

Psychology of Abortion: A Qualitative Exploration of Women's Quality of Life after Termination of Pregnancy Service Provision

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Abstract

Background

Although safe abortion is a human right, some research indicates that abortion can be considered a life event that could trigger an adverse psychological reaction, including mental ill health, particularly in vulnerable women. Unplanned pregnancies and abortions affect women's mental and physical health while increasing psychological risk; hence, measures are needed to improve the quality of life (QoL) of women post termination of pregnancy (ToP). The purpose of this study was to explore the psychological effects of abortion on women provided with this service in Rwanda, and factors surrounding QoL after service provision.

Methods

An interpretive description design was used. Focus group discussions were used to hear the voices of 30 women and girls who had sought ToP services. The six steps of interpretive description together with framework analysis guided the analysis.

Results

From responses provided by the participants with experience of ToP services five themes and six sub-themes were generated, (1) Ambivalence with mixed feelings and uncertainty, anger, wonder, and frustration; (2) Insecurity and abortion stigma, with judgement and inadequacy; (3) Personalized care with respectful care and dignity and self-reliance; (4) Lack of connection with relationships, coping, and a sense of belonging; (5) Wellness and preferences for care with hope and positive physical health.

Conclusion

The lack of psychological support post ToP negatively affects QoL and indicates an opportunity to include a psychological support package in the ToP service provision, which is the predictor of positive mental health to improve QoL in Rwanda.

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Introduction

Abortion is a common experience and a central component of sexual and reproductive health (SRH) occurring in every country and every community. Around 73 million abortions take place worldwide each year.[1] The World Health Organisation (WHO) recognises that a high number of unsafe abortions is carried out, estimating that 22 million such abortions in 2018 resulted in the death of an estimated 47,000 women while many other women developed complications necessitating medical attention.[2,3] The same authors [2] stipulate that the global annual rate of abortion for all women of reproductive age, that is, between 15 and 44, is estimated to be 35 per 1,000 women, and the abortion rate per 1,000 women aged 15–49 rose from 37 in 2015 to 39 in 2019.

In the developing world, especially in low- and middle-income countries, unsafe abortions account for 86% of the total global abortions, and Rwanda has an annual rate of 25 unsafe abortions per 1,000 women aged 15–44.[4] There has been a noticeable decline in the unsafe abortion rate in Rwanda since different measures have been taken to allow women and girls to access safe abortion services, including (1) the ratification within the penal code of 2012 to have the law determining offences and penalties in general of 2018 and the related ministerial order and (2) training and mentorship of healthcare providers (HCPs) to improve service delivery and the various approaches put in place to inform the community and health facilities. A confidential enquiry carried out by the Ministry of Health (MoH) into maternal deaths in 2020 found a drop from 25 per 1,000 to 12 per 1,000 since new measures and laws were introduced.[5] Further, a study conducted in one referral hospital in Kigali found that complications and deaths related to unsafe abortions account for 8% of all causes of maternal deaths.[6] The global commitment to ensure SRH integration into primary health care (PHC) includes services

related not only to antenatal and postnatal care, but also comprehensive abortion care as part of the sustainable development goals (SDGs).[7] The SDGs are a collection of 17 interlinked global goals designed to be a "blueprint to achieve a better and more sustainable future for all".[7]

The SDGs were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity. The SDGs, especially SDG3 which talks about good health and wellbeing, has led to a remarkable reduction in the number of maternal deaths and reduced discrimination against women and girls. Developments in this direction include services to help prevent unintended pregnancies through the provision of comprehensive sexuality education and a choice of effective and affordable modern contraceptive methods as well as access to safe abortion care and post-abortion care to the full extent of the law. As part of sexual and reproductive health and rights (SRHR), safe abortions are fundamental to people's health and survival, gender equality, and the well-being of humanity when performed and approved by trained people in a safe environment.[8] When this service is not provided in this way, abortions become unsafe and cost women's lives, despite the Global Strategy for Women's, Children's and Adolescent's Health (2016–2030).[9] The Global Strategy for Women's, Children's and Adolescent's Health is a roadmap to achieve the highest attainable standard of health for all women, children, and adolescents. It focuses on safeguarding women, children, and adolescents in humanitarian and fragile settings and upholding their human rights to the highest attainable standard of health, even in the most difficult circumstances.

Although safe abortion is a human right, studies have noted that it can be considered a life event that could trigger adverse psychological reaction, including mental ill-health, particularly in vulnerable women.[7] While having unplanned pregnancy has a strong impact on mental and physical

health, abortion itself may increase the psychological risk and adversely affect a woman's mental health; hence, various measures are needed to improve the quality of life (QoL) of women after safe abortion service provision.[2,8]

The purpose of this study was to explore the psychological effects of termination of pregnancy (ToP) on women provided with the service in Rwanda and factors surrounding QoL after service provision. The following research question was therefore formulated to orient the study: what are the typical psychological effects on women of undergoing ToP that influence their QoL?

Methods

Design

The study applied an interpretive description design. This design was chosen as it aims at exploring complex and dynamic aspects of human experience while being flexible enough to allow researchers to adapt their approach as they gain deeper insights into the phenomenon under study.[10] The six key steps to interpretive description were used to generate rich, contextually grounded understandings of complex phenomena related to QoL among participants after ToP service provision.[11] The concept of health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*", as formulated by the WHO in 1948 framed the study's categorisation (explained in the data analysis with framework), and discussion opinions with study participants were compared to define QoL post ToP.[12]

Setting and sample size

Rwanda has five provinces, including Kigali city. Each province has at least five district hospitals (DH) that provide ToP-related services. The present study randomly selected three DHs from three provinces. As concerns rural and urban contexts, we selected one rural, semi-urban, and urban DH for the focus group discussions (FGD), and three groups were constituted.

Creswell suggests a sample size of five to 25 participants in descriptive qualitative studies when one-to-one interviews are considered.[13] However, as the present study aimed at gathering and assessing outcomes post ToP, FGD were used. FGD were selected over in-depth interview (IDI) as all the women were exposed to the same service and had not been supported psychologically; thus, the sharing of their common experiences would stimulate them to express their views. The room reserved for the FGD was entirely private; only the researchers and study participants were present. This study recruited 30 participants at three health facilities with no more than 10 participants per FGD.

Population and confidentiality

Women and girls provided with ToP services a month before data collection were potential participants of the present study. We considered a period from 2019, when legal abortion was permitted under five criteria in Rwanda (rape, incest, forced marriage, the pregnant person is a child aged under 16 years (the age by which a person is not yet registered for the national identity card), and if the pregnancy poses risks to the unborn child and/or the mother).

Inclusion and exclusion criteria

The inclusion criteria regarded women and girls at any legally permissible age for abortion who had sought ToP services in the mentioned period, willing to participate and consented to discuss their experiences. The converse were the exclusion criteria. The FGDs were recorded using codes instead of names to ensure anonymity and confidentiality. Participants were also informed about their right to withdraw at any time if they wished without consequences.

Recruitment

The study participants were recruited from their communities to meet the research team at the DH where they had sought the ToP service. Selected midwives working in the labour and delivery wards and in charge of ToP services played the role of gatekeepers in each health facility and were tasked

with calling potential study participants after taking their names and contact details from the maternity registers. The research team was aware of the law and ministerial order determining offences and penalties in general and defining ToP service provision. They considered gender equality and were knowledgeable about gender, maternal, and neonatal health issues, including the country's abortion profile. The research team also had previous experience of conducting FGDs about maternal health issues and mental health problems and had undertaken a training on qualitative methods at the University of Rwanda, College of Medicine and Health Sciences. The team also included at least one mental health nurse.

Data collection

The research team composed of three (SM, GN and PU), introduced (each at the assigned site) the study purpose and procedure to the participants at the health facilities. Those who consented were included in the FGDs. Before conducting the FGDs, the research team considered existing health-related QoL measurements and identified potential health-related QoL attributes. The WHO's definition of health was used to help them understand, develop, and utilise real-world knowledge about psychological support and mental health outcomes to suggest improvements to QoL post ToP service provision in Rwanda. Using this definition, we perceived health-related QoL as a state of complete positive physical, mental, and social well-being.[14]

Focus Group Discussion

All the FGDs were held over a period of two months by a research team of three persons. The FGD topic guide was used to ensure that a common set of questions was asked. The topic guide was based on noted QoL attributes of positive (self-esteem and life satisfaction) and negative (anxiety and depression/grief) mental health outcomes post ToP service provision. While self-esteem as part of confidence in one's own worth or abilities, life satisfaction is known as an overall well-being of an individual;

anxiety is a feeling of worry, nervousness, or uneasiness about something. Depression is known as a low mood or loss of pleasure or interest in activities for long periods of time and most of the time with suicide ideation. The mentioned attributes were considered in this study as women are found to fall into two categories of mental health outcomes post ToP: positive mental health or negative mental health. These attributes informed the questions that composed the topic guide. The guide also included general open-ended questions about the process through which the women passed when they decided to undergo ToP, whether any psychological support was given (social, family, partner, and/or healthcare providers) to improve their QoL, and their feelings after ToP (satisfaction, self-esteem, anxiety, or grief/depression). They were also asked what factors they thought were associated with negative or positive mental health outcomes after ToP, and what could improve QoL after ToP services. The FGDs lasted between 45 and 60 minutes each.

Analysis

The FGD recordings were transcribed verbatim, and field notes were considered for any additional information. Data were analysed using framework analysis.[15] Framework analysis provides flexibility during the analysis process as it allows the user to collect all the data and analyse them either after or during the data collection process. As the study used interpretive description, the gathered data were recorded, and sorted in accordance with key issues and themes. Further, a five-step process of framework analysis was followed, namely (1) familiarisation with the transcripts of data collected, (2) identification of a thematic framework, (3) indexing, (4) charting, and (5) mapping and interpretation.[16] Subsequently, the researchers sought to determine which QoL attributes may be influenced by healthcare interventions, such as whether psychological interventions were provided.

In the framework-based analysis, the research team analysed the data by finding repeating themes, coding the emergent themes with phrases, grouping the codes into concepts, and categorising the concepts through relationships. According to the definition of health already stated, during the FGDs we encouraged the study participants to freely express their own understandings of the attributes mentioned and how they affected their lives after the provision of safe abortion services. Consequently, the women shared their experiences freely, and the research team did not consider data saturation as every respondent had her own experience. The research team did not write down any repeated information, and any such information was removed from the transcript. We further performed comparisons at the individual level

(what each informant valued in her experience of ToP services and mental health outcomes) and how these values applied to the entire group of participants. The final stage of the framework was mapping and interpretation, in which the relationships between themes were considered. At this stage, it was apparent that although the main themes were the same, the content differed in terms of the wider spectrum of views of QoL identified from our FGDs.

Results

1. Demography

Most of our participants 18 (60%) were married, farmers (66.6%), and had semi-primary level of education (38.8%). In consideration of former income categorization, the most of the participants fell in the third category, which is C (56.6%)

Table 1. Demographic characteristics of the study participants

Item	Sub-Item	Frequency (%)
Marital status	Married	18 (60)
	Single	4 (13.4)
	Divorced	8 (26.6)
	Prefer not to say	0 (0)
Professional status of participants	Farmer	20 (66.6)
	Public sector	3 (10)
	Self-employed	4 (13.3)
	Student	2 (6.6)
	Not employed	1 (3.3)
	Private sector	0 (0)
Education level of participants	No formal education	4 (13.3)
	Semi-primary	12 (38.8)
	Primary education	10 (33.3)
	Semi-secondary	3 (10)
	Secondary	1 (3.3)
	Tertiary education	0 (0)
	No formal education	4 (13.3)
Economic status of participants	Category E (poor income category)	17 (56.6)
	Category D	10 (33.3)
	Category C	3 (10)

Key:

Category C: Those with middle-income generation

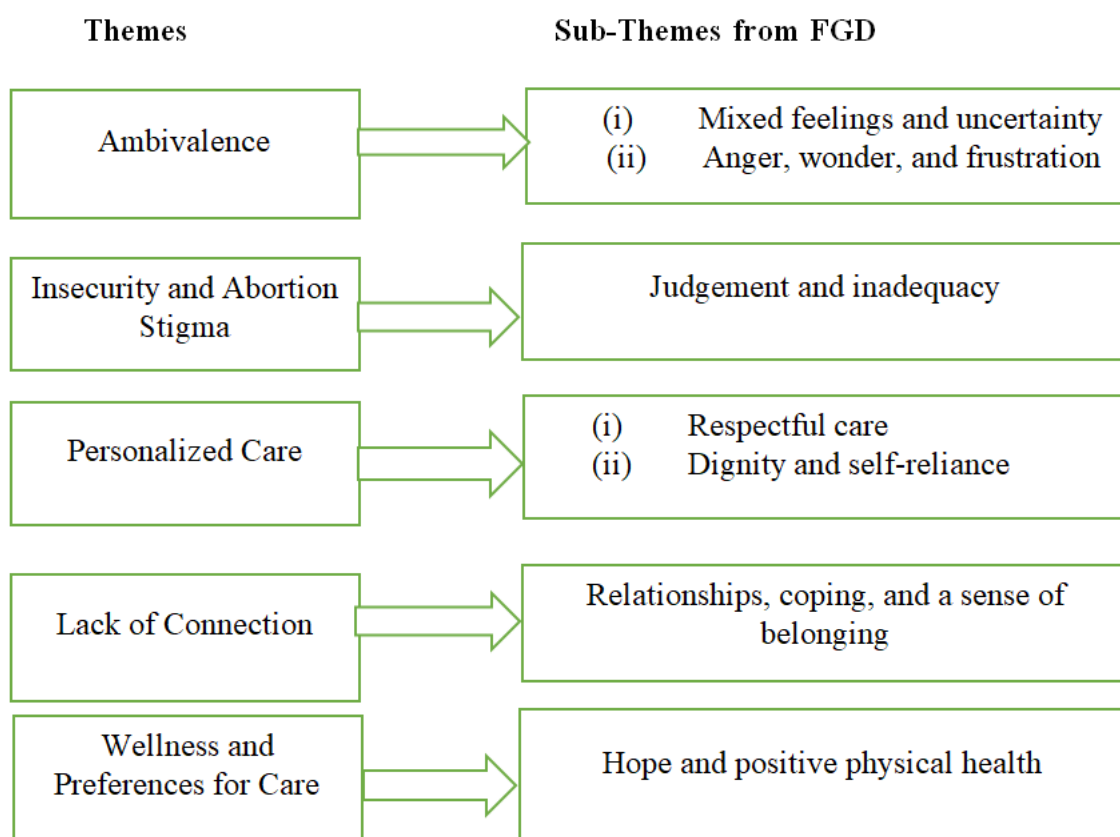
Category D: Come before E and an individual in this category can graduate to C if supported

Category E: It is poor income generation and the last on the list of the Ubudehe category

2. Emerging themes

During our FGD, several key themes emerged that encapsulate the perspectives and experiences shared by the participants. The quotes shared were the results of all the ideas and experiences of the study participants within a theme or combined themes. The themes were (1) ambivalence, with a sub-theme of mixed feelings and uncertainty, anger, wondering, and frustration; (2) insecurity and abortion stigma, with a sub-theme of judgement and inadequacy;

(3) personalized care, with two sub-themes: a. respectful care and b. dignity and self-reliance; (4) lack of connection, with a sub-theme of relationships, coping, and a sense of belonging; and (5) wellness and preferences for care, with a sub-theme of hope and positive physical health. The themes shed light on participants' QoL after they were provided with ToP. By exploring these themes and their specific sub-themes in depth, we can gain valuable insights into the lives and mental health of women and girls post ToP.



Theme 1: Ambivalence

Sub-theme: Mixed feelings and uncertainty
This sub-theme highlights women's different behaviours and feelings after ToP service provision that impact on their QoL. It includes having mixed feelings or contradictory ideas about what happened in their lives, including being raped and having unplanned pregnancies. This state also involves experiencing conflicting emotions, which can lead to feelings of uncertainty and indecision. Additionally, anger, wondering, and frustration were among the mixed feelings that emerged as the women shared their experiences. The following quote is a result of combined ideas from FGD 1:

“When I think that I was a student with a bright future and the fact that I was raped by a person I do not love and do not know; I project my future, and it becomes hard to understand. When I decided to terminate the pregnancy, I was in a total dilemma. I always remember what happened to me and get anxious. I also experience both unnecessary misery, and it's sabotaging me in many ways.” (FGD1)

The aspect of feeling unsteady was attributed to the feelings of anger, wonder, and frustration in

experiences shared during the FGDs, and this experience was common to all members of the FGD. Although the feelings of anger may appear to be very personal, the study participants revealed the same source, that is, that they stemmed from a sense of loss or guilt or the feeling that the decision was forced upon them. Similarly, the participants revealed a sense of wonder or questioning about what could happen in the future. Frustration was also noted among the study participants, especially in FGD 3, due to the complexity of the emotions surrounding the ToP as well as the potential societal or personal pressure to terminate the pregnancy. They further noted feelings of confusion and isolation and a sense of injustice.

“I get angry sometimes, and I am not sure what could happen to me if this situation comes again, as the one who raped me is still out there. My life so far has been miserable because of the situation that happened to me, which has caused me to feel frustrated in many ways. I do not want to be seen by anyone.” (FDG 3)

Theme 2: Insecurity and abortion stigma

Sub-theme 1: Judgement and inadequacy
Another factor that the participants experienced as a result of internal and external sources is judgement. Judgement by members of society, including relatives and HCPs caused the study participants to lack a sense of worth. Abortion stigma was also noted as a determinant of worthlessness and inadequacy among participants and will have a negative effect on their immediate wellbeing and therefore their ability to improve their QoL in the long run.

“They were judging us as murderers of our own children, and I reflect back on that and feel like I do not mean anything in this world.” (FGD 2). “In addition, I always feel like if I tell someone the reality of what happened to me, they will take it as lies, and it may be the source of judgement. I just keep quiet because I do not trust anyone and I do not want them to come to me either” (FGD 3).

“I am somehow not fine because I met my neighbours at the clinic when I came for the service, and I wondered if they would reveal the secret in my neighbourhood; if I had not met them, I would be more comfortable.” FDG 3.

Theme 3: Personalized care and dignity

Sub-theme: Respectful care

Our FGD also identified aspects of well-being as important parts of QoL. These tended to be more about feeling healthy, having a safe procedure, and going back to normal. The participants appreciated the compassionate and supportive care they received when undergoing ToP, which helped them to improve their QoL.

“I remember when I was raped and found out that I am pregnant, it was very stressful. However, after being provided with safe care from the health centre where I was transferred to the hospital, I felt like I was relieved of having a burden of a child whose father I do not know. They respected us during the care provision, and they guided us from the beginning to the end.” (FGD 1)

Sub-theme 2: Dignity and Self-reliance

On the other hand, those who were less distressed at the time of the FGDs expressed having positive well-being in certain areas of their lives, which included but were not limited to pursuing leisure activities, attending school, and other activities they were actively striving to undertake.

“We have resumed our productive activities, including schools. I am now back to school and performing like the others, though I have lost time. I am doing my business like any other businesswoman; the problems I face are the problems related to the labour market, like any other.” (FGD1)

Theme 4: Lack of connection

Sub-theme 1: Relationships, coping, and a sense of belonging

The FGDs identified a concept of belonging as fitting with societal perspectives and the quality of relationships, which are very important to QoL. They expressed feeling a sense of camaraderie if they have a chance to share their experience

other women who have had abortions and HCPs. The revealed that they did not have good relationships with their partners that would promote mutual support, but they wanted to have someone to talk to if need be and that this moment could help improve their QoL. As concerns coping post ToP, the participants similarly noted some sort of grief and guilt and a range of complex emotions and suggested that seeking support from friends, family members, or HCPs can provide valuable coping strategies and aid in the healing process. In terms of a sense of belonging, the participants revealed feelings of isolation and a disrupted sense of belonging. They further suggested that finding understanding and empathetic spaces, such as in support groups or counselling, can help in re-establishing a sense of belonging and connection.

"I would have feelings of belonging in a society that understands me if that space was provided. We are only provided with services, but no one is there to understand what we are passing through after we leave the health facilities" (FGD 1). "...you find ways of coping even though the ways of coping do not seem fair enough. You find ways of dealing with your life on a daily basis...otherwise, it would be better if we had that approach of sharing our experience with others and time with the HCPs who helped us." (FGD 3)

Theme 5: Wellness and preferences for care

Sub-theme 1: Hope and positive physical health

Our study participants revealed the importance of maintaining hope and good physical health. Hope can be fostered through therapy, support groups, and open conversations with trusted individuals, while physical health encompasses attending post-ToP check-ups, following medical advice, and ensuring that any physical concerns are addressed promptly, all of which were suggested in all the FGDs. Having a focal person (HCP) to undertake follow-up and address any concerns regarding their psychological status and well-being was seen as an important way to

improve their future QoL. These were necessary conditions to initiate positive changes and have hope for a better future.

"Sometimes I think I need medical personnel to talk with when I am down. It is important to us to have a trusted individual to accompany us in rebuilding our identity for our future well-being and to advise about our physical fitness." (FGD 2)

A more positive outlook tended to be expressed by our participants about the mental health problems experienced post ToP, and they suggested closer monitoring of those undergoing ToP to prevent the development of mental health problems or other diseases.

"It is good and helpful to have somebody to help us to go away from developing depression. Otherwise, we are candidates to develop more diseases, such as pressure and diabetes." (FGD 1)

Discussion

The aim of this study was to explore the psychological effects of ToP service provision on service users in Rwanda, and factors surrounding QoL after service provision. To obtain this information, we first identified the essential domains of QoL that are important in the context of healthcare interventions related to ToP, such as self-esteem, life satisfaction, anxiety, and grief/depression, as part of mental health outcomes post ToP. Five main themes pertaining to the attributes of QoL after being provided with the ToP service were identified: moral conflict with abortion; negative judgement and lack of self-esteem; respectful care and self-reliance; relationships, coping, and a sense of belonging; and hope and positive physical health. Comparing these themes with the literature, we note that our findings are similar to those of various studies.[17–18] Additionally, our findings from the FGDs highlighted how these attributes could be differentiated by positivity, negativity, and what could be done better to improve positive mental and physical health outcomes. On this note, those with distressing difficulties (at the time of the FGDs) were more likely to talk about losses (what would reduce QoL),

whereas those with improved mental health spoke more of the things that would add to QoL.

Mixed feelings and uncertainty

As regards mixed feelings and uncertainty after an abortion, it is important to acknowledge that these emotions are common and valid. Many individuals experience a range of emotions, which can include relief, sadness, a sense of empowerment, grief, and depression.[15] This finding is consistent with the domains of QoL that women and girls experience after ToP service provision and has a negative outcome on their QoL.[16] Individual beliefs, emotions, and circumstances, including feeling anger, wonder, and frustration, are behaviours commonly expressed by women post ToP and has an impact of self-distractive behaviours as part of negative QoL in long run. [17] In addition to feelings of fear and anxiety, a finding related to a study of depression symptoms that interfere with QoL is consistent with this study.[18] The literature suggests that the impact of depressive behaviour may be different from that of anxiety,[8] indicating that anxiety and depression should be treated as separate conditions rather than being combined; and that depression should be given a greater weighting when both are present. While some women are more predisposed to having mental health problems post ToP due to pressure from people around them, mental health issues, such as anxiety and depression, or a moral or ethical code that opposes abortion, all women will have deeply personal feelings about the event. However, everyone's experience is unique, and it is essential to determine which approach fits individual needs especially when it comes to feelings of judgement and inadequacy.

Insecurity and abortion stigma

Many women who have had a ToP do not feel they have a safe place to process the emotions in the aftermath of recovery.[18] due to different factors including the extreme opposition of people around them, parents' behaviours related to blame for having the procedure, and, in the case of rape and

incest, because the woman and the family do not have the same understanding. For our participants, those who were negatively judged by their societies felt very much that they were stigmatised and isolated and thus did not protect their immediate well-being to maintain positive QoL in the long run. Similarly, the behaviours of those with low self-esteem and who are unable to cope with humiliation were detrimental to QoL, as well feeling hopelessness and despair, as suggested in the literature.[14] As regards emotions, women may feel insecure about the decisions they have made or worried about the judgements of others, or they may experience guilt and grief, concerns about their future, fear, and worry about the impact on their relationships. Further, they may experience changes in their body or health that contribute to a sense of insecurity as far as physical and emotional parts are concerned.[15] This was observed in the present study, as most of our participants testified that they felt insecure after ToP service provision.

Personalized care

Tailored care after an abortion refers to the specific attention given to an individual following an abortion procedure, which includes physical and emotional support as well as guidance to recovery and potential complications.[19] Respect for the care provided had an influence on our study participants' self-trust, which improves QoL. This can be seen in their testimonies, which show that those who were provided with respectful care services had increased confidence although they desired support whenever it was needed. Subsequently, feeling loved and cared for was an important point to consider in terms of QoL.[20] Respectful care was seen as a predictor of independence among women and girls provided with ToP services. Similarly, literature reveals that respectful care contributes to a more positive patient recovery experience and can improve the physical and mental QoL of people with serious illnesses.[21] Furthermore, women's QoL after an abortion relies on strong partnerships with people around them,

most importantly, healthcare providers. After ToP, healthcare providers play a vital role in supporting women's dignity and self-reliance. The literature notes that HCPs can provide empathetic and non-judgemental care and information about post-abortion recovery as well as contraceptive counselling and can ensure follow-up when needed. [22] By respecting women's autonomy and decisions, such provision fosters a sense of dignity and self-reliance post ToP that improves QoL.

This study and previous findings are consonant in that they both identified certain aspects of well-being as important to QoL by increasing self-reliance.[7] These aspects tended to concern feeling healthy, calm, relaxed, and safe after being provided care with respect.[23] For some of the participants, particularly those who had received ToP services more recently, respectful care and self-confidence were ideal perceived determinants of improved QoL.[24]

Lack of connection

The concept of connection is fundamental to the human experience and encompasses various aspects of social and group work activities for individual development, including relationships, coping, and a sense of belonging post ToP.[23] Following an abortion, women are prone to see their relations with their partners, family members, and friends affected.

The importance of relationships is considered a predictor of positive mental health to those sought an abortion. However, the two major challenges to maintaining close personal relationships are neglect (i.e., not making time for the relationship) and not dealing constructively with conflict (which, in return, causes people to lose control of themselves).[9] Being proactive in one's personal relationships and meeting these relationships is the key to keeping people happy, supportive, and personally satisfied. Being happy, connected, and supported, help women and girls to have a better QoL if they had someone with whom to talk.

Similarly, sharing experiences with other women who have similar cases or can improve their QoL as they feel that they are not alone in the event.

Coping can be a complex process, and women may experience grief, guilt, relief, or a mix of emotions.[5] Accessing and developing coping mechanisms should be emphasised as means to navigate these feelings. The same situation applies to this study and participants revealed not having a sense of belonging in their daily life, but they felt isolated and judged and a loss of connection to their own identities and values.

The literature notes the importance of belonging and highlights that it is crucial to life satisfaction, happiness, mental and physical health, and even longevity when applied effectively.[8] Research has shown that loss of belonging has been associated with stress, illness, and decreased wellbeing and depression.[24] A social connection, which accompanies a sense of belonging, is a protective factor that helps people manage stress and other behavioural issues. Developing a sense of belonging can help individuals process their emotions, reduce feelings of isolation, and find empathy and support from others who have shared similar experiences. Our study participants revealed that they needed someone to be with and talk to as part of not feeling alone. This connection will increase personal resilience and effective coping even in difficult times. [9]

Wellness and preferences for care

Wellness and preferences for care refer to the physical, emotional, and psychological well-being of the individual who underwent the procedure as well as their choices and needs regarding post-abortion care. [10] There is a range of support factors that an individuals may require to ensure their overall well-being and recovery after the abortion procedure. These include access to healthcare, emotional support, contraception options, follow-up care, and any additional assistance or information. [11] It is important for HCPs and support

whereas those with improved mental health spoke more of the things that would add to QoL.

Mixed feelings and uncertainty

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Insecurity and abortion stigma

Many women who have had a ToP do not feel they have a safe place to process the emotions in the aftermath of recovery.[18] due to different factors including the extreme opposition of people around them, parents' behaviours related to blame for having the procedure, and, in the case of rape and

incest, because the woman and the family do not have the same understanding. For our participants, those who were negatively judged by their societies felt very much that they were stigmatised and isolated and thus did not protect their immediate well-being to maintain positive QoL in the long run. Similarly, the behaviours of those with low self-esteem and who are unable to cope with humiliation were detrimental to QoL, as well feeling hopelessness and despair, as suggested in the literature.[14] As regards emotions, women may feel insecure about the decisions they have made or worried about the judgements of others, or they may experience guilt and grief, concerns about their future, fear, and worry about the impact on their relationships. Further, they may experience changes in their body or health that contribute to a sense of insecurity as far as physical and emotional parts are concerned.[15] This was observed in the present study, as most of our participants testified that they felt insecure after ToP service provision.

Personalized care

Tailored care after an abortion refers to the specific attention given to an individual following an abortion procedure, which includes physical and emotional support as well as guidance to recovery and potential complications.[19] Respect for the care provided had an influence on our study participants' self-trust, which improves QoL. This can be seen in their testimonies, which show that those who were provided with respectful care services had increased confidence although they desired support whenever it was needed. Subsequently, feeling loved and cared for was an important point to consider in terms of QoL.[20] Respectful care was seen as a predictor of independence among women and girls provided with ToP services. Similarly, literature reveals that respectful care contributes to a more positive patient recovery experience and can improve the physical and mental QoL of people with serious illnesses.[21] Furthermore, women's QoL after an abortion relies on strong partnerships with people around them,

most importantly, healthcare providers. After ToP, healthcare providers play a vital role in supporting women's dignity and self-reliance. The literature notes that HCPs can provide empathetic and non-judgemental care and information about post-abortion recovery as well as contraceptive counselling and can ensure follow-up when needed. [22] By respecting women's autonomy and decisions, such provision fosters a sense of dignity and self-reliance post ToP that improves QoL.

This study and previous findings are consonant in that they both identified certain aspects of well-being as important to QoL by increasing self-reliance.[7] These aspects tended to concern feeling healthy, calm, relaxed, and safe after being provided care with respect.[23] For some of the participants, particularly those who had received ToP services more recently, respectful care and self-confidence were ideal perceived determinants of improved QoL.[24]

Lack of connection

The concept of connection is fundamental to the human experience and encompasses various aspects of social and group work activities for individual development, including relationships, coping, and a sense of belonging post ToP.[23] Following an abortion, women are prone to see their relations with their partners, family members, and friends affected.

The importance of relationships is considered a predictor of positive mental health to those sought an abortion. However, the two major challenges to maintaining close personal relationships are neglect (i.e., not making time for the relationship) and not dealing constructively with conflict (which, in return, causes people to lose control of themselves).[9] Being proactive in one's personal relationships and meeting these relationships is the key to keeping people happy, supportive, and personally satisfied. Being happy, connected, and supported, help women and girls to have a better QoL if they had someone with whom to talk.

Similarly, sharing experiences with other women who have similar cases or can improve their QoL as they feel that they are not alone in the event.

Coping can be a complex process, and women may experience grief, guilt, relief, or a mix of emotions.[5] Accessing and developing coping mechanisms should be emphasised as means to navigate these feelings. The same situation applies to this study and participants revealed not having a sense of belonging in their daily life, but they felt isolated and judged and a loss of connection to their own identities and values.

The literature notes the importance of belonging and highlights that it is crucial to life satisfaction, happiness, mental and physical health, and even longevity when applied effectively.[8] Research has shown that loss of belonging has been associated with stress, illness, and decreased wellbeing and depression.[24] A social connection, which accompanies a sense of belonging, is a protective factor that helps people manage stress and other behavioural issues. Developing a sense of belonging can help individuals process their emotions, reduce feelings of isolation, and find empathy and support from others who have shared similar experiences. Our study participants revealed that they needed someone to be with and talk to as part of not feeling alone. This connection will increase personal resilience and effective coping even in difficult times. [9]

Wellness and preferences for care

Wellness and preferences for care refer to the physical, emotional, and psychological well-being of the individual who underwent the procedure as well as their choices and needs regarding post-abortion care. [10] There is a range of support factors that an individuals may require to ensure their overall well-being and recovery after the abortion procedure. These include access to healthcare, emotional support, contraception options, follow-up care, and any additional assistance or information. [11] It is important for HCPs and support

systems to consider and respect the preferences and needs of individuals in order to provide appropriate and sensitive care post ToP.[27] However, most of our study participants spoke of lack of physical and psychological support when seeking ToP services, which has had a negative impact on their QoL. HCPs should ensure that individuals receive comprehensive care and support for their physical and emotional well-being post ToP to maintain positive QoL.

Strengths and limitations

The study methodology helped to examine ideas in relation to QoL as it concerns mental health outcomes and to view the data acquired in the context of the situation. The study used FGD in which every participant was given an equal chance to share her views on positive and negative mental health outcomes. One of the limitation of the study is that FGD can be challenging to undertake, but the moderators had considerable experience of working with people with a spectrum of mental health problems in past research studies and therefore the sessions went smoothly. In addition, because of its personal intimate nature, especially when the pregnancy was a result of rape in married women, questions about close and sexual relationships were difficult to raise; hence, this subject area was not fully explored. Our sample consisted exclusively women and girls who had used ToP service provision rather than those who had self-induced ToP at home, and this may have resulted in an over-emphasis on this category and narrowed our review of QoL.

Conclusions

Women and girls have negative or positive mental health outcomes after being provided with ToP services; and the impact the services have on their mental health do affect their QoL. Five domains of QoL were identified, namely, ambivalence, insecurity and abortion stigma, tailored care, lack of connection and wellness, and preferences for care, which were compared with the possible negative mental health outcomes (anxiety and depression) and positive

mental health outcomes (self-esteem and satisfaction). The lack of psychological support post ToP negatively impacts QoL. There should therefore be psychological support policy and package at individual and HF level, which are the predictor of positive mental health to improve QoL post ToP service provision in Rwanda. The support should be both physical and emotional for women and girls who seek ToP service provision. There is need to explore empirically both the positive and negative items in each theme to better understand what health means in terms of improving the QoL of women and girls post-ToP.

Authors' contribution

All authors affirm that they have played a significant role in the conception, design, data analysis and interpretation, and writing of the manuscript. However, the team contributed very much as follow:

SM: Designed the concept, corrected the proposal, collected data, analysed data and produced the first draft of manuscript

TCU: Corrected the concept, proposal and the manuscript, analysed the data

GN: Corrected the proposal, collected data, analysed the data and reviewed the manuscript

MM: Corrected the proposal, collected data, analysed the data and reviewed the manuscript

UP: Corrected the proposal, designed the tools, collected data, analysed the data and reviewed the manuscript

PM: Corrected the proposal, collected data, analysed the data and reviewed the manuscript

EN: Corrected the manuscript, introduced the study at the clinical sites (administration), refined the manuscript

LB: Analysed the data, and presented the findings, reviewed the manuscript

VS: Reviewed the proposal, analysed the data, and presented the findings, reviewed the manuscript

DM: Reviewed the proposal, reviewed the data and results, shaped the manuscript

SR: Reviewed the proposal, reviewed the data and results, shaped the manuscript

KMA: Reviewed the proposal, analysed data, critically reviewed the final manuscript
 OB: Refined the proposal, reviewed the data collected, reviewed the manuscript

Conflict of interest

All authors affirm that there is no actual or potential conflict of interest.

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