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Research paper

Lived experiences and pathways to unsafe abortion among women and adolescents accessing post abortion care at selected hospitals in Lilongwe, Malawi: an interpretive phenomenological study

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Abstract

Every year, women and adolescents in the world seek abortion for unwanted pregnancies, with nearly half of these abortions being unsafe. Women and adolescents who suffer an unsafe abortion develop short and long-term complications. In Malawi, unsafe abortion is main cause of maternal deaths. At least 23% of all maternal deaths are due to complications of unsafe abortions.
Aim: To explore lived experiences, pathways, facilitators and barriers to unsafe abortion among women and adolescents accessing post-abortion treatment at selected hospitals in Lilongwe, Malawi.
Method: Phenomenological study design was used. Study population were women and adolescents who were receiving post abortion treatment at Bwaila Hospital and Kabudula Community Hospital respectively. 25 women who had unsafe abortion in the past four years were interviewed. Data was collected by in-depth and key informant interviews. Voice recorders were used. Verbatim was transcribed, translated into English and written in the note book. Atlas-Ti software version 8.0 was used for data analysis.
Results: Pathways to unsafe abortions included power relations, lack of knowledge of PMTCT, infidelity and fear of divorce and child spacing and family size. Facilitators of safe abortion services were: village clinics, establishment of bylaws in the community, introduction of sexuality education in primary schools, promotion of sexual reproductive health mobile clinics among others. Whereas barriers to safe abortions included, social, cultural, religious, physical and attitude barriers. Lived experiences included: sterility, anger, excommunication from the church, divorce, social effects, disability, depression, loss of learning, nightmares, suicide attempts, near-death illnesses, denial and stigma.
Conclusion: Increasing investment in post abortion care (PAC), creating awareness, and improve availability of sexual and reproductive health services can reduce the cases of unsafe abortion and its adverse consequences in Malawi and similar settings.

Keywords: *Unsafe Abortion; Maternal Health; Post-Abortion Care (PAC); Sexual and Reproductive Health; Malawi.*

1. Introduction

1.1. Background to the study

World Health Organisation (WHO) defines an unsafe abortion as a pregnancy termination process carried out by someone who lacks the essential expertise or in a setting that does not meet minimum medical standards, or both.
Every year, at least 42 million women in the world seek abortion for unwanted pregnancies, with nearly half of these abortions being unsafe. Unsafe abortions kill at least 70,000 women each year, making it one of the main causes of maternal death. Five million women who procure unsafe abortions develop long-term health problems. As a result, unsafe abortions are a major public health concern (Haddad and Nour, 2009).
WHO estimates that one woman dies every eight minutes as a result of complications from an unsafe abortion in developing countries. Unsafe abortions cause short-and long-term problems such as injury to the uterus, severe bleeding, infection, infertility, persistent agony and death.
Sub-Saharan Africa accounts for a considerable portion of maternal deaths resulting from unsafe abortions. The region has the highest rate of unsafe abortions in the world. The problem in the region is exacerbated by restrictive abortion laws in a majority of countries that make safe abortion difficult to obtain, (Salomonsen, 2017).
In Malawi, pregnancy is described as pakati which literally means “between life and death”. Malawi has continuously reported one of the highest maternal mortality ratios (MMRs) in the world, with at least 141, 000 women and adolescents procuring illegal abortions annually. Nearly 18% of them die as a result of complications arising from unsafe abortions. In poor countries, chances of dying from abortion are disproportionately high (Mkulichi, 2017).

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In Malawi, the existing abortion law, enacted during the British administration (1861-1964), allows abortion exclusively for the protection of a woman's life. However, the country's constitution allows for the following exceptions: if the woman's life is in danger, if the continuation of the pregnancy may jeopardise the physical and mental health of the pregnant woman, if the pregnancy was as a result of rape, defilement or incest and gross foetal malformation. Other attempts to have an abortion are illegal and punishable by a sentence of seven to 14 years in jail with hard labour (Jackson, et al, 2011). Professional doctors, nurses, midwives and clinicians trained in provision of abortion services are legally allowed to conduct abortion (Kangaude et al, 2018).

The restrictive abortion laws are a major barrier to safe abortions, which leaves women and adolescents with no option but to seek unsafe abortion services from traditional healers and backstreet clinics. More women are self-inducing, often using dangerous methods. Chisale et al (2015) observe that Malawi experiences acute shortage of abortion services, a situation that affects uptake of the services. Other players like Marie Stopes International clinics, also known as Banja La Mtsogolo (BLM), Family Planning Association of Malawi (FPAM), Population Services International (PSI) and Christian Health Association of Malawi (CHAM) health facilities, offer abortion services, including post-abortion care. However, their services are a barrier to widespread access to abortion services because they charge for them (Benson et al, 2016). In Malawi, Post Abortion Care (PAC) is provided by primary, secondary and tertiary health facilities.

Unsafe abortion is the second leading cause of pregnancy-related mortality in Malawi, with an estimated 51,693 abortions resulting in complications needing post-abortion treatment. The Malawi Demographic Health Survey (MDHS) of 2016 estimates that at least 18% of all maternal deaths in Malawi are caused by unsafe abortion complications. The survey records that adolescent pregnancy contributes to 30% of maternal deaths in Malawi while older women, between 35-49 years old, contribute at least 16%. Unsafe abortions are also the most common cause of obstetric problems (Geubbels, 2006). Despite the focus on Millennium Development Goal 5, which called for universal access to reproductive health care by 2015 and a reduction in maternal deaths by half from 1990 to 2015, progress to reduce maternal deaths in Malawi has been erratic and painfully slow (Jackson, et al, 2011).

1.2 Study setting

This study took place at Bwaila Hospital in the city of Lilongwe and at Kabudula Community Hospital in Lilongwe rural. I purposely selected these two health facilities based on the high prevalence of deaths due to unsafe abortion complications in their catchment areas. Data collected from post-abortion registers at Bwaila Hospital indicated that between 2019 and 2020, the hospital recorded 8,587 cases of unsafe abortions. Of these cases, 3,320 were adolescents while the others were older women. During the same period, the hospital recorded 37 deaths from unsafe abortions. The hospital serves a population of 972,000 people.

During the same period, Kabudula Community Hospital registered 1,736 cases of unsafe abortions. Of these cases, 1,117 were adolescents while 619 were women. The hospital registered 11 deaths. Kabudula Community Hospital serves a population of 44,642. It is located at a distance of 66km away from Lilongwe city. Lilongwe District Health Office is responsible for providing health services to the 2.6 million people living in the district.

1.3. Main objective

To explore the lived experiences, pathways, facilitators and barriers of unsafe abortion among women accessing post-abortion treatment at Bwaila Hospital and Kabudula Community Hospital in Lilongwe

1.4. Specific objectives

1) To investigate pathways to unsafe abortions
2) To identify facilitators and barriers to safe abortion care services among women of child bearing age and accessing post- abortion care
3) To describe the lived experiences following unsafe abortion among women accessing post-abortion care

2. Methodology

2.1. Study design

A phenomenological approach of qualitative research design was used. A phenomenological framework enables the understanding of human phenomena that occur in the world of life, also called the social world (Nalubega et al, 2021). The phenomenological approach focuses on describing what all participants have in common as they experience a phenomenon, for example, infertility, blood clotting, long-term sicknesses and ruptured uterus, among others (Creswell J., 2015).

2.2. Study population

The population of interest were women and adolescents who had lived with complications of unsafe abortion and were receiving post-abortion treatment at Bwaila Hospital and Kabudula Community Hospital.

2.3. Sample size

When using the phenomenological methods of research, it is recommended the sample size should range from five to 30 participants (Smith, et, al 2009).

2.4. Sampling procedure

The study used a purposive sampling method to identify the participants required. Purposive sampling method produced a relatively uniform sample to ensure relevance and personal importance for the participants and to capture the details of women who had experienced phenomena. It used the data saturation concept from a phenomenological perspective to determine the sample size. Data saturation assumes

that the small samples in qualitative research are based on an understanding that only once a phenomenon must appear in an analytical record (Ritchie, 2003).

2.5. Inclusion and exclusion

The study included women and adolescents child bearing age who lived with experiences of unsafe abortion and were receiving post abortion care at Bwaila Hospital and Kabudula Community Hospital in Lilongwe. Whereas women and adolescents of child bearing age who were accessing safe abortions were not eligible to participate in the study.

2.6. Data collection methods

Data was collected by in-depth and key informant interviews. Voice recorders were used. Verbatim was transcribed, translated into English and written in the note book. Atlas-Ti software version 8.0 was used for data analysis.

2.7. Quality control

Pretesting of data collection tools, triangulation and voice recorders were some of the quality controls used.

2.8. Data management and analysis

Qualitative data were transcribed and translated into English and then coded and analysed using Atlas-Ti software version 8.0. Data was analysed using the thematic data analysis method. The first step that the researcher took was to transcribe verbatim, the audio recordings. The audio recordings were transcribed from Chichewa to English. The transcripts were read and actively compared with the audios and the observed meanings and patterns that emerged across the data set were used as potential codes to create themes. The transcription of the interviews took place as soon as possible to guide subsequent interviews.
I collated codes with supporting information, organised them into potential themes, and gathered all the excerpts connected to a given code. As a result, the study combined codes with related meanings and traits, while grouping other codes into sub-themes. The study removed themes that lacked sufficient supporting evidence and ensured that each one of them was distinct. The entire procedure involved concurrently writing notes and ongoing comparisons at every stage of the study, which helped in the analysis of the data at each stage and the writing of the report. Thematic data analysis was used, and the findings were presented with quotations to sufficiently support the main themes found in the data.

2.9. Ethical consideration

Ethical approval for this research was sought from the University of Zambia, Biomedical, Research and Ethics Committee (UNZABREC), the National Health Research Authority (NHRA)-Zambia, the National Health Science Research Committee of Malawi and the Malawi Ministry of Health to ensure compliance with the scientific ethical standards of the study. Informed consent was sought from study participants and confidentiality non-negotiable.

3. Results

3.1. Characteristics of participants

Despite some similarities, the results reveal some clear variances in demographic characteristics of participants interviewed. Nearly all of the participants at Kabudula Community Hospital, which is located on the outskirts of Lilongwe City, were adolescents between the ages of 14 and 20 who were single and enrolled in secondary school. However, some of the participants at Bwaila Hospital in Lilongwe City were either married or in relationships, mostly aged 30 or older, and had at least two children. They were from various religious backgrounds. A majority of the participants did not have any form of education, with a few enrolled in first classes of secondary school. Among the participants, only two had formal employment, one was a casual labourer, eight were students and others were housewives or farmers. Participants with repeat abortions were evident at Bwaila Hospital, especially among women who were involved in sex work.

3.2. Unsafe abortions practices

Some of the methods used to conduct unsafe abortions included use of dangerous objects and ingestion of unidentified medicines and other toxic chemicals unlawfully obtained from drugstores. The list of potentially hazardous local abortifacients ranged from the drinking of strong herbs, washing detergents, chemicals, pills, kitchen soot and toxic substances. Dangerous practices used includes the insertion of sharp objects such as bicycle spokes and cassava stick into the vagina, cervix and uterus. The following descriptions with participant quotes give a perspective on the reported practices.
One 17-years-old participant, an orphan who lives with her grandmother in the village, used a cassava stem to conduct an unsafe abortion, and had the following to say:
“When my grandmother could not manage to pay my school fees, a certain man offered to do so in exchange for sex. I didn’t know I was pregnant until six months later. The man refused to marry me. One elderly woman in my village referred me to a traditional birth attendant in a nearby village. The traditional birth attendant inserted a cassava stick into my vagina up to the neck of the cervix. It took 48 hours before the actual abortion was done. The traditional birth attendant did not give me any advice.” — [P1, 17 years old, Lilongwe rural].
Another student in Form One at a public secondary school in the city of Lilongwe used unidentified pills to abort her pregnancy.
"I used pills that I purchased from a nearby drugstore to end my pregnancy. My parents made me nervous. Unfortunately, I became so sick that I had to tell my mother that I had procured an unsafe abortion. The doctor told me that some of the remains of my uterus were rotting when my mother brought me here.” — [P2, 15 years old, Lilongwe urban].

The study revealed that traditional doctors and herbalists are readily available sources and providers of unsafe abortion services in Lilongwe district. There are other sources or providers of unsafe abortions such as traditional birth attendants, drugstores but traditional doctors and herbalists topped the list.

"I had four kids by the time I was 24 years old, but I was not yet married. I then had my fifth pregnancy. I wanted to abort the pregnancy but had no idea where to go until a friend mentioned a herbalist to me. When I was two months pregnant, I visited this herbalist since I had also heard from other individuals that she assisted with abortions. Because I did not want anyone to know I was procuring an abortion, I went alone.

"…For at least 30 minutes, the herbalist inserted and pushed a cassava stick into my vagina. Then, blood clots began to emerge. She urged me to leave the stick in my vagina because she believed that ultimately the blood clots would push the stick out.

"I had awful stomach pains when I arrived home and I was bleeding heavily. I told my mother that I had malaria when she asked what was wrong with me. She did not think I was telling the truth and she persisted. After the pain I had endured, I told her 48 hours later that I had an unsafe abortion, and my mother had hurried me to this hospital". [P4, 24 years old, Lilongwe rural].

This study further identified that use of kitchen soot as a method for unsafe pregnancy termination is mostly prevalent among women in rural areas.

"I initially took 20 paracetamol tablets in an attempt to abort, but nothing happened. Then, my neighbour advised me to drink kitchen soot. I drank two litres of liquid containing kitchen soot. Again, this was unsuccessful. Having a second child when the previous one was just nine months old made me anxious. I made two more litres of kitchen soot, which eventually induce labour." — [P5, 23 years old, Lilongwe rural].

Although herbal concoctions would induce unsafe abortion in women and adolescents, this study discovered that these herbal concoctions could not work in other women, forcing them to look for other options. A Form Four student at a public secondary school on the outskirts of Lilongwe tried herbal concoctions but they did not work. She explained:

"Without even telling my mother, I attempted to have an abortion by drinking a Chilambe concoction (herbal mixture). It was suggested to me to drink washing detergent if this didn't work. Although I had heard about some women dying from drinking washing detergent, I used the same method to abort my pregnancy." — [P9, 20 years old, Lilongwe rural].

A 14-year-old girl was under pressure from her mother to get an unsafe abortion as she prepared to sit for her Primary School Leaving Certificate of Education examinations. Although the girl claimed she was hesitant to obtain an unsafe abortion, she nonetheless performed it under pressure from parents.

"My mother sent me to a woman in the neighbourhood who was rumoured to be in the business of conducting abortions. The elderly woman was intoxicated when we found her, yet she still performed an abortion on me using bicycle wheel spokes." — [P7, 14 years old, Lilongwe urban].

3.3. Pathways to unsafe abortions

This study identified HIV and AIDS, child spacing, husbands' disregard for their wives' health, infidelity and fear of divorce, and family size as distinct pathways forcing women to seek unsafe abortions. The following subthemes with supporting quotes provide participants' views to these pathways.

3.3.1. Lack of knowledge on prevention of mother to child transmission of HIV (PMTCT)

Some participants interviewed at Bwaila Hospital revealed that they were living with HIV and that this compelled them to procure unsafe abortions for fear of transmitting the virus to their babies. A 19-year-old woman realised she was two months pregnant when she tested HIV positive. Her husband had died three months before. The unsafe abortion left her with complications. She explained:

"…Had I known that my child could be born HIV free, I would not have terminated my pregnancy. Imagine losing my baby and uterus. It pains me." — [P8, 19 years old, Lilongwe rural.

3.3.2. Power relations among couples

Married women reported their spouses being sole decision-makers on their sexual reproductive health choices prohibited them from using birth control after giving birth. Other respondents admitted that their husbands did not care about their health. Despite already having four or five children, their husbands insisted on having more. These compelled women to try unsafe abortion methods from untrained providers in secret as a result of the partners' vehement opposition to take birth control measures. This study found that most women who chose to have unsafe abortions did so because their husbands had forbidden them from taking birth control as a measure to enhance their health. Respondents stated that spouses did not take care regarding sexual conduct in the post-abortion period, and it was discovered that a husband's responsibility was limited to physically assisting during hospital visits.

"A doctor advised me against having more than five children because of my health status. I have chronic anaemia. However, my husband disregarded my health condition and forbade me from taking birth-control pills. I ended up becoming pregnant but I decided to abort because of my health condition." — [P26, 34 years old, Lilongwe urban].

3.3.3. Infidelity and fear of divorce

This research found infidelity and divorce anxiety as possible gateways to unsafe abortion. At least four participants acknowledged having cheated on their husbands and conceived as a result. However, their desire for unsafe abortions was driven by the fear of getting divorced if they told their husbands they were not responsible for the pregnancy and their guilty conscience over watching their husbands raise the child that was not theirs.

"We had agreed that my husband should have vasectomy because we felt three children were enough for us. But the devil lured me to go into a relationship with another man. Unfortunately, the man impregnated me but I couldn't keep the pregnancy because I feared I could lose my marriage." — [P18, 29 years old, Lilongwe urban].

3.3.4. Child spacing and family size

Furthermore, having too many children too soon was identified as another pathway that motivated some women to procure unsafe abortions. At least two women mentioned having three children in four years. The husbands refused to give their wives permission to use contraception

even after they begged them to. As a result, participants acknowledged using unsafe abortions as a method of child spacing and the strategy to control the number of children they could have.
"Since my husband could not allow me to take birth control pills, I opted for an unsafe abortion as a means of child spacing. Otherwise, I could not afford safe abortion services from private clinics." — [P3, 39 years old, Lilongwe rural]

3.4. Perspectives of facilitators of safe abortion services

Participants described facilitators of safe abortion in the context of establishment of bylaws at community level, sexuality education, promotion of sexual reproductive health and rights (SRHR) mobile clinics, access to skilled health care providers, establishment of youth friendly health spaces, timely funding for SRH services including safe abortion services, and formation of village clinics.

3.4.1. Village clinics

The participants proposed that the establishment of village clinics might bring safe abortion services closer to women and teenagers, hence increasing access to family planning services. This study found that because of the distances to the health facilities, women and adolescents were unable to access safe abortion and family planning services. Participants claimed they could not afford to pay for transportation to and from the healthcare institutions.
"... The government should consider introducing village clinics, because that would, among other things, offer safe abortion services. I believe that this would promote access to, and use of, safe abortion services. Additionally, the clinic would also help debunk some of the myths and misconceptions around the use of contraception." — [P2, 15 years old, Lilongwe rural].

3.4.2. Establishment of community bylaws

Establishment of bylaws at community level was identified as a facilitator to increasing access to safe abortion services. Respondents stated that traditional leaders would enforce these bylaws to punish spouses that forbid their partners from accessing family planning services. Some participants suggested that bylaws would be used to ban herbalists that offer unsafe abortion services in the community.
"...Therefore, as stewards of the ordinances, chiefs would ensure that the community does not have access to the pills that women and girls use to end pregnancies. Chiefs must ban all herbalists who provide unsafe abortion services to women and girls, and report them to the police. If they do this, more and more women and girls will be inspired to start using safe abortion services." — [P5, Lilongwe urban]

3.4.3. Introduction of sexuality education at primary school level

Participants expressed the need for the government to start offering sex and sexuality education at the earliest stages of primary education. In Malawi, primary schools start offering sex and sexuality education in Standard Five. However, respondents suggested that sex and sexuality education should start in Standard Three so that girls and boys grow up knowing what is right and not in terms of sexuality.
"…These days, a girl in Standard Five would already have started having sex. Unfortunately, we are not taught about sex and sexuality from an early age. Because of this, we are seeing an increase in teen pregnancies and the number of girls procuring unsafe abortions. However, if teenagers were made aware of these family planning options from a young age, they would be encouraged to use safe abortion services as they grow." — [P23, 18 years old, Lilongwe urban].

3.4.4. Promotion of sexual reproductive health mobile clinics

Participants admitted hearing about the existence of mobile clinics. Some participants reported hearing that the mobile clinics are offered by private health institutions such as Banja La Mtsogolo. The respondents expressed ignorance about whether or not the sexual reproductive health services offered by mobile clinics were free or paid for. According to the findings of this study, collaboration between private health institutions such as Banja La Mtsogolo and the government to provide sexual reproductive health services would increase the reach of safe abortion and family planning services to more women and girls.
"... If women and girls had access to family planning and safe abortion services right at their doorstep, there would be no anymore unsafe abortions. I have heard that Banja La Mtsogolo already does outreach clinics that offer sexual reproductive health services. The government should just get into partnerships with them so that such services can get to every corner of this country." — [P1, 17 years old, Lilongwe rural].

3.4.5. Access to a trained and skilled healthcare worker

This study found that there is an acute shortage of nurses and midwives at Bwaila Hospital and Kabudula Community Hospital. Key informant interviewees at Bwaila reported that the hospital has 191 nurses and midwives against the recommended number of 620. Key informants at Kabudula Community Hospital stated that the hospital had nine nurses and midwives against the recommended number of 62. According to the findings, there is a huge patient and nurse radio gap, which pushes women and adolescents to seek services from unskilled health personnel. The findings further reveal that employing more nurses and midwives would decrease patient and nurse gaps, thereby increasing access to trained and skilled healthcare workers.
"…We spend the whole day here at the hospital just to be seen by a nurse. Sometimes you come here but return home without being attended to by a nurse. Do you think you can come again if you are not attended to? Mind you, we leave a lot of work at home. Let the government do something about employing more nurse." — [P27, 42 years old, Lilongwe urban].

3.4.6. Establishment of youth friendly health services

This study found that establishing youth friendly health services (YFHS) in health facilities would increase the uptake of safe abortion services among girls. Girls want spaces that provide privacy and confidentiality when they are accessing family planning and safe abortion services. Participants reported privacy and confidentiality as lacking in spaces where such services are offered.
"To avoid societal stigma and parents' disapproval, we tend to stay away from public health facilities because these facilities do not provide safe and private spaces for us." — [P29, 21 years old, Lilongwe urban].

3.4.7. Increased and timely funding

Increased and timely funding to health facilities was identified as another facilitator for safe abortions. Key informants revealed that timely funding helps allocate resources to crucial sectors such as maternal and sexual and reproductive health. The key informants further revealed that timely funding helps them meet the facility's needs in time. However, the informants stated that they usually get one-third of their monthly allocations, which compromises service delivery. According to the respondents, the usual one-third or half of their monthly allocation does not even come on time.

"…Timely and increased funding would help us channel the resources to the sectors that matter most. This would help the hospital procure maternal and sexual reproductive health services on time. However, we usually run out of these services because we receive inadequate funding to purchase them. Increased funding would make these services available, hence motivating more women and girls to access them." — [P30, Director for Health and Social Services, Lilongwe].

3.5. Barriers to women and adolescents accessing safe abortion services

This section will discuss major themes this study identified. These are challenges preventing women and adolescents from accessing safe abortion services. The identified challenges include: health systems barriers, physical barriers, social-economic barriers, attitude barriers and cultural and religious barriers. The following themes and supporting quotes provide participants' views to the barriers to safe abortion services.

3.5.1. Lack of YFHS (Safe spaces)

Some girls interviewed stated that they want private and safe environments because they feel like confidentiality and privacy are frequently lacking in places where family planning services are provided. For instance, some participants stated being told to stand on the same queue with other clients and that this made them feel uncomfortable. Other teenagers claimed they were afraid to visit health facilities to get family planning services because they believed that medical professionals or other patients would report them to their parents. Some girls stated that to avoid these breaches of confidentiality, they would rather obtain unsafe abortion services from other sources where parents and other patients would not be aware of what services they were seeking.

"…I was apprehensive about using contraceptives because they cause a great problem when people see someone using them. The majority of girls are really afraid and, in my village, if it is known that a girl is using contraceptives, parents ostracise them. When someone has been spotted visiting such facilities, it becomes a problem at home." — [P1, 17 years old, Lilongwe rural].

3.5.2. Physical barriers

Women and adolescents receiving post-abortion care at the two health institutions reported distance as a major obstacle to accessing family planning services. The World Health Organisation recommends a 5km distance between two medical facilities. However, some of the women who sought post-abortion care at Kabudula Community Hospital and Bwaila Hospitals travelled as far as 30km and 45km, respectively.

"I stay in Kandiwo village, Traditional Authority Kayembe in Dowa. The nearest health facility there is Nambuma Mission Hospital. It is located approximately 18km away. It is a paying hospital. Therefore, hmm, I have never gone there to access family planning services. As you can see, I have mobility challenges. So, the distance is a challenge." — [P8, 25 years old, Lilongwe rural].

An inaccessible transportation system and several structural problems at the healthcare facilities compound this problem further.

"When we get pregnant, we want to be transported to the hospital in an ambulance for antenatal care, where we can also receive information on sexual and reproductive health. However, it is difficult to acquire an ambulance because the driver will claim that he only ferries 'true patients', not pregnant women. Therefore, walking on foot from the village to this hospital is tedious because it is very far, about 42km away. The only available option is an unsafe abortion." — [P11, 39 years old, Lilongwe rural].

3.5.3. Attitude barriers

Another theme from the interviews was the perceived attitude of the staff at health facilities towards patients. Participants reported nurses and midwives demonstrated stigma towards adolescents seeking family planning services. Access barriers included the health providers' lack of empathy and stereotypes.

"The other problem is that some health workers have certain prejudices towards us girls when we come here to the hospital to seek family planning services. They have a negative perception of us because they think we want to get birth control pills because we are promiscuous. For this reason, most girls don't come to the hospital to get birth control products for fear of stigma and other stereotypes." — [P2, 15 years old, Lilongwe rural].

"…Even after presenting your problem, some nurses and midwives are unable to assist you. You see them chatting on the phone with their friends. Others may even shout at you instead of helping you. These hostile attitudes prevent people from coming here to get birth control products and services. Instead, we go for the other option." — [P12, 33 years old, Lilongwe urban].

In addition, participants, particularly teenagers, stated that another significant obstacle is the stigma associated with young people utilising family planning methods. Some participants reported that parents discourage their children from utilising family planning services.

"… Parents are supposed to be giving us guidance on how to access family planning services. However, the moment you speak about birth control pills, some parents will shut you up, thinking you are promiscuous. Others would say 'just get married if you feel you are grown up instead of engaging in sexual intercourse'. This is a big barrier to safe abortion services." — [P14, 22 years old, Lilongwe rural]

3.5.4. Social-economic barrier

Social-economic factors include poverty and lack of knowledge on abortion and reproductive health services. In light of what participants said, this study has given attention to the following factors:

"… It is very tricky to use money on transportation to the health facility to access family planning services when it is the only money remaining for the next meal. For the poor, it is a challenge to go to the private clinics to access safe abortion services because their prices are prohibitive. So, what do we do? Hmm, we just stay home and look for the locally available options. Some of us feel these services [safe abortion services] are meant to benefit the rich only." [P17, 26 years old, Lilongwe rural].

"When I informed my husband that I wanted to start using birth control pills, he almost beat me up. He said that I wanted to weaken his libido so that I could engage in sexual activities with other men. I told him about the advantages of family planning services, but he would have none of it. In the end, I decided against using any birth control to keep my marriage." — [P6, 30 years old, Lilongwe urban].
"…There are rumours that birth control drugs cause adolescents to have labour and delivery problems. Other stories suggest these pills are intended to sterilise girls in order to reduce the population. Who doesn't want to have children? I want to have children after completing my studies." — [P1, 17 years old, Lilongwe rural].

3.5.5. Cultural barriers

This study found that in some cultures, a man is the sole decision maker. A woman has no say even when it comes to deciding about her sexual reproductive health rights. The husband decides how many children he wants to have without consulting his spouse and with no regard to a woman's health. Worse still, some participants stated that decisions to access family planning services are made by their spouses because of the cultural beliefs associated with taking birth control pills. Despite suffering violation of their sexual reproductive health rights, respondents reported having more children than they had wished for.
"…All my in-laws and other relatives ganged up against me when they learnt that I had asked my husband about taking birth control pills. By that time, I had just given birth to my sixth child. I wanted to rest. However, my husband refused to let me use any contraceptive. He told me his word was final because, according to his culture, he was the head of the family." — [P15, 29 years old, Lilongwe rural].

3.5.6. Religious barriers

This research further found that religious beliefs are a major block to accessing safe abortion services. Both Christianity and Islam forbid the termination of pregnancy or the use of family planning services "because a pregnancy is sacred".
"…My church is Catholic. It does not allow abortion and/or use of family planning services. To avoid excommunication from church, I choose to stay away from any health facility to access safe abortion services because I fear people can see me, which can lead to my excommunication from the church." — [P12 37 years old, Lilongwe rural]

3.6. Post-abortion lived experiences

Participants reported living with different degrees of post-abortion experiences. This study found sterility, excommunication from church, divorce, social effects and disability as some lived experiences of unsafe post-abortion complications. These experiences are described in the subthemes below.

3.6.1. Sterility

One participant became sick two weeks after procuring an unsafe abortion. She used the cassava stick to terminate her pregnancy. Her mother took her to the hospital after the sickness escalated and her condition deteriorated. At the hospital, her condition forced physicians to remove her uterus. She was not aware of her uterus removal until after she started receiving post-abortion treatment. The participant regretted having obtained an unsafe abortion because she would have to endure the pain and psychological effects of living without her own children for the rest of her life.
"I have been to different prophets and pastors for prayers to reverse my condition. The pain of dying without holding my biological child in my hands is unbearable; it breaks my heart. It also affects my confidence and self-esteem. I have since left my predicament in God's hands to see me through. I regret my action but I know God will answer my prayer one day." — [P19, 24 years old, Lilongwe urban].

3.6.2. Social effects

This study found that, culturally in some parts of Lilongwe and sub-Saharan Africa, it is believed women must have children, because women without children are regarded as witches. According to the findings, loss of uteruses among some participants jeopardised their chances of getting married, a thing which affected their social life. Other participants reported facing different stigma, such as being barred from participating in some community activities like weddings, funerals and initiation cultural activities.
"I felt bad when indunas [village headman counsellors] stopped me from participating in social gathering like funerals, weddings and initiations. I am ostracised and rejected. I am an outcast in my own community. Their argument was a barren woman lacks moral grounds to be among upright women. I cry all the time". — [P11, 32 years old, Lilongwe rural].

3.6.3. Divorce

According to the findings of this study, one participant stated divorce as a post-abortion experience, she was living with. The participant explained that she had her fifth pregnancy five months after giving birth to her fourth child. Her husband forbade her from aborting the pregnancy. The spouse had also previously blocked her from taking birth control pills. The participant, however, secretly obtained unsafe abortion services because she could not keep the pregnancy when she had a six-month-old baby.
"Unfortunately, the herbs I used to abort my pregnancy resulted in complications. I had ruptured my uterus. I decided to come here at the hospital when my condition got worse. And when news got to my husband that I was being treated for post-abortion complications, he immediately divorced me for undermining cultural norms that stipulate husbands are sole decision makers on sexual reproductive choices of their spouses." — [P9, 21 years old, Lilongwe rural].

3.6.4. Excommunication from church

Some participants disclosed that they faced excommunication from the church after the church learned they had obtained an unsafe abortion. Both Christianity and Islam forbid both safe and unsafe abortions. Pregnancy is considered a sacred condition. Besides facing excommunication from the church, participants further reported suffering stigma from their communities when news broke that they had terminated pregnancies.
"My fellow women stopped associating with me when the church excommunicated me. They labelled me a murderer and a devil. I faced humiliation and stigma. I thought the scriptures say you shall not judge so that you shall not be judged?" — [P7, 29 years old, Lilongwe urban].

3.6.5. Disability

This study found that a respondent was living with a disability due to a post-abortion complication. The interviewee explained that she did not tell her mother that she had procured an unsafe abortion. A month later, she fell sick, after feeling pains in the lower part of her abdomen. She said she went back home from school when her condition became worse. She said that her mother immediately took her to the hospital in her critical condition.

"At the hospital, the doctor discovered that some remains of the foetus were rotting in my womb. Due to my condition, doctors could not do anything on me. In addition, the health facility did not have drugs that would help doctors manage my case. Therefore, I spent two months in the hospital waiting for treatment. By the time the doctors were managing my case, my condition was so serious that it left leg paralysed." — [P23, 29 years old, Lilongwe urban].

3.6.6. Life threatening events

A participant revealed that she nearly lost her life due to heavy bleeding and unbearable pain. Another participant, a mother of four, confessed to have lost a lot of blood after procuring an unsafe abortion. She recalled that she fainted and only came back to a day and a half later.

"I realised I was admitted to the hospital two days later. I saw death coming." — [P13, 37 years old, Lilongwe rural].

3.6.7. Loss of learning opportunities

Unsafe abortions resulted in loss of learning hours for adolescents who were enrolled in school. In most cases, they were unable to return to school, despite the fact that the primary motivation for getting an unsafe abortion was to ensure that studies would continue. A Form Two student who had an unsafe abortion tells the story:

"I couldn't imagine myself dropping out of school. My aim was to go to the university. Thus, I decided to have an induced abortion in order to get back to school, although it was a very difficult decision. Unfortunately, my parents told me they would no longer be responsible for my studies." — [P6, 19 years old, Lilongwe urban].

3.6.8. Depression and guilty feeling

Many participants felt there was little that could be done to change the situation in the long run, which made them generally unhappy. More distressing was the thought about how old their children would be had they not been aborted. As a result, participants were not particularly concerned about abortion in general; rather, their main concern was that they were unable to conceive, which caused them to regret their previous actions.

"I have been fighting post-abortion depression the past two years. I am still living with the experience, and I regret it very much." — [P11, 38 years old, Lilongwe urban].

"I killed someone; hence, I feel bad. I'm in such pain because of it. I frequently hear voices asking me why I had the abortion rather than letting the child grow naturally. I believe my baby would have grown by now. Anyway, I was uncertain about where I would have been with my baby because the man had denied responsibility, my parents had no idea about it, and I didn't want them to know at all". — [P9, 22 years old, Lilongwe rural].

3.6.9. Suicide attempts

Some participants revealed that they attempted suicide because of the anxiety they had been living with for a long time.

"There was a moment when I tried to end my life. I drink alcohol to help me forget my dark past, but when I am sober, the thoughts of my irresponsible abortions and the life I denied the chance to live spring back to mind. I feel bad. It keeps ringing in my head." — [P21, 35 years old, Lilongwe urban].

4. Discussions

It is important to note that unlike many African countries, Malawi has restrictive abortion laws which have exacerbated the procurement of clandestine abortions over the years in the country (Chisale et al, 2016). The Malawi Demographic Health Survey of 2016 and other studies show that women and adolescents still have restricted access to safe abortion services (Nkulichi, 2017). As a result, they perpetually become accustomed to the utilisation of unsafe abortion services, which increases their susceptibility to unsafe abortion related complications (Kavuma, 2016). Therefore, if women and adolescents continue to have access to unsafe abortions services, there will not only be an increase in the burden of post-abortion complications among them but the fight against maternal deaths in Malawi will also not be won soon.

Using the theory of planned behaviour, this study enabled the study to map the process by which individuals form intentions to carry out behaviours that are consistent with their self-determined motives. Using the model, I analysed and drew conclusions on how beliefs and other external perceptions assume that an individual's intention to carry out behaviour is a key determinant for the carrying out of that behaviour. The analysis and discussions of the findings and literature, primarily in relation to pathways to unsafe abortions, demonstrate how subjected norms such as power relations, infidelity and divorce, lack of knowledge on PMTCT, child spacing and family size motivated women to engage in illegal and unsafe abortion. Furthermore, the theory of planned behaviour helped this study to predict how the other determinants of abortion services such as long distances to health facilities, religious beliefs, cultural practices, social-economic factors, negative attitude and legislative frameworks would continue to influence women and adolescents to have access to unsafe abortion services if they are not addressed.

From the study, there is clear evidence that lack of knowledge on abortion services, privacy and confidentiality, infidelity and fear of divorce, poverty and the need to continue with education motivated women and adolescents to procure unsafe abortion services that exposed them to various degrees of post-abortion complications. This is in agreement with Nalubega et al (2021) citing Welter (2015) that during their lifetime, many women will experience an unplanned and/or unwanted pregnancy that invariably leads to a reproductive decision-making tree that may include abortion, whether safe or unsafe.

Another critical component that still drives adolescents to access unsafe abortion is the lack of privacy and confidentiality at designated facilities that offer safe abortion services. Adolescents' inability to access abortion services greatly contradicts the Sexual Reproductive

Health Rights Policy (2017-2022) which affirms provision, accessibility, acceptability and affordability of abortion services to all women, men, and young people of Malawi through informed choice to enable them attain their reproductive rights safely. However, a majority of the public health facilities in Malawi have no youth friendly health services or privacy at the waiting rooms and therefore adolescents fear that they will be recognised or overheard stating intentions of their visit to the facility by the other clients. A study by Kavuma (2016) on determinants of unsafe abortions among adolescents conducted in South Africa corresponds with my study findings. In her study, Kavuma found that in many societies where abortion is highly stigmatised, like South Africa, adolescents are not comfortable seeking abortion services at public facilities for fear of either meeting someone who knows them or their family.

In addition to the above, this study has established that most women who became infertile due to unsafe abortion complications lived unhappy lives while others went through regrets and agony of being barren. Most women revealed having their marriages threatened while others faced separation and divorce. Further to that, most women confessed that they had difficulties getting pregnant again after suffering from complications from unsafe abortions. The findings relates closely to those by Nalubega et al (2021) who conducted a study in Uganda that confirmed sterility, self-blaming and confusion as long-term experiences of induced abortions. Our study findings contradict the argument of Zou et al (2008), that women should be made aware that there is no association between subsequent unsafe abortion and infertility. In this study, participants, particularly married women, blamed their history of unsafe abortion for their barrenness.

In conclusion, Malawi's legal environment on abortion continues to be restrictive, and this is exacerbating procurement of unsafe abortion among women and adolescents, which has resulted in different degrees of post-abortion complications. However, the magnitude of complications related to unsafe abortions has not been documented. Results of this study, therefore, provide evidence that can facilitate formulation of an abortion policy and a review of abortion laws. In March 2021, the Malawi Parliament rejected the motion to debate the Termination of Pregnancy Bill after claiming that consultations on the bill had not been widely made (Daily Times Malawi, 2021).

5. Conclusion

The study concludes that unsafe abortions continue to be a public health concern in Malawi. Evidence shows that there was high prevalence of unsafe abortion practices among adolescents and uneducated poor women, which left more women and adolescents living with various degrees of post-abortion complications. The findings have further revealed that different barriers to safe abortion, such as poverty, long distance to health facilities, stigma both in communities and health facilities and lack of knowledge on safe abortion services led to access to unsafe abortion practices. Therefore, investing in post-abortion care by procuring modern equipment, promoting awareness on sexual and reproductive health services, instituting community bylaws and liberalising abortion laws can increase uptake of safe abortion services which can ultimately reduce complications of unsafe abortion.

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