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

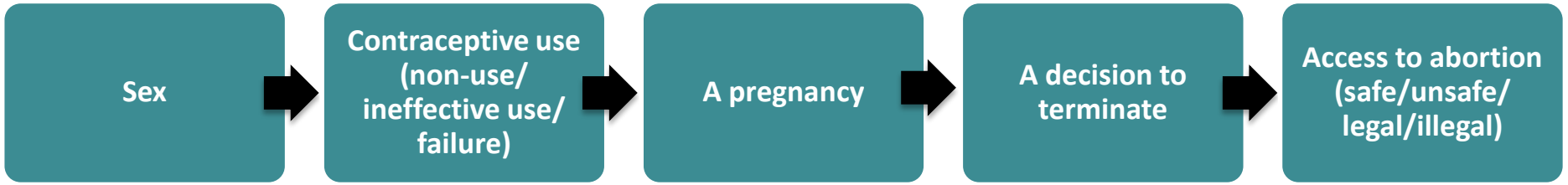
FERTILITY TRANSITIONS AND ABORTION

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

LSE

Abortion: end point of a set of events



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

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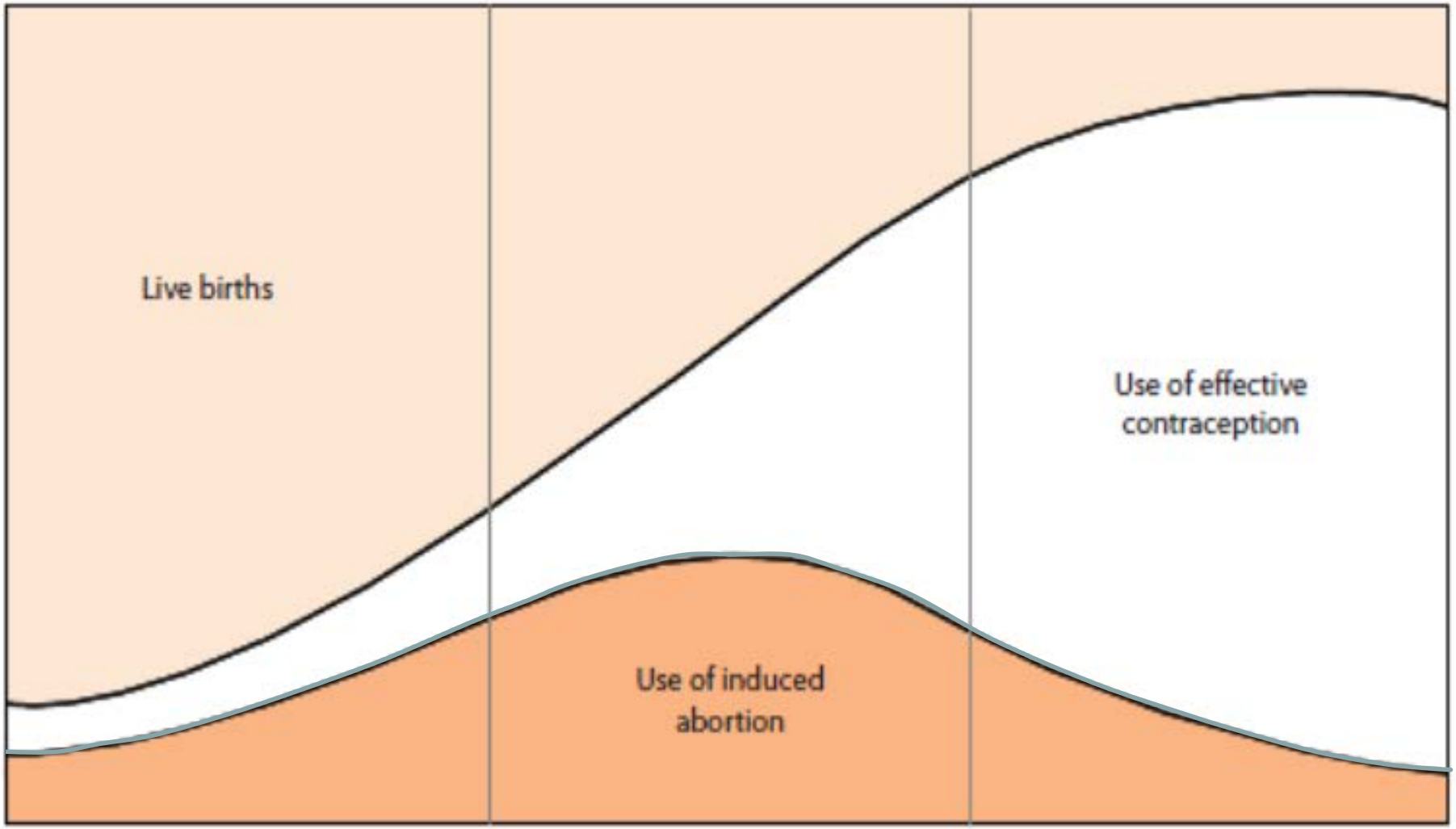
LSE

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

LSE

How, and to what extent, are rates of induced abortion and contraception related?



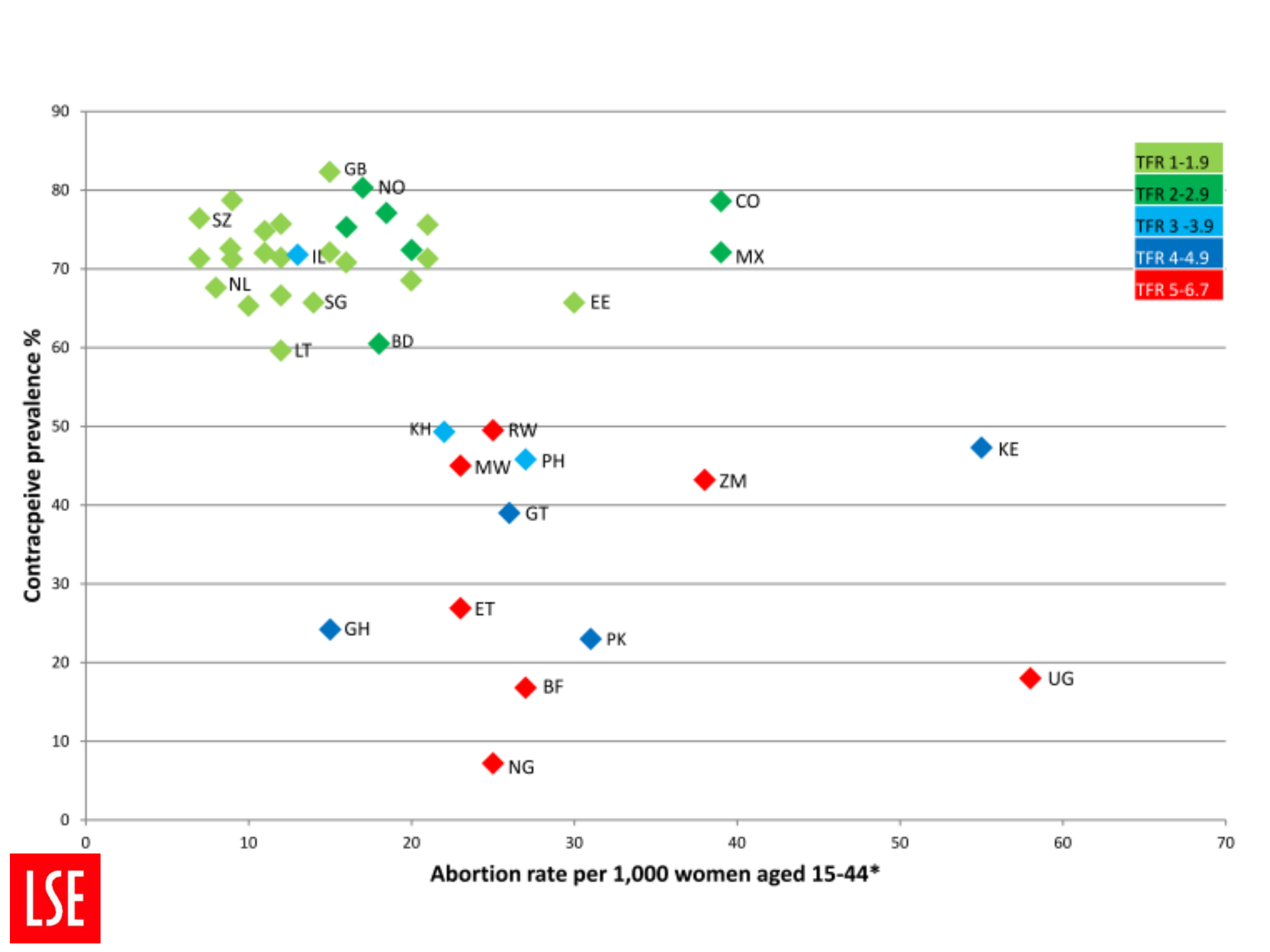
HIGH FERTILITY → LOW FERTILITY

WHO, 2008

Abortion & unmet need

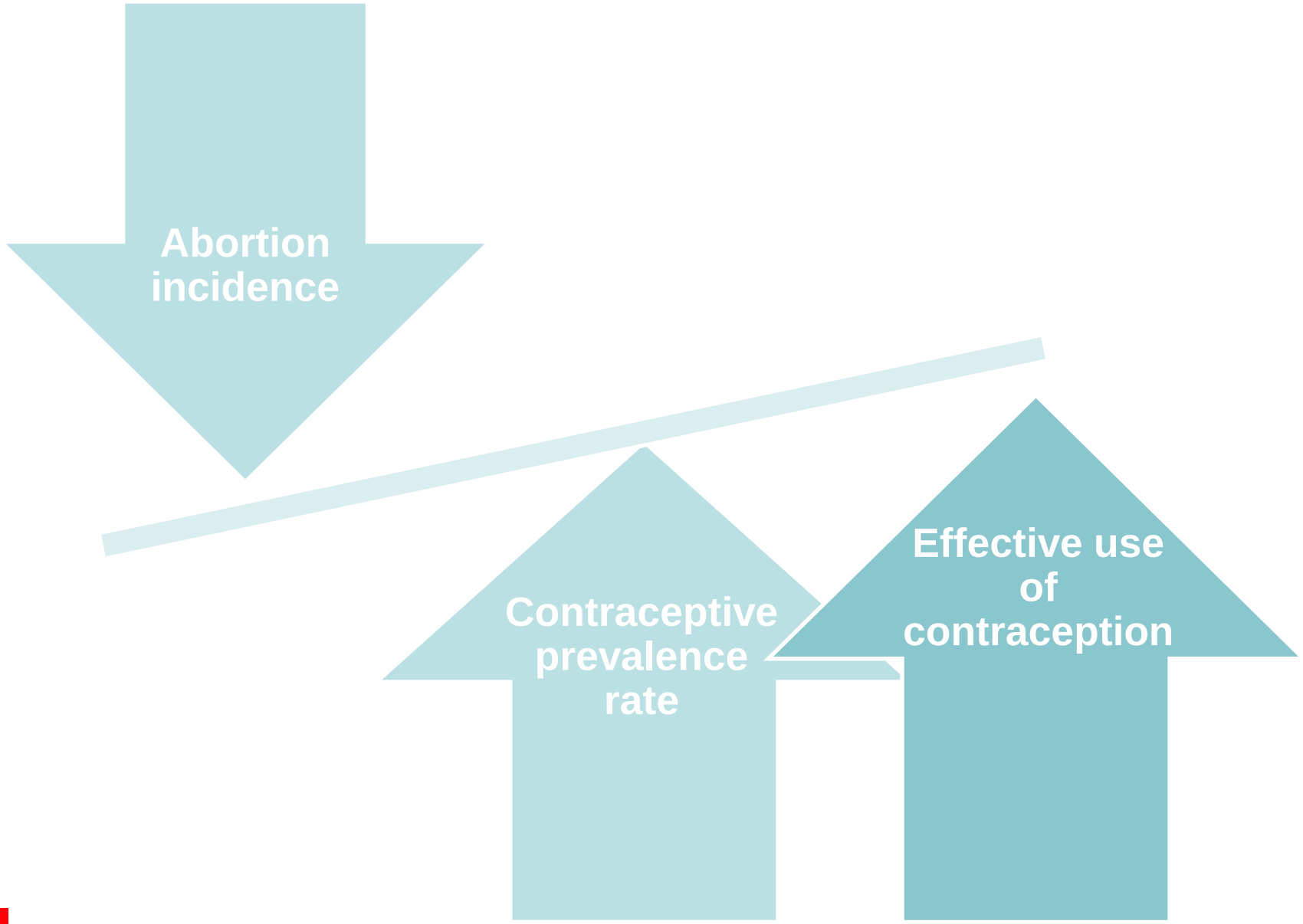
- Abortion as an outcome of unmet need for effective contraception?
- People are motivated to regulate their fertility
  - using behavioural methods
  - supplied contraception
    - × Inaccessible; and/or
    - × Inconsistently or incorrectly used

LSE


Contracpeive prevalence %
Abortion rate per 1,000 women aged 15-44*
0
10
20
30
40
50
60
70
80
90
TFR 1-1.9
TFR 2-2.9
TFR 3 -3.9
TFR 4-4.9
TFR 5-6.7
GB
NO
SZ
IL
NL
SG
LT
BD
EE
CO
MX
KH
RW
MW
PH
ZM
KE
GT
ET
GH
PK
BF
UG
NG

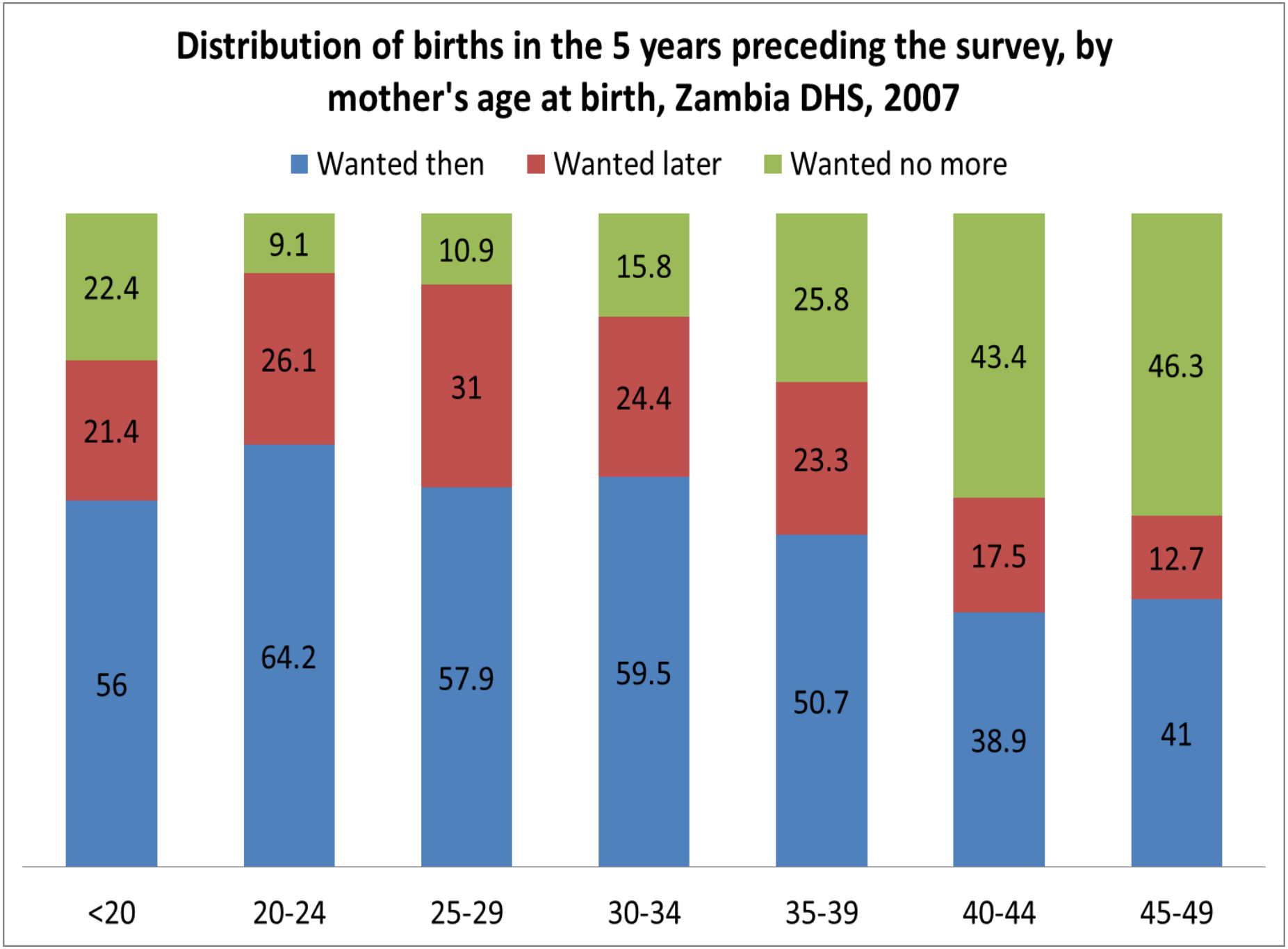
Contraception-abortion “paradox”

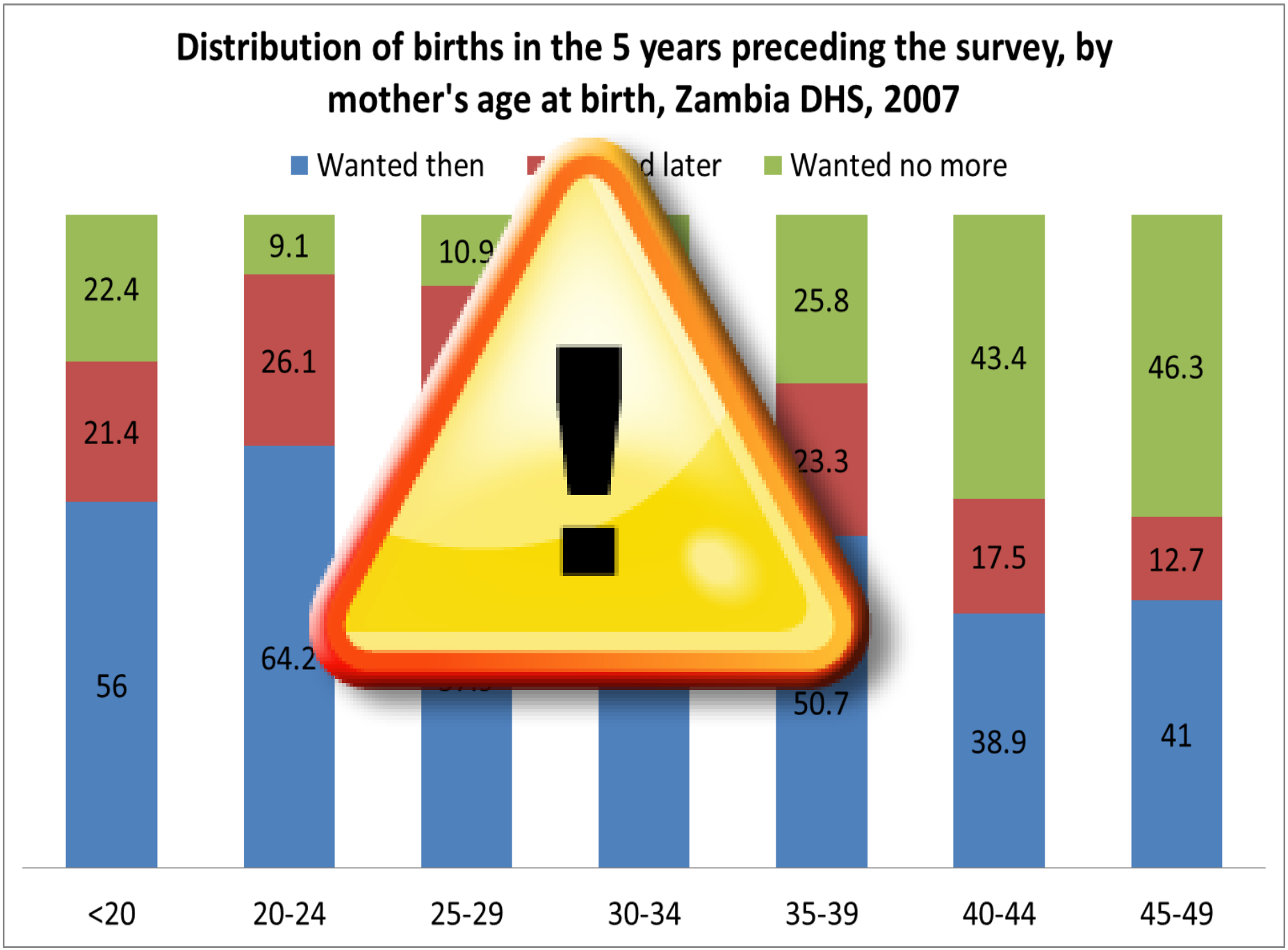
- Unmet need for contraception is high
- Contraceptive prevalence is low
- Less-effective contraceptive methods prevail


Abortion incidence
Contraceptive prevalence rate
Effective use of contraception

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
Wanted then
Wanted later
Wanted no more
22.4
21.4
56
9.1
26.1
64.2
10.9
31
57.9
15.8
24.4
59.5
25.8
23.3
50.7
43.4
17.5
38.9
46.3
12.7
41
<20
20-24
25-29
30-34
35-39
40-44
45-49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41
<20
20-24
25-29
30-34
35-39
40-44
45-49

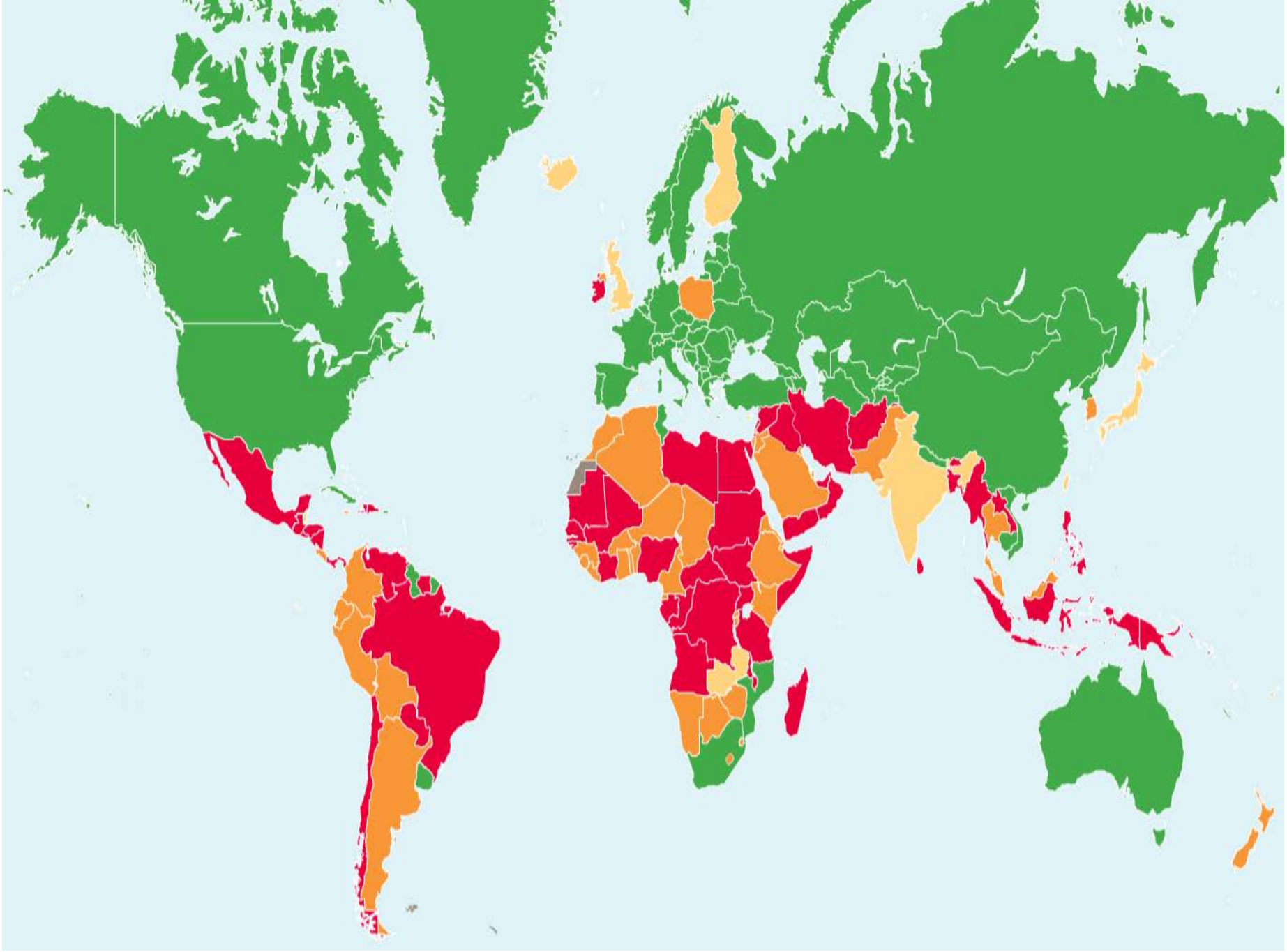
Language and data: pregnancy

- Wanted vs. unwanted
- Intended vs. unintended
- Planned vs. unplanned

Or, Unsustainable at that point in time?

MICRO PERSPECTIVES:

ABORTION TRAJECTORIES IN ZAMBIA



Center for Reproductive Rights, 2016

Legality: Zambia (Category IV)

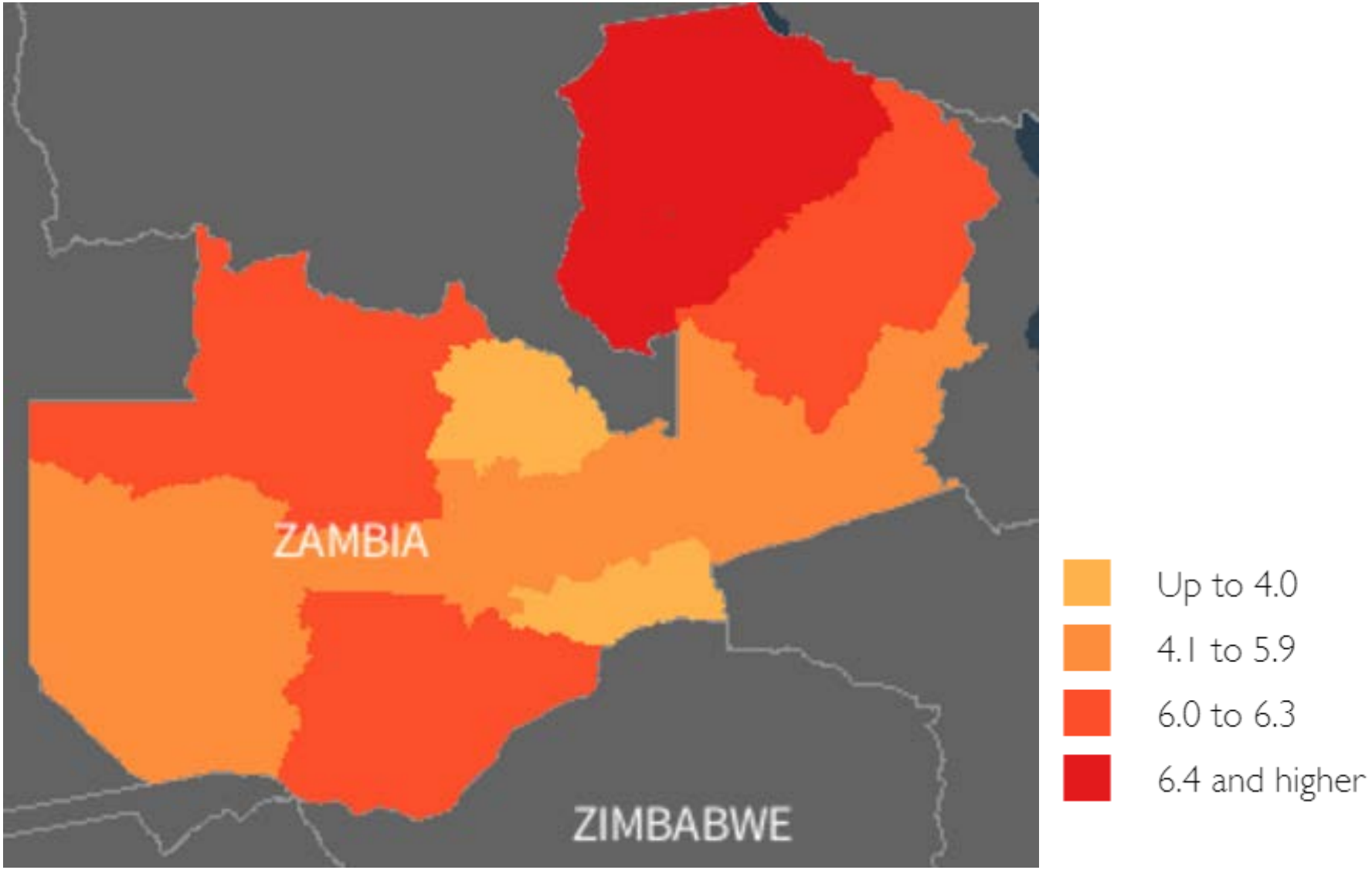
- Abortion is legally permitted:
  - To save the life of a woman
  - To preserve physical health
  - To preserve mental health
  - Foetal impairment
  - Socio-economic grounds (current and foreseeable)

- Gestational age limits apply

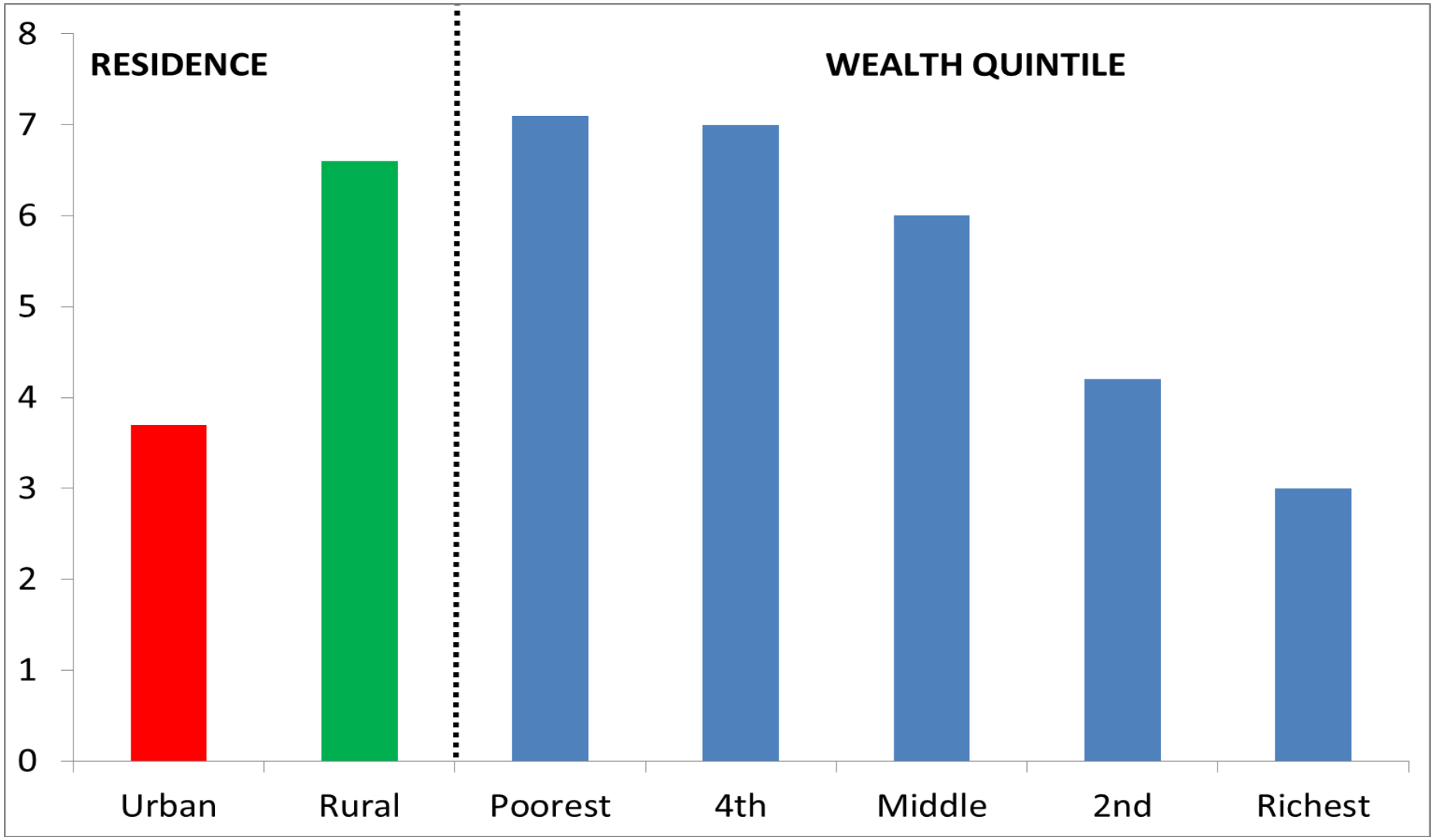
Zambia: Legality vs. services

	Adequate	Medium	Poor
Legality of safe abortion	√		
Access to safe abortion			√
Access to postabortion care			√
Access to contraceptive services			√

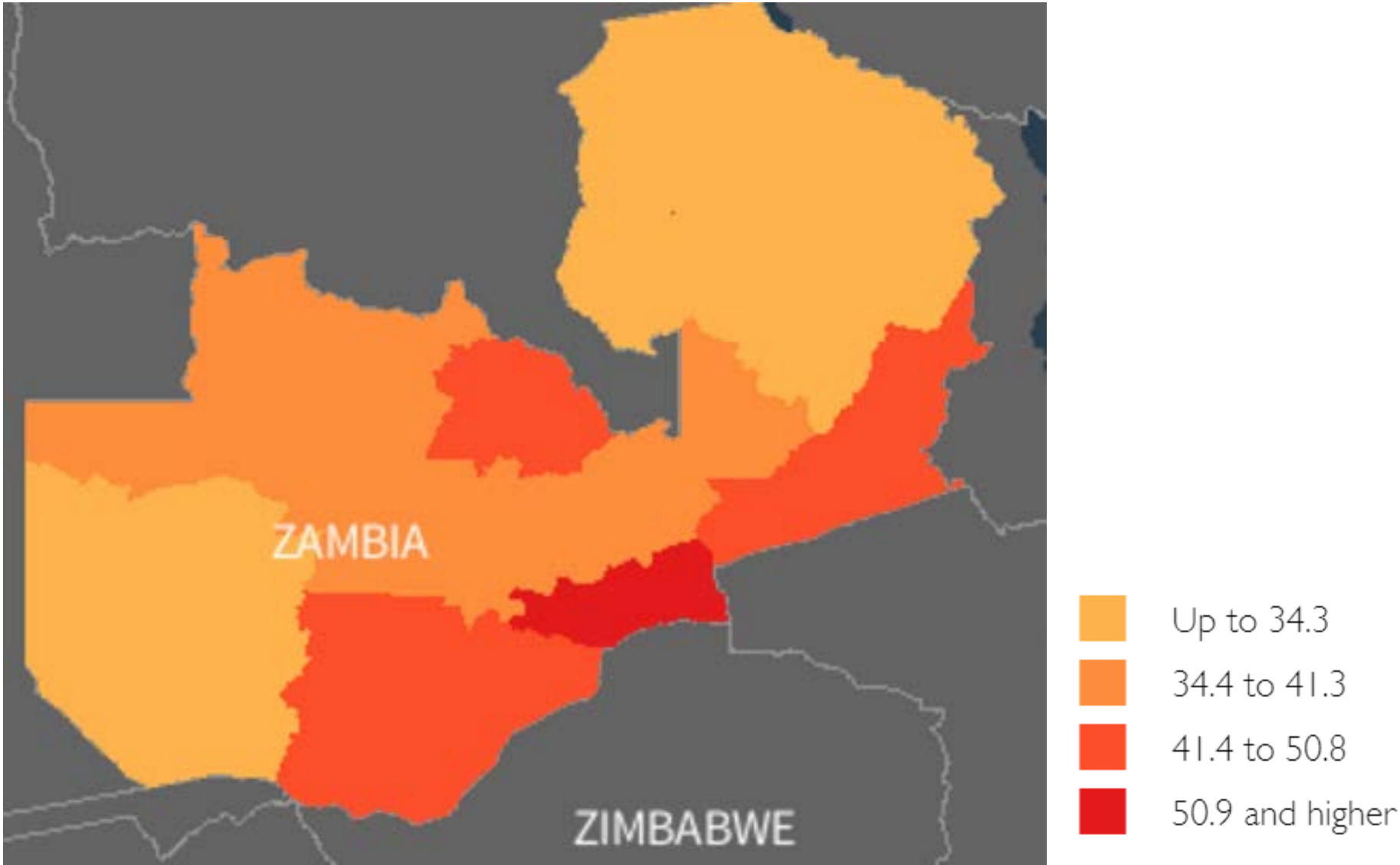
Zambia TFR 2013



Zambia: TFR


RESIDENCE
WEALTH QUINTILE
8
7
6
5
4
3
2
1
0
Urban
Rural
Poorest
4th
Middle
2nd
Richest

Zambia: Modern CPR MWRA



Comparative research design

Comparing the experiences of adolescents and women who seek:

EITHER Safe abortion (SA) services

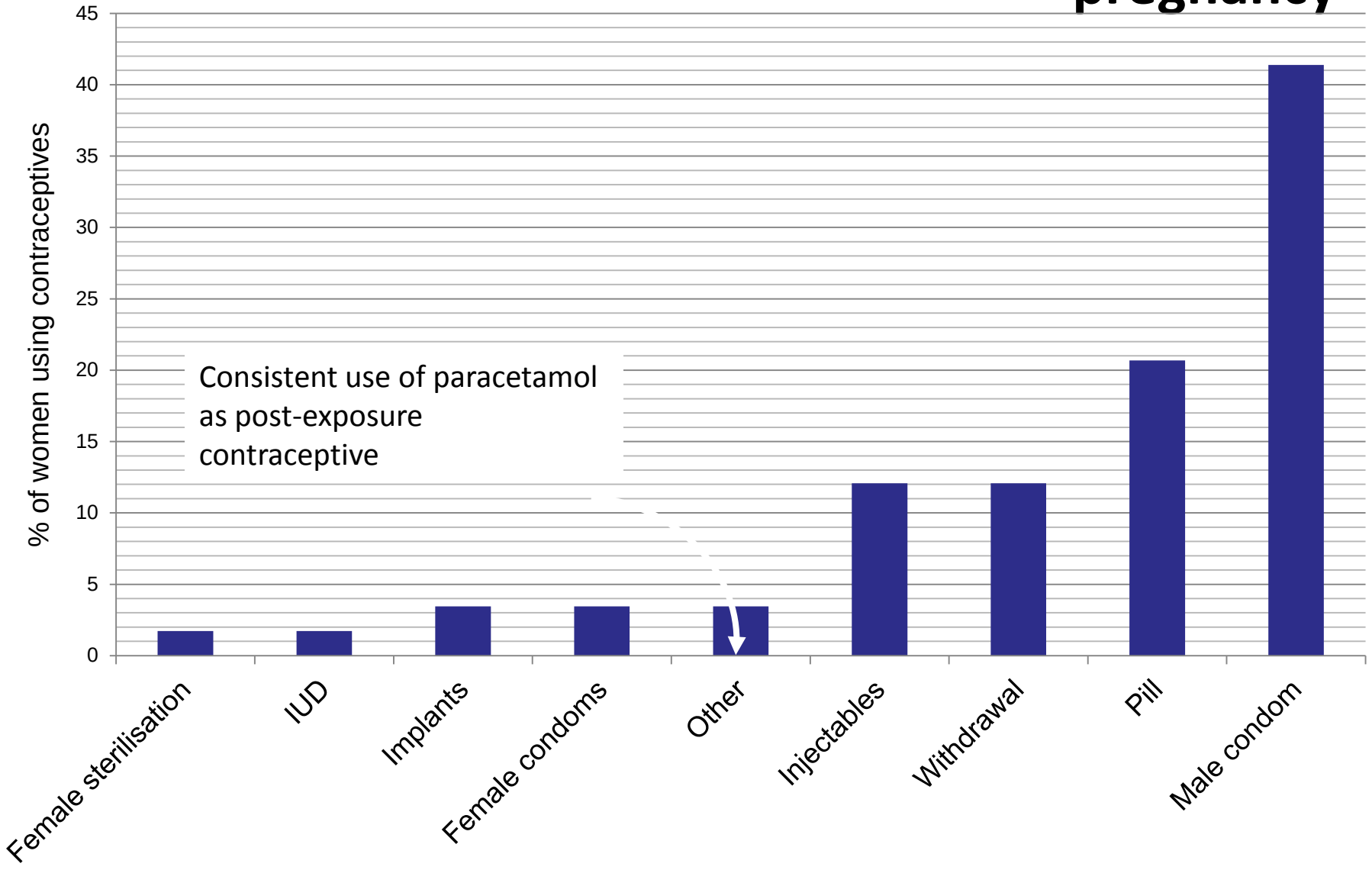
OR Post-abortion care (PAC) following an unsafe induced abortion

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



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.

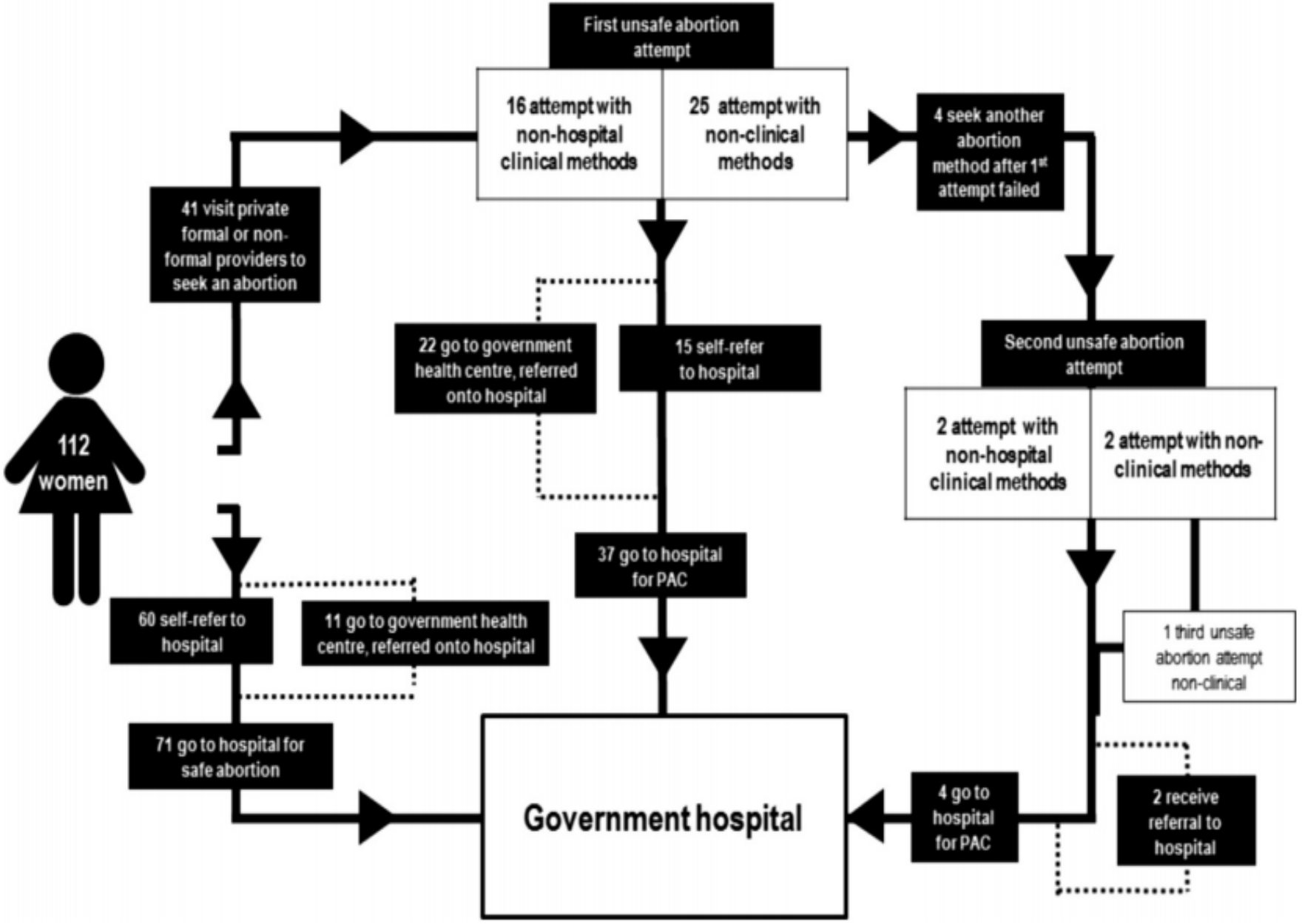
I: Who said that to you?

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


First unsafe abortion attempt
16 attempt with non-hospital clinical methods
25 attempt with non-clinical methods
4 seek another abortion method after 1st attempt failed
41 visit private formal or non-formal providers to seek an abortion
22 go to government health centre, referred onto hospital
15 self-refer to hospital
Second unsafe abortion attempt
112 women
2 attempt with non-hospital clinical methods
2 attempt with non-clinical methods
37 go to hospital for PAC
60 self-refer to hospital
11 go to government health centre, referred onto hospital
1 third unsafe abortion attempt non-clinical
71 go to hospital for safe abortion
Government hospital
4 go to hospital for PAC
2 receive referral to hospital

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

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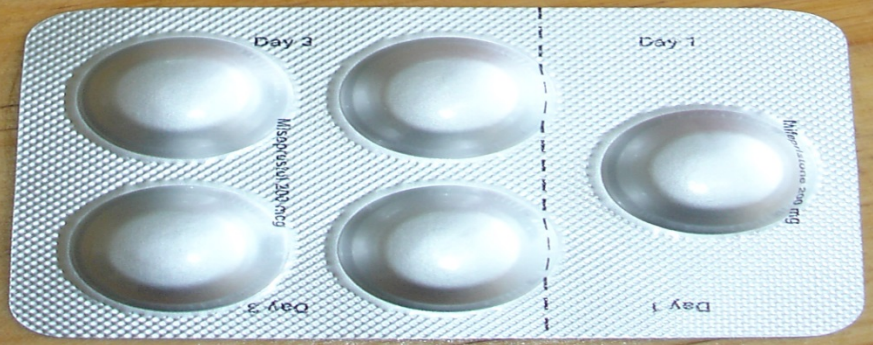
- Trajectory 3: Non-clinical abortion initiated elsewhere, followed by abortion-related care at public sector hospital (20.5%)


Guidelines for use
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)


Day 3
Day 1

Safe vs. Unsafe: Dichotomy Inadequate

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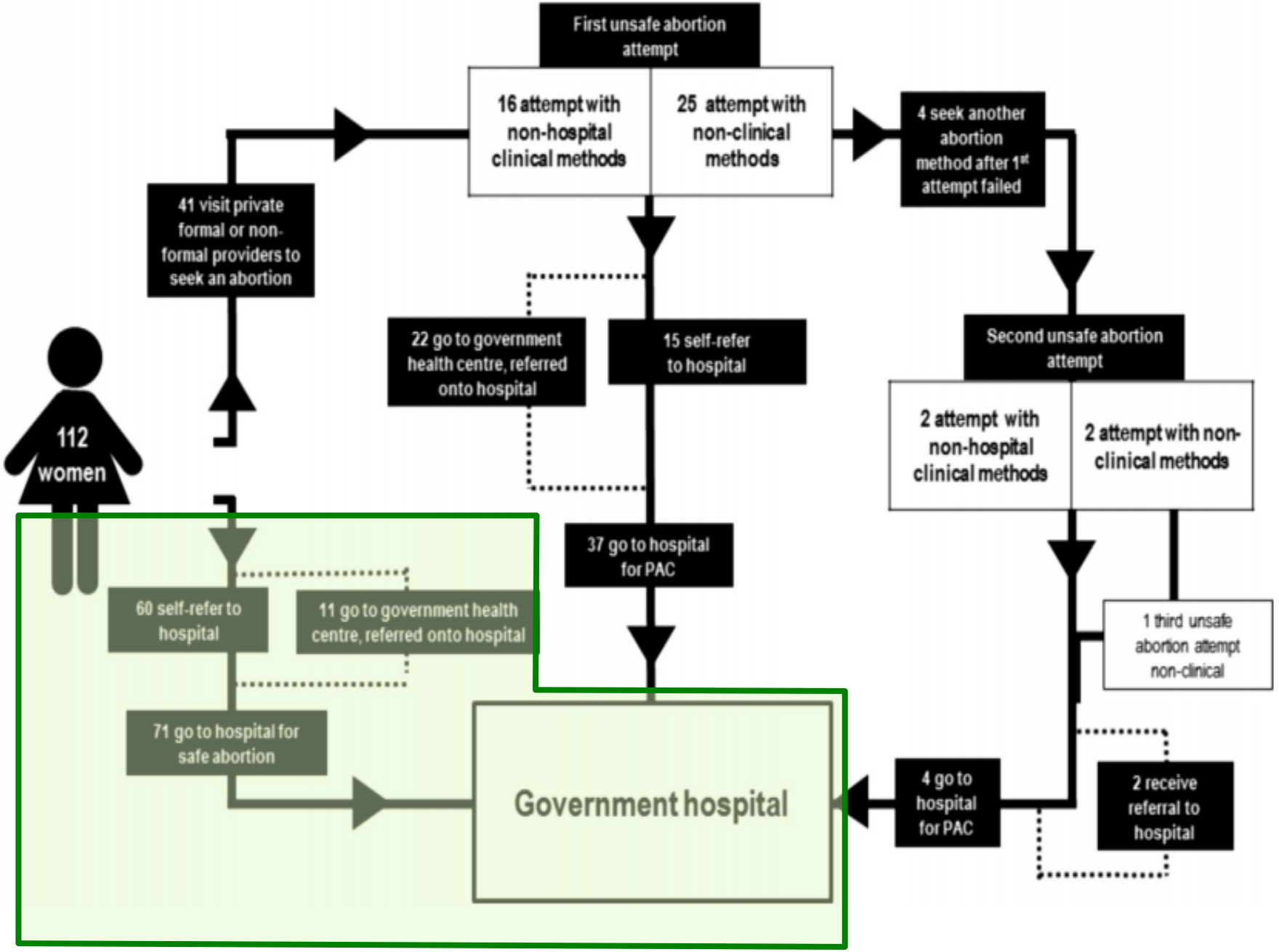
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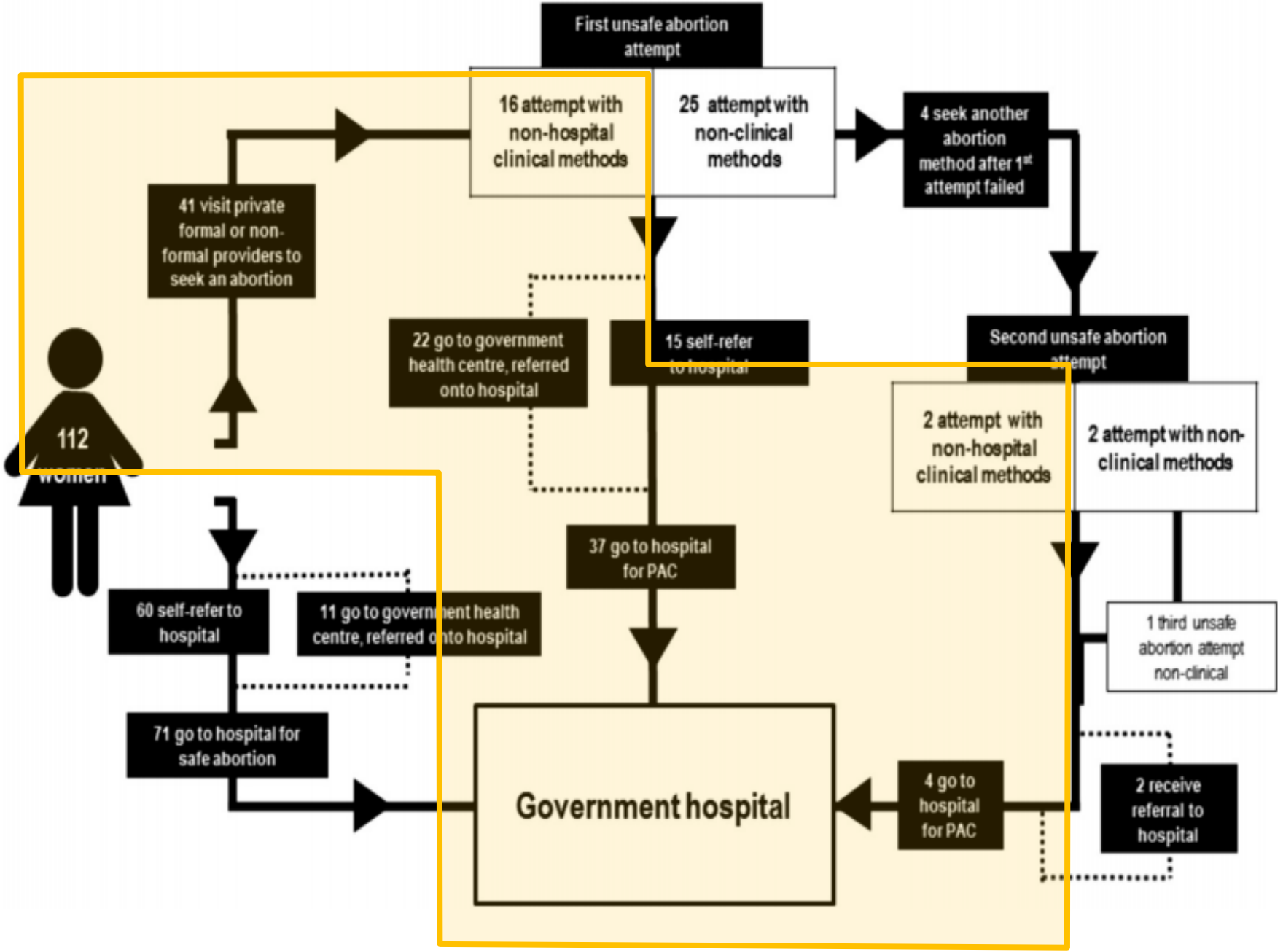
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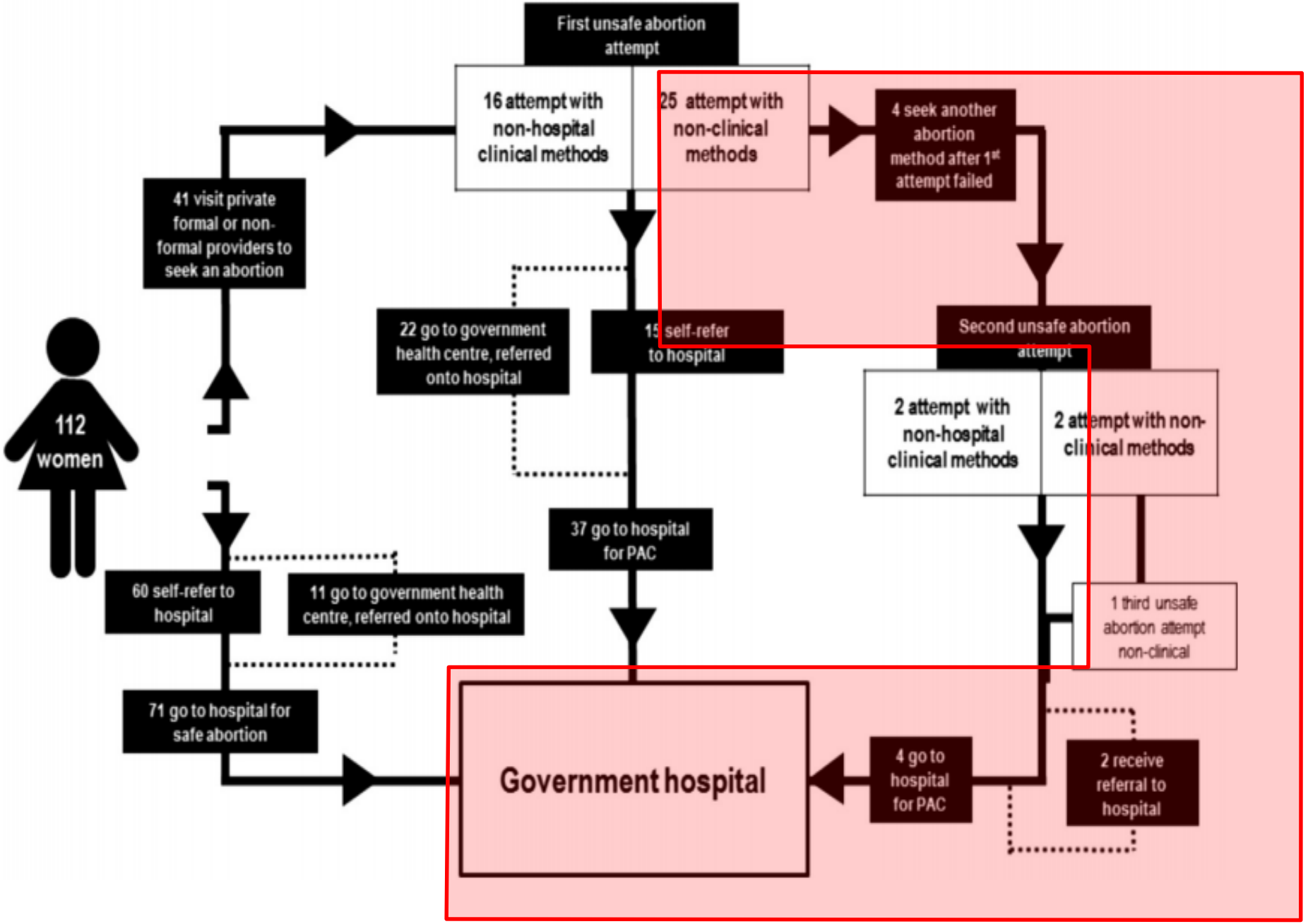
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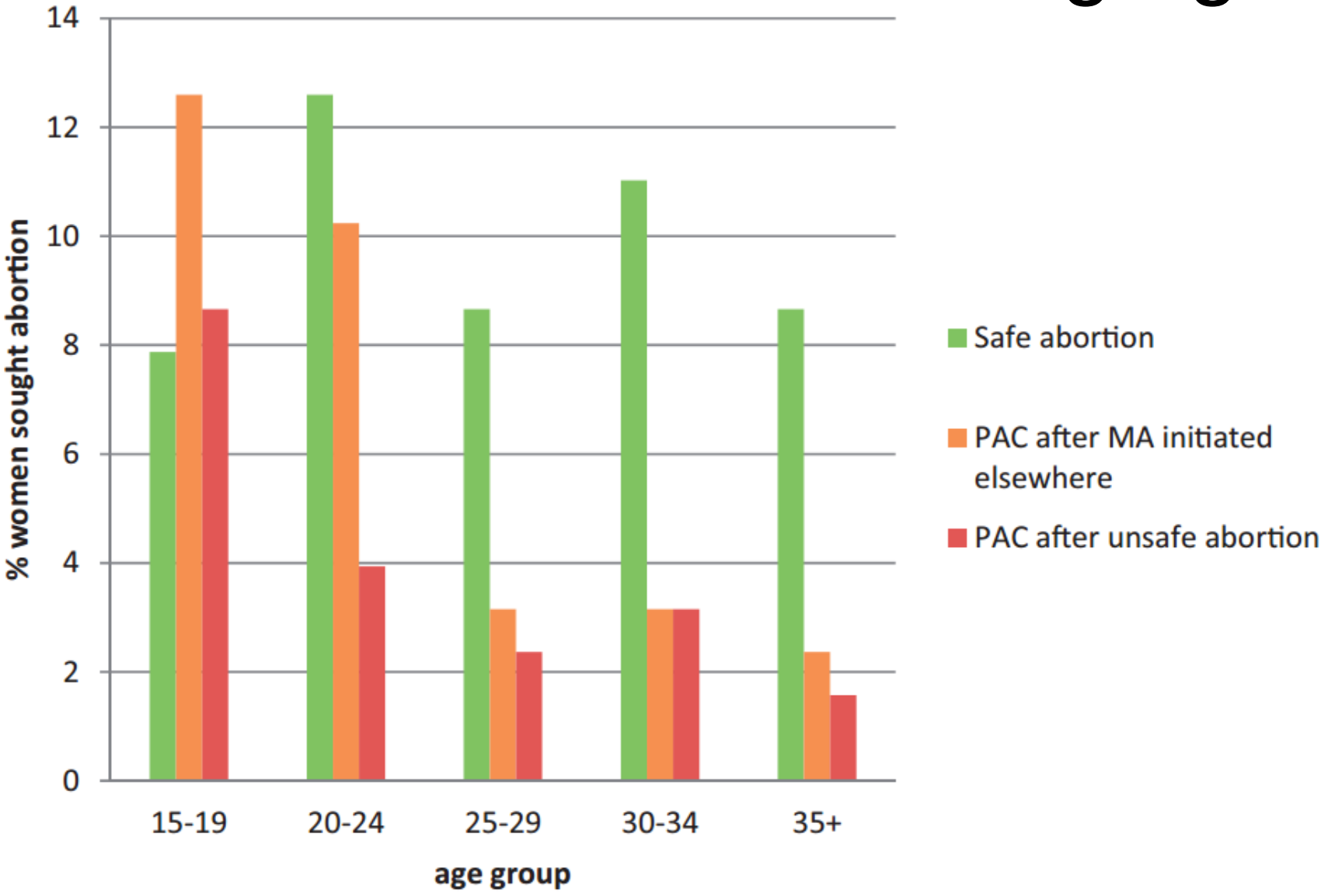
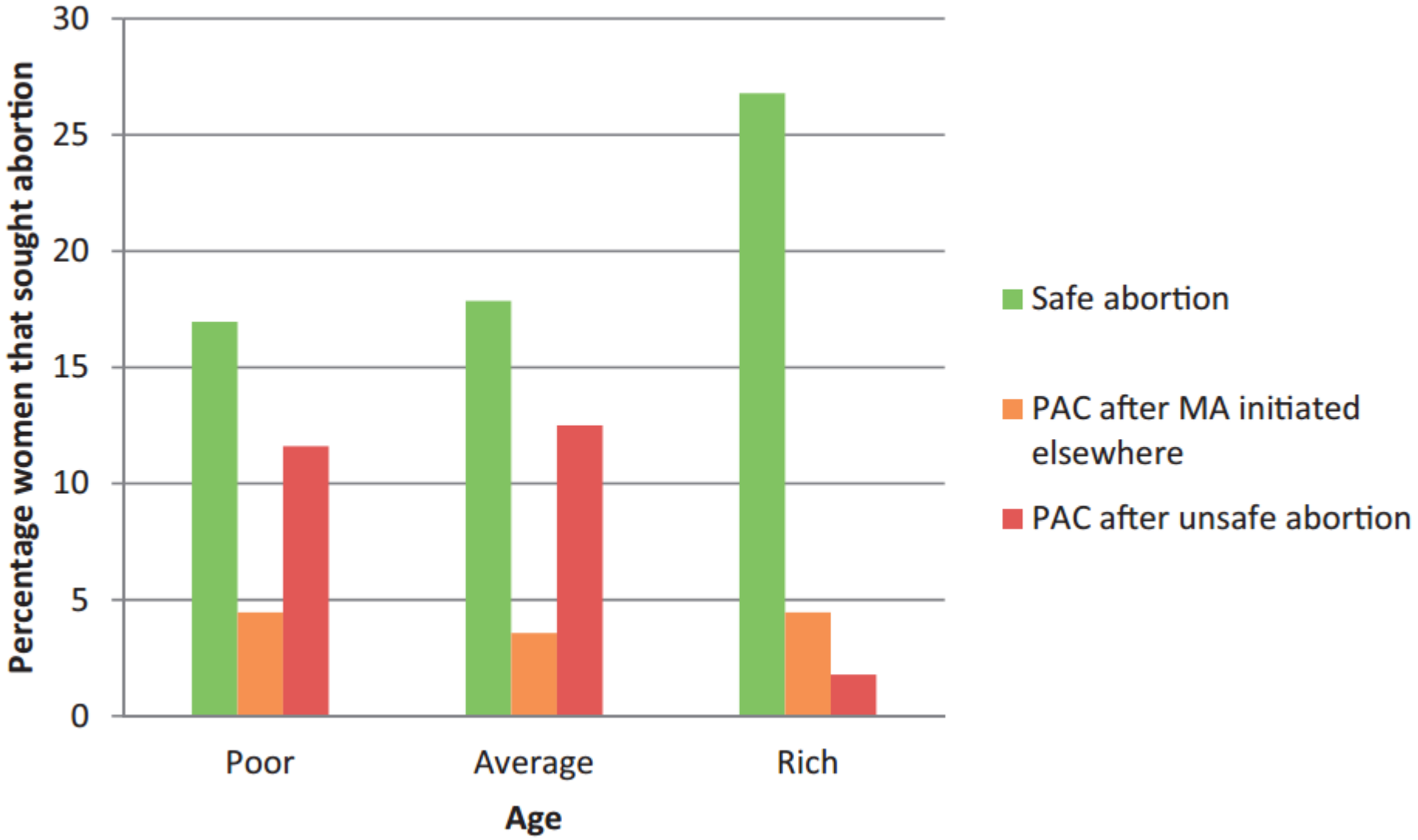
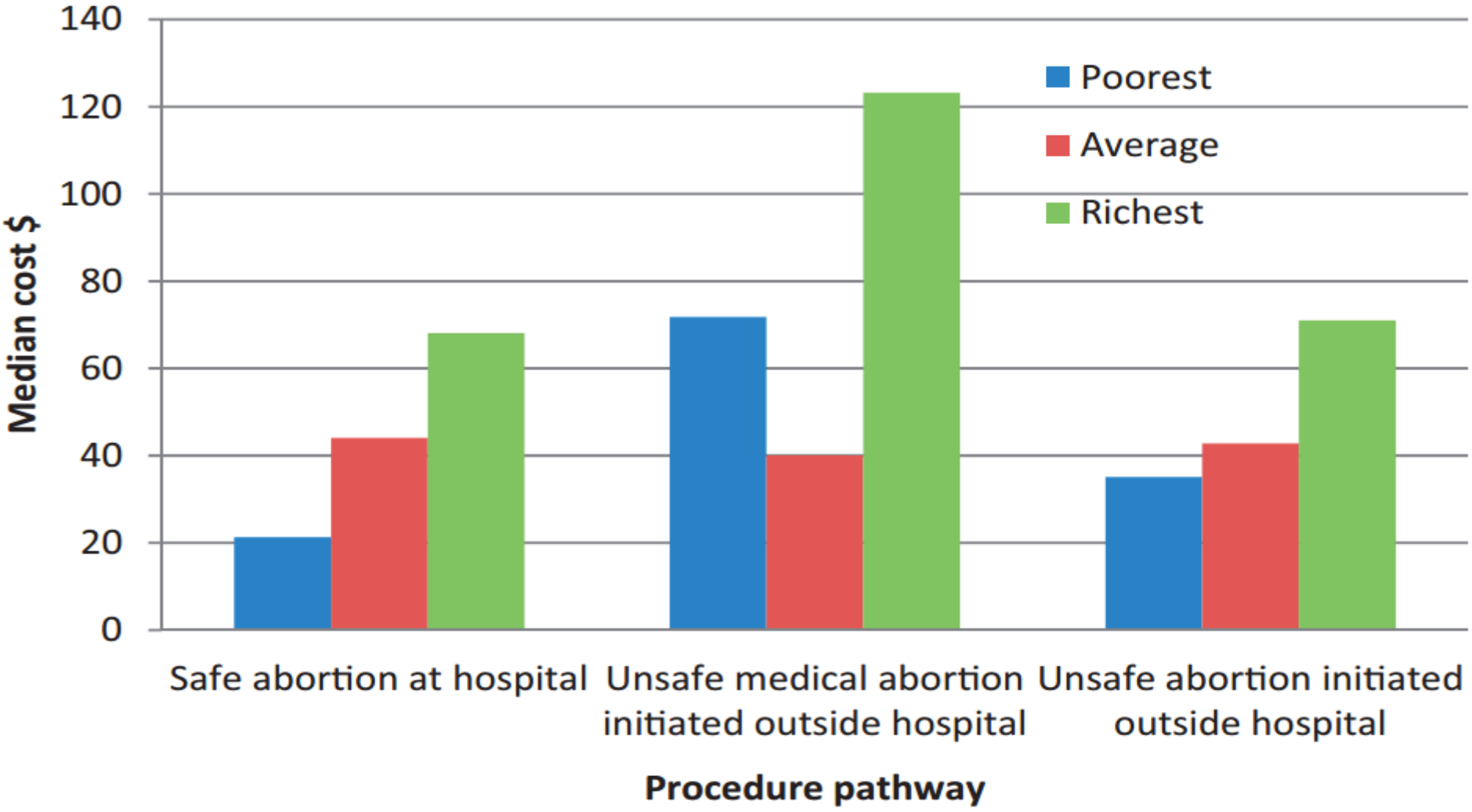
Abortion trajectory + age group



Abortion trajectory + wealth tercile



Abortion trajectory + costs (US$)



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

The influence of advice: typology 1

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."

The influence of advice: typology 3

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

Importance of risk: typology 2

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

LSE

Clandestine payment to doctor: typology 3

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)

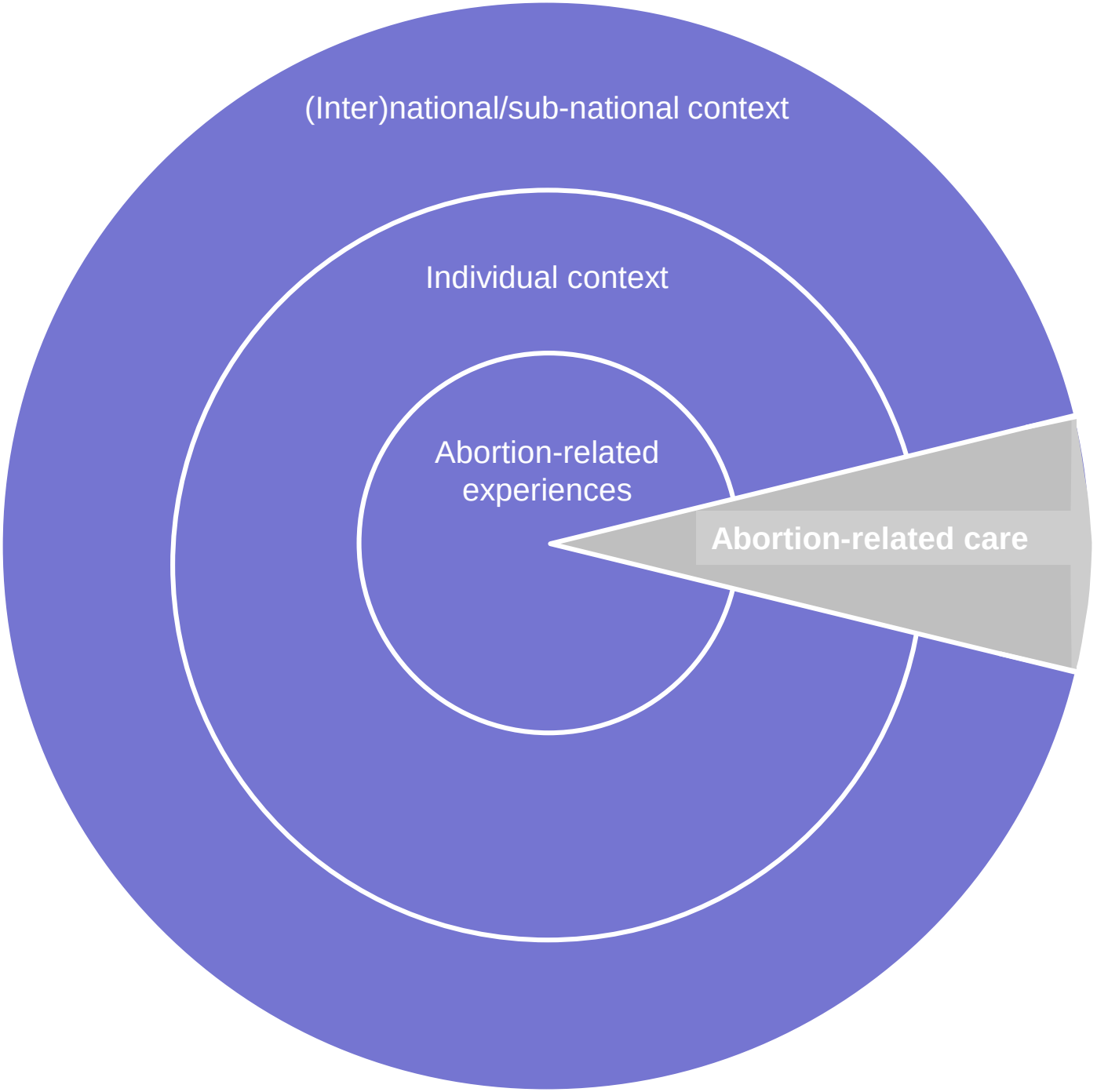
A set of structured ideas to help us understand a phenomenon

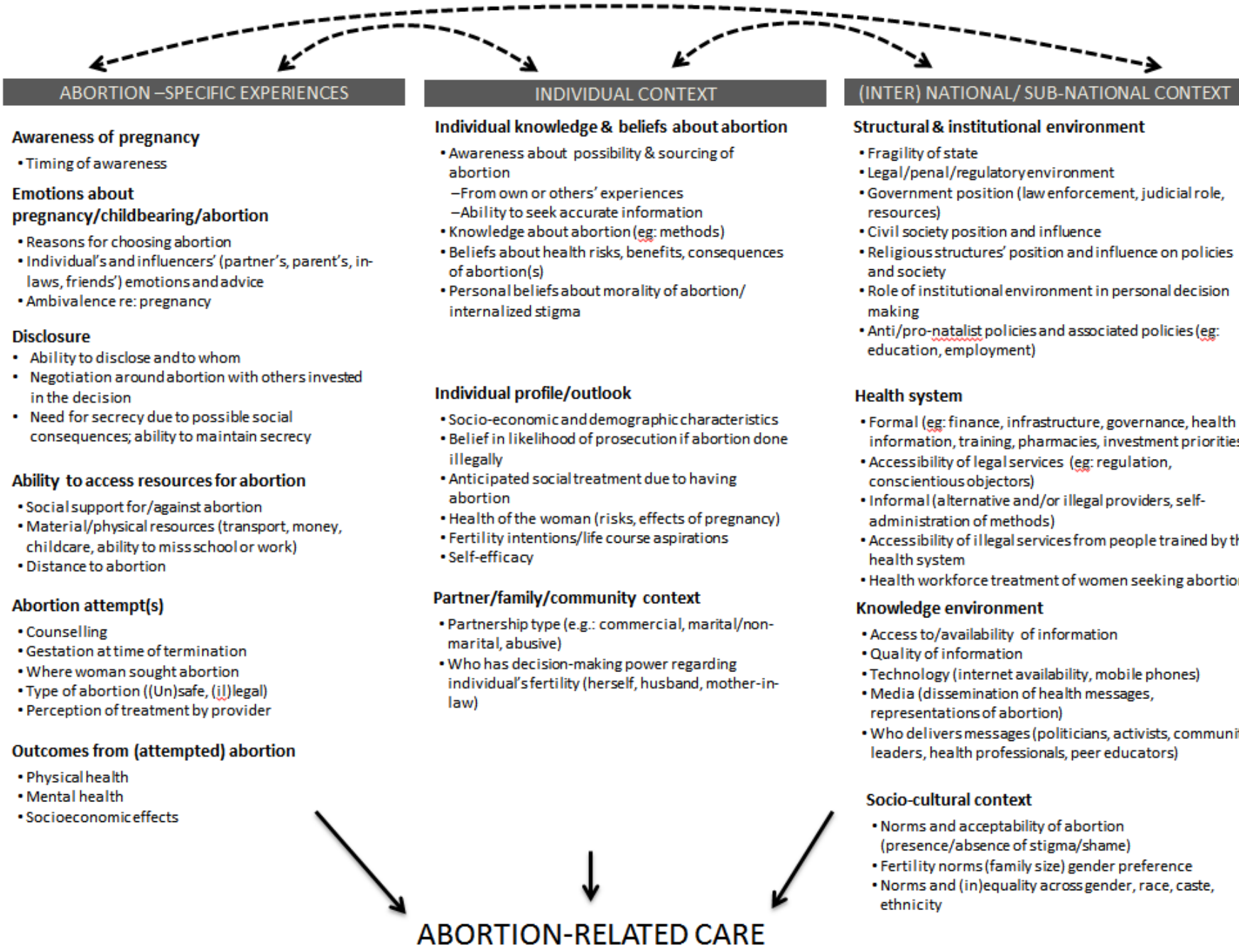
The phenomenon: Women's trajectories to seeking abortion-related care

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

LSE


(Inter)national/sub-national context
Individual context
Abortion-related experiences
Abortion-related care


ABORTION –SPECIFIC EXPERIENCES
Awareness of pregnancy
• Timing of awareness
Emotions about pregnancy/childbearing/abortion
• Reasons for choosing abortion
• Individual's and influencers' (partner's, parent's, in-laws, friends') emotions and advice
• Ambivalence re: pregnancy
Disclosure
• Ability to disclose and to whom
• Negotiation around abortion with others invested in the decision
• Need for secrecy due to possible social consequences; ability to maintain secrecy
Ability to access resources for abortion
• Social support for/against abortion
• Material/physical resources (transport, money, childcare, ability to miss school or work)
• Distance to abortion
Abortion attempt(s)
• Counselling
• Gestation at time of termination
• Where woman sought abortion
• Type of abortion ((Un)safe, (il)legal)
• Perception of treatment by provider
Outcomes from (attempted) abortion
• Physical health
• Mental health
• Socioeconomic effects
INDIVIDUAL CONTEXT
Individual knowledge & beliefs about abortion
• Awareness about possibility & sourcing of abortion
–From own or others' experiences
–Ability to seek accurate information
• Knowledge about abortion (eg: methods)
• Beliefs about health risks, benefits, consequences of abortion(s)
• Personal beliefs about morality of abortion/ internalized stigma
Individual profile/outlook
• Socio-economic and demographic characteristics
• Belief in likelihood of prosecution if abortion done illegally
• Anticipated social treatment due to having abortion
• Health of the woman (risks, effects of pregnancy)
• Fertility intentions/life course aspirations
• Self-efficacy
Partner/family/community context
• Partnership type (e.g.: commercial, marital/non-marital, abusive)
• Who has decision-making power regarding individual's fertility (herself, husband, mother-in-law)
(INTER) NATIONAL/ SUB-NATIONAL CONTEXT
Structural & institutional environment
• Fragility of state
• Legal/penal/regulatory environment
• Government position (law enforcement, judicial role, resources)
• Civil society position and influence
• Religious structures' position and influence on policies and society
• Role of institutional environment in personal decision making
• Anti/pro-natalist policies and associated policies (eg: education, employment)
Health system
• Formal (eg: finance, infrastructure, governance, health information, training, pharmacies, investment priorities)
• Accessibility of legal services (eg: regulation, conscientious objectors)
• Informal (alternative and/or illegal providers, self-administration of methods)
• Accessibility of illegal services from people trained by the health system
• Health workforce treatment of women seeking abortion
Knowledge environment
• Access to/availability of information
• Quality of information
• Technology (internet availability, mobile phones)
• Media (dissemination of health messages, representations of abortion)
• Who delivers messages (politicians, activists, community leaders, health professionals, peer educators)
Socio-cultural context
• Norms and acceptability of abortion (presence/absence of stigma/shame)
• Fertility norms (family size) gender preference
• Norms and (in)equality across gender, race, caste, ethnicity
ABORTION-RELATED CARE

- 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

Framework: ZAMBIA

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

LSE

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