Abortion trajectories: a conceptual framework and research reflections

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This presentation:

1. Macro relationships
   - Abortion and fertility
   - Contraception-abortion paradox
   - Language and data

2. Micro perspectives
   - Pregnancy termination trajectories in Zambia

3. A conceptual framework
FERTILITY TRANSITIONS AND ABORTION
Scale

• Globally
  – 96 million unplanned pregnancies per year
    • Unplanned ≠ unwanted
  – 33 million estimated unintended pregnancies as a result of method failure or ineffective use

• SSA
  – 13% all pregnancies end in abortion
  – 97% abortions unsafe
Abortion: end point of a set of events

- Sex
- Contraceptive use (non-use/ineffective use/failure)
- A pregnancy
- A decision to terminate
- Access to abortion (safe/unsafe/legal/illegal)
Abortion and fertility

$TFR = TF \times Cm \times Ci \times Ca \times Cc$

TF = total fecundity
Cm = index of marriage
Ci = postpartum infecundability
Ca = induced abortion
Cc = contraception
Abortion and fertility

$$\text{TFR} = \text{TF} \times \text{Cm} \times \text{Ci} \times \text{Ca} \times \text{Cc}$$

TF = total fecundity
Cm = index of marriage
Ci = postpartum infecundability
Ca = induced abortion
Cc = contraception
Induced abortion: data

• Much nationally representative survey data unusable:
  – “Did you have any miscarriages, abortions or stillbirths that ended before 2002?” [DHS]

• Until recently
  – Few reliable national estimates globally
  – Rare and non-representative
  – Few data of use to policymakers
How, and to what extent, are rates of induced abortion and contraception related?
HIGH FERTILITY  

Live births  

Use of induced abortion  

Use of effective contraception  

LOW FERTILITY  

WHO, 2008
Abortion & unmet need

• Abortion as an outcome of unmet need for effective contraception?

• People are motivated to regulate their fertility
  – using behavioural methods
  – supplied contraception
    × Inaccessible; and/or
    × Inconsistently or incorrectly used
Contraception-abortion “paradox”

• Unmet need for contraception is high
• Contraceptive prevalence is low
• Less-effective contraceptive methods prevail
Language and data: pregnancy

- Wanted vs. unwanted
- Intended vs. unintended
- Planned vs. unplanned
Distribution of births in the 5 years preceding the survey, by mother's age at birth, Zambia DHS, 2007

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Wanted then</th>
<th>Wanted later</th>
<th>Wanted no more</th>
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<tr>
<td>&lt;20</td>
<td>56</td>
<td>26.1</td>
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<td>45-49</td>
<td>41</td>
<td>12.7</td>
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Distribution of births in the 5 years preceding the survey, by mother's age at birth, Zambia DHS, 2007

- Wanted then
- Tried and later
- Wanted no more

<table>
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<th>Tried and later</th>
<th>Wanted no more</th>
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Language and data: pregnancy

• Wanted vs. unwanted

• Intended vs. unintended

• Planned vs. unplanned

Or, Unsustainable at that point in time?
MICRO PERSPECTIVES:
ABORTION TRAJECTORIES IN ZAMBIA
Legality: Zambia (Category IV)

- Abortion is legally permitted:
  - To save the life of a woman
  - To preserve physical health
  - To preserve mental health
  - Foetal impairment
  - Socio-economic grounds (current and foreseeable)

- Gestational age limits apply
<table>
<thead>
<tr>
<th>Service</th>
<th>Adequate</th>
<th>Medium</th>
<th>Poor</th>
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<tbody>
<tr>
<td>Legality of safe abortion</td>
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<tr>
<td>Access to safe abortion</td>
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<tr>
<td>Access to postabortion care</td>
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<td>√</td>
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<tr>
<td>Access to contraceptive services</td>
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<td>√</td>
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</tbody>
</table>
Zambia TFR 2013

- **Up to 4.0**
- **4.1 to 5.9**
- **6.0 to 6.3**
- **6.4 and higher**
Zambia: TFR
Comparative research design

Comparing the experiences of adolescents and women who seek:

**EITHER** Safe abortion (SA) services

**OR** Post-abortion care (PAC) following an unsafe induced abortion

At a tertiary hospital in Lusaka
Multi-method approach

• Quantitative survey combined with in-depth interview (n=112)
  – Refusal 13%

• Key informant interviews

• Health system costing analyses

• Medical notes analyses and data extraction (n=81)
Contraceptive method use at time of terminated pregnancy

- Consistent use of paracetamol as post-exposure contraceptive

Bar chart showing the percentage of women using contraceptives, with the following categories: Female sterilisation, IUD, Implants, Female condoms, Other, Injectable, Withdrawal, Pill, Male condom.
Pregnancy “wantedness”

I: Feel free. You can tell me. Did you want to keep? How did you feel after finding out that you are pregnant?

R: Yes, I wanted to keep it.

I: You wanted to keep it. So what then happened next?

R: I was told that there was no way that I would take care of this child.

I: Who said that to you?

R: My mother and my father.

I: Okay

R: I was asked “How I would care for that child? Where would I find clothes and how I would finish school?”
TRAJECTORIES TO ABORTION
Safe vs. Unsafe

• Trajectory 1: Clinical abortion induced at public sector hospital (63.4%)
• Trajectory 2: Clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (16.1%)
• Trajectory 3: Non-clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (20.5%)
Safe vs. Unsafe

• Trajectory 1: Clinical abortion induced at public sector hospital (63.4%)
• Trajectory 2: Clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (16.1%)
• Trajectory 3: Non-clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (20.5%)
Day 1: Take Mifepristone 200 mg tablet orally
(as advised by gynaecologist)

Day 3: Take Misoprostol 200 mcg tablets
orally/vaginally
(as advised by gynaecologist)

Strictly for the use under the guidance of
a qualified gynaecologist only

AntiPRoG Kit
Mifepristone & Misoprostol Kit (200 mg + 200 mcg)
Safe vs. Unsafe: Dichotomy Inadequate

• Trajectory 1: Clinical abortion induced at public sector hospital (63.4%)
• Trajectory 2: Clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (16.1%)
• Trajectory 3: Non-clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (20.5%)
Abortion trajectory + wealth tercile

Percentage women that sought abortion

Safe abortion

PAC after MA initiated elsewhere

PAC after unsafe abortion

Age

Poor

Average

Rich
Abortion trajectory + costs (US$)

- **Safe abortion at hospital**
- **Unsafe medical abortion initiated outside hospital**
- **Unsafe abortion initiated outside hospital**

The graph shows the median cost for different abortion procedures, categorized by cost and procedure pathway.
Framework analyses

1. The influence of advice
2. Perceptions of risk
3. Delays in care seeking and receipt
4. The economic costs

All influence either the direction of trajectory (the typology), its complexity or the timing of the trajectory.
The influence of advice: Chance not design

• The advice respondents sought and received, or did not seek, played significant role in shaping their trajectories

• Respondents’ relationships with significant others influenced who was told about their pregnancy, the decision to terminate it, how and where it was terminated and whether PAC at hospital was sought and when

• It was typically others’ knowledge of different service providers that shaped how women of typologies 1 & 2 navigated care seeking
04023 is 33 years old and married. She has two children aged under 3 and lives in a township with her husband. They both run small businesses and just get by. The pregnancy was unplanned and unexpected – they had been using condoms.

“I called a friend, I explained my situation. // And she gave me a [study hospital] doctor’s number and who I called.”
01004 is 20 years old and finishing school. Following her parents’ death she lives with her step-mother, her ‘uncle’ (step-mother’s cousin) and her siblings and cousins, of whom she is oldest. She is sexually abused by her uncle. She felt unwell but was unaware she is pregnant until her step-mother guesses she is pregnant and forces her to drink herbs to abort.

“At some time I felt dizzy and collapsed, then she made some herbal mix in a container… I didn’t know but when I came back from school, she just gave me and told me to drink then I drunk and only my stomach pained a lot… Then she made the mix again and forced me to drink. She said if I don’t drink, she will beat me. Then I drunk and my stomach hurt again. Then after two days, I told my friend at school about it and she told me to go to [study hospital] and that I should explain then I can get help.”
Perceptions of risk

• Respondents reported that they and those they confided in considered risks of various abortion methods

• Government providers (clinics and hospitals) were widely trusted and considered safe

• Avoidance or reduction of risk influenced women’s selection of non-hospital MA versus non-clinical methods (Typology 2), and the selection of non-clinical method (Typology 3)

• However for some respondents the risks of harm were outweighed by the desire for an abortion
04011 lives with her parents and brothers. She did not tell her family, but asked her friends for advice on how to terminate her pregnancy.

“They told me to try herbs from people. I told them I can’t because I don’t trust them, you can die”.

On the advice of a different friend she looks for MA drugs, at first in her local drug store and then in the town.

“So I had gone to a drug store near where I stay but they said that they don’t do that. So my friend told me a friend of hers had done it with a certain medicine in a white box they are 5 in it, that’s how she wrote for me on a paper and I went to buy in town.”
The economic costs

• Financial costs appear to influence the timing and complexity of trajectories, rather than the choice of abortion method and provider

• The hospital served a large area and finding money for transport was a first hurdle. Study not able to capture women who could not overcome it

• In order to increase efficiency in tertiary care, people are given economic incentives to access district clinics first: a referral from a satellite health centre reduces registration fee at hospital.
  – For poorer women, knowledge of how to navigate the public sector health system made care affordable but also added an additional step in their trajectory to the hospital
02008 is married with three children, the youngest of which she was still breastfeeding. She continued to take her family planning pills, including taking all of the “red pills in the Microgynon packet”, hoping that it would help her miscarry. When this did not work she took some other (unspecified) tablets. When she started bleeding heavily, however, she did not feel that she could afford not to open her market stall, so she delayed seeking care. When she eventually went to the study hospital, she is at first sent away and told to return the following day when a clandestine fee was charged.

I: OK so what happened with the doctor [when you came yesterday]?
R: Well, he was difficult, he told me that it’s not allowed by the Government
I: OK, what else did the doctor say to you?
R: He told me that he would help me, and that this should not happen again
Contributions

• New evidence for considering the role of complex influences in abortion decision-making, and links to fertility transitions
• New evidence for theorising about how women assess and act upon abortion stigma and safety, set against individual contexts
• Sheds light on the complexities involved in navigating a pluralistic health system
CONCEPTUAL FRAMEWORK

[COAST (LSE), NORRIS (OHIO STATE), MOORE (GUTTMACHER), FREEMAN (LSE)]
What’s the point of a conceptual framework?

“the main things to be studied” (Miles & Huberman, 1994: 18)

A set of structured ideas to help us understand a phenomenon

The phenomenon: Women’s trajectories to seeking abortion-related care
How we produced it

• **Consultation** with 30 expert abortion researchers to shape initial framework

• Social and biomedical science **literature (peer-reviewed and grey) searched** to identify examples to test the framework’s applicability and increase its specificity

• **Presentation** of the conceptual framework for further testing, scrutiny, review and revision
Abortion-related experiences

Individual context

(Inter)national/sub-national context

Abortion-related care
<table>
<thead>
<tr>
<th>ABORTION-SPECIFIC EXPERIENCES</th>
<th>INDIVIDUAL CONTEXT</th>
<th>(INTER) NATIONAL/ SUB-NATIONAL CONTEXT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness of pregnancy</strong></td>
<td></td>
<td><strong>Structural &amp; institutional environment</strong></td>
</tr>
<tr>
<td>- Timing of awareness</td>
<td><strong>Individual knowledge &amp; beliefs about abortion</strong></td>
<td>- Fragility of state</td>
</tr>
<tr>
<td><strong>Emotions about</strong></td>
<td></td>
<td>- Legal/penal/regulatory environment</td>
</tr>
<tr>
<td>pregnancy/childbearing/abortion</td>
<td></td>
<td>- Government position (law enforcement, judicial role, resources)</td>
</tr>
<tr>
<td>- Reasons for choosing abortion</td>
<td></td>
<td>- Civil society position and influence</td>
</tr>
<tr>
<td>- Individual’s and influencers’ (partner’s, parent’s, in-laws, friends’) emotions and advice</td>
<td><strong>Knowledge about abortion (eg: methods)</strong></td>
<td>- Religious structures' position and influence on policies and society</td>
</tr>
<tr>
<td>- Ambivalence re: pregnancy</td>
<td></td>
<td>- Role of institutional environment in personal decision making</td>
</tr>
<tr>
<td><strong>Disclosure</strong></td>
<td></td>
<td>- Anti/pro-natalist policies and associated policies (eg: education, employment)</td>
</tr>
<tr>
<td>- Ability to disclose and to whom</td>
<td></td>
<td><strong>Health system</strong></td>
</tr>
<tr>
<td>- Negotiation around abortion with others invested in the decision</td>
<td>- Socio-economic and demographic characteristics</td>
<td>- Formal (eg: finance, infrastructure, governance, health information, training, pharmacies, investment priorities)</td>
</tr>
<tr>
<td>- Need for secrecy due to possible social consequences; ability to maintain secrecy</td>
<td><strong>Individual profile/outlook</strong></td>
<td>- Accessibility of legal services (eg: regulation, conscientious objectors)</td>
</tr>
<tr>
<td><strong>Ability to access resources for abortion</strong></td>
<td>- Socio-economic and demographic characteristics</td>
<td>- Informal (alternative and/or illegal providers, self-administration of methods)</td>
</tr>
<tr>
<td>- Social support for/against abortion</td>
<td>- Belief in likelihood of prosecution if abortion done illegally</td>
<td>- Accessibility of illegal services from people trained by the health system</td>
</tr>
<tr>
<td>- Material/physical resources (transport, money, childcare, ability to miss school or work)</td>
<td>- Anticipated social treatment due to having abortion</td>
<td>- Health workforce treatment of women seeking abortion</td>
</tr>
<tr>
<td>- Distance to abortion</td>
<td><strong>Partner/family/community context</strong></td>
<td><strong>Knowledge environment</strong></td>
</tr>
<tr>
<td><strong>Abortion attempt(s)</strong></td>
<td>- Partnership type (e.g.: commercial, marital/non-marital, abusive)</td>
<td>- Access to/availability of information</td>
</tr>
<tr>
<td>- Counselling</td>
<td>- Who has decision-making power regarding individual’s fertility (herself, husband, mother-in-law)</td>
<td>- Quality of information</td>
</tr>
<tr>
<td>- Gestation at time of termination</td>
<td></td>
<td>- Technology (internet availability, mobile phones)</td>
</tr>
<tr>
<td>- Where woman sought abortion</td>
<td></td>
<td>- Media (dissemination of health messages, representations of abortion)</td>
</tr>
<tr>
<td>- Type of abortion ([U]n[safe], ([l]egal)</td>
<td></td>
<td>- Who delivers messages (politicians, activists, community leaders, health professionals, peer educators)</td>
</tr>
<tr>
<td>- Perception of treatment by provider</td>
<td><strong>Outcomes from (attempted) abortion</strong></td>
<td><strong>Socio-cultural context</strong></td>
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<td></td>
<td>- Norms and acceptability of abortion (presence/absence of stigma/shame)</td>
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<tr>
<td>- Physical health</td>
<td>- Fertility norms (family size) gender preference</td>
<td><strong>ABORTION-RELATED CARE</strong></td>
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<tr>
<td>- Mental health</td>
<td>- Norms and (in)equality across gender, race, caste, ethnicity</td>
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</table>
• The boundaries between the components and levels are not as clear as presented by the framework

• However, it offers a **departure point** for new research by drawing attention to primary components and linkages in describing and explaining women’s trajectories to abortion decision-making and behaviour

• Encourages a more holistic ways of understanding the trajectories of girls and women seeking abortion-related care

• The framework should be **continually tested** against new evidence and adapted to meet previously undocumented and/or unexpected abortion-seeking experiences
**SAFE + LEGAL ABORTION**

- 21yo college student
- Sporadically used condoms
- Decision to terminate a combination of impact on her studies and boyfriend’s denial
- Had a female relative she felt able to confide in
- Relative knew a phone number of a hospital doctor
- Relative made all arrangements, including clandestine fees, and brought her to hospital for safe abortion

**UNSAFE ABORTION + PAC**

- 17yo schoolgirl
- Never used contraception
- Disclosed to boyfriend who told her not to abort as a sin
- Mother realised she was pregnant + forced girl to drink concoction
- “Father would kill her after spending so much money on her schooling”
- Admitted to hospital for PAC

https://zambiatop.wordpress.com/
Framework applications

• For researchers to contextualise abortion decision-making research work

• For programmers and policymakers to identify problems with (and possibly solutions to) the women’s access to abortion care services
  – Service providers eg: clinician training

• To facilitate comparative work across settings
Zambia Project Team

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• Coast, Ernestina and Murray, Susan (2016) "These things are dangerous": understanding induced abortion trajectories in urban Zambia. Social Science & Medicine, 153 . pp. 201-209.

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