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"These things are dangerous": Understanding induced abortion trajectories in urban Zambia

Ernestina Coast [a, *], Susan F. Murray [b]

[a] London School of Economics, Dept. of Social Policy, London School of Economics, Houghton Street, London, WC2A 2AE, UK
[b] King's College London, International Development Institute, Chesham Building, King's College London, Strand Campus, Strand, London, WC2R 2LS, UK

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ABSTRACT

Unsafe abortion is a significant but preventable cause of global maternal mortality and morbidity. Zambia has among the most liberal abortion laws in sub-Saharan Africa, however this alone does not guarantee access to safe abortion, and 30% of maternal mortality is attributable to unsafe procedures. Too little is known about the pathways women take to reach abortion services in such resource-poor settings, or what informs care-seeking behaviours, barriers and delays. In-depth qualitative interviews were conducted in 2013 with 112 women who accessed abortion-related care in a Lusaka tertiary government hospital at some point in their pathway. The sample included women seeking safe abortion and also those receiving hospital care following unsafe abortion. We identified a typology of three care-seeking trajectories that ended in the use of hospital services: clinical abortion induced in hospital; clinical abortion initiated elsewhere, with post-abortion care in hospital; and non-clinical abortion initiated elsewhere, with post-abortion care in hospital. Framework analyses of 70 transcripts showed that trajectories to a termination of an unwanted pregnancy can be complex and iterative. Individuals may navigate private and public formal healthcare systems and consult unqualified providers, often trying multiple strategies. We found four major influences on which trajectory a woman followed, as well as the complexity and timing of her trajectory: i) the advice of trusted others ii) perceptions of risk iii) delays in care-seeking and receipt of services and iv) economic cost. Even though abortion is legal in Zambia, girls and women still take significant risks to terminate unwanted pregnancies. Levels of awareness about the legality of abortion and its provision remain low even in urban Zambia, especially among adolescents. Unofficial payments required by some providers can be a major barrier to safe care. Timely access to safe abortion services depends on chance rather than informed exercise of entitlement.

1. Introduction

Unsafe abortion is a significant but preventable cause of maternal mortality and morbidity. In Africa, an estimated 13% of all pregnancies end in induced abortion, of which 97% are unsafe (Sedgh et al., 2012). Unsafe induced abortion is more likely when procedures are clandestine and legal provision is restrictive (Grimes et al., 2006). Zambia has one of the most liberal abortion laws in sub-Saharan Africa, permitting it on a wide range of grounds (GRZ, 1972). However, legality does not guarantee abortion safety (Sedgh et al., 2012).

The World Health Organization (WHO) defines "unsafe abortion" as a procedure for termination of an unintended pregnancy done either by a person lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both (WHO, 1993). As discussed later, this binary categorisation (safe/unsafe) conceals a complex continuum of risks that change over time reflecting abortion method, provider training, gestational age, legal context, and abortion stigma (for both women and providers) (Ganatra et al., 2014; Sedgh et al., 2012). The availability and use of medical abortion (misoprostol or misoprostol + mifepristone) is increasing and has contributed reduced hospital admissions with severe septicaemia and uterine rupture caused by traditional methods, but clandestine medical abortions incorrectly used can carry risks and complications such as incomplete abortion and prolonged and heavy bleeding (Winikoff and Sheldon, 2012). Such complications require facility

* Corresponding author.
E-mail addresses: e.coast@lse.ac.uk (E. Coast), Susan_fairley.murray@kcl.ac.uk (S.F. Murray).

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admission and may be indistinguishable from those of spontaneous miscarriages. Women seeking this type of post-abortion care (PAC) are often able to avoid scrutiny about the legality and/or safety of their medical abortion.

Safety and risk are complex and overlapping concepts that operate in multiple domains, including: emotional, social, clinical, physical and financial. Risk perception, the subjective judgement about the probability and/or severity of a risk varies at the individual level and is influenced by context. How women, and the people involved in their abortion decision-making, make sense of, understand, weigh up and strategise the relative risks (safety) is under-researched. But evidence from settings with highly restricted access to "safe abortion" suggests that while abortion method safety is important it is not the only consideration in women's decision-making (Izugbara et al., 2015). Little is known about how women make decisions about safety and risk of different abortion methods in less restrictive legal settings.

Judgements about abortion risk and safety can be affected by abortion stigma, a societal construct and "a negative attribute ascribed to women who seek to terminate a pregnancy" (Kumar et al., 2009 p.628). Abortion stigma, and its associated shame, guilt, secrecy and fear, can be a critical determinant of care-seeking practices in a wide range of settings (Kinaro et al., 2009; Levandowski et al., 2012; Lithur, 2004; Osur et al., 2015; Shellenberg et al., 2011; Sorhaindo et al., 2014; Tagoe-Darko, 2013), and operates to discredit institutions, communities and individuals (Hessini, 2014). Abortion stigma is both contextualised and dynamic (Norris et al., 2011), and can be internalised, perceived and experienced (Culwell and Hurwitz, 2013). Recognition of its importance has led to efforts to measure stigma at a range of levels, including individual (Shellenberg et al., 2014) and provider (Martin et al., 2014). Managing, reducing or eliminating abortion stigma is challenging because of the episodic and (often) concealed nature of abortion (Cockrill and Nack, 2013).

Analysis of the steps from the decision to terminate pregnancy to securing abortion care provides insight into care-seeking behaviour and influencing factors, including barriers and delays to accessing care, stigma and perceptions of risk. Studies of pathways to treatment for other stigmatised health conditions may be helpful to understanding pathways to abortion care-seeking. Evidence from India shows that TB treatment-seeking behaviour can be protracted (with multiple delays) and complex, involving informal, regulated private and public providers (Kapoor et al., 2012). Similar pathways and trajectories have been noted for HIV diagnosis and treatment (Kranzer et al., 2012). HIV stigma is connected to delays and barriers to care-seeking (Jürgensen et al., 2013; Steward et al., 2013), care discontinuation (Geng et al., 2015) and experience of discrimination in care provision (Neuman and Obermeyer, 2013). However, abortion trajectories can be considered a distinct group of healthcare-seeking behaviours because issues of legality and understanding of legal rights overlay an individual's pathway to care. Unlike HIV, which is a chronic condition, abortion is episodic or transient, limiting the comparisons that can be made (Culwell and Hurwitz, 2013).

In India, where abortion is legal, women's trajectories begin with social networks of friends/relatives and progress to qualified or unqualified medical providers (Banerjee and Andersen, 2012), with more than half (53%) of women self-inducing at home. A study in Bangladesh, showed women seeking care from several providers to procure an abortion (Ahmed et al., 1999). Data on abortion in sub-Saharan Africa are rare and difficult to collect (Rossier et al., 2006), but one study from Ghana describing women's pathways to unsafe abortion highlighted the roles played by men (Schwandt et al., 2013). Our study contributes to this literature by analysing care-seeking pathways of women who had either a safe abortion or sought care following an unsafe abortion in urban Zambia. Including both these groups adds further perspectives to the body of work from more legally restrictive settings, which focus on experiences of women who have sought PAC (Izugbara et al., 2015; Kinaro et al., 2009; Levandowski et al., 2012). We analyse the details of pathways to care, barriers and delays, and the role of others in influencing these pathways in order to develop knowledge and theorisation on abortion care-seeking behaviour and its influences.

2. Study context

Induced abortion in Zambia is legally permitted if: continuing a pregnancy involves a risk to the life of the pregnant woman, her physical or mental health or that of any of her existing children, greater than if the pregnancy were terminated; a child born of the pregnancy would suffer from physical or mental abnormalities as to be seriously handicapped (GRZ, 1972); or the woman was raped (GRZ, 2009). A Post Abortion Task Force led to national Standards and Guidelines for reducing morbidity and mortality from unsafe abortion (MoH, 2009). In 2003 Zambia ratified the Maputo Protocol, the international treaty outlining obligations for States to provide comprehensive reproductive health care, including abortion (Migiro, 2013). In 2012, the medical (as opposed to surgical) abortion combination pack Medabon® (mifepristone and misoprostol) was approved for use by the Ministry of Health. Medical abortion drugs are now widely available to purchase in private pharmacies and other venues. There is also a growing private market in unregistered pharmacological abortifacients, including so-called "Chinese drugs".

Despite the legal provision for safe abortion in Zambia, a large proportion of abortions (70%) are estimated to be unsafe (Likwa et al., 2009), reflecting low levels of knowledge of the law by the population and health professionals alike (Macha et al., 2014) and high levels of stigma for those that provide and those that seek abortion (Geary et al., 2012).

Zambia's maternal mortality ratio (adjusted to remove HIV/AIDS related deaths) is estimated at 280 [170–460] deaths per 100,000 live births (WHO et al., 2013). There are no nationally aggregated data on induced abortion incidence, safe or unsafe (Macha et al., 2014). The Zambian government estimates that 30% of maternal mortality is attributable to unsafe abortion (MoH, 2009). Unsafe abortion is also a significant cause of morbidity.

There are few medical practitioners to provide safe abortions legally. For a non-emergency abortion in Zambia, the law stipulates that the abortion must be approved by 3 physicians, one of which must be a specialist. In 2014, less than 1000 registered doctors served Zambia's population of over 15 million, of which fewer than 60 were obstetrician/gynaecologists (ZAGO, 2014). Lusaka offers the optimal setting for access to safe abortion services in Zambia, with a typical urban concentration of gynaecologists and established abortion services in government facilities. Nationally, abortion services are operational in more than 75 government facilities. In addition, safe abortion services are provided by non-governmental organisations in Zambia (MSZ, 2015; PPAZ, 2015), although at the time of our study, MSZ services were temporarily suspended and women seeking abortion were referred to Government of Zambia providers. An unknown number of private medical practices are registered to provide safe abortion services, and some pharmacists have been trained to provide referral information to women seeking an abortion (Fetters et al., 2015; Hendrickson et al., 2015). The largest healthcare provider and employer in Zambia is the government. The private healthcare sector is located in the larger cities and accounts for a small percentage of health-seeking (Hjortsberg, 2003).

There are earlier studies of unsafe abortion and its consequences