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https://doi.org/10.3390/youth4040094

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Abortion as a Muted Reality in Uganda: Narratives of Adolescent Girls' Agentive Experiences with Pregnancy Termination

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Abstract: Pregnancy termination, also referred to as abortion, is a contentious subject in many countries. Uganda's culture requires young people to remain celibate; they therefore suffer from restricted access to any sexual and reproductive health information, products, and services, including contraceptives. Girls who are pregnant in Uganda are oppressed in various ways, including being expelled from school. Since abortion is illegal under Ugandan law, those abortions that take place are assumed to have a high risk of being unsafe. Most previous studies in the African context have thus focused on the phenomenon of unsafe abortion. Adolescent abortion is characterized by a rhetoric of pathology that frames girls as victims of deadly unsafe abortion practices. This paper aims to critique the view that pregnant adolescent girls are merely vulnerable victims who passively accept the denial of SRH services, including abortion. We analyzed the life histories of 14 girls in Uganda who had undergone pregnancy termination. Our findings showed that adolescent girls are not passive victims of the structural barriers to abortion. They use their agency to obtain knowledge, make decisions, successfully terminate pregnancy, and conceal the information as needed. It is therefore important for policymakers to acknowledge the agency of adolescent girls in regard to pregnancy termination and how this recognition could be of benefit in terms of devising appropriate supports for them.

Keywords: adolescent girls; pregnancy termination; agency; abortion; youth peer research; adolescent sexual and reproductive health and rights

Citation: Kakuru, D.M.; Nabirye, J.; Nassimbwa, J. Abortion as a Muted Reality in Uganda: Narratives of Adolescent Girls' Agentive Experiences with Pregnancy Termination. *Youth* **2024**, *4*, 1481–1493. https://doi.org/10.3390/youth4040094

Academic Editor: Anamika Barman Adhikari

Received: 17 August 2024
Revised: 22 September 2024
Accepted: 11 October 2024
Published: 14 October 2024

1. Introduction

Although pregnancy termination is highly contentious, there is evidence that it took place safely in precolonial Africa before the introduction of restrictive, religion-based, abortion legislation in the 18th century [1,2]. Uganda today is one of the African countries characterized by high rates of pregnancy and parenting among girls under 18 years of age [3]. In this context, reproductive injustices among young people are perpetuated by policies and laws on adolescent sexual and reproductive health and rights (SRHR) that are largely based on Euro–Western religious values and moral ethics, fused with local beliefs [4]. Although previous studies have demonstrated that at least 46% of Ugandan adolescents have had one or more sexual encounters [5], government programs and policies are designed around the assumption that girls under 18 are not sexually active [6]. Adolescent pregnancy is highly stigmatized and culturally tabooed. Girls under 18 therefore face restricted access to contraceptive information and to services that include pregnancy termination. Except for the purpose of saving a life, abortion is criminalized by the Ugandan Penal Code as a form of murder [7], yet legal restrictions on abortion, which are common in under-resourced countries, significantly increase the incidence of clandestine abortions [8]. On the contrary, a study from Ethiopia shows that a less restrictive law may not by itself lower the incidence of unsafe abortions [9]. Under Uganda's laws, although a high proportion (43%) of women experience unwanted pregnancies, only 14% of these ends in abortion. Most of the unwanted pregnancies are among adolescents and young adults and the teenage pregnancy rate among the former (ages 15–19) is 25% [10].

In the scholarly literature, the prevailing discourse about adolescent pregnancy termination has been largely a pathologizing one that emphasizes its negative health consequences when conducted by unskilled persons. The existing literature on abortion often frames adolescents as passive victims of the sociocultural and political ideals regarding adolescent SRHR. Considering the secrecy related to procuring abortions [11], we conducted a study to explore adolescent girls' agency in accessing knowledge and services in an effort to dismantle the dominant frame mentioned above. This article aims to critique the view that pregnant adolescent girls are merely vulnerable victims who passively accept the denial of SRH services, including abortion. This study follows the sociology of childhood scholarship, which regards young people as having agency—the ability to make independent decisions—despite the structural constraints that restrict them from expressing their voices and views [12]. In this article, we discuss how adolescent girls in Uganda successfully locate and obtain abortion services despite the pervasive systemic and structural barriers. There is a dearth of studies that have analyzed the nuances of girls' agency in navigating pregnancy termination in a context in which it is restricted.

A "safe" abortion can be described as one conducted by a trained health care provider, while an "unsafe" abortion is "carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" [13] (p. xix). Past studies by scholars such as Izugbara et al. have analyzed the financial consequences of unsafe abortion in sub-Saharan Africa [14]. Izugbara et al. point out that approximately 1.7 million African women are hospitalized annually due to complications of unsafe abortion and note that the annual abortion complications-related hospitalization rate in Uganda is about 15 per 1000 women. Palmer et al. discuss the cost of treating complications of unsafe abortion and advocate for a safe abortion policy [15]. While understanding the financial costs of unsafe abortion is important, it does not provide a complete picture. For example, there is limited information on how often induced abortion happens, since some cases of self-induced abortion are recorded as cases of spontaneous abortion [16]. According to Atuheire, the fact that health care providers in Africa tend to mistreat women seeking post-abortion care leads to less sanitary and less procedurally safe abortion care practices because the women fear stigma, judgment, and punishment [5]. A large body of literature elaborates on the negative consequences of induced abortion among adolescents, such as hemorrhage, infertility, trauma, and permanent disability [17–19]. In view of these dangers, the dominant narrative regarding adolescent pregnancy termination frames it as unsafe and conducted outside health centers by unskilled people due to systemic impediments to safe abortion. The available literature also suggests that women and girls seek post-abortion care only when they are suffering complications from an unsafe abortion. Despite the sustained discourse that focuses on the complications of abortion among adolescents, Espinoza et al. found that adolescents actually experience fewer physical complications than older women although they are at a higher risk of negative psychosocial consequences [20].

Due to restrictive cultural norms, adolescents in most of Africa have limited access to SRHR information, services, and products. They sometimes turn to communication media as their major source of information [21]. A recent review of the literature on abortion knowledge, attitudes, and experiences among African adolescents under 20 found that although girls have some relevant knowledge, they face barriers such as stigma, lack of resources, and bias on the part of health care providers [20]. Scholars such as Chandra-Mouli et al. [22], Chandra-Mouli et al. [23], and Denno et al. [24] identified such barriers as factors contributing to unintended pregnancy and, by implication, subsequent termination. Abortion is rarely discussed openly in Uganda, and adolescent girls are not expected to have any knowledge about it. Political, religious, and cultural leaders also restrict adolescents' access to SRH information as a way of discouraging them from engaging in sexual activities [9]. Past studies established that pregnant adolescent girls face stigma, disrespect, mistreatment, and negative attitudes from health care providers [25–27]. There is a consensus that poor access to professional abortion services compels adolescents to

resort to untrained providers and to use inappropriate methods, thereby increasing the risk of abortion-related medical complications [28]. However, research conducted by Sully et al. found that adolescents did not face greater disadvantages than older women when seeking abortion care services; the researchers also found that unmarried women in both groups faced more severe post-abortion complications than their married peers [29]. Some studies on abortion have focused on the risks that result from the lack of options available to adolescent women [5], while some, such as Mutua et al. [30], Woog et al. [31], and Ziraba et al. [32], have framed pregnant adolescent girls as vulnerable and unable to navigate the limited abortion knowledge available. This paper analyzes the nuanced ways that adolescents invoke their agency to navigate and cope with their experiences of pregnancy termination.

We also draw on Bandura's social cognitive theory to analyze and discuss how adolescent girls use their agency to navigate reproductive injustices. Bandura has described agency as being "characterized by several core features that operate through phenomenal and functional consciousness. These include the temporal extension of agency through intentionality and forethought, self-regulation by self-reactive influence, and self-reflectiveness about one's capabilities, quality of functioning, and the meaning and purpose of one's life pursuits" [33] (p. 1). Furthermore, we draw on Goffman's [34] impression management theory, in which society is perceived as a theater stage and individuals present themselves based on whether they perceive themselves as being on society's "front region" (i.e., in public) [34] (p. 66). In front-stage behavior, individuals strategically seek to create specific impressions in the minds of others based on cultural values, norms, and expectations. We apply this perspective to discuss how adolescent girls (performers) successfully present themselves to society (the audience) in ways that reflect their perception that the audience is constantly evaluating their "morality" based on whether they are sexually active and whether they have left girlhood behind and become mothers.

2. Materials and Methods

Study area: This study was conducted in one of the rural districts in Eastern Uganda. Like other regions of Uganda, adolescents in this district face significant challenges regarding access to abortion and other SRH services. Cultural norms, religious beliefs, and stigma around abortion heavily influence adolescent SRH policy and practice and limit their ability to seek out as well as receive those services. The study area is therefore characterized by inadequate access to youth-friendly SRH information, services, and products

Study design: We used a design that combined narrative research [35,36] and youth peer-to-peer research methodologies [37]. Narrative research is a design that explores the in-depth meanings people attach to their experiences through working with a small number of participants aiming to gather in-depth, rich narratives [36]. We combined this with youth peer research, which is an approach in which the youth participate in directing and conducting research with peers because of the richness of their lived experiences of the issues being studied [37]. This article is based on a larger study that investigated the experiences of pregnant and parenting female adolescents who participated in collecting, reflecting on, and disseminating the findings [38].

Study participants: For this article, we collected life history data from 14 cisgender female adolescents aged between 14 and 18. Participants were selected through a two-stage process involving a combination of purposeful and snowball sampling [39,40]. First, using purposeful sampling, 12 adolescent mothers were selected for inclusion in the larger study as youth peer researchers [37]. Inclusion criteria were being a resident of the study community; being 18 years of age or younger; and having experienced pregnancy, regardless of outcome. The 12 youth peer researchers were trained to recruit other adolescents in the community who might be willing to share their pregnancy termination experiences. Through this process, the youth peer researchers first recruited three girls. Using snowball sampling, the three girls referred others who met the study criteria, and we repeated this process until we reached the 14 adolescent girls who agreed to participate. We therefore

went through four rounds of recruitment using snowball sampling, and we stopped when we reached data saturation [41].

Data Collection: Data were collected using life history interviews, which included asking participants to narrate their life stories [42]. The interviewers followed a life history interview guide with a list of potential questions and probes. The interviews were audio-recorded with written consent and lasted between 60 and 90 min. Throughout the data collection process, youth peer researchers were supported by one of the authors (JN^1). Following Kamusiime's youth peer research approach [37], JN provided support in terms of ensuring that the youth peer researchers had the logistical supplies, and she was on standby to answer any questions that arose during the interview process.

Data analysis: Our analysis was informed by Ross and Solinger's reproductive justice framework, which describes reproductive justice as including "(1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments" [43] (p. 9). We draw on Ross and Solinger's ideas to analyze how contexts in which pregnancy termination is restricted are marred by the reproductive injustices regularly inflicted on adolescent girls as fertile human beings. We also followed Clarke and Braun's Reflexive Thematic Analysis approach, which emphasizes reflecting on the role of the researcher's positionality and subjectivity throughout the data analysis process [44]. Throughout the process, we interpreted the life stories with the aim of discovering the patterns, themes, and meanings underlying them. The audio-recorded data were transcribed into text, and the transcripts were anonymized by removing all identifying information and assigning pseudonyms to participants. The process involved meetings with youth peer researchers, who reflected on the data collection and brainstormed on emerging codes and themes. Drawing on Clarke and Braun's approach [44], we collaboratively familiarized ourselves with the data to gather initial impressions about each interview. Based on those impressions, we revisited the interviews and came up with a list of codes and collated quotes relevant to each code while continually reflecting on our positionality as individuals and as a team. We identified patterns of meanings within our data and discussed these to ensure that we had shared conceptualizations of the identified themes and their interpretations. We then grouped similar codes into themes and named the themes as sourcing abortion information, abortion decision-making, agency to avert hostility, and method of abortion. To ensure trustworthiness, we engaged in peer debriefing and keeping an audit trail [45]. We performed peer debriefing at different stages of the data analysis, including coding and the identification of themes. For the audit trail, we kept reflexive journals and engaged in proper record-keeping of raw data, field notes, and transcripts for continuous reference as necessary.

Ethical considerations: We practiced situated ethics and intentional reflexivity [46]. The authors are cisgender, adult women who were born and raised in Uganda. DK is a professor at a University in Canada, and JN^1 and JN^2 are graduate students who live in Uganda. In pursuit of epistemic justice [47], we aimed to center the participants as knowers and narrators of their stories while attempting to mitigate any effects of differences in education status and age between participants and researchers, particularly during the data analysis process. The research was approved by the Institutional Review Boards of the University of Victoria (#21-0222, approved 2 November 2021), and Makerere University (#MUSS-2O21-76, approved date 19 November 2021). Throughout the research, we adhered to guidelines set out by the UNST, Canada's Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and UNICEF's Ethical Research Involving Children [48]. For example, we obtained written informed consent and assent from study participants and their caregivers, although caregivers did not listen to the interviews. Throughout the process of data collection, we made deliberate efforts to protect study participants from harm, such as ensuring that there was a trained youth counselor on standby in case they experienced difficult emotions and required support. Participants decided where they wanted to have the interview. The youth peer researchers and participants were

compensated for their time according to the requirements of the Makerere University School of Social Sciences Research Ethics committee and the UNCST.

3. Results

The results presented below are based on life history interviews with 14 adolescents aged 14–16 at the time of abortion or 16–17 at the time of the interview (See Table 1).

Table 1. Ages of study participants.

Participant ID	Age at Interview	Age at Abortion	Number of Pregnancies
A	16	14	1
B	18	16	1
C	16	13	1
D	15	15	1
E	17	16	1
F	17	15, 15, 16	3
G	16	14	1
H	16	15	1
I	16	16	1
J	14	13	1
K	17	14	1
L	17	16, 17	2
M	17	16	1
N	17	16	1

3.1. Age and Method of Abortion

Our review of the existing literature indicated that adolescents in Africa generally procure unsafe abortions from unskilled providers who operate in clandestine environments. Our life history interview data, which included the methods used by the girls to terminate pregnancies, raises questions about this view. We found that a total of 17 abortions were undergone by girls aged 16 (seven cases), 15 (four cases), 14 (three cases), 13 (two cases), and 17 (one case), as shown in Table 1.

At the time of data collection, one 17-year-old participant had had three successful abortions and was carrying a fourth pregnancy; another had had two abortions by the age of 17. Our data show that girls as young as 13 are sexually active in spite of sociocultural expectations and the prohibitions on sexual activity involving people under 18.

Further, our data reveal that young people are not only sexually active and becoming pregnant but they also terminate pregnancies despite Uganda's adult-centric, oppressive, and discriminatory policy and institutional framework. Our participants disclosed that they used several methods of abortion, some unofficial and some administered by health care providers, including nurses and doctors. The details are provided in Table 2.

Table 2. Abortion methods used.

Method of Abortion	Number of Abortions	Percentage
Pills from friends obtained on the participant's behalf	1	5.9
Pills from nurse/doctor/health care provider	6	35.3
Health facility injection, "machine"/equipment	3	17.6
Herbs and other local remedies	5	29.4
Combination of herbs and injection	2	11.8
Total	17	100

Although abortions are illegal in Uganda, our data show that some of the abortions were conducted with the help of a qualified health care provider.

3.2. Sources of Abortion Information

During the interviews, we asked participants how they obtained information on pregnancy termination, considering that adolescents would not normally have access to this information. One participant stated, "The first source of information was from my boyfriend, who told me about abortion. Also, my sister used to tell me stories about how her friend successfully terminated an unwanted pregnancy. She explained to me the different methods of terminating an unwanted pregnancy, such as the use of . . . and local herbs" (Participant A, 17 years). Another participant, who received information from her sisters, explained as follows:

My sisters gave me the information I needed. I lived with my elder sisters who knew how these things are done. I witnessed them getting pregnancy testing kits at the local drugstore several times. When I found out that I was pregnant, my sister encouraged me to terminate it. She said that it would be terrible for me to have a child at this age since I was the youngest. She took me to the clinic where she always went, and they worked on me. (Participant D, 15 years)

Family members seem to be a common source of information, either during casual conversations or when adolescents were actively seeking information.

Our data show that friends were also a source of abortion information; one participant said, "I had a friend who had aborted twice, and she used to tell me how it is done. She also directed me to a hospital where other girls usually go to find help. No matter how advanced the pregnancy is, those people can 'remove' it" (Participant F, 17 years). Another participant elaborated on how she obtained information from friends, as follows:

I got pregnant at the age of sixteen, and I got the information from friends who had previously told me stories about how they terminated pregnancy. When it happened to me, I asked them about it and they explained the different methods. For instance, one used local herbs which she described as 'dangerous'. In contrast, others went to the hospital and approached a healthcare provider for services at a fee. It was one of my friends who got me the pills I used. She told me to put one pill under the tongue and insert another in the vagina. I had to do this to go back to school and also for my father not to know that I was pregnant because I was still young. (Participant B, 18 years)

The above data reveal that based on conversations with friends, Participant B actively sought information from a trusted source. She exercised her agency because she wanted to continue going to school and knew that she would be expelled from school if she remained pregnant.

Our findings also show that although adults, especially parents, are expected to withhold abortion information from their daughters, some of them deviate from this norm. For example, one participant shared, "It was my mother who gave me the information, and she is the one who took me to the hospital" (Participant G, 17 years). Some parents strategically cooperated with their daughters and supported them to terminate pregnancies because they considered it 'shameful' and felt it reflected negatively on their parenting skills in a cultural context in which adolescent pregnancy is stigmatized. Additionally, some parents were concerned that they were not ready to incur the costs of raising the child if their daughters kept the pregnancy. They therefore supported their daughters to terminate the pregnancy because of the family's economic precarity. Our data show that some of the adolescents who participated in our study had heard before they became pregnant about the possibility of inducing an abortion, with most of them obtaining that information from their peers or from family members (sisters and parents).

3.3. Decision-Making

Our second theme concerned decision-making: how adolescent girls decide to terminate pregnancies in a context in which access to abortion information is restricted. Their sources of information played a part here; our data show that about one-third of the girls decided independently, another third sought advice from friends, and the rest received advice from parents and relatives (especially their mother or grandmother). Each participant was

able to give a reason for terminating the pregnancy. One had gone through three abortions and elaborated, "For the first pregnancy, I decided on my own because I was not ready; the second one, I told a friend who advised me to do so, then I followed their advice; and for the third time, I asked my sister for advice" (Participant F, 17 years). Participant F made decisions based on advice from a sister and a friend but also made her own decision for the first pregnancy. Another participant decided to abort after realizing that her boyfriend was married to another woman. She noted, "I got to know that my boyfriend was married and had a child, so I decided to terminate the pregnancy" (Participant K, 17 years).

The fear of parents' negative reactions was a reason for terminating unwanted pregnancies, as one adolescent revealed: "I was so stressed about how my parents would react to this, so I ended up going to the hospital where I got the pills to abort" (Participant L, 17 years). Although some parents were considered "harsh" by their daughters, our data also show that there were some parents/caregivers who supported the decision to abort. For example, one participant said, "I made a decision based on my grandmother's advice because I did not have any way of supporting myself and the baby since the boys who raped me had fled the village after the assault" (Participant E, 17 years). Another participant noted, "My mother helped me to decide because if my father got to know, he would just kill me" (Participant K, 16 years).

Our data on abortion decision-making show that some adolescents felt they were not ready to have a child, while others procured an abortion to protect themselves from stigma and harm. The findings demonstrate the nuanced agency behind all the decisions made by the participants and, in some cases, their caregivers. Although abortion is illegal in Uganda (except to save the woman's life), some pregnant adolescents find themselves unable to keep their pregnancies due to various factors related to economic precarity and stigma arising from gendered social norms and sociocultural and political ideals that dictate who is allowed to engage in sexual activities.

3.4. The "Good Girl" Performance

Another theme concerns the disclosure of pregnancy and abortion and how agency is used to avert hostility. In the study area, being pregnant as an adolescent is a sign of sexual immorality. Additionally, not only is induced abortion considered "immoral" but it is also criminalized. We found that participants faced consequences if they failed to conceal the abortion. For example, they could risk being expelled from school, being labeled, or even facing criminal charges if it became known that they had an abortion. Our participants took deliberate steps to navigate the hostile environment by concealing both their pregnancies and their abortions. For example, despite feeling unwell after the procedure, some participants felt obliged to conceal their discomfort in order to avert hostility from members of their families and communities. One said, "I used to pretend to be well by doing all the chores as expected and also going to school. I had to be strong, and I told myself that this is my secret. I would not disclose it to any other person" (Participant C, 16 years). Another adolescent said, "I just kept it secret because I knew if my father had found out, I would have been in serious trouble" (Participant L, 17 years).

Since adolescent pregnancy is highly stigmatized, our participants utilized their agency to avoid societal judgment. For example, one participant asked to have the interview away from her home. During the interview, she expressed, "My parents do not know that I aborted, and that is why I could not have this conversation at home" (Participant C, 16 years). One of the participants' key strategies was to pretend that everything was "normal"; they pretended not to be engaging in sexual relationships, not to be pregnant, and not to have had an abortion. Our analysis also shows that they made efforts not to disclose their situation beyond the people who supported them through the process. The intentionality and forethought participants displayed in continuing to project the life of a "good" girl while navigating pain aligns with Bandura's description of agency [33]. Their strategy of striving to project the image of a "good" girl also fits Goffman's notion of impression management [34].

Although some participants did not disclose their pregnancy and abortion to their caregivers, a few did. Our analysis shows that those who were open to their caregivers had already dropped out of school for other reasons, and their caregivers knew that they were sexually active. For example, one participant was raised by her grandmother, who encouraged her to participate in commercial sex work to contribute to the household economy, as follows:

My grandmother told me I was old enough to start asking boys for "*sugar*" (local slang for money). I got pregnant in the process, but unfortunately, I lost the baby at birth. After that, my grandmother felt sorry for me. She stopped me from engaging in transactional sex and from being outside the house after 6 p.m. Unfortunately, one day, I went to play with my friends and lost track of time. On my way back home, I was ambushed and gang raped by village boys who punished me for stopping to engage in transactional sex with them, and I got pregnant. That is when I told my grandmother about the rape and the pregnancy (Participant E, 17 years).

Participant E initially deliberately concealed her assault because she was afraid that her grandmother would be angry with her for violating the curfew. She only told the grandmother because she needed advice on how to abort. Again, this demonstrates nuanced agency at different levels, including the timing of disclosing the pregnancy and the violent circumstances in which it occurred.

Another participant (F), who dropped out of school in grade 6 during the COVID-19 pandemic, explained that she engaged in commercial sex work as a survival strategy. At the time of the interview, she was carrying a fourth pregnancy after aborting three times. She narrated, "I am contemplating aborting, but last year, I lost my sister, who died using the same methods that I have successfully used three times. Although I am not ready to have a child, I am also petrified. The pregnancy is also not good for my '*kweyiiya*' (commercial sex work) because I cannot make as much money as I make when I am not pregnant" (Participant F, seventeen years).

The participant is in a dilemma; she is not ready to have a baby because of her current occupation but fears the consequences of a fourth abortion, especially after losing her sister. Her story shows that adolescents contemplate their actions and make strategic choices based on their circumstances and the experiences of those close to them. Additionally, the fact that she is contemplating a fourth abortion shows she is exercising her agency by refusing to surrender her decisions to the oppressive policies and structures of the restrictive adolescent SRHR context.

4. Discussion

Girls' attempts to claim their right not to have a child in a context in which this right is legally and socially denied represent a clear struggle for reproductive justice [43].

Our data show that, by seeking knowledge and abortion care services, despite societal barriers, our participants, even those as young as 13 years, assert their right to make informed decisions about their bodies and futures, which is a core tenet of reproductive justice [23]. Such intentionality and forethought to seek information and services within complex social networks reflect self-regulation and self-reflection, which are key components of agency in Bandura's social cognitive theory [33]. Furthermore, girls have diverse strategic reasons for terminating pregnancies, and, although induced pregnancy termination is not their preferred option, participants considered it the only alternative that would allow them to reclaim the ability to pursue their life goals while maintaining their girlhood. The analysis shows that although they felt that motherhood is important, continuing their girlhood, including going to school and avoiding the legal repercussions of disclosing an abortion were seen as more important by our study participants. As they weigh various factors, consider potential consequences, and make strategic choices, they exemplify Bandura's concept of human agency as self-reflective and self-reactive [33].

In a conservative policy and legal environment that is prohibitive of abortion, the girls seem to confide in trusted sources who will preserve their public image while they seek potentially stigmatizing knowledge and services. This strategic information management is a clear application of Goffman's concept of "front stage" performance in everyday life. This fear of stigma and judgment that influences their decision-making relates to Goffman's ideas about how individuals strategically present themselves to avoid social disapproval [49] and demonstrates how societal expectations, which are a key concept in Goffman's work, shape individual reproductive choices. Additionally, the trusted social networks point the girls to clandestine medical services, where they procure a "safe" abortion. This contradicts the dominant notion that young women generally turn to risky methods to terminate their pregnancies. Their ability to obtain safe abortion services, despite the reproductive injustices embodied in prevailing SRH policies, shows their capacity for navigating complex systems and illuminates goal-directed behavior and problem-solving that Bandura emphasizes as key aspects of human agency [33]. "Safe also means that there are healthcare providers who are potential allies in adolescent girls' struggle to realize their reproductive autonomy, in such restrictive contexts [29], and our study shows that the girls reach out to them directly or through referrals. We, therefore advocate that academic researchers and SRHR policymakers who are formulating projects centered on pregnant and parenting adolescents should adopt a girl-centered framework that prioritizes listening to the diverse voices of adolescent girls on pregnancy termination [50].

Further, the termination of pregnancy does not always have negative consequences. Some of the participants did regret the pain they endured in the process and the stress that came with being compelled by circumstances to terminate their pregnancies. However, others expressed satisfaction with their decisions, contradicting some past studies [17–19] that presented a deficit narrative of induced abortions among adolescents in terms of complications. The existing literature also suggests that because of the restrictions related to accessing abortion services in these contexts, adolescents in Africa turn to untrained providers, which leads to abortion-related medical complications [28], and that women and girls seek post-abortion care only after suffering from the complications of unsafe abortions [5]. Our findings show that none of our participants sought care for complications, but instead, some of them obtained professional help to induce abortions. Some adolescents even managed to hide their pain and not miss school after terminating their pregnancies to maintain the good girl or front-stage persona, as Goffman describes. Our findings therefore relate to those of Espinoza et al. who found that adolescents experience fewer physical abortion-related complications than older women do [20].

It is widely accepted that African girls have limited SRH knowledge. However, our findings show that despite the acknowledged barriers, the adolescent participants in our study were able to obtain useful information from friends, boyfriends, and families [21]. For example, some adolescent girls referred each other to health facilities, where they sought the services of qualified healthcare practitioners to terminate unwanted pregnancies. This finding implies that withholding information and services is not effective in stopping adolescent girls from engaging in sex, getting pregnant, or terminating unwanted pregnancies. Rather, a lack of knowledge and resources exposes them to risks, especially when there are multiple sexual partners. The fact that a young commercial sex worker in our study had had multiple abortions illuminates this burden. Additionally, the support participants received from family, friends, and partners seems to indicate that societal values regarding abortion are fragmented and that there are people who will support adolescents in need of an abortion, albeit covertly. Contrary to Smith's [21] findings, none of our participants mentioned the media as a source of information. This unexpected finding could be because the data for this article were collected from a rural area, where access to communication media is not as easy as one would expect in an urban area.

A large body of literature discusses the stigma and mistreatment from health care providers that adolescents face [25,26], although some of our participants told us that they had been supported by nurses. Our findings confirm those of Jonas et al., which show

that nurses in South Africa were friendly to adolescents seeking contraceptive services [51]. Our findings also confirm those of Sully et al., who found no significant differences in the disadvantages faced by adolescents and older women seeking abortion care services [29].

Various studies have portrayed adolescent girls as passive and vulnerable recipients of stigma, negative attitudes, and oppressive sociopolitical structures [30]. However, our study shows that the girls actively navigate stigma and pregnancy termination through an agentive strategy. If they had kept the pregnancies, they would have had to face the shame associated with being young and pregnant. Thus, although abortion is stigmatized, for these adolescent girls, it was a process they had to go through in order to manage the impressions and the images they project of themselves [34]. After the abortion, some participants demonstrated their agency by pretending to be well and executing their usual tasks at home and school in order to keep the abortion secret.

Due to the size of our study sample and the sampling strategy, it is possible that we missed interacting with some adolescents with other unique experiences. As such, our findings cannot be generalized to all adolescents everywhere. Nevertheless, our study provides in-depth insights and contributes to the growing body of knowledge on adolescent experiences with pregnancy termination.

5. Conclusions

Our study provides a nuanced exploration of adolescent girls' experiences with abortion in Uganda, challenging prevailing narratives and illuminating the complex interplay between individual agency and societal constraints. The findings reveal that despite restrictive societal norms and legal frameworks, adolescent girls actively navigate the landscape of sexual and reproductive health, demonstrating remarkable resilience and resourcefulness. One of the significant findings is the diverse sources of information accessed by adolescent girls. Contrary to assumptions about information scarcity, participants obtained knowledge about pregnancy termination from various social networks, including boyfriends, friends, and family, including parents. This underscores the limitations of policies aimed at withholding information as a means of preventing adolescent sexual activity or access to abortion services [43]. Our study also highlights the decision-making processes of these adolescents, revealing a level of autonomy often overlooked in discussions of adolescent reproductive health, and rights. Participants made independent choices or sought advice from trusted individuals, driven by factors such as unreadiness for motherhood, fear of stigma, and economic considerations. This agency aligns with Bandura's [33] social cognitive theory, which emphasizes individuals' capacity to influence their life circumstances. A particularly striking aspect of the findings is the strategic "performance" of the "good girl" image by these adolescents. Drawing on Goffman's [34] concept of impression management, participants employed various tactics to conceal their pregnancies and abortions, maintaining their daily routines to avoid societal judgment and legal repercussions. This sophisticated navigation of social expectations demonstrates the complex strategies adolescents employ to protect their futures while asserting their reproductive rights. Our study also challenges assumptions about the methods of abortion used by adolescents. Contrary to narratives of unsafe, clandestine procedures, many participants accessed safe methods provided by healthcare professionals. This finding has significant implications for policy and practice, suggesting a need for more nuanced approaches to adolescent sexual and reproductive health services.

In conclusion, our study contributes valuable insights to the growing body of knowledge on adolescent sexual and reproductive health and rights (SRHR) in restrictive contexts. By illuminating the agency and strategic decision-making of adolescent girls, we advocate for a paradigm shift in how different actors conceptualize and address adolescent SRHR. Future policies and interventions should acknowledge the diverse experiences and needs of adolescent girls and look beyond simplistic prevention strategies to provide comprehensive, girl-centered support. This approach not only respects the autonomy of young women but

also holds the potential to more effectively address the complex challenges they face in navigating their reproductive lives.

Author Contributions: Conceptualization, D.M.K. and J.N. (Jackline Nabirye); data collection, J.N. (Jackline Nabirye) and J.N. (Jacqueline Nassimbwa), data analysis, D.M.K., J.N. (Jackline Nabirye) and J.N. (Jacqueline Nassimbwa); writing—original draft preparation D.M.K., writing—review and editing, D.M.K., J.N. (Jackline Nabirye) and J.N. (Jacqueline Nassimbwa); funding acquisition, D.M.K. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Social Sciences and Humanities Research Council of Canada, grant number 890-2020-0017.

Institutional Review Board Statement: This study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Boards of the University of Victoria (#21-0222, approved 2 November 2021) and Makerere University (#MUSS-2O21-76, approved date 19 November 2021).

Informed Consent Statement: Informed consent was obtained from all subjects involved in this study.

Data Availability Statement: Due to ethical reasons, we cannot publicly share the data presented in this study, but the data are available upon request from the corresponding author.

Acknowledgments: We greatly appreciate the community members and leaders in Uganda, where this study was conducted. We acknowledge the work of the Centering Marginal Voices project team members who participated in conceptualizing this study, securing funding, and the different phases of the project implementation. These include Annah Kamusiime, Grace Bantebya Kyomuhendo, and Mandeep Kaur Mucina. We also acknowledge the work of the Youth Peer researchers who conducted the interviews and the community members and leaders who supported our efforts in different ways. We are grateful for the logistical support provided by the Nascent Research and Development Organization and the University of Victoria.

Conflicts of Interest: The authors declare no conflicts of interest.

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