scale. The scale, measuring interitem covariance of 0.77 and reliability coefficient of 0.91, was used as the main independent variable as proxy for stigma in two models. The first model is a simple logistic regression and the second a multilevel logistic regression analysis, taking account of facility level nuances. In both models the controlled variables include age, education level, marital status, gravida, and gestational age of the terminated pregnancy. Others include cost of service, mean travel time to the facility and general feeling about waiting time before receiving service at the facility. The dichotomous dependent variable has 1

indicating choice of MA and 0 MVA/other. Women who were brought to the facility bleeding from attempted abortion as well as those who did not receive information about the availability of the two procedures at the facility were excluded from the analyses as they could not make a free and informed choice between MA and MVA.

Some preliminary results

As Table 1 shows, of the 337 women who came for comprehensive abortion services only 43 (12.8%) chose MA. The index measuring level of worry about what people would say or think about the abortion service received shows higher levels for women who opted for MVA than those who chose MA. There is not much differences between the two groups of women (those who chose MA and those who chose MVA) in age and marital status. But there are some

Table 1: Demographic characteristics of women receiving MA and surgical abortion (MVA) in Ghana

		MVA (n=294)	MA(n=43)
Mean level of worry		7.33	5.87
Age	Young	44	45
	Old	56	55
Education	None/Prim	23	21
	JSS	38	60
	SS/Tertiary	39	19
Marital status	Steady partner	29	37
	Married	54	49
	Widow/Sep	17	14
Gravida	Primigravida	37	26
	Multigravida	63	74
Cost of services(GHc)	<=100	38	77
	101-200	43	16
	>200	19	7
Gestational age	1-4 weeks	15	26
	5-8 weeks	53	51
	9 weeks +	32	23
Mean travel time (Min)		47	38
Waiting time	Acceptable	75	98
	Too long	25	2

differences between the two groups in education, gravida, cost gestational age, mean travel time and waiting time. For example while most of the women who chose MA have Junior Secondary School level of education, the same cannot be said of those who chose MVA. Most of the women who chose MA paid about Ghc100 (US$20) and generally those who chose MVA had slightly higher gestational age. Average traveling time is a little more for MVA acceptors than MA acceptors (47 minutes vrs 38 minutes). Even though a majority (over 70%) of women from both groups were satisfied with the waiting time at the facility, women who accepted MA were more much more okay with the waiting time at the facility.

Preliminary Conclusion

The descriptive analysis seems to suggest that women are less likely to choose MA in favour of MVA the more they feel they are worried that people around them at would be gossiping, judgmental, disappointed or humiliating them when found out. This is because with MA, there is a possibility of being found bleeding at home and suspected of having an abortion – a source of worry they would rather avoid. They would therefore have MVA where everything is completed at the health facility before going home. More light will be thrown on this when the various factors are controlled in the simple logistics and multilevel logistic analyses.

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