

Pregnancy termination trajectories in Zambia

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Background

- The Termination of Pregnancy Act (1972, amended 1994) legalises induced abortion in wide range of circumstances
 - “account may be taken of the pregnant woman’s actual or reasonably foreseeable environment or of her age”
- The Penal Code criminalises unsafe and illegal terminations

To try to understand...

Why public sector investment in
safe abortion services in Zambia
is not fully used.

Comparative research design

ToP at a hospital

vs.

Abortion-related care at a
hospital

Methodology

- Facility-based recruitment
 - Attempts to include severe morbidities
- Novel dual interviewer approach for simultaneous mixed data collection
- Women interviewed immediately following discharge after ToP or PAC
 - n=112, refusal rate=13%
- Extraction and analysis of medical notes
- Framework analysis used to facilitate within and across case explanatory analysis

Methodological failure

Qualitative longitudinal (QL) component

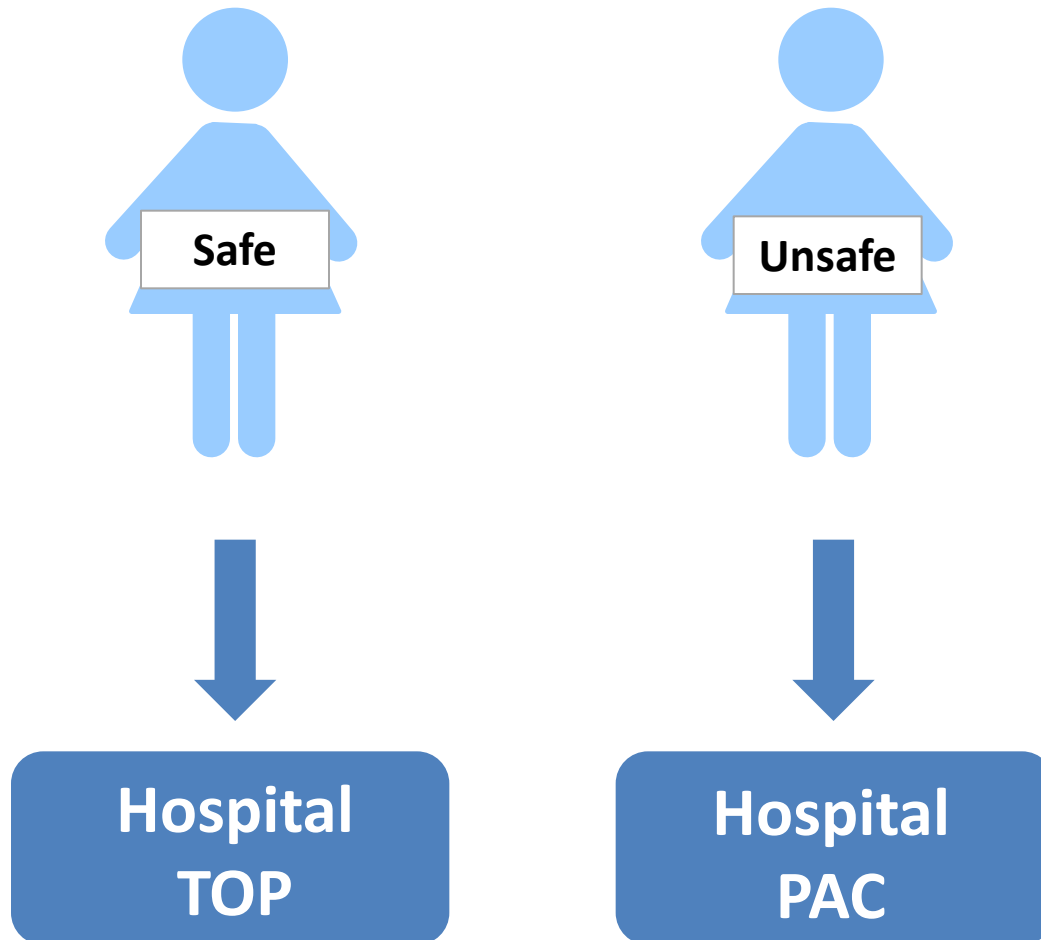
- 3/112 achieved

- Despite 90%+ agreement for follow-up

But you have to try....

RESULTS AND DISCUSSION

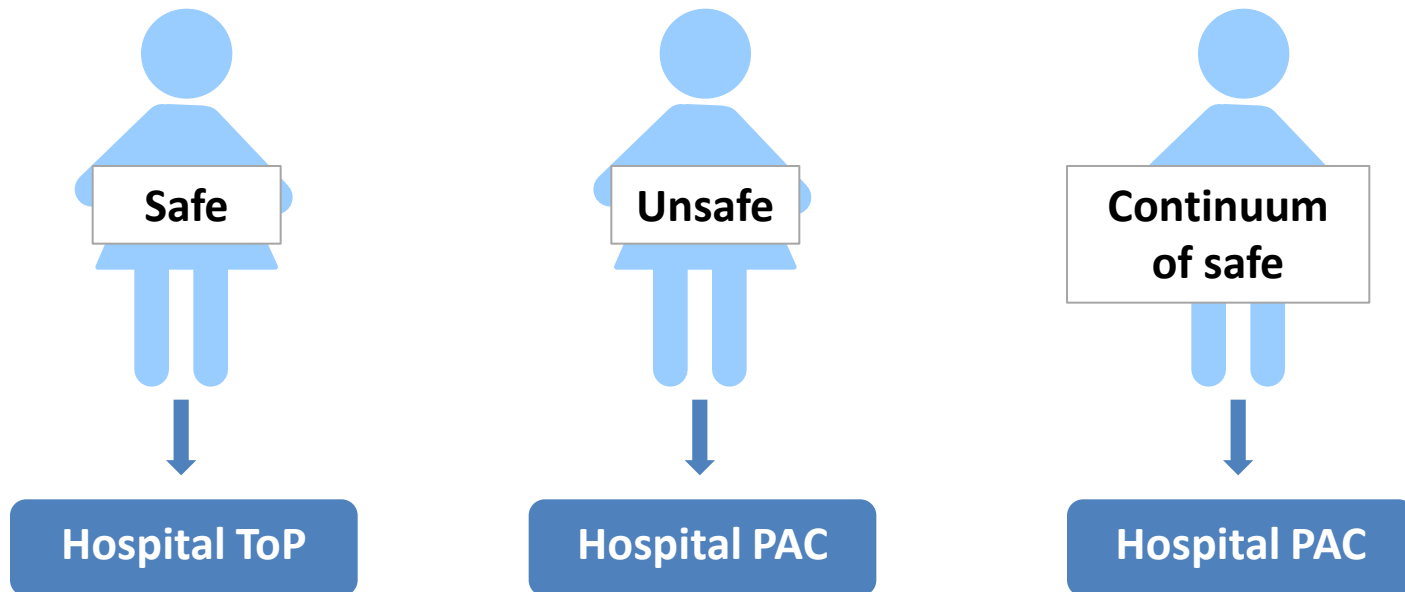
Facility-based design aims to capture some of the safe/unsafe dichotomy



Safe/unsafe dichotomy



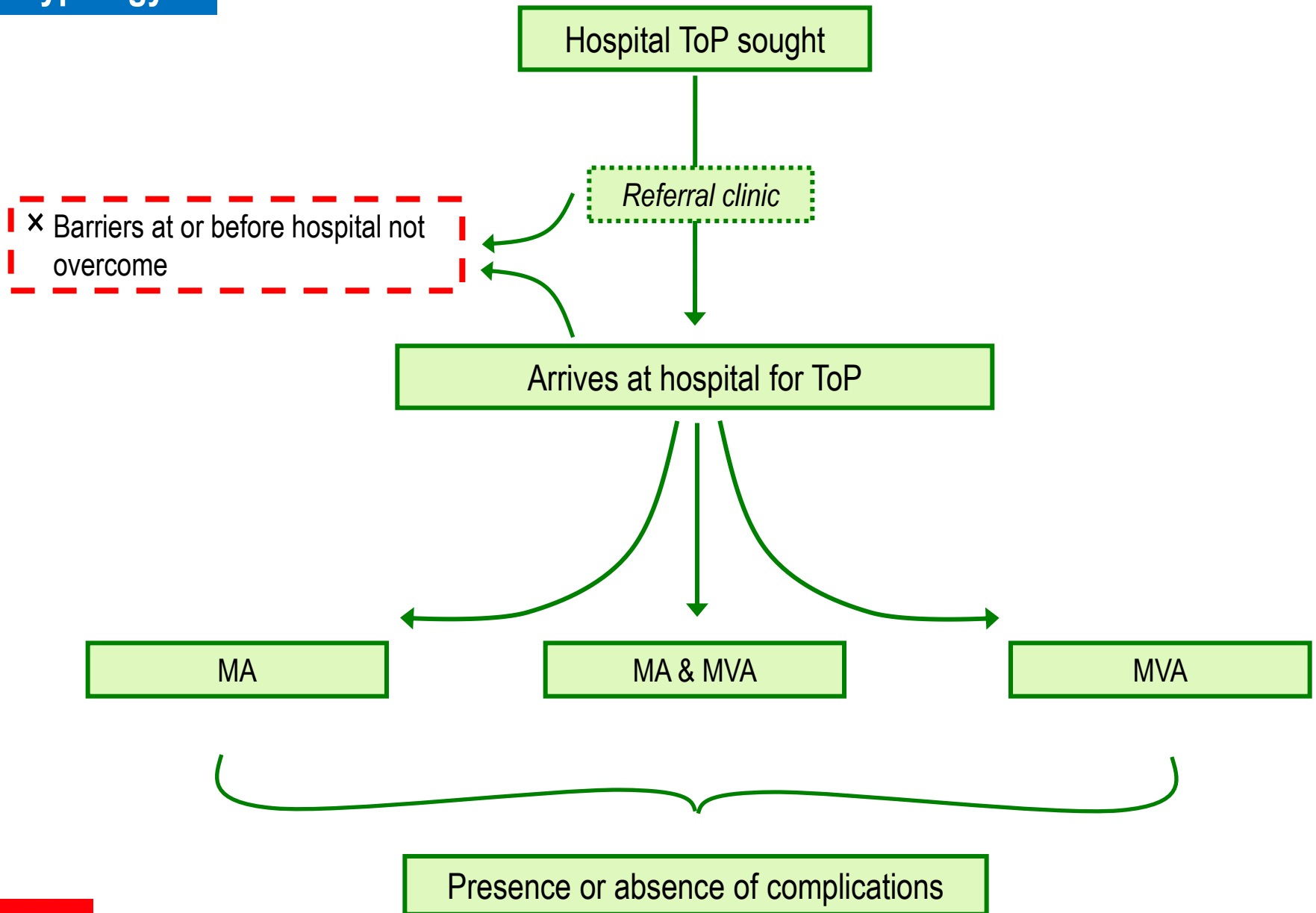
Not all TOP initiated outside study
hospital is equally unsafe



3 typologies identified

- Developed 3 typologies of the trajectories for women receiving care in public sector hospital
- Typologies:
 - Give better purchase on the data and help **explain difference**
 - Help identify **points of intervention**

Typology 1



Typology 2

'Clinical' ToP sought from unregulated setting

Typology 3

MVA performed or MA commenced with clinical input (e.g. pharmacist)

- × ToP completed without complications
- × Complications from successful or unsuccessful ToP treated outside hospital
- × Death

Referral clinic

TOP unsuccessful without complications

Arrives at hospital for abortion-related care

Review, antibiotics

2nd dose MA

MVA

Presence or absence of complications

Typology 3

- × TOP completed without complications
- × Complications from successful or unsuccessful TOP treated outside hospital
- × Death

Non-clinical ToP sought

Non-clinical ToP performed

Typology 2

TOP unsuccessful without complications

Referral clinic

Arrives at hospital for abortion-related care

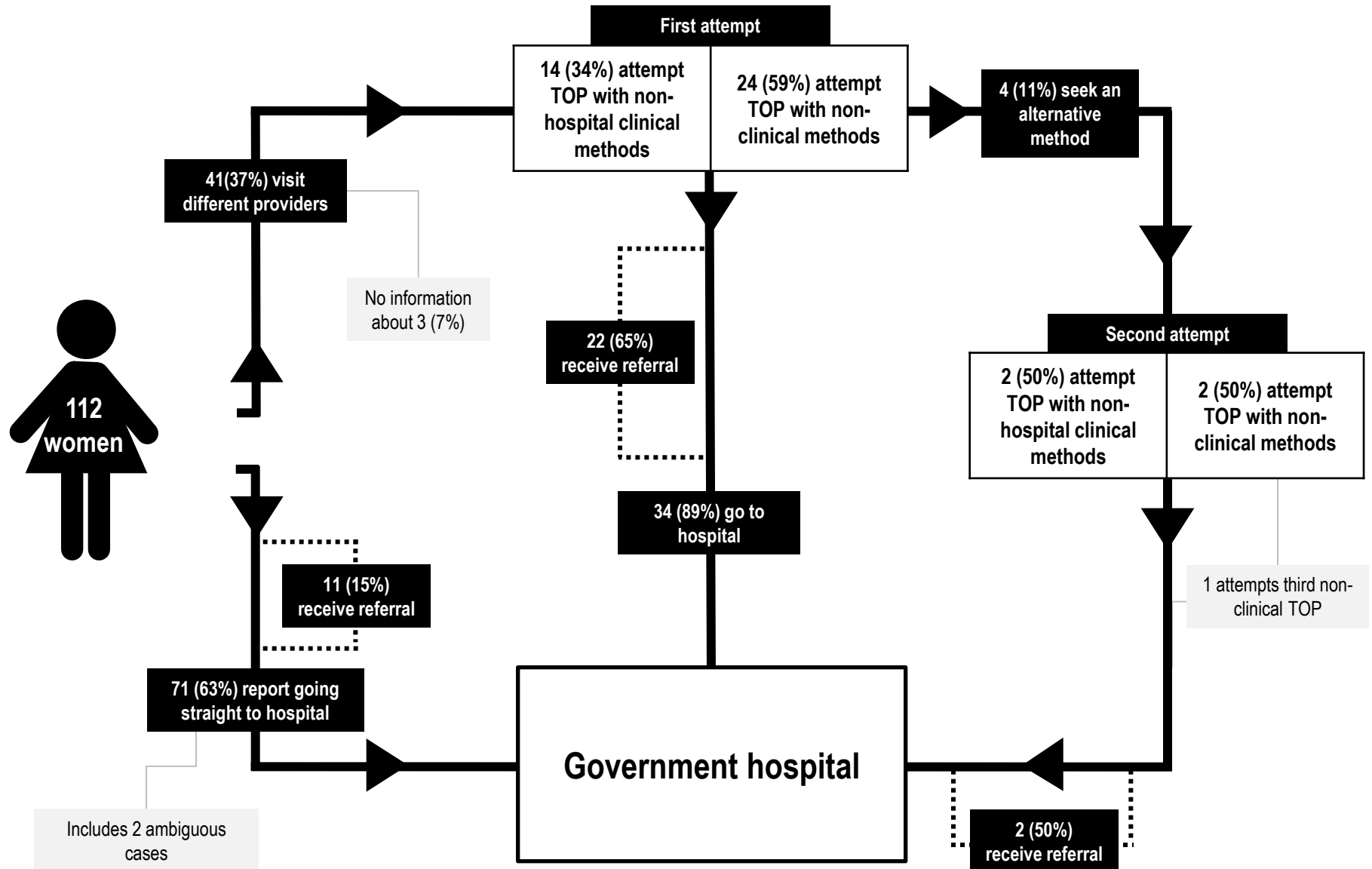
Review, antibiotics,
other treatment (e.g.
blood transfusion)

MA

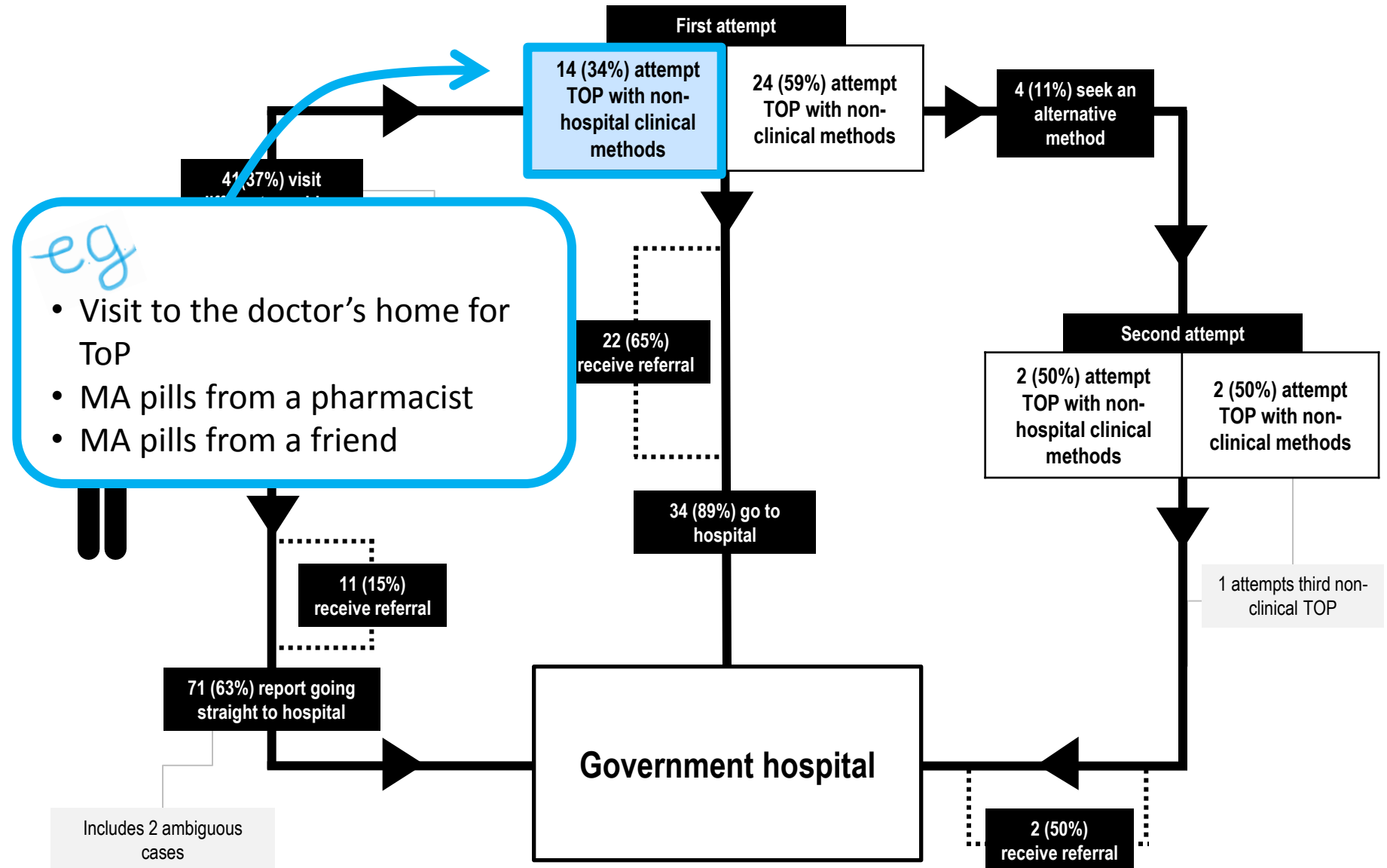
MVA

Presence or absence of complications

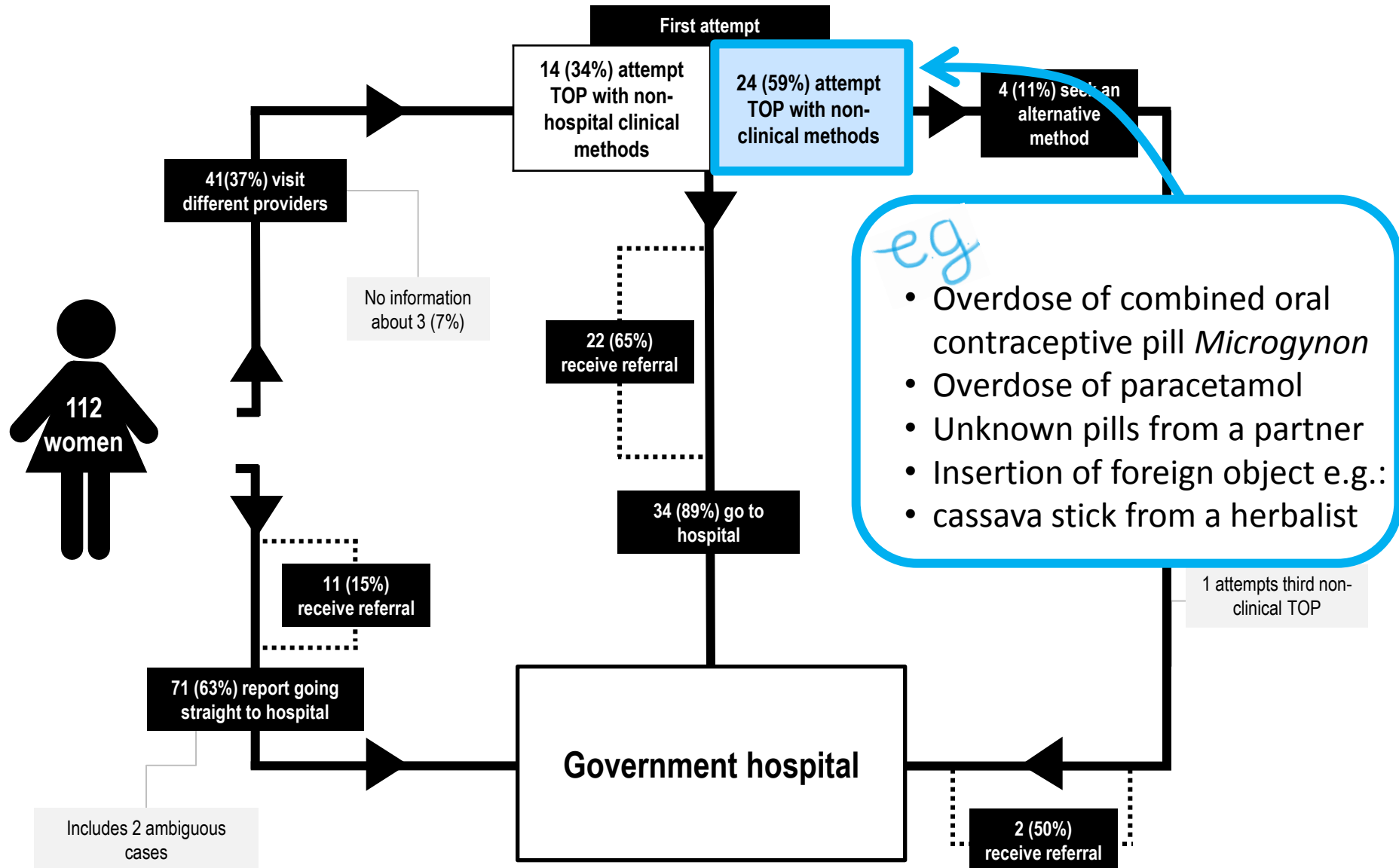
Study participants' complex trajectories



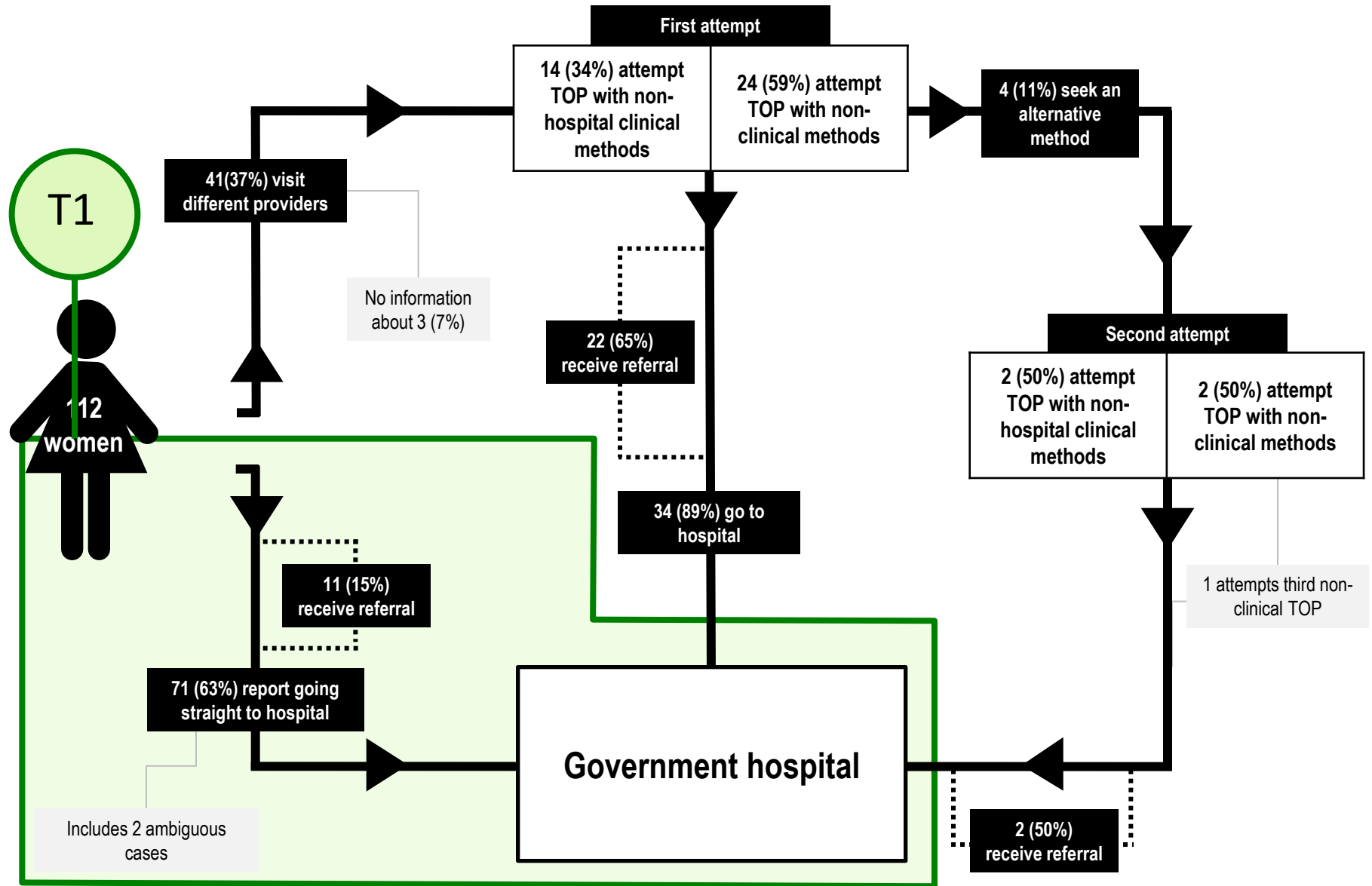
Study participants' complex trajectories



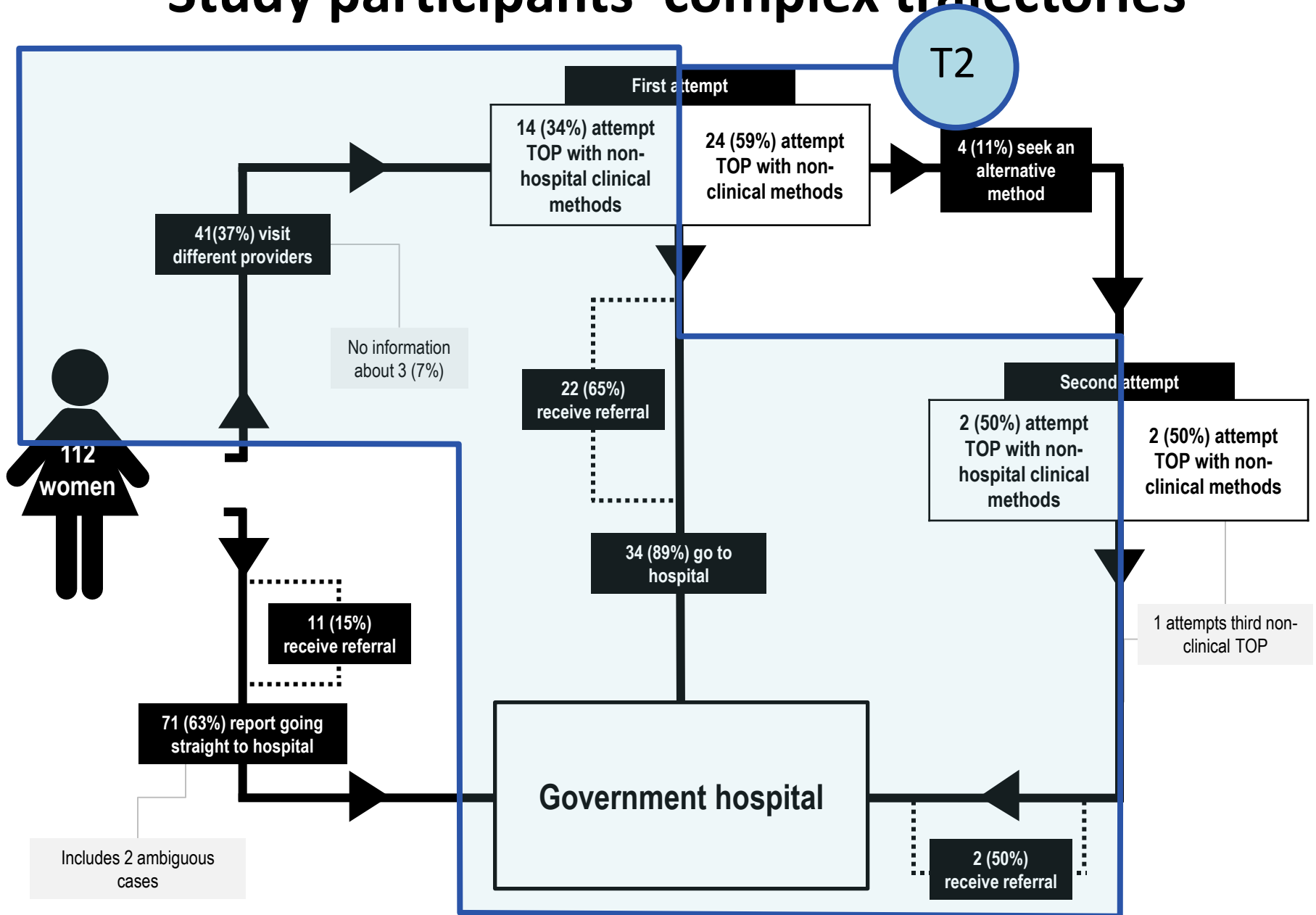
Study participants' complex trajectories



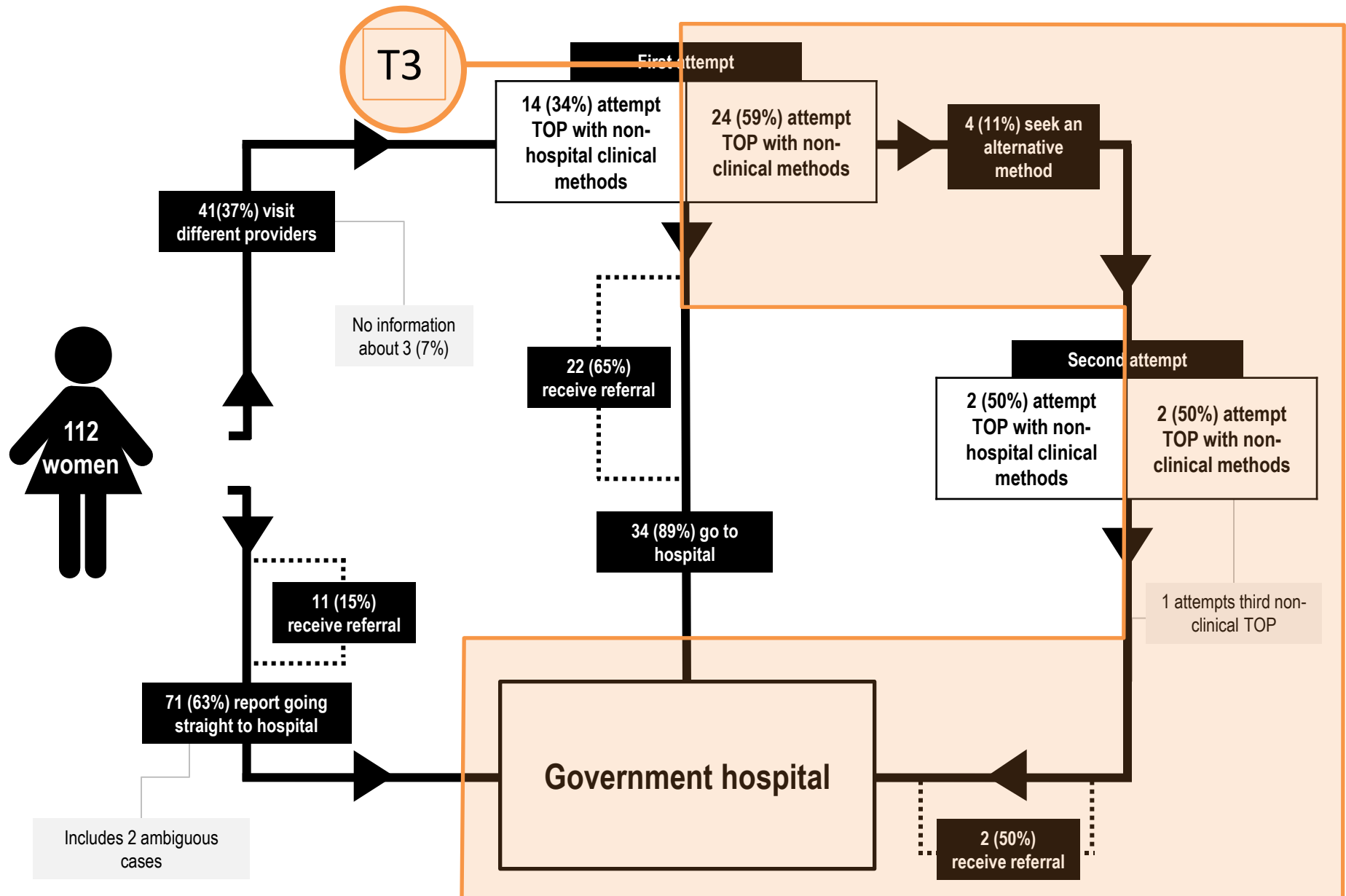
Study participants' complex trajectories



Study participants' complex trajectories

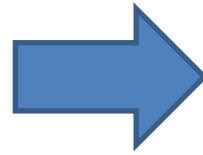


Study participants' complex trajectories



Four themes

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

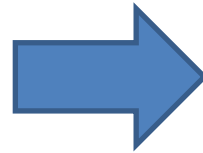


All influence
trajectory

- direction
(typology)
- complexity
- timing

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All influence
trajectory

- direction
(typology)
- complexity
- timing

Vignettes + Quotes

The influence of advice

- Advice 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
- Others' knowledge of different service providers shaped how women of typologies 1 & 2 navigated care seeking

The influence of advice: **typology 1**

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. Her 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 2**

17 years old and works as a housemaid. She went for a pregnancy test at the local clinic with her sister. The pregnancy was unplanned but her partner wanted to continue with the pregnancy while she reports getting mixed messages from “other people”. Ultimately she didn’t feel ready for a child. She attempts to terminate her pregnancy with tablets from a friend before attending a local clinic and then on her mother’s advice, the study hospital for PAC.

“It was my friend, I had told her... She is my friend and I have known her for a long time now. I told her and I asked her if she knows medicine for aborting... She said there is someone I know but these things are dangerous you may die together with the child and I told her to just get for me...One was for drinking and the others 4 for inserting... [I] started paining around 23 hours... [I] went to [local] clinic. They referred me here. // I told mum at home [that I had taken the medicine], yes that’s when she told me that we go to the clinic and she told me that I should have told her.”

The influence of advice: **typology 3**

28 years old, married and one child. She kept both her pregnancy and subsequent actions secret from her husband

I: So when you knew that you were pregnant did you do anything to try and terminate it?

R: I only had some Panadol... I only took two

She reports continuing to take her contraceptive pills, possibly hoping to precipitate a miscarriage. When the pregnancy continued, she escalated her attempts and went to a herbalist

“I was given something to insert... I was given medicine, a stick... They inserted it themselves”

Subsequently, her husband brought her to the hospital at night, as an emergency admission, after telling her husband that she had high blood pressure. She seems to have had no knowledge of the possibility of a safe(r) ToP.

Perceptions of risk

- Respondents reported that they and those they confided in considered risks of various ToP methods
- Government providers (clinics and hospitals) were widely trusted and considered safe
- Avoidance or reduction of risk influenced women's selection of provider and methods (Typology 2 + 3)
- However for some respondents the risks of harm were outweighed by the desire for a ToP

Importance of risk: **typology 2**

She 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.”

When the MA causes her pain she tells her mother who took her to the local government clinic, then referral to hospital.

Importance of risk: **typology 3**

She is young, at school and lives with her mother. Having decided to terminate her pregnancy, she found her friends discussing various non-clinical methods and selected the one she thought was safest.

“I went home and decided to try whatever they were saying. That *Cafemol* really drugged me, felt like I was dying... I took twenty *Cafemol* tablets.// They said a lot of things that people take to terminate the pregnancy... I heard that you can drink Coca-Cola with some tablets, some were saying you drink *Jerico* [hair gel], some said you should drink *Cafemol*. A lot was said even for using sticks.

I: So of all the stuff said, you chose to use *Cafemol*?

R: Yes, felt that it is safer.”

Delays in care seeking and receipt

- Delays in care seeking common, particularly among typologies 2 and 3.
- Some delays connected to the healthcare system – long queues, forgotten appointments and economic costs (official and informal)
- Lengthier delays appear to be linked to
 - denial of pregnancy, or
 - non-disclosure of ToP attempts to clinicians associated with stigma of unplanned pregnancy and induced abortion, especially for younger women of typology 3

Delays associated with non-disclosure: **typology 3**

When the *Cafemol* overdose is followed heavy bleeding, discharge and pain, she starts a lengthy process of care seeking:

“I was just feeling okay until after two weeks when I started wondering if I was rotting... That started worrying me a lot //

[I] went to [local clinic]. I explained to them something else because I was scared to tell them that I did something. They gave me prescriptions there but I did not buy the medicine because I knew that it was the wrong medicine. I went home and my mother asked me if I was given any medicine and I said yes. I tried to hide from my mother for few days but I [then] decided to tell her what was happening //

I: So from the clinic, you went home and what happened next?

R: I got sick that I could not move out of bed because of the pains... I then decided to tell my mother about what happened... She was very annoyed with me... I stayed for three days, very sick... On the third day, she called me from work and told me to meet her at some station so that she can take me to [a local clinic]

She was referred to the study hospital for sepsis.

Economic costs / barriers

- Financial costs of seeking a ToP influence the timing and complexity of trajectories
- 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.
- Economic “incentive” to access district clinics first: a referral from a satellite health centre reduces registration fee at a hospital from K80 to K10.
 - 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

Clandestine payment to doctors: **typology 1**

- For some women, the clandestine cost of a ToP within the hospital is significant, and introduce further delays

20 years old, from a poor family and stays with her mother's friend ('aunty') as a maid. She told her aunty who called a hospital doctor for a ToP and they came to the hospital. However they were charged more than they expected and had to leave to find the outstanding balance. Only when returning several weeks later was she given a medical abortion.

I thought that... when we got here, everything would happen. That I would be admitted and given some medicine, but than that did not happen there and then, two weeks passed and I was told to come back... Yes, I had come before, almost a month ago... About the money. We did not manage the money that we were told was not enough... We thought that maybe we would be charged 100, so that is the money we come with. So we gave him a 100 and had a balance of 200 [still to pay]. So that is how we went back....We paid 200 [today], but it is not enough yet, we still have a balance.

Clandestine payment to doctors: **typology 3**

Married with three young children. When she found out she was pregnant, 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

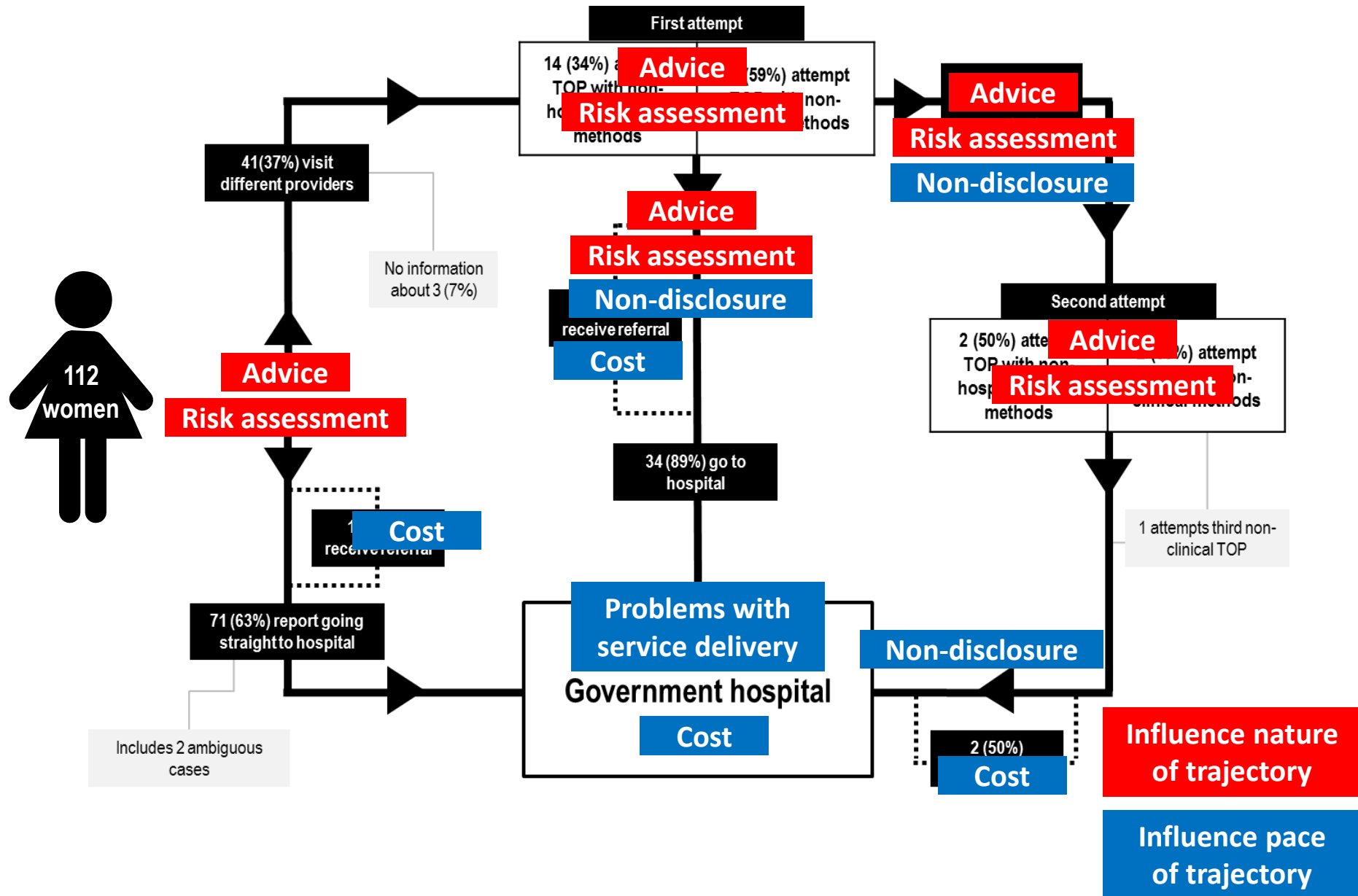
The respondent subsequently revealed, after extensive probing, that the doctor had charged her K200 for treatment. She was very reluctant to reveal what she had paid: “Won't I be taken to the police?”

CONCLUSIONS AND IMPLICATIONS

Knowledge of safe ToP

- Care-seeking trajectories of women who knew that safe ToP services were available from physicians were relatively straightforward
- For women unaware of these services, the process to achieving a TOP is more complex:
 - the nature of their trajectory influenced by advice from others and evaluation of risks;
 - the pace of their trajectory influenced by the costs of services and the process of disclosure

Influences on trajectory



Implications

- The false perception that ToP is prohibited contributed to steering women towards clandestine methods or clandestine payments for safe and legal treatment
- A group of women who had received medical abortion (MA) from non-physicians
 - Although Zambia ToP Act only permits ToP by physicians, MA bought from a pharmacist and self-administered may be expected to be safer and more effective than other methods, such as inserting a foreign object.

And finally...

One small part of a wider project

<http://personal.lse.ac.uk/coast/ZambiaTOP.htm>

- Research instruments included

Also comparative (ToP vs. PAC) analyses of:

- Health system costs
- Individual costs
- Household costs

Research impact and uptake phase (started 1st June 2014)

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