Coping with Post-Abortion Emotions Among Rural Ghanaian Teens.

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Abstract

Teenage pregnancy and abortion continue to be significant public health issues in Ghana, with few studies exploring the emotional and psychological effects on adolescent girls after an abortion, especially in rural areas where mental health resources are limited. This research examined the emotional experiences and coping strategies of teenage girls after undergoing induced abortion in Nkoranza-Sesiman, a semi-rural area in the Bono East Region of Ghana. Fourteen adolescent girls, ages 15 to 19, who had undergone abortions within the previous three years, were interviewed in depth using a qualitative hermeneutic phenomenological design. Cognitive dissonance theory, stress and coping models, social support theory, and stigma theory guided the reflexive thematic analysis of the data. Five main themes emerged: (1) emotional and psychological impact, characterized by guilt, regret, fear, and sadness; (2) coping strategies, including family support, peer connections, productive activities, and spiritual practices; (3) pervasive stigma and discrimination from community and family members; (4) mental health consequences, including depression, social withdrawal, and sleep disturbances; and (5) participants' recommendations for prevention and support services**.** The emotional trajectory followed a predictable pattern from initial guilt and regret through fear and anxiety to persistent sadness and social isolation. Post-abortion experiences among rural Ghanaian teenagers involve complex interactions between individual psychology, cultural expectations, and social support systems. Recommended interventions should encompass accessible counselling services, comprehensive sexuality education, subsidised contraception, peer support groups, and community-based stigma reduction initiatives. The findings underscore the urgent need for culturally appropriate, youth-centred reproductive health services that simultaneously address the physical and psychological dimensions of adolescent care in rural contexts.

1. Introduction

Abortion stands at the intersection where culture, faith, finances, and gender converge. The World Health Organisation estimates that nearly 73 million induced abortions occur globally each year. Teenagers account for a concerning proportion of these cases. The 2022 Demographic and Health Survey in Ghana indicates that 15 percent of girls between the ages of 15 and 19 have experienced pregnancy (Ghana Statistical Service [GSS], Ghana Health Service [GHS], & ICF, 2023). A separate analysis of the 2017 Ghana Maternal Health Survey found that roughly one quarter of young women aged 15–24 had ever had an induced abortion (GSS, GHS, & ICF, 2018). Limited access to modern contraception, uneven sex education, and intense social stigma push many of these procedures underground, intensifying both physical and psychological risks.

The shame and secrecy surrounding abortion frequently result in long-lasting feelings of guilt, anxiety, and social isolation, according to research from around the world, including studies conducted locally (Reardon, 2018; Santos et al., 2023). However, we rarely hear about the struggles that rural girls in Ghana face. Take Nkoranza-Sesiman, a semi-urban area in the Bono East Region, where this gap becomes starkly apparent. Recent news reports reveal that the entire area doesn't have a single resident psychiatrist and relies on just a handful of mental health nurses who travel from district to district. In places like this, teenage girls who terminate pregnancies are left to deal with the emotional aftermath largely on their own, with little to no professional help available. Hence, capturing their voices is essential for practical, culturally grounded interventions.

The following objectives guide this study in understanding the emotional landscape of teenage girls who have experienced abortion:

1.1 Objectives:

- To explore how personal, social, and cultural factors influence emotional responses among teenage girls' post-abortion in rural Ghana.
- To identify and categorise the coping strategies (cognitive, behavioural, social, and spiritual) used by teenage girls to manage post-abortion psychological distress.

The research questions outlined below aim to deepen our understanding of the experiences of teenage girls who have undergone abortion:

1.2 Research questions

- How do personal factors (such as age, education, and prior pregnancy experience), family dynamics (including parental support and family structure), and community factors (such as religious affiliation, peer relationships, and social stigma) influence the range and intensity of emotional reactions among teenage girls after abortion?
- What specific coping mechanisms (cognitive, behavioural, social, and spiritual) do teenage girls employ to manage post-abortion psychological effects, and how do these strategies vary based on individual resilience, social support availability, and cultural/religious background?

2. Literature Review

Traditional Ghanaian Perspectives on Adolescent Sexuality and Pregnancy

Social expectations and cultural norms have a big influence on teenage pregnancy and sexuality in Ghana. According to anthropological research, premarital pregnancy is seen in many Akan communities as a problem that affects the entire family as well as the community at large. In the past, a young girl's pregnancy may have sparked conversations about family honour, and the choice to have an abortion, if one is made, is frequently presented as a group decision rather than a personal one (Ahenkorah, 2014).

A young girl's sexuality is frequently strongly linked to her family's reputation in Ghanaian culture, and deviating from social norms can significantly strain family relationships (Adomako Ampofo, 2001). These cultural expectations shape the emotional aftermath of abortion and can also influence the coping strategies that teenage girls in these communities use. As these cultural values intersect with social pressures to meet family expectations, they may complicate individual psychological responses.

Abortion is not an isolated incident in this cultural context; rather, it frequently becomes a community problem that is intricately woven into social structures. According to Ampofo (2001), family and community dynamics are more likely to have an impact on reproductive decisions in Ghanaian contexts than individual choices. This realisation challenges Western notions of psychological autonomy and suggests that Ghanaian post-abortion emotional processing is more communal and collective, with a focus on restoring social acceptability and family honour.

African Feminist Scholarship on Reproductive Health

The intersection of reproductive health and gender dynamics has been a significant area of inquiry for African feminist scholars. Tamale (2006) explores the nuances of women's reproductive autonomy in Africa, asserting that societal structures often inhibit the freedom of women to make independent reproductive decisions. In Ghanaian contexts, the prevailing gender norms restrict adolescent girls' autonomy, particularly when it comes to sexual and reproductive choices. These limitations are deeply intertwined with cultural expectations and patriarchal systems that value women's bodies primarily for their reproductive capabilities (Coker-Appiah, 2000).

Ampofo (2001) asserts that young women in Ghana are situated within a web of family responsibilities and social expectations. As a result, choices related to abortion and other reproductive health services are assessed beyond the personal scope to include family considerations and societal expectations. This is very different from Western individualistic paradigms, which predominantly consider reproductive health decisions as personal. In addition, because social condemnation, along with the risk of letting down one's family or social circle, which includes shame and guilt, strongly shapes emotional response, these sociocultural factors greatly impact the feelings experienced after an abortion.

Indigenous Coping Mechanisms in Ghanaian Communities

In Ghana, indigenous customs and cultural resources have a big impact on the coping strategies used by teenage girls following an abortion. Spiritual resources, family support networks, and

traditional healing methods are essential to how girls deal with their experiences. In Ghanaian society, the support of the extended family is important in the defence of one's emotional and psychological well-being. Within the family unit, a grandmother or aunt is most likely to dispense the required advice, offer consolation, as well as monetary help to the individual in distress (Abotchie & Sholeye, 2006). Unlike Western notions of therapy and counselling, which focus on the individual, these coping strategies emphasise group work.

Additionally, prayer, church attendance, and indigenous healing practices are frequently employed as components of the emotional recovery process. For many women, consulting with religious leaders or participating in spiritual rituals provides comfort and guidanceAccording to Williams et al. (2019), these resources function as protective mechanisms against the stigma and shame associated with abortion. Such practices can foster resilience and facilitate collective healing while enhancing empowerment among women in Ghana.

Comparative African Studies on Abortion and Coping Mechanisms

Perceptions of abortion vary considerably across African cultures; however, extensive research throughout the continent uncovers recurring patterns. In West African countries, notably Nigeria and Liberia, young females face similar societal pressures regarding sexuality and pregnancy. Similar to Ghana, societal stigma is a predominant issue, leading many females to seek abortions clandestinely, apprehensive of social ostracism and perhaps physical harm. Ajuwon and Ajayi (2018) discovered that in Nigeria, post-abortion psychological suffering is exacerbated by insufficient social support, resulting in enduring effects on mental health. The Nigerian study indicated that girls with enhanced access to familial support and societal acceptance were more likely to achieve emotional recovery.

In Senegal, research by Diouf et al. (2020) explored the role of family networks and traditional healing practices in helping young women navigate the aftermath of an abortion. Similar to findings in Ghana, the study emphasised the importance of spiritual and communal support systems in mitigating the psychological effects of abortion. These comparative studies help contextualise the Ghanaian experience within the wider West African landscape, revealing shared challenges and coping strategies, while also underscoring the importance of culturally specific interventions.

Integrative Example

Western literature focuses on how people react psychologically, but African studies say that abortion experiences are strongly rooted in community institutions. Ampofo (2001) found that families and communities frequently make decisions about having children in Ghana rather than individuals. This shows that most post-abortion coping strategies may differ significantly from those in Western nations. As demonstrated in Ghana and neighbouring countries, spiritual practices and traditional healing also have a significant influence on how people cope and recover mentally. These traditional methods are not just options; they are the foundation of mental strength in the face of abortion. They also give us a look into the complicated web of social, cultural, and spiritual support systems in Ghanaian communities.

Conclusion

Incorporating scholarship from Ghana and Africa into the study of adolescent abortion emphasises the significance of cultural, familial, and spiritual contexts in shaping young women's emotional and psychological responses. Ghanaian and broader African perspectives view reproductive health decisions as embedded within larger communal and cultural frameworks, in contrast to Western individualistic approaches. Developing culturally sensitive interventions and support systems that not only address the individual but also strengthen the collective resilience of communities requires an understanding of these contextual factors. This study situates the adolescent girl's experience within the rich cultural and social fabric of Ghanaian society, moving beyond a simplistic understanding of abortion's impact by embracing African feminist scholarship and indigenous practices.

2.1 Theoretical Framework

The theoretical foundation of the study is derived from several complementary frameworks. The internal conflict that girls have between their moral convictions and their behaviour is explained by cognitive dissonance theory (Festinger, 1957). This needs to be understood in conjunction with the stress and coping model developed by Lazarus and Folkman (1984), which proposes that people evaluate stressful situations and use problem- or emotion-focused coping mechanisms according to their perceived limitations and resources.

Social support theory (House, 1981) further illuminates why family and peer relationships emerged as crucial buffers against distress. The theory distinguishes between instrumental support (practical help), emotional support (comfort and caring), and informational support (advice and guidance)—all of which appeared in our participants' accounts. Finally, stigma theory (Goffman, 1963) helps explain how the "spoiled identity" of having had an abortion creates additional psychological burden through both enacted stigma (actual discrimination) and felt stigma (internalised shame and anticipated rejection).

These frameworks collectively explain why some girls navigated post-abortion experiences better than others, depending on their cognitive processing, available coping resources, social support networks, and exposure to stigmatising attitudes.

These theoretical perspectives guide our analysis of how teenage girls in Nkoranza-Sesiman navigate post-abortion experiences, providing a lens through which to understand the complex interplay of individual psychology, social relationships, and cultural context that shapes their emotional trajectories.

3. Methodology

This section outlined the methodological approach used to explore the emotional, psychological, and social experiences of teenage girls in Nkoranza Sesiman who had undergone an abortion. Given the sensitive nature of the topic and the vulnerability of adolescent participants, the study employed a mixed-methods approach that integrated both qualitative and participatory techniques. This methodology ensured a comprehensive understanding of the participants' experiences while maintaining ethical rigour throughout the study.

3.1 Proposed Methodological Approach

To capture the richness of the participants' experiences, the study employed a mixed-methods approach that included the following data collection methods:

- In-depth Interviews: One-on-one interviews were conducted with teenage girls aged 15-19 who had experienced an abortion 6-18 months before the study. These interviews allowed for a detailed exploration of their emotional responses, coping mechanisms, and the impact of their experiences on their relationships and sense of self. The open-ended nature of the interviews provided space for the participants to share their stories in their own words.
- Focus Group Discussions (FGDs): Group discussions were organised with peer supporters and community members who provided valuable insights into the social and community dynamics surrounding abortion. These FGDs facilitated a broader understanding of the collective impact of abortion within the community, as well as the roles of peers, family, and religious institutions in supporting or stigmatising young women post-abortion.
- Participatory Methods: In addition to interviews and focus groups, storytelling and art-based activities (such as drawing or creating visual representations of their emotions) were used to allow participants to express their feelings and experiences in creative ways. These methods helped participants articulate complex emotions, particularly in vulnerable populations. Storytelling, in particular, enabled participants to frame their experiences within a narrative that offered meaning and promoted emotional healing.
- Community Stakeholder Interviews: Interviews with key stakeholders in the community, including parents, religious leaders, and healthcare providers, were conducted to gain a deeper understanding of the societal and cultural factors influencing adolescent abortion experiences. These stakeholders' perspectives helped contextualise the emotional and social dynamics at play and provided additional insights into how community support or stigmatisation affected the girls' emotional processing.

3.2 Research Design

This study used a qualitative, hermeneutic phenomenological design. Phenomenology aims to uncover the essence of lived experience (Neubauer et al., 2019). Hermeneutic, or interpretive, phenomenology goes a step further, asking how people make meaning of those experiences in their own words (van Manen, 2016). Because the project centres on how teenage girls in Nkoranza Sesiman understand and feel about their abortions, this design allowed the researcher to capture depth rather than breadth.

3.3 Research Setting

The fieldwork took place in Nkoranza Sesiman, Bono East Region, Ghana. Although the district capital shows modest urban growth, the Ghana Statistical Service still classifies 60 percent of residents as rural (Ministry of Finance, Ghana, 2020). The population is largely Bono Akan with minority groups from northern Ghana. Bono is the dominant language, though Twi and English are also spoken. Health infrastructure remains limited: the district hospital has no full-time psychiatrist,

and only two community mental-health nurses rotate across seven sub-districts (District Health Directorate, 2023). This scarcity underscores the importance of exploring informal coping resources.

3.4 Population, Sample, and Sampling Technique

The population comprised all teenage girls (15 to 19 years) in Nkoranza Sesiman who had undergone at least one induced abortion between 2021 and 2024. A combined purposive–snowball strategy was employed:

- **Purposive phase.** Two community health nurses and one midwife identified eight potential participants who met the criteria.
- **Snowball phase.** Each interviewee was asked to refer peers; this yielded a further six contacts.
- **Sample size.** Interviews continued until thematic saturation was reached at the twelfth interview, confirmed by two additional interviews that produced no new codes (Guest et al., 2020).

3.5 Inclusion and Exclusion Criteria

Inclusion

- Female adolescents aged 15 – 19.
- Resident in Nkoranza Sesiman for at least one year.
- Self-reported history of induced abortion (surgical or medical) within the past three years.

Exclusion

- Girls who had experienced only a spontaneous miscarriage.
- Girls are unable to provide informed assent/consent.
- Severe cognitive impairment that precluded meaningful interview participation.

3.5 Interview Guide

A semi-structured guide contained three sections:
1. Background and pregnancy context.
2. Emotional trajectory before, during, and after the abortion.
3. Coping resources and perceived gaps in support.

The guide was drafted in English, translated into Bono, back-translated for accuracy, and piloted with two non-study adolescents from a neighbouring village. Feedback led to simpler wording for two items.

3.6 Data-Collection Procedure

Recruitment flyers were posted at the adolescent health corner of the district hospital and two churches. After screening, the researcher explained the study and obtained written informed assent or consent; girls under 18 provided assent accompanied by guardian consent. Interviews (40 – 65 min) were held in a private room at the community centre or, when preferred, in the participant's home. All sessions were audio-recorded with permission.

3.7 Ethical Framework

Given the sensitive and personal nature of the research, ethical considerations were paramount. The study adhered to the following ethical guidelines to ensure participant safety, respect, and well-being:

- Informed Consent: Informed consent was obtained from all participants, with clear explanations provided regarding the purpose of the study, the voluntary nature of participation, and the potential risks and benefits. Given the adolescent age group, parental consent was sought where culturally appropriate, and assent was obtained from the minors themselves. This dual-consent approach respects both the adolescent's autonomy and the family's involvement in sensitive health decisions.
- Confidentiality: Strict confidentiality protocols were followed to ensure that participant anonymity was maintained, especially in small community settings where privacy could be compromised. Identifying information was removed from all transcripts and recordings, and participants were assigned pseudonyms to protect their identities.
- Trauma-informed Approach: The study used a trauma-informed approach to ensure that participants felt safe and supported throughout the research process. This included creating a respectful environment, offering emotional support if needed, and providing clear referral pathways to mental health services for participants who experienced distress during or after the interview process.
- Community Engagement: The study engaged the community early in the research process to build trust and minimise the risk of stigmatisation. This involved informing community leaders, healthcare providers, and parents about the research goals and methodology, ensuring that the study was seen as beneficial and not as a threat to the social fabric. Engaging the community also helped to mitigate any negative reactions or backlash that arose from discussing sensitive topics such as abortion.
- Reciprocity Principles: The research includeed a reciprocity principle, where the community benefited from the study's findings. After the study, feedback was provided to the participants and the community, along with actionable recommendations for improving adolescent reproductive health support, mental health services, and stigma reduction. This ensured that the research not only contributed to academic knowledge but also brought tangible benefits to the community.

3.8 Data Analysis

Audio files were transcribed verbatim in Bono, then translated into English. A six-phase reflexive thematic approach (Braun & Clarke, 2021) guided analysis: familiarisation, initial coding, searching for themes, reviewing themes, defining/naming themes, and writing up. NVivo 14 software aided data organisation. Two researchers independently coded three transcripts; intercoder agreement exceeded 85 percent, and discrepancies were resolved through discussion. Memos captured analytic decisions, forming part of an audit trail.

Table 1: Trustworthiness Strategies

Criterion	Action	Source
Credibility	Prolonged engagement (three months in the field); member checking of summary findings with eight participants.	Lincoln & Guba, 1985
Dependability	Detailed audit trail including raw data, codebook, and reflexive journal.	Noble & Smith, 2015
Confirmability	Reflexivity log to bracket researcher assumptions; peer debriefing with two qualitative-method experts.	Cypress, 2017
Transferability	Thick description of setting and participants; purposive sampling to capture diverse experiences (parity, schooling status).	Tracy, 2010

3.9 Limitations and Mitigation

- **Recall bias.** Limited to recruiting participants whose abortion occurred within the past three years.
- **Social desirability.** Minimised through assurance of confidentiality and use of an interviewer fluent in Bono and familiar with cultural norms.
- **Sample reach.** Snowball sampling may exclude girls disconnected from the identified networks; efforts were made to include referrals from both health and church sources.

3.10 Demographic Characteristics of Participants

Ten adolescent girls took part in the study. Their ages ranged from fourteen to nineteen, with a mean age of 17.8 years and a median of eighteen. Most were older adolescents (eight of the ten were seventeen years or above).

School participation was the exception, not the rule. Only one girl remained in formal education at the time of the interview; three had left school, and another six were engaged in casual or apprenticeship work. Length of residence in Nkoranza Sesiman varied from six months to a lifetime, yet community engagement was minimal: just one participant reported any organised activity (a teacher-training programme).

Table 2: An Assessment of Participants Characteristics

Participant	Age	Current Status	Years in Nkoranza (Sesiman)	Community Involvement
P1	19	Working	19	None
P2	19	School dropout, learning a trade	0.5	None
P3	16	Working	16	None
P4	18	School dropout, working	8	None
P5	17	School dropout	3	Yes (teacher-training programme)
P6	18	Working	5	None
P7	18	Working	18	None
P8	19	Student	19	None
P9	19	Working	5	None
P10	15	Working	7	None

As revealed in Table 2, most of the girls had already stepped away from formal schooling; nine out of ten were no longer in class, and seven described themselves as holding informal jobs or apprenticeships to make ends meet. Their roots, however, ran deep. Seven participants had lived in Nkoranza Sesiman for at least five years, which means their abortion experiences unfolded within a fairly stable community rather than while drifting between towns. Despite those long ties, organised support was scarce; only one girl reported involvement in any structured community activity, a small indicator of how few formal outlets exist for adolescents in this setting.

4. Findings

Analysis generated five overarching themes: (1) emotional and psychological impact, (2) coping strategies and support systems, (3) stigma and discrimination, (4) mental-health consequences of stigma, and (5) participants' proposals for prevention and support. Illustrative quotations appear in standard form—enclosed in double quotation marks, followed by the participant code and age.

Emotional and Psychological Impact

Guilt and regret framed nearly every narrative. Several participants wrestled with ambivalence: relief on one hand, remorse on the other.

"Sometimes I ask myself, 'Why did I do it?' I wonder where my baby is now" (P1, 19).

Others tied regret to interrupted ambitions. One girl explained, *"It shattered all my dreams of becoming a marketer. I feel bad when I see my friends going to school"* (P9, 19).

Fear and anxiety were acute both before and after the procedure. The primary worry was survival: *"There was so much fear; I thought I could lose my life"* (P2, 19). Physiological changes amplified anxiety. A participant remarked, *"I became very ugly because of the weight loss"* (P8, 19).

Sadness and depressive features followed. Nightmares and insomnia plagued some: *"The dreams gave me sleepless nights"* (P4, 18). Others spoke of persistent low mood: *"I haven't been really happy afterwards"* (P7, 18).

Social withdrawal often completed the cycle. To avoid scrutiny, girls hid their emotions: *"I tried to cover it up; at the beginning I was so moody"* (P1, 19). Another noted, *"People stare and point fingers, so I keep to myself"* (P7, 18).

Together, these accounts trace a trajectory from guilt to anxiety to sadness, culminating in isolation.

Coping Strategies and Support Systems

Family was the main buffer. *"My mother and the man in my life are my support"* (P2, 19). Parenting, for one respondent, offered solace: *"I drew my child close to me and consoled myself with her"* (P1, 19).

Peer connections helped when available. Fifteen-year-old P10 credited friends and distraction: *"Going out with my friends and keeping busy helped me cope."*

Productive activity served as a diversion: *"My work became a good distraction"* (P2, 19).

Formal help was less common but valued: *"I sought counselling"* (P4, 18). One attempt ended badly when a counsellor "tried taking advantage" (P3, 16), underscoring the fragility of external help.

Faith practices are threaded through many stories. *"God has been with me. I pray He forgives me"* (P9, 19).

Stigma and Discrimination

Direct ridicule came from both the community and kin. *"People heard about it and mocked me"* (P4, 18). One mother said, *"You are a disappointment"* (P9, 19).

Indirect stigma—conversations and glances—was pervasive. *"When my friends talk about abortion, I feel guilty even though they didn't mention my name"* (P5, 17). Anticipating judgment, several chose secrecy: *"I kept it to my family only"* (P4, 18).

Mental-Health Consequences of Stigma

Stigma deepened pre-existing distress. Two girls described depressive spells: *"I stayed away from social activities; I felt depressed"* (P2, 19). External criticism reinforced guilt: *"The pointing of fingers contributed to the guilt"* (P7, 18).

Prevention Ideas and Desired Support

Participants advocated practical prevention, contraception access and frank sex education: *"Promote condoms and family-planning"* (P5, 17). *"Provide free drugs to prevent pregnancy"* (P6, 18).

They also called for safe peer forums: *"Create a girls' group so we can talk openly"* (P7, 18).

5. Discussion

Abortion is not a one-time event that takes place in a clinic; for many young women, it triggers a series of emotions that can last for years, some of which are buried and some of which are loud. The teens we talked to went through a familiar but agonising cycle: regret and guilt, then fear and sadness, and finally a silent withdrawal from others. The same arc is described in studies from South Africa to Iran (Pourreza & Batebi, 2011; Zareba et al., 2020).

Guilt, Regret, and Cultural Collision

Most of the girls framed their decision as a collision between practical need and moral code. They knew the pregnancy threatened schooling or family honour, yet ending it felt like breaking an unwritten rule. As outlined in our theoretical framework, this internal conflict exemplifies cognitive dissonance, where contradictory beliefs create psychological tension that manifests as persistent guilt. The theoretical integration of cognitive dissonance theory with stress and coping models helps explain why some girls managed this tension better than others, depending on their available coping resources and social support networks. Pourreza and Batebi (2011) note that such dissonance erodes self-worth; our data echo that finding, as several girls described feeling "emotionally weak" months after the event.

Fear and the Body

Fear appeared twice, first as panic over possible death from bleeding, later as dread of discovery. Drawing on the theoretical perspectives outlined above, this dual fear reflects the intersection of health anxiety and social stigma fears predicted by our integrated stress and coping framework. That dual fear matches Umar and Ajuwon's (2024) report that worry about physical harm and social exposure drives post-abortion anxiety among Nigerian adolescents. One participant linked weight loss to feeling "very ugly," a reminder that body changes can reinforce anxious self-scrutiny.

Sadness, Sleep Loss, and the Downward Spiral

Unresolved grief manifested as nightmares and insomnia, which are symptoms that frequently hasten a decline into depression (Zareba et al., 2020). This pattern illustrates how maladaptive coping mechanisms can prolong psychological distress, which is in line with the theoretical framework previously discussed. The girls' accounts suggest a vicious loop: sadness disrupts sleep, sleep loss worsens mood, and an exhausted mind struggles to process regret.

Withdrawal as a Shield

Social retreat acted as both armour and cage. According to Lazarus and Folkman's (1984) stress and coping theory, this withdrawal represents an avoidance-based coping mechanism that, although protective at first, eventually makes it harder to access social support networks. The girls were deprived of comfort but shielded from gossip by staying inside. Koly et al. (2023) show that isolation magnifies depressive symptoms; our participants confirmed this, describing loneliness even in crowded family homes.

What Helps? People, Purpose, and Prayer

Most teenagers could name at least one lifeline, even in the darkest of times. By showing how protective factors can act as a buffer against psychological distress following an abortion, this finding lends theoretical support to the integration of resilience theory with social support models. Nonjudgmental space was provided by mothers, partners, or a single, trustworthy uncle. This aligns with our theoretical framework's emphasis on social support theory, which distinguishes between the emotional, instrumental, and informational support that family members provided to our participants. Work and apprenticeships gave others a reason to get up each morning, an effect Keys (2010) calls "therapeutic distraction." A few accessed counselling; when it was competent and kind,

it helped, reinforcing Raphi et al.'s (2021) finding that professional support can shorten the emotional recovery curve.

Faith surfaced repeatedly. Prayer was less about penance than about reassurance. "God has been with me; I pray He forgives me," one girl said. Religion can both soothe and shame, but in this sample, it leaned toward comfort, mirroring Canário et al.'s (2011) observation that spiritual coping often softens grief.

Stigma: The Silent Amplifier

Open ridicule hurt, but even imagined judgment carried weight. Indirect comments, "talks on abortion", were enough to reignite guilt. This finding supports our theoretical framework's integration of stigma theory, demonstrating how both enacted and felt stigma compound the psychological burden beyond the abortion experience itself. Wallace et al. (2024) show that such ambient stigma predicts long-term anxiety; our data underline that risk.

Girls' Solutions

Asked what would help, the participants did not plead for complex programmes; they asked for condoms that do not cost money, honest talks about sex, a small peer group where no one laughs, and counsellors who listen first and lecture later. These requests align with evidence that youth-friendly contraception and peer-support clubs lower repeat pregnancies and boost mental health (Sudhinaraset et al., 2022).

6. Conclusion and Recommendations

The emotional aftermath of abortion in Nkoranza Sesiman follows a familiar script: guilt, fear, sadness, loneliness; however, each feeling cuts deeper when there's no safe space to talk. Things could change if we had better sexuality education, free contraception for anyone who needs it, and real, private counselling in schools, in churches, wherever. Yet what the girls themselves asked for, more than anything, is simple: someone who will listen without judging.

Above all, these girls ask for one simple thing: someone who will listen without judging.

Recommendations

1. **Embed counselling where girls already go for care.** Every facility that treats post-abortion complications, such as, district hospital, health centre, or even a pharmacy kiosk, should offer a quiet room and a trained counsellor or nurse who can listen first and advise later. A short in-service course for existing staff would cost little yet close the biggest gap our participants described: talking to someone who will not judge them.
2. **Give schools a real, not token, sexuality curriculum.** Head-teachers and guidance coordinators need resources that go beyond "say no." Lessons on contraception, consent, and where to find confidential help would let girls act earlier, before pregnancy or panic sets in.
3. **Subsidise contraception for adolescents—no ID, no lecture, no fee.** A free monthly pack of pills or condoms handed out at youth corners, churches, and market days could tame the cycle of crisis pregnancies. The National Health Insurance Scheme already covers some methods; extending that coverage to every adolescent would be a logical next step.

4. **Create peer-led support circles.** Small groups run by trained youth mentors, meeting after school or on Saturday mornings which would let girls share stories without fear of being "the only one." Our respondents asked for exactly this kind of space.
5. **Work with faith leaders, not against them.** Pastors, catechists, and women's-fellowship heads set the tone in Nkoranza Sesiman. Engaging them in workshops on stigma reduction could turn potential critics into allies who preach compassion and confidentiality from the pulpit.
6. **Train male partners.** Several girls blamed partner pressure for the pregnancy or the abortion. Couple-based workshops—run through apprenticeship centres or churches, could teach young men contraception basics and respectful decision making. When boys understand the stakes, girls carry less of the burden alone.
7. **Add mental-health screening to post-abortion follow-up.** A simple three-question tool on guilt, sleep, and intrusive thoughts would flag those who need a referral. Local nurses could administer it during routine wound checks or family-planning visits.
8. **Support mobile and digital helplines.** A toll-free number, WhatsApp chat, or radio call-in slot staffed by counsellors could reach teenagers too shy to speak face-to-face. Low-bandwidth solutions are vital in semi-rural zones where data costs bite.
9. **Invest in longitudinal research.** A twelve-month follow-up study would show whether the suggested interventions, in which school curricula, free contraception, and peer groups could lower repeat pregnancies and ease emotional distress. Evidence will help donors and district health managers scale what works and drop what does not.

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