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## Medication abortion in Zambia: trajectories, costs and healthcare provider perspectives

### Seminar presentation

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# Medication abortion in Zambia: trajectories, costs and healthcare provider perspectives

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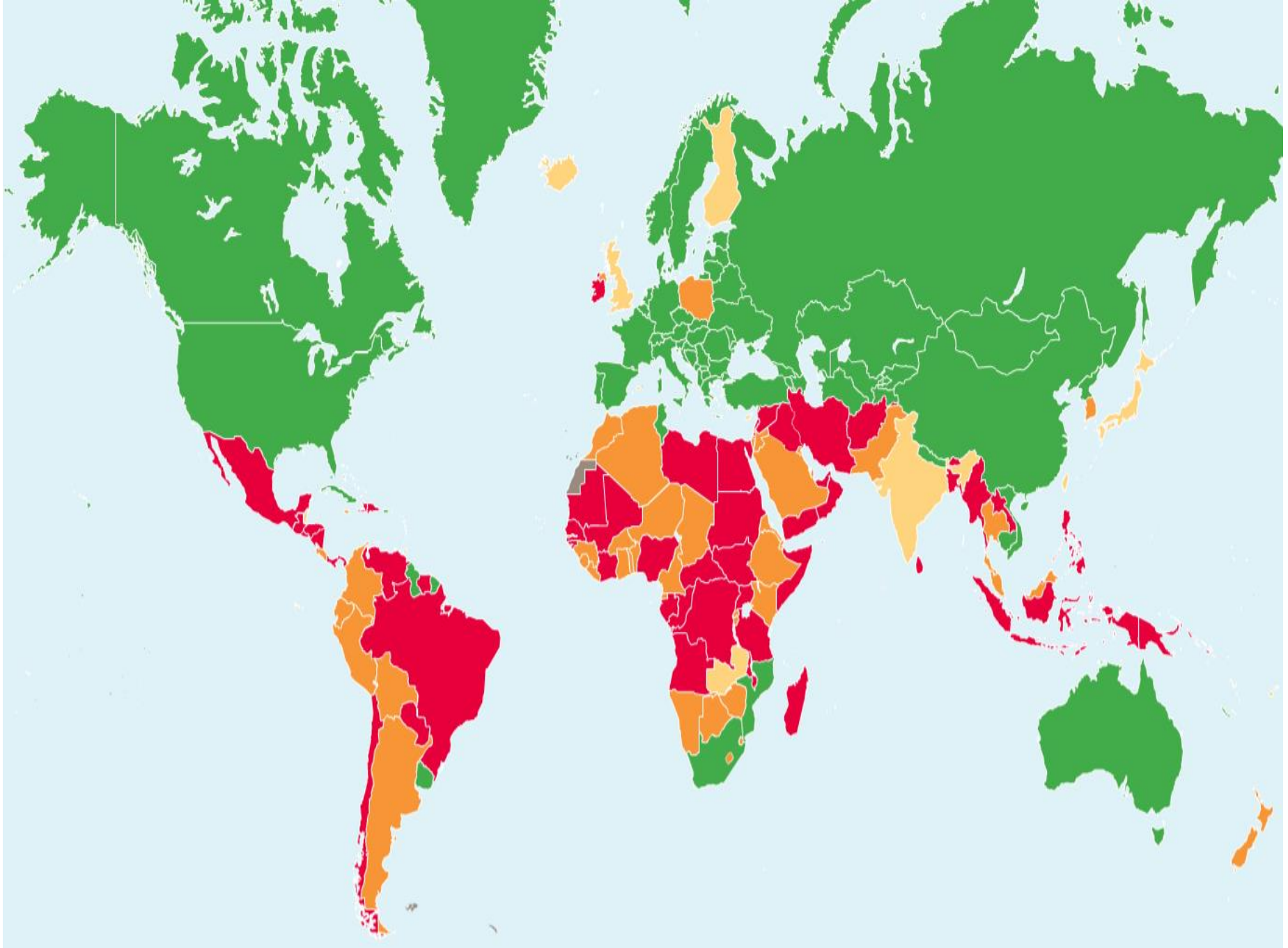
# Research questions

How and why do women procure MA outside of the formal healthcare sector?

What are the costs, for women, of procuring MA?

Are the reasons for, and practices of, conscientious objection to providing abortion care by healthcare professionals in Zambia influenced by abortion method?

**CONTEXT: ZAMBIA**



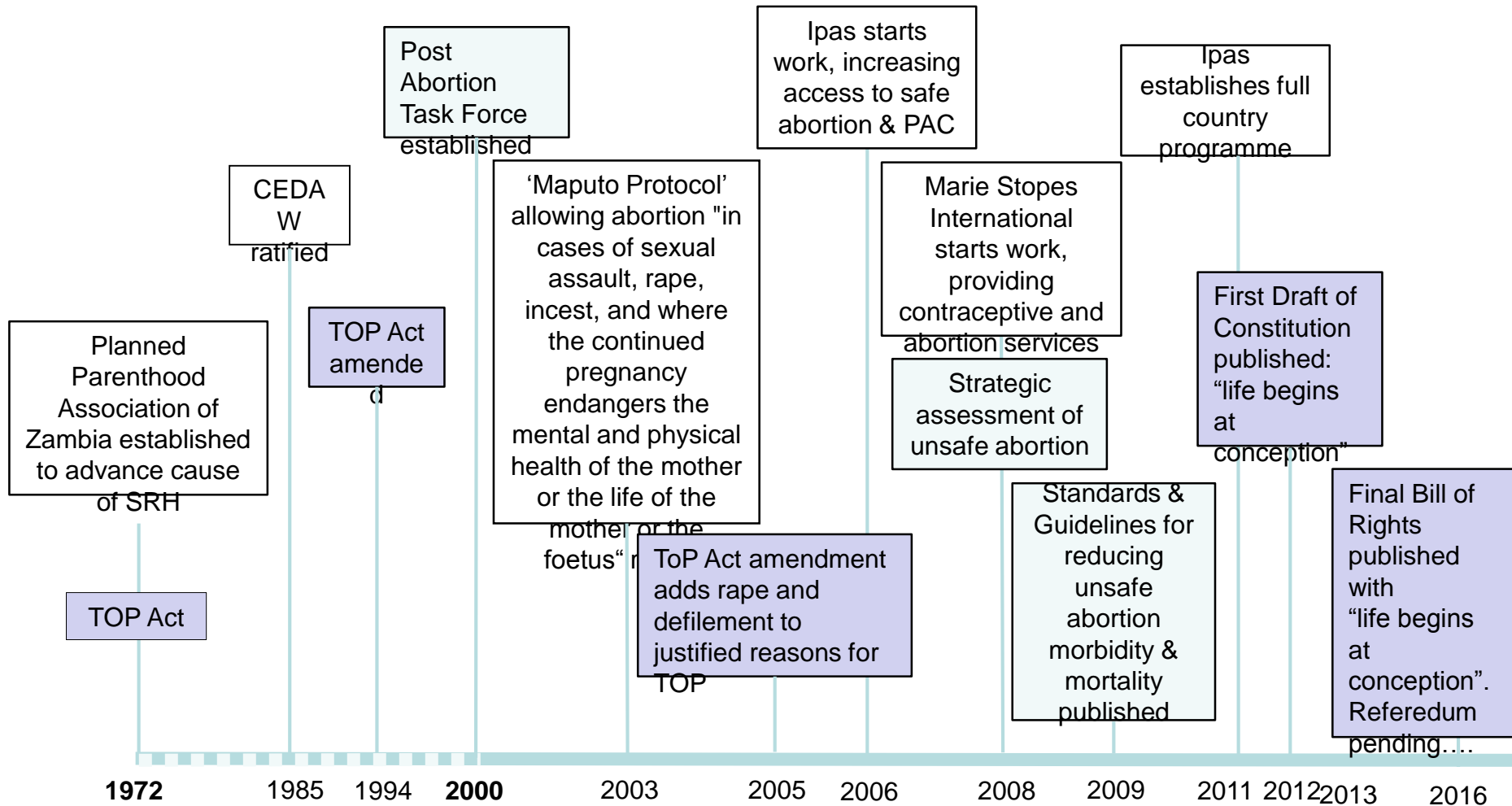
Center for Reproductive Rights, 2016

# Legal context

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)

Practitioners can determine what constitutes an emergency situation that requires only one doctor's signature based on the foreseeable circumstances including the risk of unsafe abortion.



- International treaties
- Ministry of Health
- Zambian laws
- NGOs

# Conscientious objection

Law of Zambia makes provision for registered medical practitioners to refrain from performing or assisting with abortion.

The right to conscientious objection does not allow practitioners to:

- opt out of performing abortions when pregnancy poses a “grave, permanent” risk to the mental or physical health of a woman
- obstruct a woman from seeking an abortion elsewhere (e.g. by giving misinformation, not referring)



# Pharmaceutical landscape

2012: MA combination was approved for use by the Ministry of Health.

MA drugs are now widely available to purchase in private pharmacies and elsewhere.

Growing market in unregistered pharmacological abortifacients, including so-called “Chinese drugs”.

# **STUDY METHODS + DESIGN**

# Data

1. Healthcare providers interviews(n=55) (2015)
2. In-depth (n=112) interviews conducted with women seeking hospital-based care (2013), either for post-abortion care (PAC) or for a safe abortion (SA)

Why?

Complex interplay between women's abortion-seeking and the health system within which they seek that care.

# Healthworker interviews

Role	Facility	N
Senior health administrator	Rural and urban settings	4
Specialist obstetrician gynaecologist	Large urban hospital	15
Doctor (non-specialist)	Rural hospital	6
Clinical Officer	Rural hospital or clinic	4
Midwife	Rural hospital or clinic	13
Nurse	Rural hospital or clinic	5
Community health worker	Rural community	8

# **Hospital-based interviews: adolescents + women**

Quantitative survey combined with in-depth  
interview (n=112)

– Refusal 13%

Medical notes analyses and data extraction (n=81)

<http://www.abortionresearchconsortium.org/>

# Limitations: Who is missing?

- Women with “off the books” arrangements with hospital doctors
- Women that did not seek (or need) hospital-based PAC following MA
  - Sought no care
  - Sought care from other provider (including self-care)
- Non-government healthcare workers
  - NGOs in Zambia (PPAZ, MSZ)
  - Unknown number of private medical practices are registered to provide safe abortion services
  - Some pharmacists have been trained to provide referral information to women seeking an abortion
- Informal healthcare providers
  - Pluralistic health system eg: herbalists

# Methodological failure

Extensive efforts to do longitudinal qualitative research

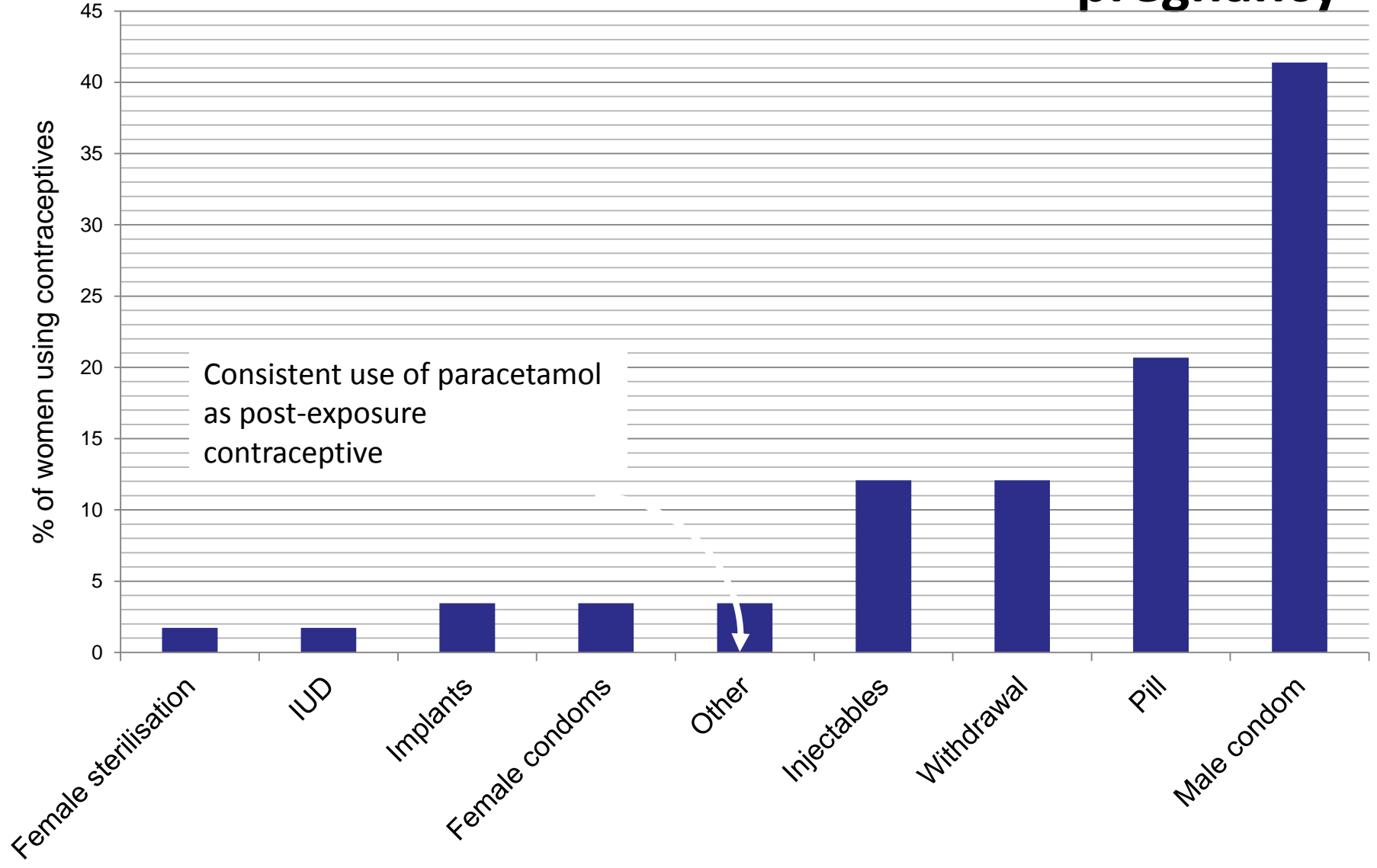
Yielded only 3 out of 112 2<sup>nd</sup> interviews

3 great interviews

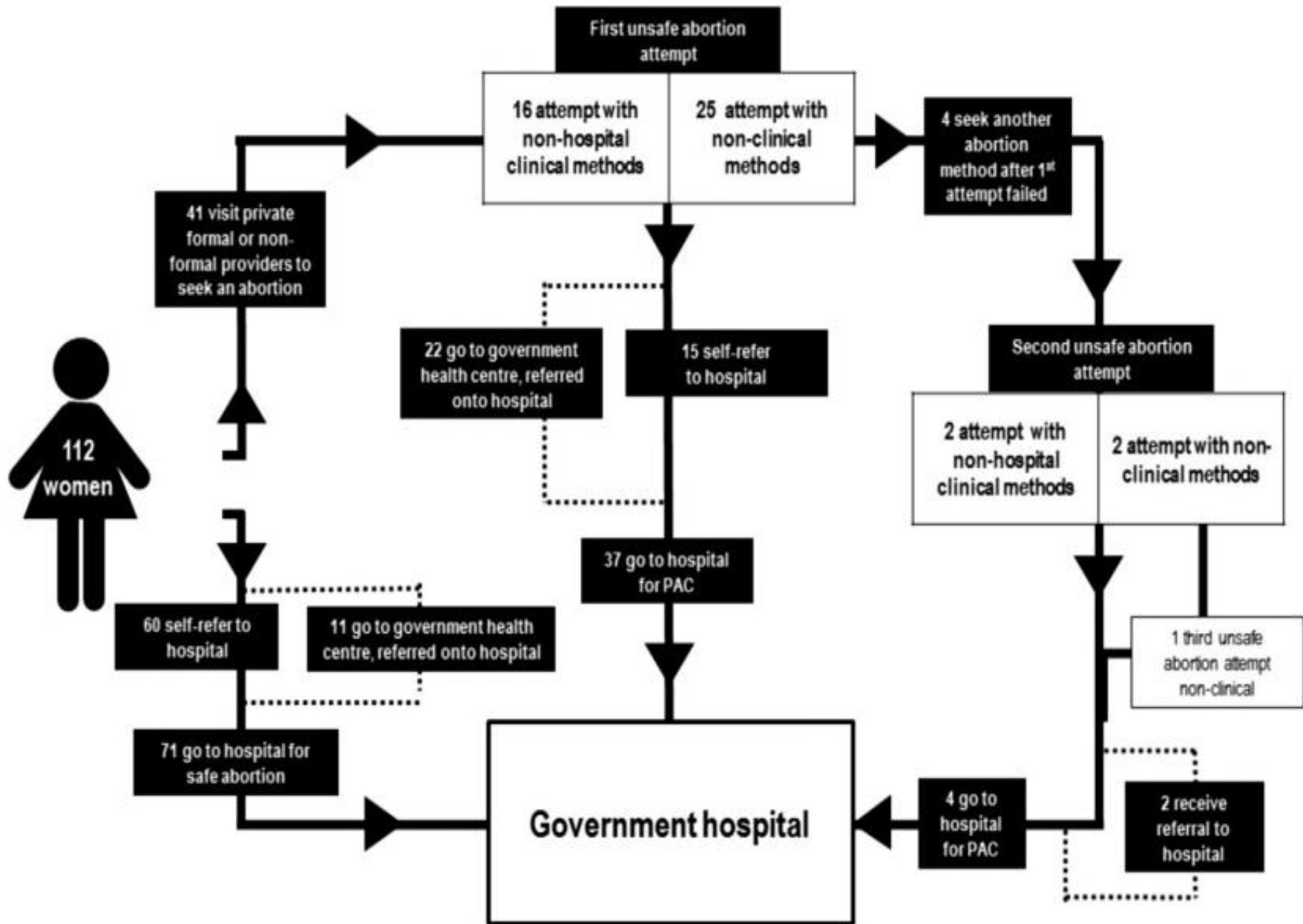
# **A NOTE ON PHARMA USE**

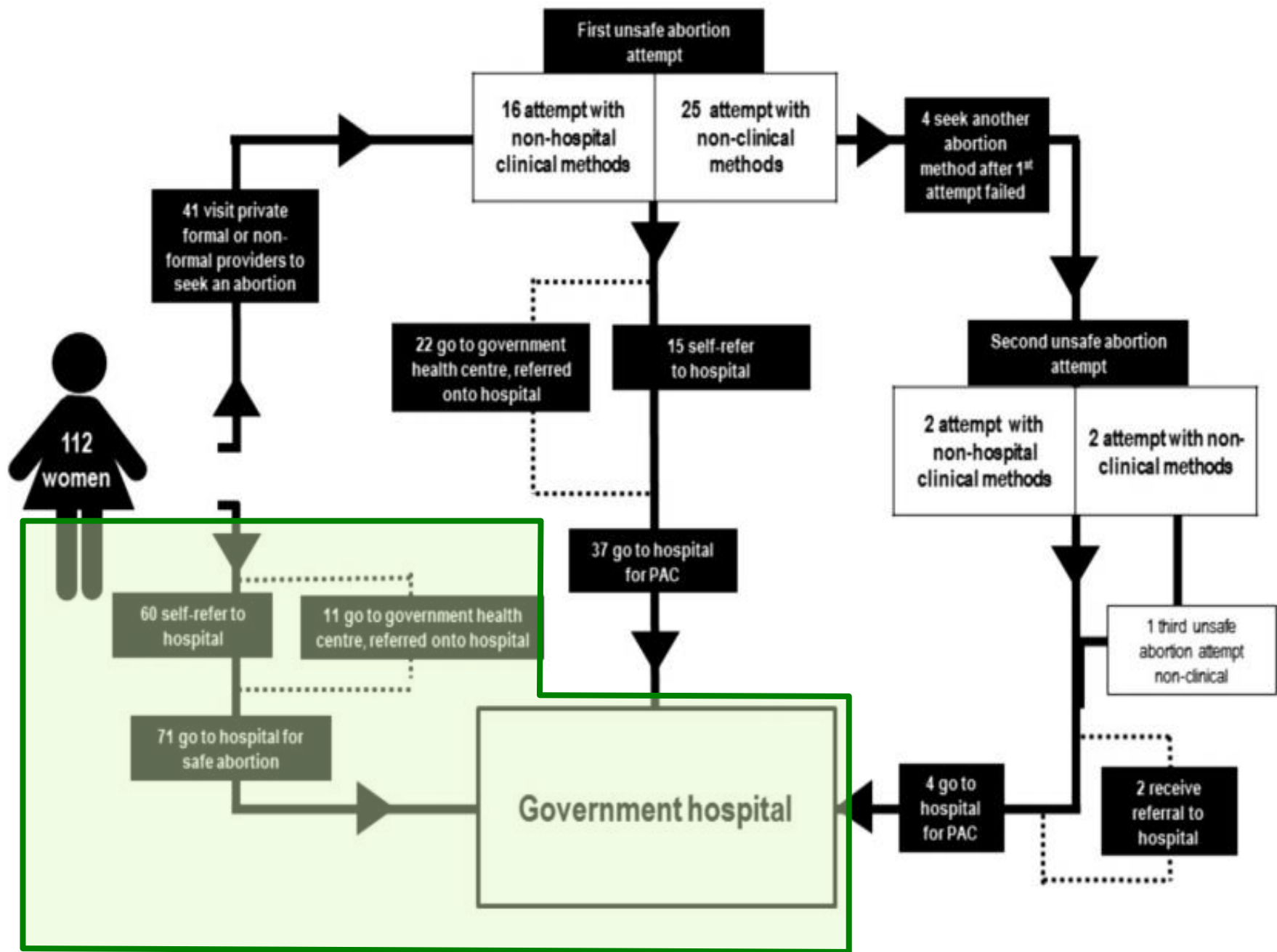


# Contraceptive method use at time of terminated pregnancy



# **TRAJECTORIES TO ABORTION**

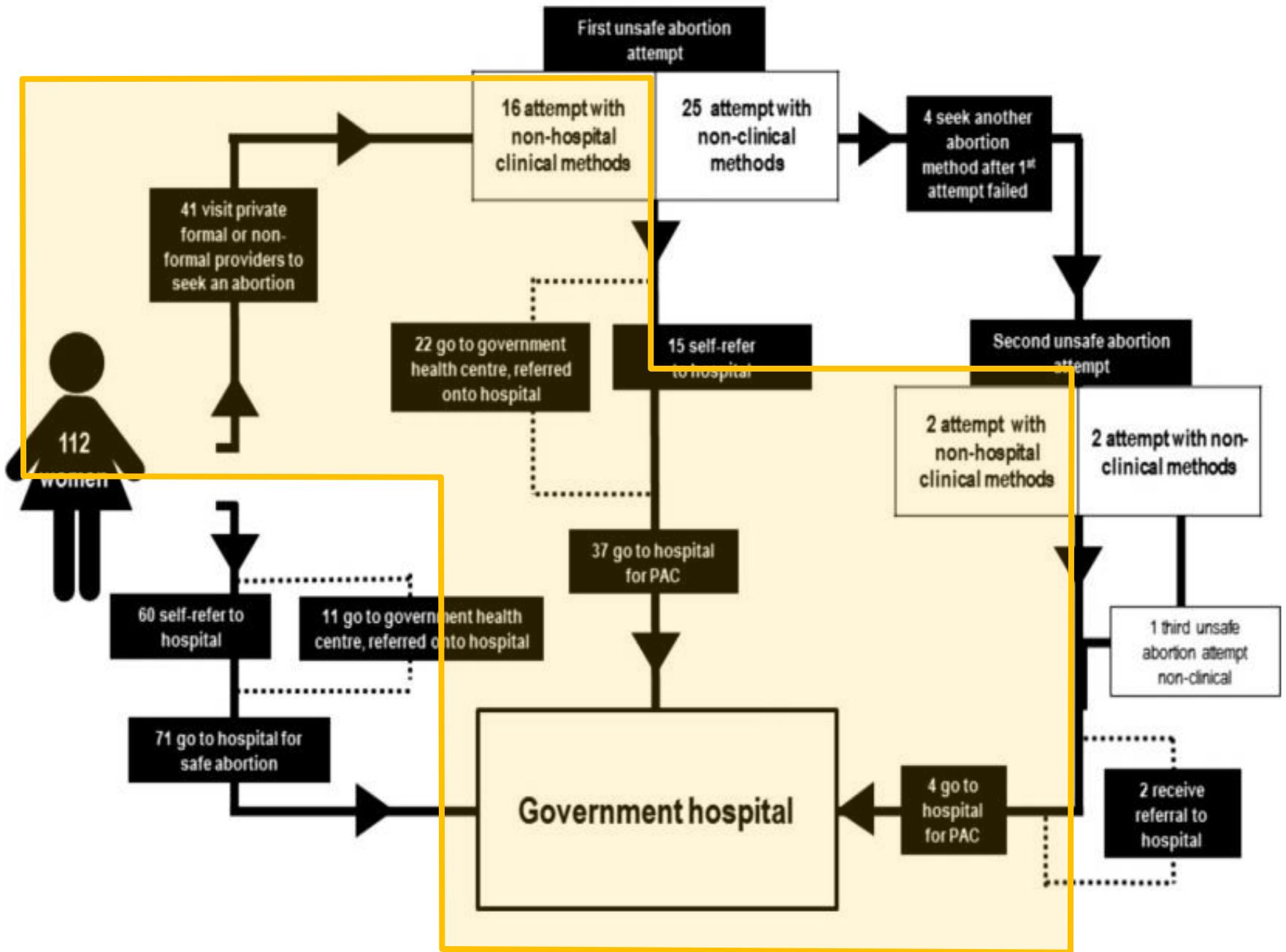


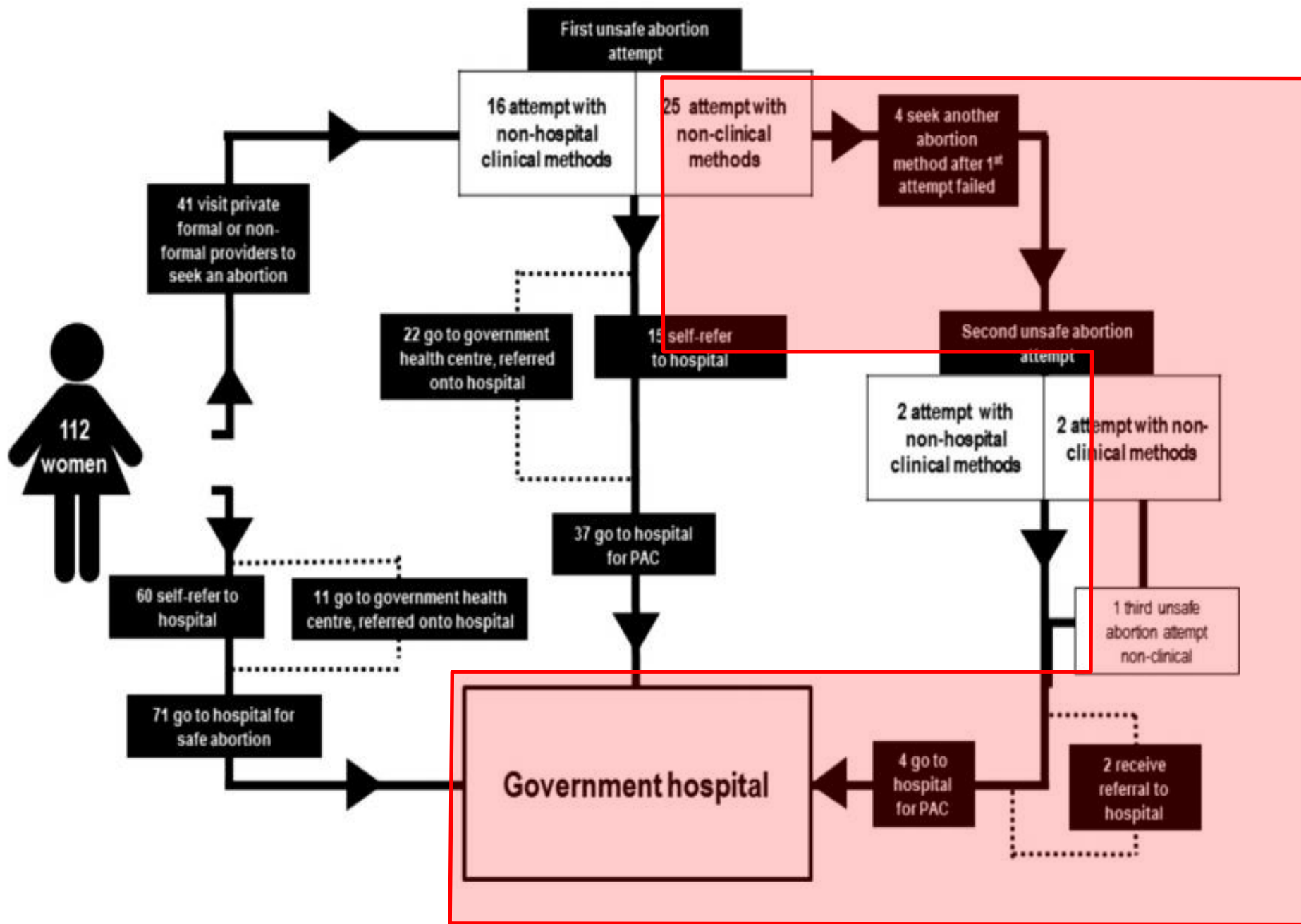


39.1% of our sample sought an abortion clandestinely and subsequently post-abortion care.

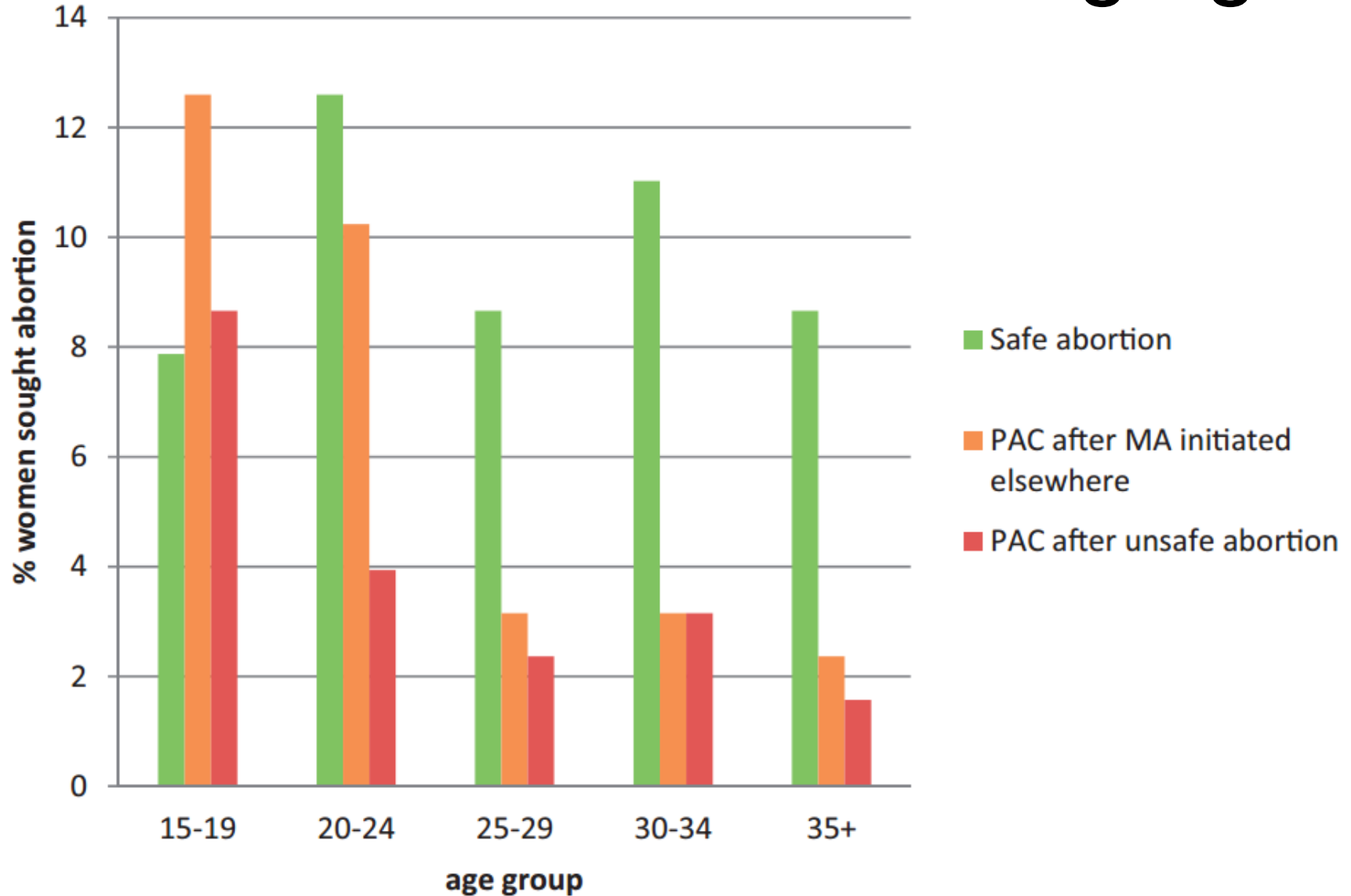
Of these women

- 32.6% initiated an abortion using MA
- 67.4% initiated an abortion using another method.



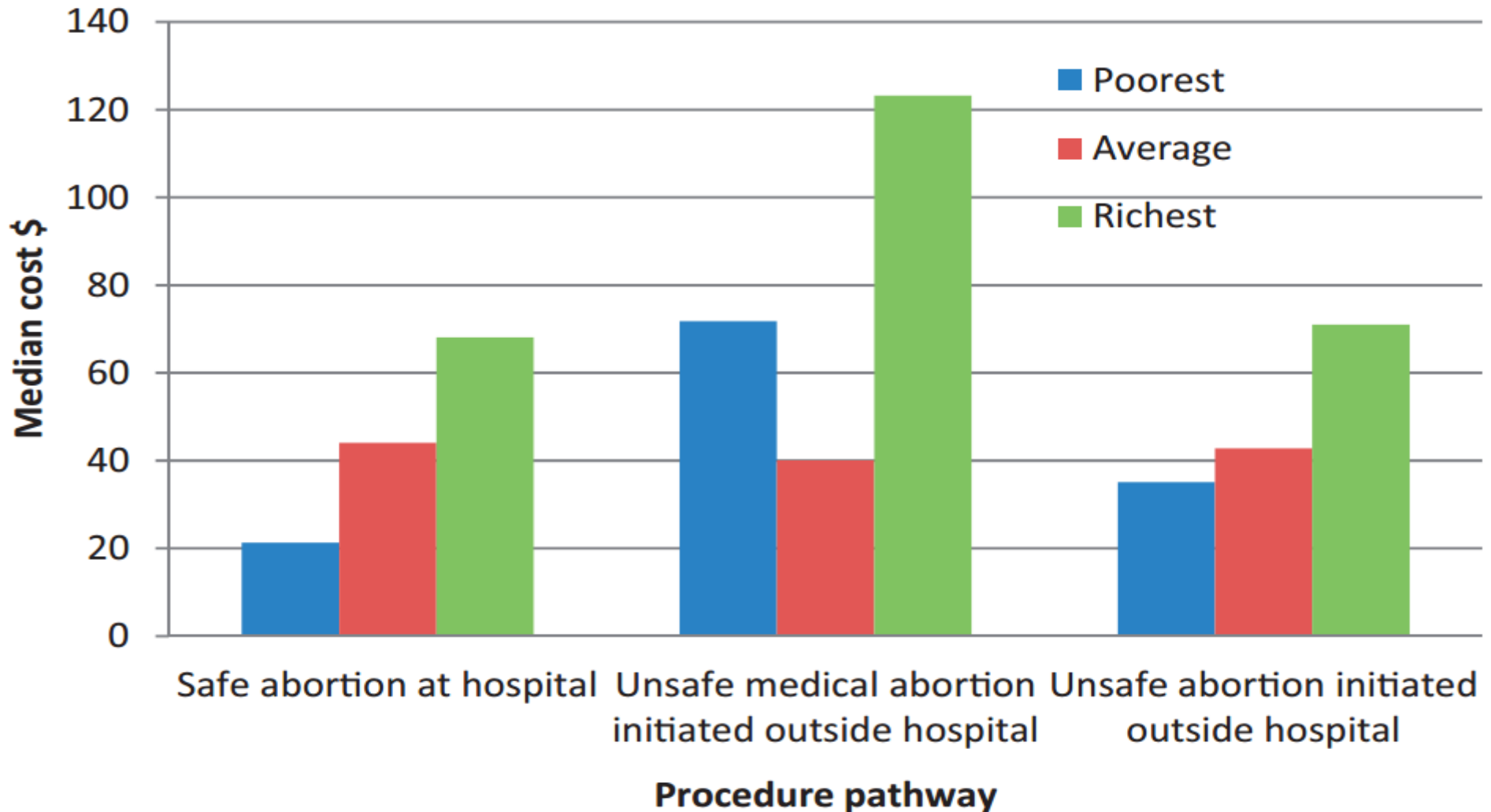


# Abortion trajectory + age group





# Abortion trajectory + costs (US\$)



# Costs: Direct + Indirect

- Women who sought a SA incurred the lowest overall costs (US\$52.6).
- Women who initiated MA clandestinely incurred higher costs compared to women who used some other unsafe method
  - US\$82.4 vs. US\$62.5

# Significant unofficial provider payments

For women seeking PAC following MA initiated elsewhere, these payments represent 27% of the overall cost of abortion care-seeking.

Unofficial provider payments paid by women who initiated a MA clandestinely were highest, probably because providers know these women are more desperate for their services.

This group of women also had substantially higher costs related to the purchase of medicines, accounted for by the need to purchase the MA drugs under the counter.

# Women's trajectories to MA

- Disclosure
- Advice
- Expectations about relationships
- Influenced by
  - who was told about their pregnancy
  - the decision to terminate it
  - how and where it was terminated

# Nexus of risks

*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 other 4 for inserting...*

# Decision-making about abortion method

Glory asked her friends directly for advice on how to abort, and persisted until she found information on an option she felt she could pursue:

*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 sought out MA drugs:

*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 he wrote for me on a paper and I went to buy in town.*

# Healthworkers

- Only specialist obstetrician gynaecologists were aware they were permitted to carry out abortions.
- Their beliefs about abortion shaped whether or not they performed these services.
- Practitioners at rural health facilities were unaware of that they are permitted to carry out abortions following training.
- All participants working outside the urban hospital in our sample, including the senior administrators, were unaware of a national policy for conscientious objection.

# Lack of knowledge: law + services

John was a rural midwife. He had treated a schoolgirl who presented with an incomplete abortion.

He asked her about how she had procured the abortion. She told him that she had been to a private clinic offering MA in a neighbouring town.

John visited this private clinic, under the guise of seeking an abortion for a girlfriend. He asked detailed questions about the regimen and the drugs being dispensed.

He felt satisfied that what was being offered, for a fee at this private clinic, was clinically acceptable.

Back at his health centre he had – informally – provided information about this private clinic to women who disclosed to him that they had unwanted pregnancies.



# Assumptions about abortion seekers

Conscientious objectors tended to report

- Requests for abortion came only from adolescents and adulterous women
- Requests from married women were not regarded as legitimate requests, since these women had “no reason” not to continue their pregnancies.

# Medical hierarchies

Obstetrician gynaecologists who were providing abortion care reported systematic discrimination from senior doctors who conscientiously objected to abortion.

Junior doctors who did provide abortion used a variety of strategies to ensure abortion care was available without their senior doctor's knowledge:

- referring clients to doctors with supportive consultants
- providing abortions outside of usual consulting hours
- recording an obfuscated treatment plan on clients' files (e.g. spontaneous abortion).
- noting on prescriptions another reason the drugs were required  
*“[in order to prevent] pharmacists refusing to dispense the (MA) medicine or else verbally assaulting their client.”*

# Summary

- Despite the high costs that women incurred obtaining MA drugs clandestinely, high value placed by women on its privacy and perceived safety.
- It is likely that many of the women in our study who initiated a clandestine MA and subsequently sought PAC did so because they were inadequately prepared for the symptoms (not complications) they could experience.

Health practitioners that demanded unofficial payments from women seeking abortion care exploit the community's low levels of knowledge about the law and the highly stigmatised nature of abortion in Zambia.

The high level of stigma and the false perception that it is illegal also contributes to steering women towards clandestine sourcing of MA.

Healthcare providers did not differentiate between methods of abortion;

either they conscientiously objected to abortion, or they provided abortion.

There was no evidence that the availability of MA was changing provider perspective with respect to conscientious objection.

# Zambia Project Team

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