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BR RJCDC SH.18.01 F1

Working Draft II

Suggestions Invited

Epidemiology of Abortion: Some Research Considerations*

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*Prepared, in part, with the support of the International Projects Assistance Services, Carrboro, N.C..

11/89

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Introduction

1. The 1989 UNFPA State of the World Population Reports suggests that 20-33 percent of all pregnancies are deliberately terminated. If correct, this means that approximately 150,000 abortions are performed every day, or about 50 to 60 million a year. Only about 33 million of the "guessestimated" 50-60 million annual abortions are performed under legal circumstances. Thus, there is an increasing urgency to learn more about the prevailing abortion situation, particularly who provides what services, the pathways women pursue to obtain such services, and the quality and impact of such services on women's lives and the public health system.

2. Designed to stimulate discussion, this Working Draft offers suggestions for planning and conducting research on the epidemiology of abortion, with a particular focus on psychosocial aspects. It is very much open to revisions, additions, or changes; there is no claim to present a comprehensive review. Working Draft II is based on our research experience and consultations, prior TFRI publications, and on references to the literature, usually cited in Abortion Research Notes. Many of our suggestions are adaptations of the ideas of others, to whom much credit is owed. Specific references will have to await a more extensive compilation of the literature and development of an appropriate annotated bibliography, as already initiated by IPAS and WHO (Geneva).

Working Rationale

1. Our focus is on legally restricted abortion, that is, on countries where abortion is technically illegal but available under certain conditions from formal service providers (e.g., physicians) or traditional service providers (e.g., a variety of nonphysicians). More specifically, the purpose is to facilitate service and policy oriented research studies that, hopefully, will make a difference in public health decision making, improving access to safe abortion services for all segments of the population regardless of income or location of residence, and strengthening public health oriented programs for reducing unwanted pregnancies and reliance on abortion through more effective contraceptive practice.

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2. While we will cite diverse approaches to the study of women who have experienced abortion, we propose that particular consideration be given to "pathways to abortion," that is, how a woman reaches a service provider after she has made the decision to terminate an unwanted pregnancy. In addition, we place more emphasis on studies with service providers (regardless of their qualifications), comparing providers' perceptions of women's needs and their responses to such needs with how women perceive their own needs and the services provided to them.

3. For designs of studies in countries where abortion is legal reference should be made to the monograph prepared by the International Union for the Scientific Study of Population Committee on Demographic Aspects of Abortion, published in 1977 as IUSSP Paper No. 7. For studies of the longer term development of children born to women denied abortion we suggest the TFRI monograph, Born Unwanted, published by Springer Publishing Company (New York) and Avicenum (Prague). The Prague Study is continuing with a WHO/EURO grant to look at the situation of the first born children of the now young adults and their partners.

Retrospective Surveys

1. Complete coverage of pregnancy losses is seldom attained in retrospective surveys. Respondents tend to "forget" because they are reluctant to report events that may be a source of personal embarrassment or are perceived to be counter to prevailing sociocultural attitudes. Nevertheless, pioneering studies conducted in Latin America in the 1960s suggest that for every abortion ending with admission to hospital for complications there were two or more abortions that did not appear in the statistics because there were no complications requiring hospitalization. (Note studies by Armijo and Monreal and by Gaslonde, summarized in PAHO Scientific Publication No. 306 for 1975).

2. Forgetting occurs regardless of the legal status of abortion. Several studies in Central and Eastern European countries, where legal abortion is readily available and well recorded, show that about one third or more of women known to have had an abortion deny having had one when asked in subsequent surveys.

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3. In an attempt to provide public health decision makers with a more reliable tool for assessing the magnitude and impact on health services of illegally induced abortion, the WHO Task Force on Sequelae of Abortion developed in the late 1970s a two phase methodology, tested in four urban centers in Malaysia, Nigeria, Turkey, and Venezuela. The first phase consisted of data collection on women admitted to hospitals with a diagnosis of abortion; the second phase called for random sample of followup interviews at home. The social and demographic characteristics of the women classified as cases of induced abortion differed from setting to setting. All the centers encountered difficulties finding the women for a postdischarge interview. Results from one setting were not directly applicable to others. The large number of denials of any abortion, whether spontaneous or induced, raised further questions about the validity of studies based on pregnancy histories provided by the woman. (The WHO Study was summarized by Figa-Talamanca et al in the International Journal of Health Services, 1986, 16, 375-389.) Guidelines for the Selection, Training, and Supervision of Interviewers were prepared by WHO.

Prospective Surveys

1. One means of assessing the extent of omission in retrospective data is to compare retrospective rates with prospective rates of loss obtained from the same or similar sample of women. In such comparisons, prospective rates far exceed the retrospective, confirming that the importance of forgetting. (See Santee's study in Chile in PAHO Scientific Publication No. 306 and Casterline's review in Studies in Family Planning, 1989, 20, 81-95.)

2. Although more expensive to conduct, prospective surveys tend to yield more valid data, especially when embedded in general studies of reproduction among selected population subgroup samples. (TFRI experience in the San Francisco Bay area is particularly instructive as noted in W.B. Miller's monograph on the Psychology of Reproduction.)

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Suggested Indicators for Estimating Public Health, Economic, and Psychological Costs of Illegal Abortion (Hospital Studies)

1. Health factors or complications associated with the procedure, including pelvic injury, systemic effects, and other complications, as described by Tietze and Lewit in Studies in Family Planning, 1972, 3(6), p. 107.

2. Type of treatment required, management, and associated costs, including duration of stay in emergency room and/or days of hospitalization, type(s) of surgery performed, number of blood transfusions, types of drugs administered, and proportion of hospital services devoted to abortion complications. (A good example is J. Fortney in Public Health Reports, 1981, 96, 574-579).

3. Personal, psychological, and socioeconomic factors, including days of work lost, costs of child care, effect on partner's job, partner's response, psychological experiences following the abortion, etc. (Note, for example, a study from the Dominican Republic published in the TFRI monograph on Abortion in Psychosocial Perspective, New York, Springer Publishing Company, 1978, 225-238.) Economic costs need to be considered in terms of percentage of family income, how funds were obtained, need to borrow, etc. A study soon to be initiated in the Sudan will endeavor to assess the "average cost" of treating incomplete abortions in a hospital with the cost of averting unwanted pregnancies through other programs.

4. While hospital records may suggest trends in the incidence of abortion and related mortality, such data are often incomplete. Induced and spontaneous abortions may be combined, admission standards may influence record keeping, and the vast majority of women obtaining abortions are unlikely to require admission to hospitals.

5. Although death certificates may offer a minimum indication of abortion related mortality, they are often of doubtful value in view of the many variations regarding the accuracy and completeness of such records as well as the efficacy of the registration system.

6. An important consideration is the pathway by which the woman reaches the hospital. What was her specific experience, with what kind of service provider, using which technique, at what charge to the women, and with what results? Answers to

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such questions are unlikely to be obtained from most hospital records and will require community-based research.

Community Studies: Perceptions of Clients and Providers

1. Recognizing that most women obtaining abortions do not experience complications of a nature requiring the attention of public hospital facilities, a number of pilot studies have developed methodologies for eliciting information on "pathways to abortion," the experiences and perceptions of women finding providers in countries where access to abortion is legally restricted. Such studies, often using snowball samples, have been reported from the Philippines, Thailand, and Mexico. A protocol is being developed by IPAS (Box 100, Carrboro, NC 27510). A report of the Mexican study has been accepted for publication in the American Journal of Public Health, 1990; the questionnaire is available from IPAS.

2. It is increasingly recognized that a particular need exists for studies of the range of formal and traditional providers, who they are, their services, procedures, fees, followup, contraceptive counseling, etc. Pilot studies have been conducted in Mexico and are being planned in Belgium and the USSR.

3. If admission to hospital occurs, it will be important to ascertain the prevailing climate of opinion, the perceptions of hospital staff regarding treatment of incomplete abortion, the provision of contraceptive counseling to avoid future unwanted pregnancies, and the perceptions of the women of services provided.

Qualitative Research

1. In recent years, much attention has centered on focused interviews which the endeavor to elicit information on specific topics while leaving the manner of asking questions and their timing or sequence to the discretion of the moderator. The intent is not so much to obtain statistically generalizable quantitative data but qualitative information indicative of underlying attitudes, opinions, and behavior patterns that can be related to other available information or planned research. Focused group

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discussions differ from the sample survey approach representative of a broad population by focusing on specific topics in greater depth in small groups of about 6-8 participants.

2. If used in the pilot phase, findings from focused group discussions can be used to suggest changes or additions to already planned questionnaires. They may lead to the identification of key variables for explaining underlying processes at work in specific situations, which, in turn, may stimulate further research. (Michele Shedlin has developed particularly productive techniques for organizing focused groups and analyzing the results).

3. Focused groups may also be used for postquestionnaire followup, providing an opportunity to probe for additional information, particularly in regard to motivation, decision making, sequence of persons consulted, future planning, etc. The results obtained can be useful in validating questionnaire findings.

An Approach to Abortion Research

Based on concepts developed at the Institute of Population Studies in Exeter, we offer a research outline that might be considered in developing a project. Each stage builds on the prior one as follows:

1. Identify needs/Why the research is necessary for short and long term.
2. Review possible quantitative and qualitative approaches/advantages and disadvantages.
3. Conceptualize the project in terms of service and policy implications.
4. Develop a project outline in terms of subjects and variables for study.
5. Design methodology for assessing the variables to be studied.
6. Conduct a pilot study.
7. Review findings with consultants to improve study design.
8. Implement the study.
9. Analyze the findings.
10. Communicate results and state limitations.

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Proposed Manual of Abortion Research Methods, Questionnaires, and Cautions

1. It is proposed that as a next step there be developed an operations research style Manual of Abortion Research Methods. It might describe presently used methods, already available and tested questionnaires, and the elements of information required for their use. Examples could be provided to aid in method selection.

2. In planning abortion research it is important to ask key questions, some of which are suggested in Emily Moore's International Inventory of Information on Induced Abortion (Columbia University, 1974):

a. What is the de facto (not de jure) abortion situation?
b. What cultural perceptions of abortion prevail?
c. How readily can abortions be obtained from medical facilities?
d. Are physicians willing or reluctant to provide abortion services?
e. How costly are abortions in terms of average monthly income?
f. Are effective modern contraceptives readily available?
g. What are prevailing family size norms?
h. What pressures exist for or against childbearing?
i. What is the sociocultural perspective on out-of wedlock birth?
j. What norms exist for sexual activity in younger people?
k. What is the prevailing male/female attitude to abortion?
l. Are there religious strictures against abortion?
m. What is the secular influence of the church?
n. Are health personnel well regarded?
o. Are women with complications willing to report to hospitals?
p. What country or culture specific considerations exist?
q. Other issues to be considered?

3. Distinguishing factors with population subgroups?

a. Educational level, income, occupation?
b. Urban? Rural?
c. Age?
d. Marital status/cohabitation?

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e. Religious affiliation/church attendance?

f. Prior reproductive experiences?

4. Is the sample representative?

   a. Does it consist only of ob/gyn or clinic patients?

   b. Is it limited to women of particular sociodemographic background?

   c. How do those who responded differ from those who do not?

5. Are there differences in data collection and analysis?

   a. Time span covered (e.g.,one or several years)?

   b. What was the training of the interviewers?

   c. What was the likely extent of underreporting? In what subgroups?

   d. What methods were used in data analysis?

Questionnaire Bank

1. Ideally researchers should have access to examples of questionnaires that have been productive in particular settings. Perhaps a suitable organization could be persuaded to invite researchers to donate their techniques to a questionnaire bank which would facilitate the exchange of experience.

2. In test development it is especially important to consider the instrumentation process, including item generation, pretesting, and assessment of reliability and validity. Special care needs to be taken in adapting items developed in one cultural context. to another. In addition to using a translation/retranslation procedure, the cuyltutal appropriateness of each item needs to be assessed.

Examples of Questionnaire Item Categories

1. Demographic Items

   a. Age in years; date of birth

   b. Last year of school

   c. Religion; church attendance

   d. Employment, current job, income, patner's job and income

   e. Marital history

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f. Age at sexual debut and method of contraception, if any
g. Contraceptive method used at last intercourse

2. Reproductive History
    a. For each pregnancy, record age and marital status at conception
    b. Inquire about wantedness/intendedness; sex of child
    c. Type of facility where abortion occurred; complications; costs
    d. Reasons for abortion; whether partner agreement
    e. Perceptions of abortion; provision of contraceptive information
3. Life Events Scale
    (various forms available)
4. Abortion Service Providers
    a. Gender, age, level of education
    b. Number performed in last 12 months; methods; stages of pregnancy
    c. Patients seen -- ages, socioeconomic status, marital status
    d. Follow up (Instructions on what to do if -)
    e. Provision of contraceptive information

References

An annotated bibliography needs to be developed, building perhaps on the IPAS collection and the experience of colleagues associated with IPAS, IWHC, Population Council, WHO, PAHO, TFRI, and other organizations.