UNIVERSITY OF EDUCATION, WINNEBA

LIVED EXPERIENCES OF WOMEN WHO HAVE UNDERGONE UNSAFE ABORTION IN BAAKOKROM IN THE NEW JUABEN SOUTH MUNICIPALITY

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MAY, 2024

DECLARATION

Student Declaration

I, Adwoa Akyamaa Ofosu Sarpong, hereby declare that this thesis is the result of my original research and that no part of it has been presented for another degree in this University or elsewhere. I am solely responsible for any shortcomings. All references used in the work have been acknowledged.

Signature: ……..…..

Date: ……

Supervisors' Declaration

I hereby declare that the preparation of this research was supervised by me in accordance with the guidelines of supervision of thesis laid down by University of Education, Winneba and I confirm that the student has my permission to present it for assessment.

Kojo Oppong Yeboah Gyabaah Ph.D (Principal Supervisor)

Signature: ……..

Date: ……

Dr. Victor Owusu Ph.D (Co-Supervisor)

Signature: ……..…..

Date: ……

DEDICATION

To my beloved parents Mr. and Mrs Ofosu Sarpong

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LIST OF ABBREVIATIONS

CAC	Comprehensive Abortion Care
D & C	Dilation and Curettage
D & E	Dilation and evacuation
GSS	Ghana Statistical Services
IGF	Internally generated fund
MA	Medical Abortion
MoH	Ministry of Health
MVA	Manual Vacuum Aspiration
NHIS	National Health Insurance Scheme
PAC	Post-Abortion Care
PPAG	Planned Parenthood Association
SRH	Sexual health
WHO	World Health Organization

ABSTRACT

Abortions done through crude methods present higher chances of complications. The purpose of the study was to explore the lived experiences of women who have undergone unsafe abortion in relation to their sexual health, socio-cultural life and economic life in Baakokrom in the New Juaben South Municipality. The study employed a phenomenological research design, and a purposive sampling technique was used to get targeted women who have undergone unsafe abortions living in Baakokrom. Self-administered, semi-structured interview guides were used as the instrument to collect data for the study which involved ten participants. The finding reveals that women were ignorant of the usage of contraceptives, leading to unplanned pregnancies. Sexual health experiences revealed that participants who used traditional herbs and concoctions did not have a negative influence on childbirth and sexual activeness. The study also found out abortion stigma is not concentrated on only socio-cultural influences but also is deep-rooted in government and political backgrounds. With respect to economic experiences, the study indicated that employed women have lost strength due to abnormal abdominal pain. This has led to a reduction in productivity leading to low income levels making them continuously depend on men. The study recommended that there should be massive education on contraceptive use, reproductive health and abortion laws. Also young girls should be encouraged to attend school to reduce unplanned pregnancy in the area.

CHAPTER ONE

INTRODUCTION

1.0 Background of the study

Unsafe abortions are a common worldwide phenomenon. It occurs regardless of the country's geographical location and or legal status of abortion.

According to Glazier et al. (2006), reproductive health encompasses more than just the absence of sickness or infirmity; it also includes a condition of total physical, mental, and social well-being in all aspects of the reproductive system and its functions and processes. Some severe abortion complications, such as perforations and other physical injuries as well as septic shock, necessitate surgical removal of the uterus, further impacting reproductive health. Some complications, such as anaemia and chronic weakness, might last for a long time following an abortion. Pain, inflammation of the reproductive system, and pelvic inflammatory disease are among chronic diseases that can develop after an unsafe abortion. These conditions can last forever and ruin a woman's health(Singh, 2015).

Globally, 211 million pregnancies are estimated to occur annually, with 46 million ending in unsafe abortion and only approximately 60% of which are performed in safe settings (WHO, 2005). This can occur spontaneously as a miscarriage, or be artificially unsafe through chemical, surgical or other means. Abortion resulting from natural causes is termed spontaneous abortion while that resulting from an intentional act of human is termed as unsafe (Worldometers, 2015).

Abortion is explained as the termination of pregnancy following the death of or after the spontaneous or unsafe expulsion of a human foetus, or the outcome of the death of the embryo or foetus, during the first 12 weeks of gestation (Francome, 2017).

Spontaneous abortion is described as the natural loss of pregnancy before 20 weeks of gestation. Spontaneous abortion is colloquially known as a 'miscarriage' (Griebel, Halvorsen, Golemon, & Day, 2005). Depending on the method employed during the process, abortion might be either safe or unsafe. Certain abortions are considered safe when done using the right procedures, either clinical or medication.

Abortion is illegal in Ghana, according to Act 29, section 58 of the Criminal Code of 1960, as amended by PNDCL 102 of 1985. Albeit abortion is illegal, an exception to the abortion law is in the event of rape, incest, or the risk to a woman's life or health (mentally or physically) and should be performed by a licensed medical practitioner. An attempt to alleviate the detrimental impacts of unsafe abortion has been adopting a comprehensive reproductive health policy that prioritises maternal morbidity and mortality in Ghana (Taylor, et al., 2011). This legal and policy framework influences women's decisions because the widespread misunderstanding of the law makes most women seeking abortion still seek clandestine abortions which are usually unsafe (Lithur, 2014).

Poor awareness of Ghana's relatively liberal law on abortion, stigmatisation, exorbitant expenses, non-harmonisation of safe abortion service prices, terrible abortion experiences, and mistrust of healthcare providers are among the top barriers to getting safe abortion services in Ghana (Bain, et al., 2019) In Ghana, most healthcare is provided by the government and is largely administered by the Ministry of Health and Ghana Health Services. The healthcare system has five levels of providers: health posts, health centres and clinics, district hospitals, regional hospitals and tertiary hospitals. Health posts are the first level of primary care for rural areas. In the Eastern Region, there are several healthcare systems that have these five-level providers but

unfortunately, Baakokrom does not have any of these healthcare systems to provide quality reproductive health services for the people in the community. This could be the reason for unplanned pregnancies and considering the community influence on culture and socio-economic characteristics such as being able to fend for yourself or being a student can inform women's choices to have an unsafe abortion since they are no immediate health professionals to talk to and to avoid stigmatization from the community.

The current study was concerned with the lived experiences of women who have undergone unsafe abortions concerning their sexual health, socio-cultural life and economic life. To address the issues relating to unsafe abortion the current study exploited the sexual health, economic and socio-cultural impact on the lives of women who have undergone unsafe abortion in Baakokrom and find solutions to this public health problem. A qualitative approach was suitable for the research because it gave room for women to express their views, thoughts, and emotions and share their experiences without restrictions on what to say about what they have been going through.

1.2 Statement of the Problem

The (World Health Organization, 2012) reports that 47,000 deaths occur each year due to unsafe abortion, making abortion the leading cause of maternal mortality. Approximately 14 million unintended pregnancies have been observed to occur in sub-Saharan Africa annually (Ameyaw, Budu, Sambah, Baatiema, Appiah, Seidu, & Ahinkorah, 2019). In Ghana, the pregnancy rate is estimated at 194 per 1,000 fertile women per year, with an estimated 23% of pregnancies ending in abortion (Keogh, Otupiri, Chiu, Polis, Hussain, Bell, & Larsen-Reindorf, 2020). In Ghana, abortion

remains a major contributor to maternal mortality accounting for 15-30% of maternal deaths (Asamoah, Moussa, Stafstrom, & Musinguzi, 2011).

Although abortion is illegal in Ghana, unsafe abortion continues to occur despite the 1985 abortion law stating that it is legal if performed in the cases of rape, incest, and danger to the life or health of the women (Adde, Darteh, & Kumi-Kyereme, 2021; Strong, 2021; Alhassan, 2021). However, since the legal provision that is 1985 abortion law is included in the Criminal Code, it has been widely interpreted as a crime. It took the Ministry of Health (MoH) twenty years to translate the legislation into functioning policy documents.

Sexual health experiences of women who have had unsafe abortion data, Rominski and Lori (2014) revealed that hospital-based studies also indicate that abortion complications are a major cause of gynaecological admissions, abortions constituted 38.8% of admissions to the Obstetrics and Gynaecology wards of the Komfo Anokye Teaching Hospital. Statistics from Eastern Region conducted by Ganyaglo (2012), indicated that abortion complications were the second leading cause of death due to maternal causes, behind post-partum haemorrhage, between 2004–2009, a period which spans the introduction of the policy changes around abortion care, in the Eastern region. Also, statistics from Baakokrom are scarce, thus getting accurate records is very difficult since family members protect the culprit because they know it is illegal hence they do not report such cases to the hospitals. Also, there is no health centre or clinic to assess this vital information in Baakokrom. However, the Koforidua Hospital is one of the state-owned regional referral hospitals according to the 2017 Ghana Maternal; health Survey approximately 16% of women in their reproductive age had ever had an abortion in the area. There are various issues surrounding the recording and

classification of unsafe abortions, miscarriages and stillbirths in lowest and middle-income countries, including Ghana (Angell, Abdul, Munim & Gold 2019).

Socio-cultural life experiences revealed by women who have had unsafe abortions are that family, friends, partners, and pregnant women are key players in aborting a pregnancy in the Ghanaian context (Bain et al, 2019). Scholars have discovered that most women only tell a small number of people about their abortion, even if it was an unsafe one (Cowan, 2014; Herold et al., 2015; Major et al, 2000). According to Agyekum (2015), there are several other factors that can be used to predict if a respondent has experienced pregnancy loss. These include the respondent's age, educational level, marital status, place and area of residence, kind of occupation, and wealth index. Unwanted pregnancies among unmarried women are strongly frowned upon by many cultures and religions; as a result, some women opt for risky, clandestine abortions rather than risk having their reputations tarnished at a public facility (Payne et al., 2013).

Economic life experiences shared by women who have had unsafe abortions are abortions could be precipitated by a woman's economic status, followed by religion and sometimes social status. A low or middle-income earner may abort a pregnancy not because she hates being pregnant but because she can't afford to raise a child. Even those married and in the same income category tend to abort pregnancies they think will increase their financial obligations. Most young people in Ghana who engage in unsafe abortion are students (Appiah-Sekyere, 2013). This is because most of the students are unprepared to give birth, have financial difficulties and also fear being margined or mocked by their colleagues in the schools. The lived experiences of women who had undergone unsafe abortion in terms of economic status and regarding the role

of decision making on reproductive choice and abortion, in-depth interviews with adolescent female in Accra revealed that majority of participants were strongly opposed to abortion, but nearly all described situations (such as being in an unstable relationship or not having enough money to raise a child) in which they considered abortion to be acceptable (Henry & Fayorsey, 2012).

Extensive literature demonstrates that the drivers of unsafe abortions are prevailing in quantitative research methodologies, with few qualitative methodologies making it difficult to find the clear voices of participants as qualitative evidence. Also, there are other studies related to the research topic such as Lived Experiences of Adolescents Undergoing Legal Abortion in a Province of Thailand by Lakkhana Chainok, Puangpaka Kongvattananon, and Shirley C. Gordon (2022), (Flanagan, Alicia M. 2012), and Women's social and emotional experiences with abortion and An Exploration of the Lived Experience of Women who had Abortions and the Effects of Abortion Secret on their Relationships: An Interpretive Phenomenological Analysis study by Marckdaline Johnson (2019). These studies produced data that fails to grasp the sexual health, socio-cultural life and economic status experiences of women who have had unsafe abortions. Also, there have been few attempts in the Ghanaian context to explore the lived experiences of women who have had unsafe abortions and therefore the need for a community-based study to explore their experiences after an unsafe abortion in Baakokrom in the Eastern region. The researcher encountered women who have had about five unsafe abortion cases since 2015. These acts occurred within the community and after the abortion had been performed resulted in excessive bleeding. In addition, since Baakokrom is a small community, anytime a case of that nature happens, almost all the people in the community get to know it. Again, in 2021 a young

student stopped schooling due to fear of stigmatization after a classmate got to know she had done an unsafe abortion.

The researcher thus employed qualitative study to investigate women experiences of unsafe abortion and provide an insight into a more detailed exploration of the participants' viewpoints.

1.3 Purpose of the Study

The study aimed to investigate the lived experiences of women who have had an unsafe abortion.

1.4 Research Objectives

Specifically, the study sought to;

1. Examine the sexual health status of women who have ever had unsafe abortion in Baakokrom.
2. To assess the socio-cultural lives of women at Baakokrom who have ever had unsafe abortion.
3. To analyse the economic status of women in Baakokrom who have ever had unsafe abortion.

1.4 Research Questions

The following research questions addressed in the study:

1. What are the sexual health status of women who have ever had unsafe abortion in Baakokrom.
2. What are the socio-cultural lives of women at Baakokrom who have ever had unsafe abortion?
3. What are the economic status of women in Baakokrom who have ever had unsafe abortion?

1.5 Significance of the Study

This research addressed the discrepancies in literature by providing up-to-date data on lived experiences of women who have undergone unsafe abortions. Conducting health related issues in geography is quite rare hence what makes this study a geographical piece is its attempt to find out whether social determinants of an area have an influence on women's decision on unsafe abortion practices and the public health condition on the lives of people who indulge themselves in act at a defined geographical area or location.

The study's findings would have global policy implications for female sexual and reproductive health and the MoH in Ghana. The study's findings are intended to aid medical professionals in the study context, such as physicians, nurses, pharmacists, and other paramedical workers, in providing meaningful health education against abortion and abortion laws to women in the study area. The study can be used as a guide or a resource material for the general public, especially women who want to know more about abortion.

1.6 Scope of the Study

The study delimited to only people living in the Baakokrom Township in the New Juaben South Municipality, and the outcome might be different if other towns were included. Moreover, the participants who participated in this study lived in the New Juaben South Municipality, and the outcome might be different from participants from different municipalities.

1.7 Limitations of the Study

Self-reporting scales were used in the instrument to measure variables for analysis. This might affect the result of the study since some of the respondents are likely to

overestimate their responses. In addition, the study covered only one town in the New Juaben South Municipality, which could affect the results. On the other hand, the literature review places the study in perspective and helps ground the results and conclusions in the literature.

Moreover, since abortion is highly stigmatized in Ghana, underreporting is a possibility, as people may use terms like miscarriages and stillbirths instead of unsafe abortion, likely impacting the study results. Furthermore, because respondents were asked to remember incidents that might have occurred many years ago, there are chance respondents were subjected to recall the trauma and pain they experienced. As a result, the study was based on information gathered during the data collection.

1.8 Definition of Terms

I. Abortion: Abortion occurs when the embryo, placenta, and foetal membranes leave the uterus too soon, ending the pregnancy. Abortion can occur on its own or pose a health risk.

II. Contraceptive: Any process, medication, or item that aids in preventing conception is considered a contraceptive.

III. Illegal Abortion: Terminating a pregnancy without a valid legal reason is known as an illegal abortion.

IV. Unsafe abortion: When a woman undergoes a pregnancy termination without proper training or in a setting that does not meet basic medical requirements, it is considered an unsafe abortion.

V. Legally restricted abortion: Restrictive abortion laws limit access to services by making abortion legal only under certain circumstances. Therefore, women are more prone to seek out abortions that are not legal.

VI. Spontaneous Abortion (Miscarriage): A miscarriage or spontaneous abortion can happen naturally, or it can be induced artificially using chemical, surgical, or other methods.

1.9 The organisation of the Study

For the study, five chapters were organised. In the first chapter, which serves as an introduction, the following topics are covered: the study's relevance, delimitations, issue description, objectives, research questions, and background. In the second chapter, the study delves into the current literature. The primary focus of this review was on the basic idea of what causes unsafe abortions and the actual experiences of women who have undergone such procedures. The technique and study area are described in Chapter 3, and the outcomes of the data analysis are analysed in Chapter 4. Chapter 5, the last one, included the study's summary, conclusion, and suggestions.

CHAPTER TWO

LITERATURE RELATED REVIEW

2.0 Introduction

This chapter reviewed the related literature of the study to provide a focus and guidance for an adequate understanding of this study. In this context, the researcher discussed the fundamental concepts of unsafe abortions and the factors that influence women to have unsafe abortions. Specifically, the chapter focuses on the following, Theories, Conceptual Framework, the concept of abortion, types and reasons for unsafe abortion. Effects of unsafe abortion, access to post abortion care, awareness of abortion issues and empirical review of unsafe abortion experiences.

The determinant of unsafe abortion have generally been classified as individual (proximate) and systemic level determinants (Alan Guttmacher Institute, 2013). Mundigo 2006 revealed that proximate determinants are the individual-level determinant that leads to an unexpected pregnancy and a choice of abortion. These individual-level determinants include background factors (i.e., family size, marital status, educational level), contraceptive factors (i.e., failure, misuse, and non–use), and primary factors (rape, incest, or sexual violence or rape). On the other hand, systemic level determinants are the decision-making processes leading to unsafe or safe abortion. The systemic level determinants include social factors, policy-related factors, and health service factors, economic and religious-related factors.

2.1 Research Theories

Various theories have been used in research to investigate the experience of people who indulge in an act and whether or not they contemplated the probable implications of the conduct in question before doing the act. In investigating the experiences of women

who have undergone unsafe abortion the Ethical Theory of Egoism and Crisis Theories guided the study to understand the lived experiences of women who have undergone unsafe abortion in Baakokrom.

2.1.1 The Ethical Theory of Egoism

The Ethical Theory of Egoism is grounded on the tenet that everything must be done for the greatest potential good of oneself (Sanders, 1988). This theory explains a person's motivation for committing an act in this study. A person's desire to abort a pregnancy is driven by her desire to put her interests ahead of everyone. As a result, every woman's move or decision after discovering she is pregnant unintentionally must be in her favour.

The most common reasons a woman will think about having an abortion are to put off having a child till a more suitable time or to devote more time and energy to her current family. Other reasons for having an abortion include not having assistance from the child's father, not being able to finance further children, wanting to send current children to school, having one's education interrupted, relationship issues, feeling too elderly, and relationship troubles with one's partner. (Bankole, Singh, & Haas, 2019).

Once a woman is not financially stable or secured to cater for an unplanned pregnancy they turn to put their interest first. The theory aided in how relevant the decision to abort untimed pregnancies due to finances have affected or impacted women lives and to analyse their lived experiences in relation to the economic lives of affected women in Baakokrom.

According to the Ethical Theory of Egoism, a pregnant woman needs to make a decision and behave in a way that makes her fit and acceptable in her family and community. This is true even though she is likely unmarried, still in school, has enough children,

and lives with a partner who is not ready for a child. Her only concern is doing what is best for herself. As a result of the high regard in Ghanaian society for families and individual dignity (Nukunya, 2013), her community may not accept or view her as having acted socially appropriately if she becomes pregnant while single and unmarried; as a result, she may feel pressured to find a way to end the pregnancy in order to preserve her dignity.

An effective kind of ethical egoism maintains that, as there is no other acceptable course of action, it is unethical to refuse to pursue one's own self-interest (Baier, 1966). Although it might be beneficial to pursue one's own interests alone, a more moderate form of egoism would suggest that doing so is not inherently undesirable. That is to say, depending on the specifics of the situation, a person may be able to balance acting in his own self-interest with acting morally (Baier, 1966).

Unwanted pregnancies among Ghanaian women may be caused by emotional factors. The feelings a woman has in relation to getting pregnant, carrying a child, and ending a pregnancy can be complex and ever-changing. She experiences these feelings as a result of the reactions she gets from informing others about her pregnancy, especially those who will either help her decide whether or not to terminate the pregnancy or who will have to deal with the fallout from her decision (Coast, Norris, Moore, & Freeman, 2014). According to the theory, women chose to terminate pregnancies in order to avoid social stigma and shame; as a result, the theory provided a framework for studying the impact of unsafe abortion on the sociocultural lives of women who made this decision.

2.1.2 Assumptions of egoism theory

Emmons (1969) argues that egoism theory assigns a moral and ethical value to the choice to pursue one's own self-interest, based on the assumption that it is always right to do so. A basic tenet is that people are inherently selfish and should be unrestrained in their pursuit of self-interest by societal and moral standards.

2.1.3 Critique of egoism theory

The problem of objectivity is one of the main arguments against egoism as an ethical theory. This is owing to the fact that fulfilling one's desires is essential to living a meaningful life. Similarly, if he could indulge his passions and fantasies without fear of retaliation, his life would be much more fulfilling (Gotthelf, 2000). Asking someone to be selfish or self-centred may deprive him of valuable experiences like love, friendship, community, and fellow feeling, according to the underlying assumption. Because of this, he has a hard time understanding what other people are up to. That is, he stops caring about their suffering and other emotions that non-selfish people can easily understand (Williams, 1973). Facione, Scherer, and Attig (1978) also state that someone who strongly believes in selfishness has a higher chance of becoming a psychopath. As a result, when people let their egos get the best of them, they lose the ability to understand what other people are going through mentally. In light of this interpretation of egoism, it would appear that an egoist is essentially a pitiful, self-centred animal.

Some have argued that egoism isolates people from the larger social context in which they live (Huemer, 2002). For their part, egoism's detractors have built a number of arguments against it on top of this. Accordingly, it is presumed that all egoisms share common foundational concepts. Critics basically take it as read that if you choose to

live your life on your own terms, you won't have time for the good things in life, like love, friendship, and companionship. For the simple reason that a rational egoist is likely to act in a way that benefits his own interests while also improving his standing in society (Kobzeff, 2011). The inability to comprehend that certain people may genuinely derive solace and happiness from particular social institutions, like families, was the target of most of the criticism. Egoism, as a philosophical framework, permits people to act in accordance with their desires. The fact that egoism does not ethically condemn acts like stealing, deprivation of property, physical injury, or murder makes its detractors question the plausibility of an egoist community.

2.1.4 Caplan crisis theory (1964)

A crisis can be considered as a period of transition in which an individual has the opportunity to grow or mature as a person but also faces the risk of a negative impact and greater vulnerability to stress. According to Caplan (1964), a crisis disrupts the steady state. An obstacle to major life goals that is, for the time being, impassable by the application of conventional problem-solving procedures puts people in a crisis. Thus, there comes a period of disarray and confusion, during which there are many unsuccessful attempts to find a solution.

The researcher tried to find out what circumstances compelled women to choose an unsafe abortion procedure and whether they considered the risks and losses that come with it before making a decision. Childbirth is the foundation of the family structure, which is why it is cherished and celebrated with rites of passage such as outdooring and naming rituals, adolescent-puberty-marriage-and-funeral rites, all of which have the family as their main focus. It is normal for a person to grow up, get married, and have children in Ghanaian society. For this reason, a woman who gets pregnant outside of

marriage is looked down upon and deemed promiscuous and has gone against what is expected in the culture. A woman who has a pregnancy that will not be accepted by society has a crisis and must take measures that will assist her to resolve the crisis as quickly as possible.

The research theory aided to examine the lived experiences of women who have undergone unsafe abortion. What circumstances prompted women to choose an unsafe abortion procedure and whether they considered the risks, losses that come with it before making a decision and aftermath of making such decision.

2.1.5 Assumptions of Caplan crisis theory

Several key assumptions or components are outlined by Caplan Crisis Theory (Caplan, 1964) that define what a person goes through in a crisis. A leading incident, disorder and imbalance, inability to cope, decreased defensiveness, and the brief duration of an acute crisis response are among the most important of these. For every crisis to begin, there must be a precipitating event, some first, observable incident in the person's life (Slaikeu, 1990). Situations that seem less spectacular (e.g., incidents of bullying in a school, a marriage, or the move from college to a career) can occur alongside larger-scale natural catastrophes and conflicts. A critical component of any occurrence that triggers a crisis is the degree to which the impacted person perceives it as threatening (James, 2008).

Some of the symptoms of this imbalance, first described by Caplan (1964), that people in a crisis state are more likely to experience include physical symptoms, anxiety, feelings of inadequacy, confusion, physical exhaustion, and a decrease in functioning in relationships (e.g., family, social, and work). Elevated emotionality, disturbed eating and sleeping habits, ruminating, withdrawal from social connections, class skips,

impaired language skills, and brief thoughts of suicide are all symptoms of this woman's disequilibrium. A person's ability to cope may deteriorate as a result of the impairment of functioning, which might affect areas that have been coping techniques or supports in the past. There are two parts to coping: managing one's own emotions and dealing with problems (Lazarus, 1980).

2.1.6 Critique of Caplan crisis theory

According to Study by Corgi (2022), crisis theory's merits lie in its emphasis on the steps involved in a crisis and the customised approach to intervention. Given that the theory lays out the steps individuals take during a crisis, it also aids in recognising the difficulties that a crisis can cause and the most efficient ways to alleviate those difficulties. The idea facilitates self-adoption and self-control in times of crisis, according to Macdonald (2016), by illuminating the phases of a crisis. Consequently, the theory delves at the reasons behind a crisis from an individual's perspective (France, 2015). It looks at the question of whether a particular crisis has existential, developmental, or situational causes. At its core, theory facilitates easy management and control of crises by investigating their causes. Among the theory's shortcomings that render it impractical in crisis management is its emphasis on individual agency. The incorporation of ecological issues, however, is one of the strengths of the extended crisis theory, as pointed out by Slaikeu (1990). Because it analyses how the environment plays a part in crises, crisis theory is highly beneficial. The theory distinguishes itself from previous crisis theories by investigating the impact of environmental factors on crisis situations. A number of crises go unnoticed because other theories place too much emphasis on one particular aspect of the problem (France, 2015). Macdonald (2016) argues that counsellors can effectively mitigate a crisis by considering the subject's environment in addition to the immediate situation.

2.2 Conceptual Framework

Ogula (1998), states that, the conceptual framework describes the study's major independent and dependent variables and their relationship. The study was designed with respect to the variables used in the objectives.

For the purpose of the thesis the analysis relating to lived experiences of unsafe abortion hinged on a framework which condenses with the determinants of unsafe induced abortion in developing countries as describe by Axel I. Mundigo. Some of the variables use for this research framework was used in his article. He did not have a pictorial framework but used the determinants to explain the push factors of unsafe abortion.

The paper reviews two types of determinants of induced abortion: proximate and systemic determinants. According to Mundigo 2006, there are two main determinants of unsafe induced abortion which is classified as individual level (proximate) determinants and systemic level determinants. Individual level determinants are those that results in an unintended pregnancy and the decision to abort. These include educational level, family size, contraceptives etc. Systemic level determinants on the other hand are those which influence the decision process leading to a safe or unsafe. These include policy, health services, social and economic factors.

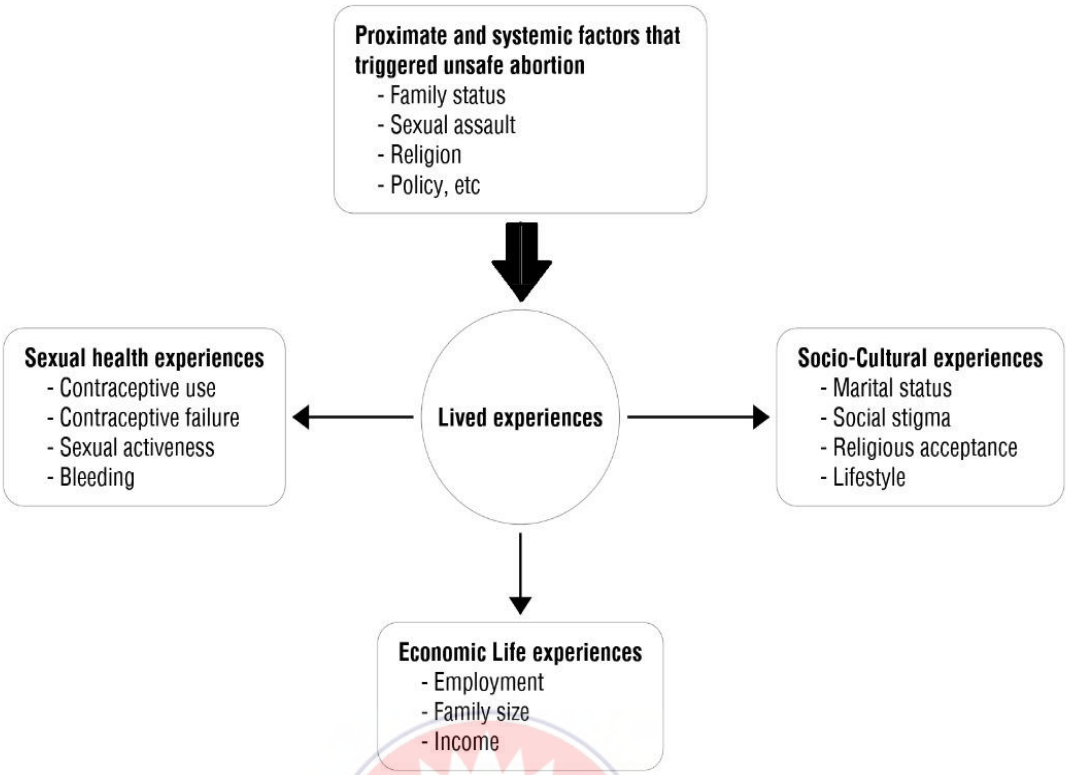

Figure 2: **A Conceptual Framework of experiences of unsafe abortion**

Source: Adopted from Mundigo, (2006)

The Ethical theory of Egoism and the Caplan Crisis Theory are the proximate and systemic factors which grounded the conceptual framework. From Figure 1, the proximate factors are the Individual-level variables that lead to unwanted pregnancy and the decision to terminate. Among these are education, marital status, family size and composition, and contraceptive factors such as non-use, misuse, and failure of contraceptives. Additional factors include incest, sexual assault, and rape. On the other hand, systemic factors influence the decision-making process that leads to safe or unsafe abortion thus policy, health-care considerations, social, economic, and religious factors. These factors explain the tenet of both theories.

The lived experiences of women who had undergone unsafe abortion in Baakokrom were investigated based on their sexual health, socio-cultural life and economic life expressed in Figure 1.

Abortion is deemed legal, safe, available, and economical because of policy. Under the auspices of legislation, health services can restrict or protect women's reproductive rights. This means that abortion is lawful or illegal if the practice is supported by law or frowned upon in society. They include demand and supply issues such as accessibility, availability, infrastructure, quality, cost, service provision, and information. In certain societies, abortion is influenced by social factors such as home and cultural norms and values, union stability, partner influences, and gender preferences. Others include parental influence or fear, which can significantly influence teenage decision-making, regardless of adolescents' decisions or preferences. Among these, include income and financial resources, employment position, economic objectives, and welfare/assistance programmes, among other things.

A woman's emotional state during pregnancy may also depend on her partner's level of dedication to the relationship. Sometimes, a woman may try to get pregnant so that she and her partner can take their relationship to the next level. They can tie the knot if their partner gives their approval. Contrarily, if he rejects the idea of a relationship or the pregnancy, the woman may decide to get an abortion since she no longer wants the baby (Coast et al., 2014).

Religion has a significant impact on society and individual decisions on sex, contraception, and abortion. The framework also highlights how knowledge of the legality of abortion could influence one to have an unsafe abortion.

2.3 The concept and types of abortion

There is a wide spectrum of possible health, physical, financial, and social issues that could arise during pregnancy and delivery. Because of these risks, carrying a child is an extremely risky and hazardous endeavour for the majority of women around the globe (World Health Organisation, 2011). Abortions are performed when a woman experiences unwanted pregnancy or a medical problem during her pregnancy (Gutmacher Institute, 2015; Finer and Zolna, 2014). Determining the end of a pregnancy prior to the 28th week is, hence, considered an abortion (WHO, 2012). This can happen naturally as a miscarriage, or it can be caused purposefully via chemicals, surgery, or something else entirely. The phrase "induced abortion" is used to describe pregnancies that end due to deliberate human intervention, in contrast to "spontaneous abortion" which occurs as a result of unplanned pregnancy complications (Worldometers, 2015). A miscarriage or spontaneous abortion does not occur on purpose to terminate the pregnancy but rather as a result of complications the pregnant woman may have. Abortions can be classified as either safe or unsafe.

Abortion can be an intentional act of human beings to discard the unwanted foetus before it grows. Abortion can be considered safe or unsafe depending on the method used during the process. Certain abortions are considered safe when it is done using the right procedures either in clinical or medication. Notwithstanding, depending on the extent of pregnancy, the WHO (2018) recommends three ways of safe abortion. These include Manual Vacuum Aspiration (MVA), Medical Abortions (MA), and Dilatation and Evacuation (D&E). Manual Vacuum Aspiration (MVA) is a method of removing pregnancy remains from the womb after a miscarriage using suction undertaken with the patient awake, Dilation & evacuation (D&E; performed after 16 weeks' gestation) and Medical abortions are legalized procedures using medications to terminate ongoing

pregnancies (Centres for Disease Control, 2016). The medical abortion procedure entails ingesting of a pill, used up to the first 9 weeks of pregnancy (American Pregnancy Association, 2015).

Nevertheless, a study conducted in 2016 by the WHO defines unsafe abortion as a procedure of pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. The World Health Organization (2012), estimates that an annual 22 million unsafe abortions occur globally, almost all of which take place in developing countries.

In 2008, the World Health Organisation (WHO) performed a study on the topic of safe and unsafe induced abortion. The study found that in developing countries, unsafe abortions are more common because women do not have access to pre-abortion counselling or advice, the abortion providers are unskilled, the conditions are unclean, or the treatment is provided outside of official or adequate health facilities. This could be because women are reluctant to seek medical attention in a timely manner in the event of complications due to legal restrictions and social and cultural beliefs associated with induction, or because there is a lack of post-abortion check-ups and care, such as contraceptive counselling, to prevent repeat abortions.

In Ghana abortion could be precipitated by economic status a woman finds herself in, followed by religion and sometimes social status. A low- or middle-income earner may abort a pregnancy not because she hates being pregnant but because she can't afford to raise a child. Even those married and are in the same income category tends to abort pregnancies they think will cause increase to their financial obligations. Also in Ghana, the three main religions thus Christianity, Islamic and traditionalists as well as our culture frown on getting pregnant before marriage hence women who get pregnant

before they are married sometimes abort pregnancies so as not to be seen as a disgrace to the church and the family.

2.4 Reasons and effects of abortion

An unplanned pregnancy happens when a woman can't control when or how many children she has (Sundaram, Bankole, Juarez & Singh, 2012), and this is the main reason why women resort to induced abortions. According to research by Finer, Frohwirth, Dauphinee, Singh, and Moore (2015), there are typically a myriad of factors that contribute to the decision to undergo an abortion. Some of the reasons and factors that influence women to choose abortion include their age, religion, economic status, culture, relationships, reproductive history, resource limitations, interference with the mother's education or work, lack of preparation for motherhood, and the desire to have an abortion. According to the 2017 Ghana Maternal Health Survey, 35% of married women and 20% of sexually active women do not use any kind of contraception, despite the fact that they do not wish to have a child soon or at all. Consequently, an unanticipated pregnancy accounts for 37% of all births in Ghana: As per the 2018 report by GSS, GHS, and ICF, 23% are ill-timed and 14% are undesired.

2.5 Effects of Abortion

There may be results or repercussions to abortion, regardless of how safe or unsafe it is. Unless these consequences become intolerable and last for a prolonged period of time, they might not be considered complications. In such a case, immediate medical assistance is required. The procedure chosen to end a pregnancy determines the likelihood of certain physical complications (Kruse, Poppema, Creinin & Paul, 2012). Their research made it quite evident that there are significant consequences regardless of the approach. These include headaches, dizziness, pelvic cramps, and severe vaginal

bleeding. Permanent problems, such as infertility, genital fistula, persistent pelvic pain, inflammatory illness of the pelvis, and death, are also a possibility (Achilles & Reeves, 2011; Kruse et al, 2012).

In general, women's health suffers after abortion, and this is especially true following unsafe or clandestine abortions (Shadigian, 2015). Ten percent of women who have abortions will experience difficulties right after the procedure, with two percent of those complications being life-threatening. This was one of the most important takeaways from the study. The expert further stated that the risk of problems may increase as the gestational age increases.

In their 2012 study, Kabore, Bankole, Rossier, and Sedgh classified abortion consequences as either acute or long-term. The list of potential problems is long and includes illnesses like fever, stomach aches or cramps, amniotic fluid embolism, cervix, vaginal, uterine, and fallopian tube injuries, among many others (Kabore et al, 2012). Surgical abortions are associated with an increased risk of long-term consequences, such as breast cancer, placenta previa, and premature babies, compared to medicinal abortions. Also, contrary to what some studies have found, this study found no correlation between abortion and infertility, ectopic pregnancies, or subsequent miscarriages. According to research by Bartz and Goldberg (2014), the most common side effects were nausea (54% of the time), breast pain (28% of the time), fatigue (50% of the time), and excessive vaginal bleeding (10%). Anorexia (a lack of appetite) and bulimia (compulsive overeating) are two examples of eating disorders that some people may have; nevertheless, these conditions are often associated with depression (Reardon, Strahan, Thorp, & Shuping, 2014).

Factors that increase the likelihood of serious complications after an unsafe abortion were investigated by Gerdts, Prata, and Gessessew (2012). Results are based on an analysis of 266 women who visited one of 30 clinics for an incomplete abortion therapy throughout the research period. In total, 81% of patients encountered serious problems. The only difference between women who had minor issues and those who had major ones was that the former were far more likely to be married. Compared to women who did not suffer from significant difficulties, those who did had a higher mean parity and more pregnancies in the past. There was a 1-week difference in the mean uterine size between women who did not experience serious problems and those who did when they were evaluated for treatment of incomplete abortion. According to Erdts, Prata & Gessessew (2012), the two groups shared comparable rates of previous contraceptive use and abortion histories.

2.6 Access to Post Abortion Care

Healthcare expenditures related to women experiencing unsafe abortions or post-abortion complications amount to 159 million USD in Africa and 333 million USD in Latin America, respectively, every annum (Shwe, et al., 2019). Information, geographic, and economic accessibility are all aspects of service accessibility (Mundigo, 2016). Women in locations where doctors are scarce, such as rural towns and villages, are denied access in jurisdictions where only doctors can conduct abortion-related services (Morhee & Morhee, 2016).

The perspectives of Ghanaian doctors on the establishment of safe abortion units were examined in a 2007 study by Morhe, Morhe, and Danso. Finding out how well doctors understood the abortion law in Ghana at the time was the main goal of the research. Another was to find out how many doctors were willing to give safe abortion services

and how many were in favour of setting up clinics to do so. At KATH, or the Komfo Anokye Teaching Hospital, researchers carried out their experiments. The 74 doctors who participated in the study were chosen at random. This research relied on numerical data. A system of self-administered questionnaires was used to gather the data. Let me share with you the main findings. Out of the 74 people who took the survey, 59 thought that health centres in Ghana should provide abortion units. Thirty-three people agreed to perform the surgery, while twenty-seven people said they were simply interested in counselling. Nevertheless, fourteen of them refused to provide any assistance in the event that the units were set up.

Although 80% were in favour of the idea of abortion units being set up, not all of them were prepared to provide services, according to the conclusion drawn by Morhe, Morhe, and Danso (2007). Perhaps these people felt that abortion was a major issue in the nation that needed fixing. There are a variety of factors personal, familial, community, societal, political, economic, and systemic that may affect the accessibility of abortion-related services, programs, and policies as well as the results of these interventions (Biggs, Gould & Foster, 2013).

Although Comprehensive Abortion Care (CAC) was introduced in 2006, research has revealed significant flaws in its administration. Provider reluctance to offer needed care, misunderstandings regarding the legality of services delivered, and a lack of protocols are just a few of them (Aniteye & Mayhew, 2013). These disparities must be addressed for the health system to respond appropriately to guarantee cost, accessibility, quality of care, and availability for all women (Berer, 2016).

2.7 Knowledge on Abortion Issues

The role of policy in combating unsafe abortion has sparked heated debate. Those sceptics point to nations like India, where unsafe abortion rates have remained high despite abortion liberalisation (Sousa, Lozano, & Gakidou, 2015). In addition, Coast, Norris, Moore & Freeman (2018) state that women's understanding of abortion's legal status can be skewed by prevailing religious regulations, cultural beliefs, and social mores, which in turn can force them to choose unsafe abortion methods that are not typically practiced in public.

Although Ghana passed abortion legislation in 2003, it has been demonstrated that the delay in formulating and implementing policies has failed to translate the law into essential services. As a result, abortions that can be obtained legally are prone to /clandestine procurement due to providers and clients' lack of information (Morhee & Morhee, 2016).

Women in Ghana are influenced by the legality of abortion when choosing an abortion technique, according to research by Klu, Atiglo, Manyeh, Immurana, and Dalaba (2020). Interestingly, they discovered that there is a correlation between women's increasing awareness of the legal status of abortion and an increase in the usage of hazardous abortion procedures in Ghana. They advocated for a shift in cultural attitudes and the lowering of barriers to safe abortion services in Africa so that women may more easily access them. This is due to the fact that a woman may resort to an unsafe and often hidden technique of abortion if she is aware that the laws of Ghana ban it except in certain cases (such as rape, incest, or when the health of the mother or the unborn child is in danger), but if societal, cultural, and religious standards do not condone it, she may still choose to have an abortion.

Research on the perspectives of Ghanaian women who have experienced difficulties during an abortion was undertaken in 2009 by Konney, Danso, Odoi, Opare-Addo, and Morhe. The goal was to find out how women felt about safe abortion services, what their demographics were like, and how well they knew the abortion law. Using a structured questionnaire, data was collected within two months for the cross-sectional study. Women admitted to Kumasi, Ghana's Komfo Anokye Teaching Hospital (KATH) due to difficulties arising from abortion were asked to participate. Nearly half of all admissions to the gynaecological unit were due to problems associated to abortion, according to the report. The ladies were, on average, 26 years old. Out of 296 patients surveyed, 28 percent reported having an induced abortion. A quarter of the population was single, a third lacked a high school diploma, and nearly all (92%) were unaware of the abortion law in Ghana as it stood at the time. They were in agreement that access to safe abortion services is important, and nearly all of them were willing to use them. Patients visiting the Komfo Anokye Teaching Hospital for treatment of abortion-related problems lacked awareness of the abortion law as it stands, according to the study's authors. Thus, it is necessary to make abortion services available in a safe environment, encourage women to use these services, and raise public knowledge about the importance of legal protections for abortion (Konney, Danso, Odoi, Opare-Addo and Morhe, 2009).

Knowing the laws of one's country regarding (safe) abortions is knowledge about the abortion laws of one's country. Among these are the circumstances in which an abortion is considered safe for the mother. A woman is said to have information on the ligality of abortion if she has a general grasp of the laws that control abortion and knows when it is lawful to get an abortion. For example, in Ghana, abortion is permissible in circumstances of foetal impairement, incest, or rape. Furthermore, a pregnant woman

has the right to an abortion if she or her unborn child's life is in imminent danger, or if she believes that she or her child's life will be endangered if she goes through with the delivery. According to Klu et al. (2020), numerous factors impact women's understanding of safe abortion methods. Consequently, it is critical to have a clear understanding of abortion services and the selection of safe and unsafe abortion techniques, particularly in light of the stigma and misunderstanding that surrounds the procedure. Researchers have looked into these questions in an effort to find answers. For example, Gbagbo (2019) discovered that under half of the women in Ghana were aware that abortion is lawful under certain circumstances. In addition, the study discovered that women with higher levels of education were more likely to know that abortion is legal, which impacted their choice to seek out safe abortion options. Earlier research by Mote, Otupiri, and Hindin (2012) found that women were more likely to choose safe abortion techniques when they knew abortion was permitted under certain circumstances.

Furthermore, research suggests that in societies where moral and religious norms and laws forbid abortion, there are a variety of factors at the individual, household, community, society, and national levels that can impact one's understanding of the abortion's legality (Mundigo, 2006; Klustey & Ankomah, 2014).

These factors include but not limited to age, marital status, ethnicity, geographical location and economic circumstances.

Also, studies have found that knowledge on legal status of abortion is low among some health professionals (Labandera, Gorgoroso & Briozzo, 2016) and this negatively influences service provider attitudes towards privacy and stigmatising provider behaviours (Rahman, DaVanzo & Razzaque, 2014).

Abortion was deemed unlawful with moral and religious undertones in many nations around the twentieth century. It was also linked to many health problems and deaths, especially when done unsafely (Rahman, et al., 2018). However, in recent years, abortion regulations in both the developed and developing worlds have been liberalised, and Ghana is no different. These liberalisations were accompanied by the promotion and advocacy of contemporary contraceptive use to reduce the rate of unsafe abortions and the resulting mortality (Rahman, et al., 2018).

The Provisional National Defence Council (PNDC) Law 102 liberalised the country's abortion laws. According to the law, safe abortion will only be recognised as legal under the following conditions.

1. If rape is the cause of conception (non-consensual penetrative sexual intercourse).
2. Female minor defilement (consensual or non-consensual sex with a girl under 16/mentally handicapped).
3. Incest (consensual or non-consensual sex with a female of blood relation).
4. Pregnancy poses a risk to the health or life of the mother or the foetus.

Unsafe abortions are often based on social, mental, and physical health, there is a wide range of interpretations for these legislative adjustments and repercussions to Ghana's abortion law (GSS, GHS, & ICF, Ghana Maternal Health Survey 2017; Owoo et al., 2019). As a result of these investigations, it was concluded that abortion regulations should be liberalised and amended. Abortion decision-making will empower women and strengthen their rights and ability to make an informed choice. How well-informed are women about the legalities surrounding abortion? If they are aware of the laws of abortion, what variables (internal and external) influence their choice of abortion method?

These questions have been the subject of studies that have attempted to provide possible explanations. Gbagbo (2019) survey in Ghana indicated that less than half of women knew that abortion was permitted under certain circumstances. These women were more likely to know about abortion's legality if they were well educated. This knowledge influenced their decision to seek out safe abortion providers. Study after study have found a correlation between women awareness that abortion is legal in certain circumstances and their willingness to use safe abortion techniques (Mote, et al., 2010; Shah & Åhman, 2012; Gbagbo, 2019).

According to a research, information about abortion's legality can be influenced by a variety of factors at the individual, home, community, social, and national levels in a society with rigid cultural systems and moral and religious rules and customs (Klutsey & Ankomah, 2014; Coast et al., 2018). Some of these characteristics include but are not limited to age (Dehlendorf & Weitz, 2011), marital status (Atakro et al., 2019aa), ethnicity (Jones & Jerman, 2013), geographic location (Ostrach & Cheyney, 2014), and economic situation (GSS, GHS, & ICF, Ghana Maternal Health Survey, 2017). Combining these multidimensional factors impacts information about abortion's legality and the decision-making process about abortion

2.8 Lived Experiences of Unsafe Abortion

There may be a wide range of sociocultural practices that contribute to women's choice to have an unsafe abortion. It is well-known that unsafe abortion can have societal effects. Healthcare workers, members of the community, and family members of women who have had abortions all contribute to the pervasive stigma that these women face. Due to significant social sanctions against sexual behaviour, a lack of finances, and inexperience in seeking healthcare, stigma can have a particularly impactful effect

on unmarried and young women. Even in nations where abortion is legal, easily accessible, and performed without risk, the procedure is stigmatised and may have societal ramifications (Sedgh, et al., 2007). According to the Ghana Maternal Health Survey (2017), three percent of participants said they had an abortion so they wouldn't have to feel shame. Researchers in Guatemala and Uganda found that women who undergo unsafe abortions face severe social stigma and even physical violence from their families and neighbours (Jagwe-Wadda, et al., 2006).

Unmarried young women who are suspected of having an abortion may have difficulties in finding a life mate. Not only do married women face stigma from their husbands and others who suspect infidelity, but there are also substantial socio-psychological effects that can arise from both external attitudes and internal experiences of guilt and shame (Singh, 2015). One consideration in choosing to forego an abortion is the stability of the union in relationships involving young people, particularly those in which neither partner is married (Olukoya, et al., 2011). In order to extrapolate the stability of a marriage, the survey discloses important questions. The reasons given by 9% of the respondents who chose abortion were a lack of love or desire to remain with the father (GSS, GHS, & ICF, Ghana Maternal Health Survey, 2017). Ghana is one of numerous countries that legalise abortion in cases of sexual assault, rape, or incest. But nobody ever talks about these occurrences because of the stigma. Because of the social shame associated with certain practices, such as incest, some families resort to seeking the help of unqualified health care providers in order to terminate a pregnancy. This is done in an effort to preserve the family's reputation.

Unsafe abortion and its complications account for a significant portion of maternal mortality rates in poor nations. For example, according to Sedge, et al. (2007), over half a million women and girls die every year as a result of complications associated with unsafe abortions. One in five maternal deaths in East Africa occur as a result of unsafe abortions, which account for an estimated fourteen percent of all pregnancies (WHO 2004; Sedge et al., 2007). The incidence rate of mobility is high due to unsafe abortions. Unsafe abortions claimed the lives of almost 70,000 women in 2005 (WHO, 2005). The authors of a 2003 study on surgical complications following unsafe abortion were Bhutta, Aziz, and Korejo. Tragically, they discovered that these procedures lead to septicaemia, intestinal damage, hemorrhagic shock, and the victim's death. Sexual activity is the first step in becoming pregnant. Relationships are the most common setting for sexual activity.

The probability that a pregnancy resulting from sexual intercourse is intended or wanted is affected by various aspects of the sexual connection, such as marital status, the length of the relationship, and the power disparity between partners. Unmarried women in Uganda, for instance, are disproportionately likely to become pregnant by chance due to their vulnerability to sexual pressure and their lack of knowledge on how to avoid being pregnant (Ajayi & Ezegbe, 2020). There is a substantial worldwide burden of abortion due to both the danger of death (about 350 per 100,000 abortions) and the non-fatal sequelae. Risky abortions and complications after the procedure cost women dearly in terms of health, life, and money (Soleimani et al., 2020).

The average age of the woman when her relationship started was 17, according to Bingenheimer, et al. (2016). The percentage of relationships in which the woman's male partner was five years older than her was 44%. Men who were either working and not

in school (36% of the relationships) or were in school and not employed (50% of the relationships) were the most common. Women reported receiving basic and auxiliary financial support in most relationships (84% and 87%, respectively), and 75% of the time, they had some financial reason to start the connection.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

Various aspects of the research process, including the research philosophy, design, approach, study area, population, sampling technique, data gathering process, analysis, and ethical considerations, are covered in this methodology chapter.

3.1 Research Philosophy

The research philosophy used for the study is Interpretivism. It is based on the premise that human experiences are intrinsically subjective and are shaped by the environment in which they occur (Neuman, 2013). In the study, the researcher employed Interpretivism, as the researcher wanted to find out the hidden reasons behind undergoing an unsafe abortion and understand their personal experiences after their actions.

3.2 Research Design

Researchers engaging in phenomenological studies rely on participants' first-hand accounts of an event to fill in the gaps in our understanding of it (Ishtiaq, 2019). Several people who have all witnessed the event have their accounts summarised below. Interviews are a common component of this approach, which has solid philosophical foundations (Giorgi, 2009; Moustakas, 1994). The study of ordinary human experience is known as phenomenology. In studies where one or more people's actual experiences with an idea or phenomenon are under investigation, this method is employed (Mohajan, 2018). According to Creswell (2018), a phenomenologist is someone who studies subjective experiences. Areas with little prior knowledge were studied using this research method (Donalek, 2000). According to Creswell (2018), this particular

line of research seeks "The central underlying meaning of the experience that emphasise the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on the memory, image, and meaning." Some examples of activities that represent phenomenological research include reading, talking, sending emails or messages, listening to music, etc. The present study's focus on the sexual health, economic, socio-cultural, and other lived realities of women who have undergone unsafe abortions made this research philosophy a good fit.

3.3 Research Approach

A qualitative approach was used to determine the personal experiences of unsafe abortion practices among women in the reproductive age range in Baakokrom. In this study, key informant interviews were conducted with participants. The qualitative approach was used to describe people's own experiences with a specific occurrence in their lives (Polit & Beck, 2012). It allowed the researcher to understand better the life experiences of women who have undergone unsafe abortion practices in Baakokrom. In addition, the qualitative paradigm was chosen because of the following advantages it has over the other methods. It is flexible to follow unexpected ideas during research and are based on available data, interviews are not limited to particular questions, and can be redirected by researchers in real time, data are based on human experiences and observations.

3.4 Study Area

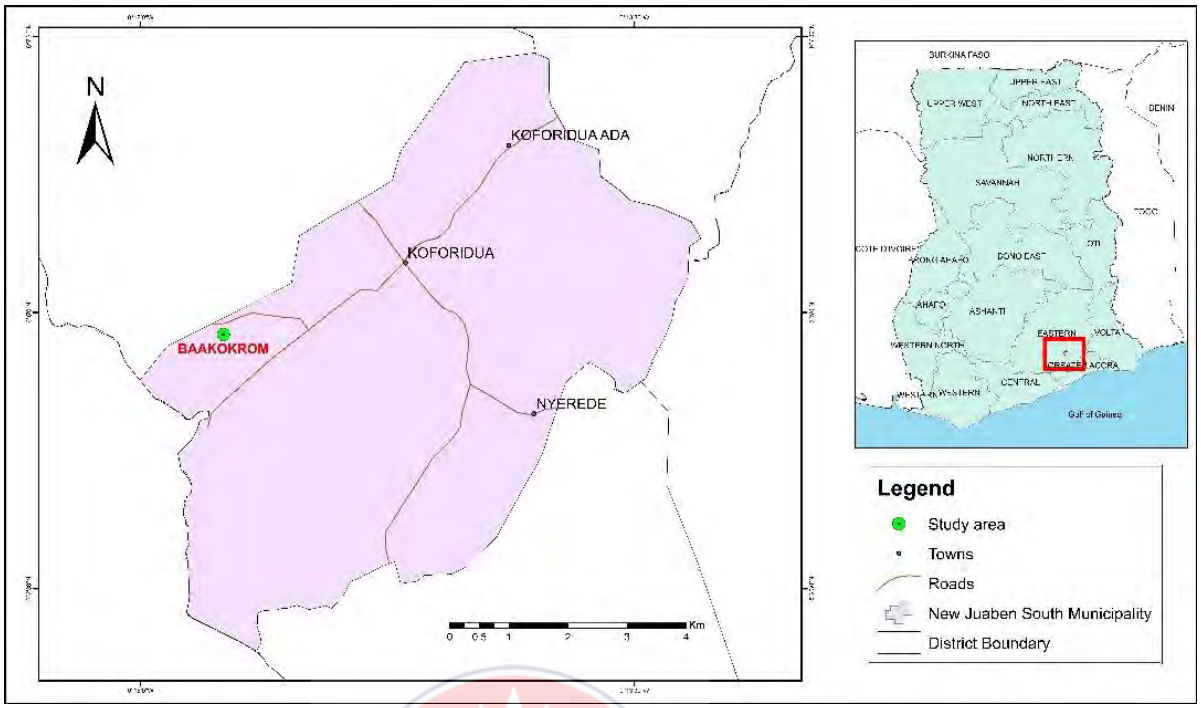

Figure 2: District Map of New Juaben South showing the study community
Source: Ofosu Sarpong Adwoa (2024)

The study took place in Baakokrom, a town in New Juaben South Municipality in the Eastern Region of Ghana. Baakokrom is a rural community, its absolute location is 3PM7+29V, Koforidua. It is boarded at the northeast by Nyamekrom community, southwest by Daasebre Estate and east by Effiduase town. The municipality is 110 square kilometres, accounting for 0.57% of the Eastern Region's total land area. It is bordered on the northeast by East-Akim Municipality, east and south by Akuapim North District, and West by Suhum Kraboa Coaltar District. Baakokrom has no clinic or hospital which could focus on reproductive health and gender-related issues operating hence the rise of teenage pregnancy and unsafe abortion. The area (Baakokrom) was chosen for this study because it appears the incidence of abortion is high in the Eastern Region. This is because Ganyaglo (2012), indicated that abortion complications were the second leading cause of maternal deaths, behind post-partum

haemorrhage, between 2004–2009, a period which spans the introduction of the policy changes around abortion care, in the Eastern region.

The main economic activity of the people in Baakokrom is farming and most of the inhabitants are low-income earners since there are few job opportunities in the community. The area has no primary, secondary or tertiary institution except two private day care schools. Moreover, most of the inhabitants are not formally educated thus the Children do not start school early since they need to attend the school at nearby communities and some have to assist their parents in their farms. It has been a trend in Baakokrom since the females do not attend school early they become off age and easily give up in schooling after few years. Also because of that, they feel of living indent by engaging in sexual relationship which results most given birth below the age of 18 years. Most of the young girls at Baakokrom only completed Junior High Schools with few enrolled to Senior High Schools and beyond.

Baakokrom has no health facilities except CHPS compound which is located in the next town where they have access to contraceptives yet few patronise due to the misconception about it and poor education on it. Age at first sex mostly depend on how prospective ones' parents are but mostly occur at tender age. Most of these young girls are into sexual relationship and are done in secretes, they mostly discussed among themselves in schools.

3.5 Study Population

The study's target comprised all women residents in the Baakokrom Township in the New Juaben South Municipality in their reproductive aged between 16 years and above who have ever undergone an unsafe abortion between the previous 1-5 years.

Participants were chosen explicitly if they met, particular demographic and phenomenological criteria (Johnson-Hanks, 2008). The participants in this study were women who had undergone unsafe abortions between the previous 1-5 years. For example, women under the age of 18 who could not give consent were excluded from participating in the study. Women who had informed someone about their abortion were included in the study. Women who had attempted but failed to have an abortion were barred from participating in the study because it only enrolled women who had successfully unsafe aborted a pregnancy. The woman must be a resident of Baakokrom or had the unsafe abortion in Baakokrom in order to participate because the research in conducted for a specific criterion of women in the community.

3.6 Sample size determination

Researchers Smith, et al. (2009) indicated that the sample size should be between 5 and 25 individuals when conducting phenomenological research. In this study, the researcher used 10 participants. This is because Guest, Bruce and Johnson (2006) concluded that about 12 participants are sufficient sample saturation for interview studies analysed for emergent themes. Also, phenomenological research gives room for the researcher to continue conducting interviews until it is found that additional interviews fail to add substantively to the understanding of the emergent structure of the experience. The participants in this study were women who had undergone unsafe abortions between the previous 1-5 years.

3.7 Sampling Techniques

A non-probability sample type (purposive sampling) was used to get the targeted women who have undergone unsafe abortion. Using this strategy allowed the researcher to discover respondents of interest from a pool of extremely knowledgeable people

about a particular topic (Creswell, 2012). Thus people who have successfully done unsafe abortion was useful for the research. Snowball sampling was employed to determine whether or not the participant knew of any other women who had an unsafe abortion.

3.8 Process of Data Collection

For the study, the researcher conducted semi-structured interviews with women who have had an unsafe abortion and took notes about some of the things they had to say in a notebook. It was anticipated that the use of semi-structured in-depth interviews assisted the researcher in obtaining participants' perspectives on the phenomena and its description and elicit meaning from those who have personally encountered it (Creswell, 2007).

The instrument used was interview guide two senior lecturers evaluated the semi structured interview questions for construct, content, and face validity. The necessary changes to the contents of the semi-structured interview questions made after the feedback is received helped shape the interview questions. The interview took approximately 20 minutes. It begins with the background information of the interviewees and continued with the reasons for abortion, what transpired and their experiences. When designing semi-structured interview questions, the errors and ambiguities in the questions can easily be overlooked (Wilkinson & Birmingham, 2003).

Participants were chosen based on the researcher's knowledge of individuals who have undergone unsafe abortions in Baakokrom. With the help of a community gate keeper six (6) women who have undergone unsafe abortion were identified. Four consented to participate in the study. Snowball technique was employed to identify other

participants. Using this strategy allowed the researcher to discover respondents of interest from a pool of extremely knowledgeable people about the topic (Creswell, 2012).

The field data collection exercise was conducted in Baakokrom of duration of nine weeks from 1st October 2022 to 29th November 2022. Before the interview the researcher ensured that each participants' consent from was read and could ask questions before and at any point of the interview. This enabled rapport building and trust which made the participants to feel comfortable. Participants through referral embraced the opportunity given them to share their experiences. There were challenges faced during the conducting of the interviews. Participants preferred interviewing in the evening and in the homes since during the day they will go about their businesses hence making interview eat deep in the evening with mosquito bites.

Some participants were mostly disturbed by their young kids who caused distraction and delayed interviews. There were times participants will not be ready to conduct interview either from tiredness from the days' work or cooking evening meals.

After obtaining consent from the participants, the researcher used a tape recorder to record all of the information obtained throughout the interview. As a result, it was easier to record every piece of information. The interviews were conducted in Twi, a language that the participants were familiar with and the interviewer could speak. The captured audios were transcribed verbatim and translated into English for further analysis.

3.9 Analysis

The Data analysis was accomplished by the researcher listening to the audio recordings after the researcher have sought the consent of the participants before using a tape recorder to record all of the information obtained throughout the interview. This was done to ensure that the participants information gathered was for this study only and any information given was treated confidential and noting in a notebook what has been recorded in the process of transcription. After transcribing the recorded data, the researcher double-checked its accuracy to ensure that it corresponds to the participants' narrations, if applicable.

Data analysis in this study followed the steps adopted by researchers in the tradition of the social phenomenology of Alfred Schütz (cited in Carvalho, Merighi and Jesus 2010), which includes reading; detailed re-reading of each testimony to grasp the experience's global meaning; identification and later grouping of the significant aspects of testimonies to compose concrete categories. Objective syntheses of different meanings of actions that emerged from experiences were done.

A deductive approach to content analysis was used to analyse the qualitative information gathered from the interviews. This technique is used for the analysis because is it based on previous knowledge drawn from literature or theory. The recordings were completely transcribed into verbatim transcripts which were analysed to detect patterns for content analysis. The transcriptions were coded using the NVivo analysis and organised into reasonable group.

3.10 Ethical Issues Considered

These ethical protocols were followed for this study

3.10.1 Informed consent

To avoid violating the concept of informed consent in social research, participants were given letters of introduction to request approval before the questionnaire is administered. The data collection intentions were explained to the participants in this letter. Before the interview the researcher ensured that each participant's consent form was read and they could ask questions before and at any point of the interview. This encouraged trust and bonding with participants which made them to relax.

Participation was voluntary, permission was asked before audio recording. Also, all participants were told that they could alert the interviewee and skip any portion of the interview that they were not comfortable discussing.

3.10.2 Debriefing

The researcher provided participants with information explaining the purpose of this research study, how privacy/confidentiality is maintained, as well as the risks and benefits of participation in the research study. At the start of each interview, the researcher ensured that each participants' consent form was read and signed, and to provided participants many opportunities to ask questions. The researcher strived to build rapport with participants during the commencement of the interviews.

3.10.3 Cultural sensitivity

Given the sensitive nature of this particular study, the researcher ensured the interviewing process, as well as information gathered within, did not pose a threat or harm to their culture or beliefs hence participants at any time hence they could opt out of the interview anytime they felt posed danger to them or did not want to answer due

to raised emotions. Additionally, the researcher interviewed participants where they were comfortable and had enough time to participate in the interview.

3.10.4 Assured confidentiality and anonymity

The participants were assured that their personal information was safely secured. In order to achieve this goal, participant's occupation and age were used instead of their real names before interviewing making it harder for people to recognise the participants. The individual respondent had the option to withdraw from the study at any time.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the results from the field and discusses the findings alongside the literature. The findings are the opinions and experiences of women who have practiced unsafe abortion. These experiences were gathered through interview. The results are presented according to the objectives of the study.

Table1: Socio-demographic characteristics of participants

Variables	No. of participants = 10	%
Age		
< 20	00	0.0
20 - 24	5	50
25 – 29	4	40
30 – 44	1	10
Religion		
Christianity	7	70
Islamic	1	10
No religion	2	20
Education		
Basic	2	20
Secondary	4	40
Tertiary	4	40
Occupation		
Self-employed	6	60
No work	4	40

Source: Field data (2022)

The ages of participants of the interview, it ranges from twenty (20) years to thirty (30) years. These are young women who are in their active reproductive age. It is not surprising that many are sexually active which has resulted in pregnancies with some being aborted. Out of the ten (10) interviewers three (3) were in the age category of 28 years. Another two (2) were in the age of 23 years. The rest had one (1) individual each

representing in the ages of 20 years, 22 years, 24 years, 25 years and 30 years respectively.

Another area in the socio-demographic characteristics of the participants is seen in education. Out of the total participants who participated in the interview, two had basic education. This covered education from primary to Junior High School level. The reason they provided for education at this level has to do with inadequate financial resources in their family. Again, four participants have had education up to the Senior High level. Lastly, another four interviewers have also experienced education at the tertiary level. This current study reflects the study done by Baruwa et al. (2022) on Unsafe abortion in Ghana, prevalence and associated factors. The results indicated that the prevalence of unsafe abortion was higher among women aged 25 to 34 years, those who had secondary-level education, those living in urban areas and in the Ashanti region, those of Akan ethnicity and those belonging to non-Catholic Christian denominations.

Notwithstanding, a study done by Geelhoed, et al.(2002) found that, women who are in urban areas, or have higher education use more contraception and performed unsafe abortion the more than those in rural areas, less educated, and did not use contraception. This study does not reflect the current study since all respondents lived in a rural area and is less educated but rather performed unsafe abortion. Moreover, the prevalence was higher among single women, those who had no children, those who started sexual intercourse before the age of 18, those who were currently using a contraceptive, those exposed to media and those who knew about the legality of abortion. This may be due to the fact that the condition in Ghana is the same across the country.

With respect to religion of participants, it became evident that Christianity stands at seventy percent and Islamic stands at ten percent. Those with no religion stands at twenty percent and its evident in the study that those who represented no religion were not really atheist, however, they were in the Christianity religion but due to stigmatization in the church, they decided to stay in the house without going to church anymore. The reason for high percentage in Christianity could be as a result of the Christian religion dominant in the area. A study done by Ilboudou, et al. (2014) in Burkina Faso found that unsafe abortions were prevalent among Christians [They were comparing only Christians and Muslims in their study] which concur with the study. In the area of occupation, those who are self- employed were seen to be in the majority. Six out of the ten participants who participated in the interview were self- employed.

Notwithstanding with marital statuses of the women that were interviewed, it became evident that three (3) out of the total number of ten, were married and seven (7) of them were not married. Those who are not married are either in school or apprenticeship, putting their lives together and hoping to get married. It is important to note that in a study by Otoide et al (2011) found that sexually active unmarried people may use abortion to delay childbearing or in certain parts of the world as a contraceptive replacement. Also, Boah, et al. (2019) revealed that older and married women were less likely to suffer from unsafe and unsafe abortion. Thus married women are not faulted when they get pregnant making is unlikely for them to engage in unsafe abortion. This reflects the current study on the efforts participants adopted to delay or prevent being pregnant.

4.1 Sexual health experiences on unsafe abortion

The results were presented according to sub themes from the interviews conducted. The sub-themes used under the sexual health experiences of unsafe abortion on women who underwent unsafe abortions was described as unmarried relationships, contraceptive use, contraceptive failure, Method in terminating pregnancy, and bleeding after the procedure.

Unmarried relationships

The interviewer pursued to find the number of relationships participants has, it became evident that all of the participants have been into relationships in one way or the other. Few had been with five men including their current relationships. Again, a few participants have also been with two and four men. In finding out the purpose of going into the various relationship, it became clear that almost all of them went to relationship because of money. It became evident that many households who could not support these females and made them look elsewhere for the supports. The men who were available to offer the supports also took advantage of these women.

One of the participants indicated that

> *"I needed money. I was the only person taking care of myself. My parents were not supporting me. It was only me. So the option I had was to date those guys and get money. So that is the reason"* (22 years, unemployed participant).

Another participant said

> *"reason for going into several relationship was to get more money to see herself through school''* (23 years, unemployed participant).

The other reasons are also seen aside money, this includes doing it because of the fun of it, love, peer pressure among others.

With respect to other factors, one participants also had this to say

> *"…that time, you know when you are young the mind is childish, and that time the guys really loved me so I had no option I wanted to have fun, get popular and to be seen as a high time girl"* (20 years, unemployed participant).

Contraceptive use

By way of Contraceptive use, it indicated in the study that even though some of the participants used contraceptives (drug, condom) a lot did not use it. Participants who did not use contraceptive had no knowledge about its usage because of their naivety, financial constraints to purchase and shyness to buy the contraceptive.

One participant indicated that

> "*With the first pregnancy because I was inexperienced I didn't really take any medicine or contraceptive.*" (20 years unemployed).

Another participant said

> *''even if I knew of the contraceptives I won't get money to buy. Again I would have felt shy to buy it from the drug store''* (20 years unemployed).

Participants who knew about the contraceptives were reluctant to buy because they were scared of misconception about the effect of the pills on their health. Participants started using contraceptive pills after they learnt how to use the drug. This is because they cannot stop having affairs with their partners and they are afraid of becoming pregnant. These contraceptives came in a form of condoms and pills.

It was also evident that the contraceptive use was limited among the women since the men were not interested to use then. There were also instances where the women were sure the men would use condom to prevent any form of pregnancy but they refused.

> *'' then the guy said he doesn't use condom during sex because it's not nice so I had to let him have sex without wearing condom''* (30 years old unemployed).

Contraceptive Failure

Another area has to do with contraceptive failure. This failure led to lot of pregnancies, which ended up being aborted. Yet of these participants, a lot had issues with contraceptive failure and four participants were successful with the use of contraceptive.

One of the participants indicated,

> *"yea I took the contraceptive, for the second pregnancy that I gave birth and the last one that I aborted, I took it but it didn't work (28 years self-employed).*

Another participant also indicated,

> *"it failed. Sometimes I took medicine, other times too I used condom" (23 years unemployed).*

Some participants explained that the men deceived them with the use of condom or either withdrawal method yet they did not. The participants further explained that they didn't understand how the contraceptives worked. In addition, they didn't know the difference between the daily taking of contraceptive pills and the emergency contraceptives hence they believed they were taking wrong dosage that's why it failed.

A participant also pointed out that:

> *''when we started I told him to use condom and he assured me that he would withdraw when the sperm is coming. But unfortunately I think that did not happen. In the first month I didn't see my period (menstruation), through to the third month, I didn't see it again. That was when I realized I was pregnant''* (24 years self-employed).

Method used to terminate pregnancy

In looking at what transpired after contraceptive failure, it became obvious during the interview that they used different methods to terminate pregnancy which included mixture of coca cola and sugar, mixing of concoctions, herbal drugs, paracetamol, boiled dry leaves of plantain and sugar, crushed bottle with soft drink, and excessive

alcoholic drinks (three bottles of beer). With respect to the method used, one of the participants had this to say:

> "*I was really shy to go to the drug store to get advice on what to do, so it was my cousin who went to find out about how it could be done. She was told I should crush bottle into very smallest particle and mix it with drink (liquid beverages) and take it orally, and I did it* (28 years, unemployment).

Another participant also indicated

> "*I cannot really tell because it was my friends who got them for me. They were also afraid; it was kind of illegal. All that I knew was that they told me once I take the medicine I was going to be fine and the abortion would be cleared so I took it (*23 years unemployed).

Again, another participant also added that,

> *I told the guy about it and he asked me to wait, I waited for a long period of time but he couldn't give me any better response so I went to see one of my friends. She told me I can take some things, something like paracetamol to get it aborted, when taken overdose. So with the first pregnancy, I took paracetamol because it was at its earliest stage, it was like one month, so I took plenty of it. Then I started bleeding, I bled so much. I also had strong abdominal pains. It really painful. It lasted for about one week….I didn't go to any hospital because after the fifth day, the bleeding reduced to small drops* (24 years self-employed).

Surprisingly, almost all of the participants disclosed that abortion done using traditional herbs and concoction did not have negative influence on their childbirth and their sexual activeness.

Bleeding after the procedure

Furthermore, experience shared about bleeding they went through after unsafe abortion was that, all of the respondents bled not less five days after engaging in unsafe abortion. One of the respondents indicated

> *"the bleeding took about six days and I could see it, it really affected me"* (28 years self-employed).

Also the aftermath effect on menstruation reveled that few of the participants had difficulties getting pregnant because of their irregular menstrual cycle. With respect to this, a respondent indicated that

> "*when I am about to have my menses, I feel a lot of pains. The menses doesn't come well too. You know that it is supposed to come at least seven days or five days, but It only comes two days and stops* (28 years self-employed).

4.2 Socio-cultural life experiences of Participants who have had unsafe abortion

The socio-cultural experiences were described in smaller themes. These were societal stigma, religious acceptance (norms), lifestyle (attitudes), marital status, union stability, partner and parental influence.

Societal stigma

Societal stigma was one of the reasons participants opted for an unsafe abortion. The stigma came from friends, schoolmates, family members among others. In some communities in Ghana, pointing of fingers and low conversation become the order of the day when one deviate from the norms of the society. In seeking for response on societal stigma it was established that all the participants were not married when they had the unsafe abortion. They were concerned about the negative comments from family, the community and most especially church since they are unmarried yet pregnant. Also some parents won't welcome unwanted pregnancy in their homes and stop taking care of their education since they are not married.

> ''*…. You see this area is small and we know each other so there are gossips around. Before you know the Pastor and church members will hear so I can't attend church''* (23 years unemployed).

Another participant said

> *''I sing at church and am also a leader of the youth. Due to embarrassment and disappointing members of the church I had to abort it. Also I come from a poor background and the family can't feed an extra mouth"* (28 years self-employed).

The consequences notwithstanding, it became evident that society, the family and the churches only reacted within few moments and sometimes few years, then they all begin to accept them back into the family system or the community.

With respect to this, one participant had this to say,

> *''when my parents found out that I had given birth they weren't happy about it, but right now they have accepted it because they know that people make mistakes. Also the abortion I did when they found out they were very angry but now they know that now I am growing and I have to live my life. They have accepted it" (20 years unemployed).*

However, few of the participants kept is as a secret from close family members. Their secret hidden safe from all this embarrassment from relatives.

One participant indicated

> *"with my family, no one knows anything about it. My mum even doesn't know, myself and my cousin decided to do, so it is a secret between the two of us, only the two of us" (22 years unemployed)*

Religious acceptance (norms)

Religious acceptance (norms) was also factored into socio-cultural life. Religion is a subset of culture because religious beliefs and practices are found in all societies. Religion involves shared beliefs, rituals and practices that binds people together.

Interestingly, in a small community, information spread like bush fire. This is because the members who constitute the household are also members of the churches and the community at large. Few of the participants have kept it a secret from their church while the rest have been exposed.

One participant indicated,

> *"my church has no idea about what has transpired, they don't know. I have already told you that I don't go to church now" (23 years unemployed).*

In some instances, the church also becomes aware when individuals transfer the information. With respect to this, one participant indicated that,

> "…*the church also got to know because of the lady I fought with who decided to reveal all the secrets. I used to sing at church but I became shy and decided not to attend church anymore.*" (23 years self-employed).

When members of the church became aware of the act done by some young women, these individuals stop going to church. Those who are very confident have the belief that they are not the only people who have committed abortion in the world. However, they also feel guilty anytime the preacher man mentions anything closer to what they did in the past.

With respect to the church, another participant said that,

> *"I go but you know what, anytime the pastor preaches it is like he was talking about me. So I always feel shy before my friends and feel guilty* within. (28 years self-employed).

This was not different from what participant had to face, most of the participants whose secret were exposed face social stigma. One of them indicated that

> *''Some people heard it but not the Imam. We live in a compound house roughly people got to know of it. You know in life it is not everyone who will like you, so they took it outside and it also became an issue. With my friends and the people around, they couldn't say it in my presence but they said it behind me. I couldn't go out because people will be looking and pointing finger at me. It took some time before I could go out. After he married me then I became comfortable moving around* (25 years old self-employed).

Lifestyle

Furthermore, the lifestyle of participants after the unsafe abortion was influenced either positively or negatively. This is because almost all of them have lost confidence in themselves. They are now enlightened on the effect of unsafe abortion and know what to do when they ever have an unwanted pregnancy. Also they stopped the promiscuous behavior and focus on their work and school. Several participants were ashamed that they aborted their pregnancy. They felt shy and guilty because of societal stigma. A few of them do not care and they are not ready to change and have a better life.

One participant said

> "*... this unsafe abortion has exposed me to learn the usage of different drugs so now am not afraid to get pregnant or even abort besides I can teach other girls on how to do it. In fact, I can say I am now a bad girl or a high class girl.''* (24 years self-employed).

Another participant said

> "'*I feel bad aborting, my conscience won't let me be anytime I see someone with a small baby. I am now a quiet lady I used to be outspoken but after people started teasing me with the abortion I don't feel comfortable.''* (28 years self-employed).

Another participant said

> *''I don't care if they are aware I have done an abortion or not I am still me I haven't changed.''* (24 years self-employed*).*

Marital Status

Another socio-cultural experience had to do with marital status. The study found out that more unmarried women indulged in unsafe abortion more than the married women did. Many have faced abandonment, lack of trust and disappointment. In an effort to find the effect of unsafe abortion on the marital status of respondents, it became evident that whiles most have been able to keep it secret and within the smaller circle, few have been exposed to the household due to health reason. Those who have kept it secret have vowed never to let anyone know, not even their partners due to the condemnation. Few of the unmarried participants are now willing and ready to get married but it has not been successful because of societal thoughts of they not been able to have kids in the future.

One participant had this to say

> "*...yea, I have made up my mind to get married, but I have not gotten any man to come forward because they know I have conducted an unsafe abortion''* (28 years self-employed).

Another participant indicated that

> "*Now I don't even know the direction of my life because of this abortion issues. Even the guy I am staying with currently, I got pregnant for him but I had a miscarriage. That one I did not destroy it with anything. I was even happy that I would give birth for him but I had a miscarriage and they had to rush me to the hospital. It was there that it was discovered that I had done abortion before. They asked me if it was true that I had done that before and I had to affirm it. They therefore concluded that it was because of the previous abortions that's why I had the miscarriage. Now the guy am staying with has lost the love he had for me. Now I don't even know if he will even marry me. How he used to treat and handle me previously has all vanished. This is the new guy, not the ones I had been with in the previous pregnancies. He was ready to do everything and I was also ready to settle down with him but the pregnancy is no more coming again* (25 years self-employed).

Partner influence and union stability

By way of partner influence and union stability, the study indicated that participants experienced influence from their partner. It is evident that partners are part in the decision-making process of these participants since all participants who told their partners they were pregnant were forced or misled to have an unsafe abortion procedure. This means some women were not in support of having an unsafe abortion but due to external influence, they condoned.

> *''Sister it wasn't easy, it was stressful making a decision to have an abortion because I was scared of this traditional procedure but my boyfriend and my mum forced me to do it. That's because my mom said she has used that method before so soo hmmm I, I, I used it…''* (30 years unemployed).

Maximum of the participants experienced some level of influence from their partner. To keep their relationship with their partners some participants said they had to abort even though they wanted to have the baby. Partners have both direct and indirect influence in the lives of women in terms of decision making and keeping the relationship stable.

However; several of the participants are currently not with the men they had the unsafe abortion. They have met new men whom they either hid their abortion status from or tell them and face the consequences.

One participant said

> "*my current boyfriend is not aware that I have done an unsafe abortion because of that I don't even want him to visit me here otherwise people will inform him*'' (28 years self-employed).

Another indicated that

> "*he is aware of the unsafe abortion but he told me he will only marry me when I get pregnant for him because that will be the only way he can know I can bare him children. But am scared what if it's a hit and run like the other man I had abortion for am confused hmmm* (24 years self-employed).

One married participant said,

> "*He is aware of what I have done and so he doesn't trust me enough sometimes he thinks I can get pregnant with another man and abort is without his knowledge. I convinced him severally and am sure it will take some time before he will get over it''* (30 years unemployed).

In other words, these women hide information from their parents with regards to relationship let alone pregnancy. Therefore, the men made sure that they do not inform them about the pregnancy, hence urging the women to resort to other methods.

Parental influence

With respect to parental influence, participants whose parents had high expectations for them which may include getting married before they become pregnant were forced to opt for an abortion. To keep their relationship with their parents some participants said they had to abort even though they wanted to have the baby. Also in household where parents hardly stay in the house, it was difficult for them to know that their children had done an abortion hence few participants took advantage of that and had an abortion.

They become aware after the acts have already been done and the consequences become exposed. These participants have lost trust and respect from their parents due to the act, while parents vowed never to take care of their children all because they disobeyed them and got pregnant.

One participant had this to say

> "*my father got very angry, he even threw me out of the house and said he would not take care of me, but my mum understood because she knew me very well. She was able to talk to my father of which they both warned me not to see me making friends within the community. My parents restricted my movement I no longer go out for parties, funerals or roam freely with the community*" (22 years unemployed).

In the same vain, another participant also indicated that,

> "*when I did the abortion my parents told me they are no longer going to take care of me. So I went and told my grandmother. She had to come and convince my parents before they finally decided to help me with the education. Now I no longer have many friends so that I will not be influenced again''* (23 years unemployed).

This is an indication that some parents would not take the issue lightly when their children become pregnant let alone an abortion at their young age. Few parents of these young women who became pregnant had no idea about the behavior of their children. Some parents trusted their children to the extent that they could not believe if they told them their children had become pregnant.

4.3 Economic life experiences of Participants who had unsafe abortion

The Economic life experiences was grouped into sub themes thus employment status, family size and Status of their income.

Employment status

The first experience shared was employment, it became obvious that a several of them engaged in relationships purposely for monetary benefits while the remaining few went in for sexual pleasure. They however ended up with an unwanted pregnancy. This

nearly affected the work they do for a living including participants who were apprentice. Some of the participants who experienced severe health consequences after the unsafe abortion indicated that they have become weak and they easily get tired with little work done. With respect to this, one participant indicated that:

> "*I lost strength, I also become dizzy most of the time and could not work for long hours my madam nearly sacked me"* (25years self-employed).

Another participant said

> *''though I am self-employed I ant not work for long hours I usually have waist and abdominal pain. Also some customers come to my shop to gossip about girls who have done an abortion and I feel* uncomfortable'' (22 years self-employed).

Another participant said,

> *''I still in my selling business. I don't care whether people and aware of getting an abortion or not. I need to feed my child and myself''* (23 years self-employed).

Status of their income

In finding the proceeds they got form their occupation after the abortion, it became evident that participants experienced consequences of the unsafe abortion either direct and indirectly. The direct consequences are the ones that were handled by the participants and their household. It turned out that those who had some money ended up spending it on themselves through purchasing of drugs and other needs. They have virtually come to nothing as their main objectives were met but temporary. Also indirectly, unsafe abortion had left dire consequences on their health making it difficult to work for longer periods to get more money to take care of themselves.

Other things being equal, inability to work for a longer period will also lead to less income and this experience was shared by participants. This has made most of them resort to their families for support especially those who are unmarried. Those who are

not married also resort to other guys who in turn also demand sex as compensation from them.

One participant had this to say,

> ''*these men are supportive though. When something happens and I call them they support. The thing is that they will also demand something in return. They will not give the money for free, something to balance it* '' (22 years unemployed).

Family size

Family size after the unsafe abortion have been influenced since all participants cannot afford to feed a large family, one participant who live from hand to mouth indicated,

> "*Hmm, the little money I get I am using it to take care of me and the child and also to buy contraceptives so that I can prevent any more pregnancy*" (28 years self-employed).

The participants have vowed not to have so much family should they be married while few attributed to personal reasons, many attributed it to the difficulty in the economy of the country. With respect to the family size, one participants also indicated that

> "*I might give birth to two or three because things are expensive these days and I don't want to give birth to many children and I cannot take very good care of them"* (23 years unemployed).

In other instances, the men who got the women pregnant also refused to accept the pregnancies and even urged these women to go ahead to abort the pregnancies.

With respect to this reason, one participant indicated in the interview that

> "*I was an apprentice, I was learning, and there was no money too. I could not give birth at that time, I would have suffered because the man responsible was not interested in the pregnancy so I had to abort it*" (25 years self-employed).

Another participant had this to say

> "*… because I was in SHS, I couldn't tell my parents about it so I had to abort it. The second is that the guy was not ready to be responsible for the pregnancy and advised me to have an abortion*" (22 years unemployed).

Another participant said,

> *''you know one person doesn't get pregnant alone, these men when you get pregnant they don't want you to keep it even if you don't want to abort. Also I don't want to disrespect him since our culture says women should be humble and submission''* (30 years unemployed)

Also financial weakness to raise a child was a problem. It became evident that altogether, interviewed Participants termed their pregnancy as unwanted since that wasn't their main reason for engaging in unprotected sex. In finding out the reasons why participants engaged in unsafe abortion, it became evident in the study that many of them realized they had made mistakes in getting pregnant. They had not anticipated of getting pregnant even though they had affairs with their boyfriends.

One participant according to her said,

> "*I cannot take care of any kid so I had to make sure they don't come at all. Beside it's not the kids I am even thinking about or interested in, I needed the money they will give to me to perform the abortion and the profit I will make after cost of abortion That's why I became pregnant* (24 years unemployed).

Although inadequate money to afford proper abortion services were also reason why the abortion was clandestinely participants decided to undergo unsafe abortion because they could be arrested and prosecuted when they visited the hospital since they believed abortion is illegal in Ghana. The men are afraid of been identified as an accomplice to illegal abortion when they visit the hospital to have an abortion.

4.4 Discussion

Research objective one sought to examine the sexual health status of women who have ever had unsafe abortion in Baakokrom. Several participants have been in a several relationships because they are not married. The relationship is also an avenue to get financial support from their partners because many families could not support these females and made them look elsewhere. The men intend demand for sex which may cause the woman to get pregnant. In Uganda, unmarried women are at high risk for unintended pregnancy, given exposure to sexual coercion and sexual activity without the capacity to prevent pregnancy (Ajayi & Ezegbe, 2020).

Participants knowledge on contraceptive usage was low and they were reluctant to buy due to shyness and misconceptions about it usage. This indicates that appreciable portion of the participants in Baakokrom were naive of the usage of contraceptives especially the pills and the injectable. Moreover, the natural method of contraceptives was also not used to prevent unwanted pregnancy. In addition, it is possible little or no knowledge on usage led to the contraceptive failure hence participants relied on friends to advise them on the best family planning method. The findings from the study indicated Baakokrom do not have any formal health sector where women can easily access counselling services on the different contraceptive methods. Some participants had to use contraceptives after their first pregnancy and having had an unsafe abortion. It is important to note that in a study by Otoide et al (2011) indicated that sexually active unmarried people may use abortion to delay childbearing or in certain parts of the world as a contraceptive replacement. This reflects the current study on the efforts participants adopted to delay or prevent being pregnant.

Several methods were used to terminate pregnancy clandestinely however, almost all of the participants who used traditional herbs and concoction had no problem during childbirth and their sexual activeness. It is possible that the herbs were not harmful to them and did not affect their fertility. Also it is likely the traditional herbs are cheap and readily available. This reflects the study of adolescents and young adults in Ghana who are more likely to resort to abortion as a way of regulating their fertility because of misperceptions about contraceptive effectiveness (Adde, et al., 2021). It is possible that they might be a level of truth in what they experienced hence the herbs used could be investigated, tested and approved which can be used by health professionals or could it be a mere coincidence? Moreover, it was found out that unsafe abortion done when pregnancy was in the early stages had no negative influence on their sexual health. Due to the restrictive nature of the law participants that experienced complication such as excessive bleeding, pains, cramps etc. after the unsafe abortion were scared to visit the hospital perhaps they thought they were criminals.

Participants socio-cultural experiences was assessed and experiences shared by participants in Baakokrom were no different from those that were identified from other studies. A study done by Kumar et al. (2019) indicated that stigma associated with abortion has been regarded as a societal phenomenon replicated in local settings in Cameroun. Our cultural norms and religion frown on getting pregnant before marriage. Therefore, all participants were concerned about the negative comments from family, the community and did not talk about the abortion except to close trusted relatives, friends or people they know have successfully done an unsafe abortion. This is similar to a study by (Lithur, 2014), as an overwhelming majority of the participants contacted either their friends, boyfriends or close family relative to seek abortion services when they realize they are pregnant. Unfortunately, those that their secret was exposed were

stigmatised in the society, church and among family members even though many engage in the act but because their secret is not out. This implies that if the act is kept as a secret you are free from all societal judgment.

The humiliation, fear of abandonment and denial of pregnancy etc. have change the lifestyle of several participants to critically make decisions concerning serious or casual relationships. Some women expressed the experience of the unsafe abortion process to be an on-going one in the women lives because subsequent life events, such as the birth of a child or having difficulty in conceiving another child, could compel them to re-evaluate the abortion experience in relation to identity.

Participants also blamed themselves for failing to detect character flaws in their partner aspects of the relationship prior to pregnancy. Some reported that they had felt bad that it took such situation (unsafe abortion) to make them know the genuine intentions of their partners because the men did not marry them. Ghanaian cultural settings frown on abortion hence after their secret was out it became difficult for them to find a husband since men they had the abortion with were not ready to settle down with them since it's a taboo and such women might find it difficult getting pregnant again. This was no different from what were identified from a study by (Voetagbe et al., 2010) that, pregnancy outside of marriage is frowned upon by most Ghanaian norms, and abortion is seen as a taboo subject to deep stigma, particularly in traditional societies. Participants reported experiencing such feelings as anger, sadness, depression, and betrayal. The study revealed that union stability was affected. The husbands of some married participants also did not trust them to stay faithful.

Moreover, some participants needed time to consider their options, discuss contraception with their partner, or complete the abortion process before making decisions about family planning. Perhaps participants involved the men in the decision making because they are trusted them or they knew some methods of terminating pregnancy. The partners influenced the type of abortion procedure used by some participants. Parents also had some level of influence on their children both direct and indirect influence in the lives of women in terms of decision making. Therefore, to keep their relation with their parents some participants aborted the pregnancy irrespective of their age and occupation. It is worth nothing that participants considering parents feeling in their decision be link to how they were brought up.

Economic experiences revealed several women in this study chose their own reputation and income, rather than risking their own lives and that of the fetus's potential life, as their top priority. Some women now fell less guilty of the act with time and they have grown relatively less concerned about being judged negatively by others because of the abortion due to what they gain such as financial support, gifts and other incentives when pregnant. This is in line with a study done by Krugu et al. (2017) in Bolgatanga, Ghana to determine the type of relationship that results in their early pregnancy. The study indicated that young women's motivations for sexual relationships are mostly 'beyond love' and seem to focus on economic factors. Most of the participants mentioned financial benefits or academic support as reasons for a relationship and did not seem to perceive a relationship as something that could be fun or enjoyable. Could this be as a result of youthful exuberant and lust? While others have done so by making changes in their lives that were more in keeping with their best interests and discouraging pre-marital sex.

Also some participants income reduced especially those who had complications after the unsafe abortion. They went to the pharmacy or hospital for treatment and spent their earnings since cost for treatment from complications of unsafe abortion was expensive. This is in line with a study done by Singh (2015) where Singh looked at the direct and indirect economic consequences of unsafe abortion victims. The study indicated that the direct costs is seen in the provision of medical care for women who are hospitalized as a result of complications of unsafe abortion. The indirect costs also included, the loss of productivity from abortion-related morbidity and mortality among women and other household members. The study indicated that the employed women indicated that they have lost strength due to abnormal abdominal pain as a result of the abortion while the students still depend on men for survival. This has led to reduction in productivity leading to low income levels making them to continuously depend on men. This results of study confirms that of Soleimani et al. (2020) thus Women pay heavily for unsafe abortions and post-abortion complications, not only with their health and their lives but also financially. Moreover, the decision to have a large family size is greatly influence by availability of emotional, social, and financial resources for child-rearing and that their circumstances for bringing a child into the world or having a child at that time fit their goals.

4.5 Conclusion

The chapter identified the socio-demographic characteristics of participants. It also discussed the lived experiences of unsafe abortion by participants. This involves the reasons for undergoing unsafe abortion, the experiences of unsafe abortion on sexual health of participants, the experiences of unsafe abortion on socio-cultural lives of participants, and the experiences of unsafe abortion on economic lives of participants.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter covers the summary of the entire study, draws conclusion and recommendations based on the findings of the study. This chapter summarizes the various issues that were discovered and then draw conclusions based on the findings. It also includes recommendations on how to improve the condition of unsafe abortion. Suggestions on further research into the area was presented.

Chapter one of the study revealed the three objectives, relevant literature review was discussed on these objectives. The study included 10 participants in the interview. A non-probability sample type (purposive sampling) was used to get the targeted women who have undergone unsafe abortion in Baakokrom

The findings were extracted from the opinions and experiences of women who have practiced unsafe abortion through interviews. The results were presented according to the objectives of the study in chapter four.

5.1 Summary of Key Findings

This part of the study summarizes the findings from the preceding chapter. With respect to the objectives sought to achieved, the following was observed.

1. The study identified the sexual health experiences of women in Baakokrom. There was a mixed reaction with respect to the usage of contraceptives to prevent pregnancy or was ignorant about its usage which led to failure on the usage leading to unplanned pregnancy. Unfortunately, participants bleed after the unsafe abortion and some bleeds during sexual intercourse with their men accompanied with menstrual changes.

2. The study also discovered that almost all of the participants disclosed that abortion done using traditional herbs and concoction did not have negative influence on their childbirth, their sexual activeness after abortion and feeling pains and cramps.
3. Under socio-cultural experiences, religious settings were supposed to be places where wrong doers can always find refuge however, the study indicated that some religious people looked down on individuals who had committed abortion in the past therefore some women have relocated to different areas to start to all over again.
4. The study reveals abortion stigma is not concentrated on only socio-cultural influences but also is deep-rooted in government and political backgrounds, organisations, communities and personal relationships. Provider reluctance to offer needed care, misunderstandings regarding the legality of services delivered.
5. After going through a lot of difficulties as a result of the abortion, many of them are now ready to settle down and marry. Unfortunately, when the men find out about the abortion experiences the women have gone through, then the eagerness to marry reduces. This is the reason why many women have vowed not to reveal any secret about past abortions to anyone.
6. However, some women now fell less guilty of the act with time and they have grown relatively less concerned about judged being negatively by others because of the abortion due to what they gain when pregnant.
7. With respect economic experiences, the study indicated that the employed women indicated that they have lost strength due to abnormal abdominal pain because of the abortion while the students still depend on men for survival. This

has led to reduction in productivity leading to low income levels making them continuously depend on men. The experience has affected the family size in that those with small size based their argument of the state of the Ghanaian economy.

8. During this time of realizing, the unplanned pregnancy participants considered their plans and whether having a child at that time fit their goals. Those who wish to have large size have now regretted they aborted when the opportunity came.

5.2 Conclusion

- The study sort to investigate the lived experiences of women who have undergone unsafe abortion in Baakokrom in relation to their sexual health, socio-cultural life and economic life. It was concluded that, unsafe abortion is common in Baakokrom where abortion law has not gained much publicity hence the need to educate them for the ignorance of the law can be fatal. Unsafe abortion tends to expose women to several consequences usually depending on the method used and the stage of the pregnancy.
- Sociocultural values and religion are barriers why these women went through unsafe abortion. Stigmatization from friends, family members and church members are reasons why women seek unsafe abortion. In addition, after the unsafe abortion of a woman's secret is exposed, she still goes through stigmatization while the men are left out. The study concluded that women would consider stigmatization more painful to suffering a health and economic outcome.
- Most of the women resorted to local methods such as herbal tea, which are readily available at Baakokrom where they can prepare themselves. This is

because either they fear the criminalization of the abortion law or they do not have money to access the health facility because it is expensive.

5.3 Recommendations

From the findings of the study, the following recommendations as well as recommendations for future studies made was:

- There is the need for massive education by health professionals on the following: proper use of contraceptives, community treatment of people who have done unsafe abortion and what to do when there are health implications.
- Moreover, further investigations should be done by Pharmaceuticals who make medicines concerning the use of traditional herbs and concoction for abortion. This is because participants who used this method to terminate pregnancy did not have negative effect on their childbearing and their sexual activeness after abortion.
- Also, there should be enough employment opportunities provided by individuals and the government in the community since they are few in Baakokrom hence it was not surprising that their income levels were low. This made them susceptible to the demands of sex from men.
- Again, young men and women should be encouraged and advised by parents, community and Church leaders to be chaste till they get married. This will help in the reduction of many teenage pregnancies which lead to unsafe abortion. Area for future research work can be purposefully designing qualitative studies to assess the perceptions of healthcare workers towards providing safe abortion services.

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APPENDIX

Semi-Structured Interview

UNIVERSITY OF EDUCATION, WINNEBA

Thank you for taking part in this important *study on experiences of women who have had unsafe abortion. This interview seeks to generate data and to understand the experiences of women in this community.* We will be gaining your thoughts and perspectives in order to better understand how we, along with others can better support the health of people. *There are no right or wrong answers. Your responses will be kept anonymous and confidential and will be used only for this academic purpose. Participation is voluntary, and a participant is free to withdraw from the study at any point they want*. The interview should take approximately a maximum of 20 minutes to complete. *Thank you.*

BACKGROUND INFORMATION

1. What is your Age?
2. What is your level of education?
3. What is your Occupation?
4. What is your marital status?
5. What is your religious affiliation?
6. How many conjugal relationships have you had?
7. What was the purpose of having of your previous conjugal relationship?
8. When was the first time you missed your periods?
9. How many conceptions have you had?
10. How many children do you have?

LIVED EXPERIENCE OF UNSAFE ABORTION

1. What are your reasons for undergoing unsafe abortion?
2. What exactly transpired in the process of inducing an abortion?
3. Could you please share some of the experiences of having an unsafe abortion on your sexual health?
4. Could you please share some of the experiences of having an unsafe abortion on your sociocultural life?
5. Could you please share some of the experiences of having an unsafe abortion on your economic life?
6. What you wish you had not done.