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Assessment of Induced Abortion Practices in Urban Haiti

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An abstract of
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Abstract

Assessment of Illegal Abortion Practices in Urban Haiti
By Erin Berry-Bibee, MD, MPH

Background:
In Haiti induced abortion is illegal except to save the life of the mother. Although abortion is believed to be widely practiced in Haiti, very little data exist on what those practices are and what the impact is on women, communities and health care systems.

Objectives: This study aims to describe methods used to induce illegal abortion, ways in which women gain knowledge about and access to those methods, and to learn about facilitators and barriers to abortion related care.

Methods: We conducted 8 focus groups with community women (n=62) and 13 interviews with women's health providers.

Results: Among focus groups, there was widespread knowledge of misoprostol and herbs for self-induced abortion. Women described use of multiple agents in combination with misoprostol. Women reported stigma as a significant barrier to care. Providers perceived existing post-abortion services to be adequate.

Conclusion: Awareness of methods to induce abortion is high among women in urban Haiti and self-induction of abortion appears to be widely practiced; yet knowledge of the safest self-induction options remains incomplete. Women's healthcare providers are aware of the need for post-abortion care services, yet there remain substantial barriers to care, including health care accessibility and stigma. Introduction of safe abortion education strategies, improved post-abortion care services and strengthened respectful care could greatly improve overall reproductive health care in the region.

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Chapter I. Introduction

Every day, women die unnecessarily from pregnancy-related causes. According to the World Health Organization (WHO), hemorrhage, sepsis, hypertensive disorders and unsafe abortion are the top four causes of maternal deaths worldwide (WHO, 2011). The risk of dying from an unsafe abortion, depending on the region, ranges between 350-800 times greater than from a safe abortion (WHO, 2011 and Grimes, 2006). Currently about half of all abortions globally are unsafe, which is, unfortunately, an increasing trend (Sedgh, 2012). This indicates that unsafe abortion continues to be a preventable public health crisis. Researching abortion practices in regions where abortion safety is unknown can thus provide crucial information needed for efforts to reduce maternal mortality. In Haiti, maternal mortality is higher than any other country in the western hemisphere, yet there is very little published data on abortion in this country (WHO, 2012). Although illegal, anecdotal evidence suggests that abortion is widely practiced in Haiti. This study aims to gain a better understanding of these abortion experiences.

In Millennium Development Goal 5, set in 2000, the United Nations asked the world to decrease the maternal mortality rate (MMR) by three fourths. Since 1990 significant progress has been made towards that goal and globally the MMR has decreased by half (United Nations, 2013). However, much work still needs to be done to improve maternal health. For example, the MMR is nearly 15 times higher in developing regions of the world than in the developed regions (United Nations, 2013). In recent decades the small Caribbean nation of Haiti has made significant progress in improving their maternal health. From 1990 to 2010, maternal mortality in Haiti dropped from 620/100,000 live births to 350/ 100,000 live births (WHO, 2012). However, Haiti continues to have the highest maternal mortality in the Western hemisphere (Primes, 2008, WHO 2012), indicating the need for continued progress. Maternal mortality in Haiti stems from

three leading events; hypertensive disorders of pregnancy, maternal hemorrhage, and infection (WHO, 2011). To continue the downward trend in maternal mortality rates in Haiti, further investigation into the root causes of these events is needed. Availability of and access to contraception is a very important method for primary prevention of maternal mortality by preventing unintended pregnancies. The total fertility rate in Haiti decreased from 4.7 to 3.5 from 2000 to 2012 (MSPP, 2013). Over that same time period, the use of modern methods of contraception increased from 22% to 35%, and the unmet need for family planning dropped from 40% to 35% (MSPP, 2013). In addition to the roles of contraceptives, access to safe abortion services and post-abortion care have been identified as important factors that can contribute to primary prevention of maternal mortality (Grimes, 2006).

The World Health Organization defines unsafe abortion as "a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both" (WHO, 2005). The WHO estimates that in 2008 alone 21.6 million women had unsafe abortions and that approximately 13% of all maternal deaths worldwide (47,000/358,000) were due to unsafe abortion practices (WHO, 2011). The WHO estimates that in Latin America and the Caribbean, 12% of maternal deaths were due to unsafe abortions in 2008. (WHO, 2011) While legality of abortion is not the only factor that can contribute to unsafe abortion, the WHO, and others, recognize that legality is a major component: "unsafe abortion mainly endangers women in developing countries where abortion is highly restricted by law" (Grimes, 2008, p.1908). The Guttmacher Institute reports that Haiti is among the most restrictive of nations in Latin America and Caribbean region in that it allows for abortion only in case of saving the life of the mother (Guttmacher Institute, 2012). The 2012 DHS survey estimates that 4% of Haitian women reported ever having an induced

abortion (MSPP, 2013). However, anecdotal evidence from local practitioners and USAID reports suggests that the abortion rate is significantly higher (Coffman, 2001, Lathrop, 2011, Primes, 2008; WHO 2011). However, very little other data is available on induced abortion practices in Haiti. Thus, the overall rate of illegal abortion, unsafe abortion and maternal morbidity and mortality from induced abortion in Haiti is unknown. In order to begin to ascertain the impact that induced abortion has on maternal health in Haiti, this project used qualitative methods to investigate the knowledge, attitudes and practices of induced abortion in urban Haiti as described by community women and local women's health practitioners.

The study took place in Cap Haitien, Haiti, the second largest city in the country with a population of 300,000 and a catchment area of over 1 million. The city has only one public hospital for the region, Justinian University Hospital, and several smaller health centers. Ft. St Michelle is a small public health center with a maternity unit that services the poorest communal section in the city, Petite Anse. Cap Haitian is also home to Konbit Sante, a Maine-based non-governmental organization (NGO). Konbit Sante's mission is to help strengthen the health of the community by working within the existing public health framework to build capacity (Konbit Sante, 2014). This research was a collaborative effort between Justinian University Hospital, Emory University researchers and Konbit Sante.

As very limited data exists about induced abortion in Haiti, this research applied some features of grounded theory in order to generate preliminary information around abortion practices in the region that could be used in the future to direct more specific research questions and projects (Charmaz, 2006). The features of grounded theory used include simultaneous data qualitative collection with early data analysis, codes and themes created from the data itself, not from pre-existing conceptions, writing analytic memos, and discovery of basic social processes

(Charmaz, 2006). We aimed to generate theory about induced abortion in Haiti through systematically analyzing focus group discussions with women and in depth interviews with women's health providers. We used the analytic tools of coding, memoing and sorting for analysis. Traditional grounded theory describes taping and transcribing interviews as counterproductive to the fast paced generation of concepts in the data by taking field notes (Strauss, 1998). However, as multiple languages were spoken and the majority of the data collection was done in Haitian Creole, taping, transcribing then translating the data were vital in this project.

Given that very few data have been published on unsafe abortion practices in Haiti, this study sought to use qualitative methods to explore and describe the environment and culture around the subject. This valuable formative data will serve as a foundation for future research. The specific objectives of the study include:

1. To learn what methods are being used to induce abortion and how women gain knowledge about/access to those methods in Cap Haitien, Haiti.
2. To learn about the stigma surrounding induced abortion as perceived by community women and health care providers in Cap Haitien, Haiti.
3. To learn the perceptions of abortion morbidity and mortality by health care providers and community women in Cap Haitien, Haiti.
4. To assess perceived barriers to receiving post-abortion care among health care providers and community women in Cap Haitien, Haiti.
5. To assess some of the perceived barriers to providing post-abortion care specifically by providers at Justinian University Hospital

Chapter II. Review of the Literature

Globally, unsafe abortion accounts for approximately 13% of all maternal deaths and almost all abortion-related deaths occur in developing countries (WHO, 2011). The mortality rate from unsafe abortions on average is 350 times higher but can be up to 800 times higher than from safe abortions (Sedgh, 2012 and WHO, 2011) In addition to increased mortality, it is estimated that approximately 5-8.5 million women a year worldwide experience complications from unsafe abortion that they should seek medical attention for, however only about 65% of these women actually receive the post-abortion care they require (Singh, 2006 and Vlassoff, 2009).

Globally, many socio-contextual factors exist that contribute to the safety of abortion in given regions. These include, but are not limited to, the legal status of abortion, women's human rights status, access to safer abortion techniques (misoprostol and manual vacuum aspiration), education about safer self-induction, social and religious stigma, and access to modern contraceptives (Grimes, 2006; Hyman, 2013).

In addition to the physical effects unsafe abortion has on women, a study published in 2009 highlights the significant financial burden that unsafe abortion care can impose on health systems. Providing post- abortion care after an unsafe abortion caused a significant financial impact on those health systems studied (Vlassoff, 2009). Very little specific data exist on the impact of induced abortion practices specifically in Haiti, as most estimates combine Latin American and the Caribbean as one large unit. Any data that exist on the Caribbean, as a region, are unlikely to be reflective of Haiti, given that the Caribbean data reflects the large number of safe legal abortion performed in Cuba.

Published in 2013, the 2012 Haitian Demographic and Health Survey (DHS) is the fifth survey of this kind ever done for Haiti. The survey is a nationally representative sample of 14,287 women ages 15-49. In this survey about 4% of Haitian women reported having at least one induced abortion (MSPP, 2013). USAID reports and discussions with local practitioners both suggest that the abortion rate is much higher (Primes, 2008, Lathrop, 2011; WHO 2011). Women were asked specifics about any induced abortions that took place since 2007. When asked the method of their abortion 36.2% of women reported having a dilation and curettage, 38.8% reported using misoprostol, 25% receiving injectable medication, and 26.3% reported using herbal or plant based medications (MSPP, 2013). Since 2007, abortions in Haiti took place primarily in people's homes (59.6%) followed by private health establishments (31.7%); few took place in public health establishments (8.5%) (MSPP, 2013). Other than the DHS survey, no other specific studies have been conducted to address illegal abortion in Haiti. Although the DHS survey provides nation-wide statistics of reported abortions and methods used, by the very nature of large surveys, it is unable to fully describe the abortion experience for women in Haiti.

Lathrop's 2011 study addressed post-partum family planning and family planning needs in the University hospital in Cap Haitien where this study took place. They conducted 6 focus groups with post-partum women and 3 focus groups with providers and then developed and distributed a questionnaire. They reported high rates of unintended pregnancy in the postpartum population, high interest in family planning services and low uptake of contraception. In addition, they noted that "providers expressed concern about the volume of induced abortions and maternal deaths within the hospital" (Lathrop, 2011, p. 240). Although no additional information was obtained about abortion practices, this study indicated the need for further investigation on abortion in urban Haiti and its potential contribution to the poor state of

maternal health in Haiti.

Although very limited published data exists on induced abortion practices in Haiti, it is clear that women are facing high rates of unintended pregnancy and high rates of unmet need for family planning. Large survey data and anecdotal evidence also suggest abortion is taking place. However, it is unknown how women and health care providers are accessing information about abortion, how women are accessing the different methods, and what the specific complications are. Similarly, very little is known about the impact stigma plays on the abortion experience in Haiti for women, health care providers and their communities.

Chapter III. Methods

Qualitative research methods were chosen for this study in order to describe and explore illegal abortion in the Cap Haitien community. Given the sensitivity of the topic there was extensive discussion about the best ways to generate data. To obtain data from women in the community, it was determined focus group discussions with women in the community would generate greater discussion than in-depth interviews given the participants could talk about women "in general" instead of feeling like they were being asked personally, or targeted individually. However, if discussion were difficult in focus groups setting the plan was to switch to in-depth interviews. Women of reproductive age were chosen for focus groups to ensure descriptions were of current practices. To obtain data from women's health care providers, in-depth interviews were performed for feasibility.

Institution review board approval was obtained through Emory University (Atlanta, USA) and ethics committee approval was obtained through Justinian University Hospital (Cap Haitian, Haiti). Data collection took place in May 2013. The research assistants were Haitian women's health community nurses with prior experience in both qualitative and quantitative

research methods. Validated training tools were used to refresh research assistants on ethical research practices and to familiarize the team with the principle of qualitative research and the specific data collection tools (Rivera, 2004 and Hennink, 2007).

III. A. Participants

Focus Group Participants

Using a combination of purposive and convenience sampling, community health agents recruited participants for the focus groups. Community health agents are community members that are employed by the public health system and serve to educate the people in their communities on important health topics like tuberculosis, HIV, prenatal care and more. These community health agents also administer vaccines and provide postpartum care to mothers and infants after home deliveries. As such, they are respected and well known in their communities. Each of the 10 community health agents working in different neighborhoods of the communal section of Petite Anse (in Cap Haitien) were asked to recruit approximately 10 women to participate. The health agents promoted the focus group attendance through word of mouth in the community. Focus group dates and time were arranged based on availability of research team and participants. Any potential participants were asked to come if available and willing to participate. Inclusion criteria for participation in the focus groups included being female, 18 years of age or older, willing to participate, and speak either Haitian Creole or French. As all participants spoke Haitian Creole as their primary language, all groups were conducted in Haitian Creole.

In Depth Interview Participants

In parallel to the focus groups of community women, we also conducted in-depth interviews with key informants in women's health. Research assistants and the principal

investigator identified key informants through a combination of purposive, snowball and convenience sampling from the Justinian University Hospital and Fort St Michele health center affiliated providers. Inclusion criteria for interview participants included ages 18-70 years, self-reported provider of health care services to women, willing to participate, and speak Haitian Creole, French or English.

III. B. Measures

Focus Group Measures

Focus group guides include open-ended questions addressing the use of contraception, social acceptability of abortion, common terms used for abortion, community perception of abortion, how women find out about abortion, what methods are used (medical, medicinal/herbal, surgical), where women go to access these methods, perceptions of abortion related complications, and questions that address the stigma of abortion in the community (Appendix 1). The questions asked women about hypothetical situations and community experience rather than their personal experiences (Appendix 1).

Focus group guides were developed in collaboration with two US OB/GYNs with both clinical and research experience in abortion and contraception; one Haitian OB/GYN who trained at and practices at the Justinian University Hospital, two senior Haitian nurses with women's community health and research experience, three junior Haitian women's health nurses and one Canadian- based medical anthropologist. The focus group guide was initially written into English then translated into Creole by a Haitian OB/GYN. A second translator verified the translation for accuracy. Each question was pilot tested internally amongst the research team for clarity and accuracy. After each focus group was conducted, the team reviewed the guide and

small improvements were made to questions in attempts to promote more discussion and/or improve understanding.

In-Depth Interview Measures

An in-depth interview guide was developed by the primary author. Each guide contained 5 sections; introduction, contraception, unintended pregnancy, abortion and reproductive health stigma. Each section contained 2-3 subsections of questions that related to their experiences during their training, current and common practices and suggestions for future efforts/improvements (Appendix 2). The specific questions asked during each interview varied based on the background and position of the interviewee and responses given.

III. C. Procedures

Focus Group Procedures

Upon arrival, subjects were privately, verbally consented and their age was recorded. No personally identifiable information was collected. Each focus group lasted approximately 2 hours and took place in a private space. In order to conduct the focus group we required a minimum of 4 and a maximum of 10 participants per group. The focus groups were conducted in Haitian Creole by a Haitian nurse research assistant and audio recorded. Two additional research assistants took notes and the primary author took non-verbal observational notes. Participants received a phone card and a light snack for their participation. All audio-files were transcribed verbatim in Haitian Creole and translated into English. The number of focus groups was determined by the principal investigator through on-going evaluation of the data to assess for saturation of themes. From May 15 -May 27, 2013, eight focus group were conducted, each in a different neighborhood, with between 6-9 participants in each group. A total of 62 women participated.

In-Depth Interview Procedures

After being identified as potential interviewees, participants were contacted via phone or e-mail using a recruitment script (Appendix 3). Participants were consented, via written consents, immediately prior to the interview in French, Haitian Creole or English per their preference. Age, gender, provider type, specialty and years in practice were recorded. Each provider was assigned a subject ID. Maximum effort was made to maintain confidentiality. No personally identifiable information will be published or presented. Interviews were conducted in English by the primary author with a translator fluent in English, Haitian Creole and French in a private room. Participants received a phone card and light refreshments for their participation. Interviews were audio recorded, transcribed and translated into English, by a Haitian OB/GYN. A total of 13 interviews were conducted due to a combination of saturation of themes and participant availability. This included 2 attending OB/GYN physicians, 2 OB/GYN residents, 3 OB/GYN nurses, 4 traditional birth assistants (1 of whom is also a community health worker), and 2 herbal practitioners (1 of whom is also a community health worker).

III. D. Data Analysis

English transcripts from the focus groups and interviews were de-identified by removing participant's names (if used) and any other identifiable information. We used the concepts of grounded theory to guide data analysis. Maxqda version 10 (VERBI GmbH, Berline) qualitative data analysis software was used for analysis. Transcripts were read by two analysts for common themes, and codes with definitions were created from those themes. The two analysts then coded four transcripts (2 focus groups and two interviews) and wrote memos about additional themes. The two analysts discussed the codes and memos applied to this subset of transcripts, and then made adjustments to the codebook as needed. Using this second, finalized codebook, all

transcripts were coded for common themes by the primary analyst. Select transcripts were coded by the second analyst and the coded segments compared for intercoder agreement. There was a high degree of concurrence of the coded segments between the analysts. Coded segments were retrieved and reviewed for common findings. The mapping tool was used to generate summaries for each code.

Chapter IV. Results

Focus Groups

In the eight focus groups there was a total of 62 women, with a mean of 7.8 participants in each group (range 6-9). The mean age of participants was 28 years (range 20-50). Several prominent themes arose from the focus group discussions including widespread knowledge of methods for self-induction of abortion with misoprostol combined with a potpourri of herbs and other medications. Additional themes included reliance on men to acquire misoprostol, information gathering from community-based sources, high social and religious stigma, and high perceived health-care related stigma potentially leading to delayed post-abortion care.

Women in the focus groups spoke easily and freely about common abortion practices in their communities. In early sections of the discussion that focused on contraception and unintended pregnancy, participants often brought up the topic of abortion spontaneously. When asked specific questions about abortion, participants were also quick to share their responses. Women were very engaged in the topic and expressed appreciation to the research team for having a forum for them to discuss this topic.

Abortion methods

Among focus groups, there was widespread knowledge of misoprostol and herbs for self-induced abortion. Women described use of multiple agents typically in combination with misoprostol. Women in the focus group were very familiar with misoprostol and its use to causes an abortion, they referred to it by its trade name, Cytotec. The following two statements are typical of the conversations that happened in every group.

> A friend told me to take leaves of "pyeba" and "nim" to drink with one cytotec and put two cytotec in the vagina, the baby fell [the abortion was a success].

> They used to buy 4 tablets of cytotec with a cold “fiesta”[*soda*], they put 3 in the fiesta and one in their vagina. Some of them add provera to the cytotec. Others buy leaves like “tobacco” or they drink the pills with coke. There are many ways to throw a baby (have an abortion).

Nearly every participant in each focus group gave at least one example, with very specific instructions, of how to self-induce an abortion. “You can buy three cytotec, put one in the vagina and drink two with cold beer but if the woman is weak, she will get sick”. Although the most common regiment for self–induced abortion was misoprostol in combination with beer and/or an herbal tea remedy, not all regiments included misoprostol. “They can use "ti kole" and "boul de mass" (local herbs) to drink with a bottle of beer and two tablets of ampicillin 500. Or they can take ginger with pepper with the beer to throw the baby too.”

Many regiments included potentially dangerous doses of other medications including chloroquine and other antibiotics. One participant told the story of a young boy who had given his girlfriend 10 chloroquine pills to cause an abortion. Several other participants chimed in by saying “If he give [sic] her chloroquine, he has to give cytotec too; the chloroquine won't work

without cytotec." A second participant responded, "Cytotec and chloroquine, they work together." This conversation demonstrates incomplete knowledge of misoprostol and how this incomplete knowledge can lead to dangerous practices, making self-induced unsafe abortion even riskier for the women in this community.

Although perceived as less frequent than medication and herbal remedies for abortion, women were also knowledgeable about abortion procedures happening in their communities. Women used the term "dilation", "curettage" and "washing" to reference going to a physician to have an abortion procedure. Women perceived this as a safer yet far more expensive route that is out of reach for these women. Some women were able to give specific names of providers and clinics they could go to, however, the majority of women stated the less specific instructions that one could go to a "private" clinic, meaning a private practice clinic.

Within the communities in which our focus groups took place, participants described that if a woman wanted to have an abortion she would first attempt an herbal remedy or an herbal remedy with misoprostol. If that did not work, then she might seek services and advice from an informal health worker/traditional doctor in her community. "When they try the traditional doctor but no success, they go to hospital. The hospital is the last option."

If the abortion is incomplete at this point then, and only then, can most women seek service from the hospital and licensed physicians. "If she goes to the doctor to remove the baby, the doctor won't; she has to induce the abortion on purpose to force the doctor remove the baby." These quotes highlights that hospital based care is avoided by many women and suggests this may lead to delayed life-saving care.

The informal health workers/traditional doctors the women spoke of may include an

herbal practitioner, a voodoo priest or a *charlatan*. A *charlatan* is a person that does not have formal education in healthcare but delivers medical care and advice at a discounted rate. Women perceive services from a *charlatan* to be dangerous and gave stories of *charlatans* using foreign objects like hangers and roots/sticks to cause abortions. "Yes, some women go to a doctor "charlatan". They use an instrument called "seso" (*hanger*) to perform the abortion."

Male involvement

When asked about how women access the medications needed for self-induction women spoke of the need for a man to purchase misoprostol. Most often women spoke of the male partner as the person who would buy the medication, however, paying another man to acquire the medication was also mentioned. "… sometimes you have to pay a man to do that for you [buy the misoprostol] , they won't sell it to woman." Women did not speak of this specifically as a major barrier to accessing misoprostol but indicated it could pose a problem to some women.

Information seeking behaviors

Throughout the focus groups participants were asked where they receive information about the health topics we were discussing. To better understand the responses women gave, the health education sources are separated into three groups; 1) Formal health educators (doctors, nurses, health centers, and hospitals), 2) Health liaisons (those with some health training and connections with the formal health system for example, traditional birth attendants and community health agents), and 3) Community-based (those with no formal training like friends, family members, male partners, and charlatans). When asked about contraception and prenatal services, women quickly identified formal health educators and health liaisons as their primary source of information. However, when the discussion was centered information seeking around

the decision to have an abortion or gaining information about how to have an abortion, women primarily identified community-based sources. The male partner seemed to be the most common information source for women in these communities about abortions. They occasionally brought up interactions with health liaisons to gain information but rarely reported seeking information about abortions from the formal health educators. In several focus groups women reported they had heard of women talking to a formal health educator or health liaison about an abortion and that person lied and gave them medication to make the pregnancy thrive instead of causing an abortion.

Decision making

Many potential factors go into personal reproductive health decisions. Questions asked in this section focused on some of the important factors a woman in Haiti might have when faced with an unintended pregnancy and what might lead her to seek an abortion. Common responses included poverty, misery, hunger, issues with paternity and the need for the woman to continue school. One participant reported, "sometimes, their decision (to have an abortion) is based on the poverty in Haiti, 'I am not working, if I have a child, what will he eat?'" A common proverb in Haiti is that 'children are the wealth of the poor'. When women talked about the decision to have an abortion this proverb was commonly invoked but often framed in the context of the needs of children and avoiding future suffering as a reason for abortion.

> I have a child, he has to go to school, I must work. If I am not working or doing any business, I can't have a child. They say "children are the wealth of the poor" but you need to educate them to let them being [*sic*] a wealth.

> The hardest thing is to see the child suffer, we want to give them something but can not,

which is why I do not want a child now. The child did not ask to be born.

While most of the issues women discussed were factors that would lead a woman to choose an abortion, the groups discussed things that would influence a woman to continue the pregnancy. A minority of participants in each group said if they had an unintended pregnancy that they would "resign themselves" to have the baby because having an abortion is "a wickedness". In addition, women spoke of the medical risks like hemorrhage, risk of future infertility, and death after an abortion as reasons that might factor into the decision. In every focus group at least one story was shared about a women who died from complications of an induced abortion. The groups conveyed that the decision to have an abortion was a complex decision that weighed the very real risks of parenting, pregnancy and abortion in this community.

> "When you have a non-desired pregnancy and you have two other children already, you have a lot of grief. You can not take care of the children you have, sometimes you give them what you have to eat but you do not eat anything because there is not enough for everyone but if you're pregnant you should anyway eat something in the little you have. You are in misery, you're humiliated. Sometimes 4 or 5 months, you're trying to abort, it does not work. You get sick, you have nothing, they must do a konbit in the neighborhood (*each neighbor gives a little money*) to get you to the hospital; sometimes you arrive at the hospital too late, you die and the other two children fall into greater misery." (FG7)

In these discussions many women brought up the unique influences younger and/or nulliparous women face. Every group discussed that if a woman has no prior children that having an abortion, due to possible complications, could prevent her from having desired children in the

future. This was seen as far too great a risk for many women. However, at other points in the conversation these same women talked about how if a young girl was still in school and became pregnant she usually needed to have an abortion in order to continue school. This particular aspect demonstrates that young pregnant women in Haiti are faced with a real paradox. Do they have an unsafe abortion and potentially face a future without children? Or do they choose to continue the pregnancy and be forced to quit school thus halting potential economic growth. In addition, young women seem to face the fear of being thrown out of their parent's house if they find out she is pregnant, furthering her economic hardship.

Stigma

Throughout the discussion it was clear that abortion is stigmatized in Haiti. Some women felt the need to state their moral opposition to abortion for themselves personally, which was typically framed in religious overtones. Afterwards, they were able to talk more openly about what they knew about abortion, often citing more liberal views on the subject then they had previously stated. When asked specifically about the role of the church in abortion, women unanimously stated that the church is openly and strongly opposed to abortion. However, in several groups women openly came out about their support of abortion and even able to share personal abortion experiences.

When asked about what would happen to a woman if her community found out about her abortion, unanimously in every focus group women said that she would be humiliated and disdained by the community; "a dog has more value than that girl". However, these women were aware of the double standard that the community puts on women. They reported that if a woman has too many children, cannot afford a baby, or is too young, then she will also be stigmatized in

the community. When asked what would happen if a woman had an abortion, and her neighbor's found out, one respondent said,

"They will criticize this woman, you are a bad person. You do an abortion, they criticize you. You don't do it, they criticize you".

In addition to being criticized, the focus groups discussed that the community might reprimand a woman who had been found out about having an abortion by being striped from any public position she held, like a community committee or a church choir. Another element of perceived stigma around abortion was the stigma women faced when seeking post-abortion care. Focus group participants were asked what would happened if a woman went to the hospital for care after an abortion. The overwhelming majority of women said they thought this woman would be humiliated and forced to wait longer.

> "I know a woman who was bleeding after inducing an abortion, she went to hospital for care. The doctor received all the patients before giving care to her and he did it (dilation and curettage to stop her bleeding) without anesthesia. (FG6)"

No one reported fear of being refused care they just thought they would be made fun of or scolded for having an abortion. "When the doctor is taking care of these women, they make you suffer to discourage you to do that again." (FG 7) A minority of participants said they would receive the same quality care and that they would be well taken care of.

Euphemisms for abortion

When developing the focus group guides the research team realized there were many terms for abortion in creole. Thus, in the focus groups women were asked what phrases or words the community used when referencing an induced abortion. Most commonly people used the

phrase “throw the baby”, ‘bad deal” and “drink the baby”. In addition, common phases reference abortion as sending the child to do something you could not offer this child if it were born. For example “send him to study” “send him abroad”, “give him a visa/passport without a stamp”, or “send him to study in the US/Miami”. A woman who had an abortion is commonly called “the mother of small death”.

Legality

Many participants in the focus groups were unsure if abortion was legal in Haiti or not. The question of legality often spurred a discussion in which participants tried to rationalize whether it was legal or not. Often the focus group participants came to the conclusion that they though it was probably illegal because the church says it is a “wrong” thing to do. Several participants mentioned they had never heard of anyone getting arrested for having a self-induced abortion so perhaps that meant it was legal.

In-depth interview results

Overall the in-depth interviews with health care providers were harder to conduct. Providers were eager to talk with me but more closed off to longer discussions on the topic than focus group participants. Providers were aware that self-induced abortion was widely practiced in their communities. All of the traditional birth attendants, community health workers and nurses reported they were not familiar with what specific methods were being used in the community, and they did not provide any specific education to women seeking abortion information or services. Physicians reported they see many women coming in for incomplete

self-induced abortion after taking misoprostol and any combination of other medications and herbal remedies. Physicians perceived self-induced abortions to be safer now than it was in past decades and attributed the increased safety to the used of misoprostol.

Providers perceived post-abortion care services provided by the hospitals and health care centers to be free of stigma and biases. Physicians reported that women usually did not disclose when they took medications to induce abortion. Physicians reported they sometimes they had to work hard to get the patient to disclose what she took, which they saw as hindering care. Additionally, physician perceived limited resources including access to blood products as potential barriers to providing post-abortion care. However, overall providers reported that post-abortion care services were adequate.

Providers were able to correctly identify that abortion is illegal in Haiti, however most providers were unable to correctly identify when abortion is legal. Some providers stated that abortion was legal in the case of rape, incest, maternal health and/or fetal anomalies. Most providers but not all correctly identified that abortion was legal in order to save the life of the mother.

Chapter V. Discussion

Self-induced abortion using a potpourri of medication and herbs appears to be widely practiced by women in Cap Haitien. Women are using misoprostol as an abortifacient, however, great misunderstand exists about its efficacy and correct use. This has led to potentially dangerous combinations of medications that threaten maternal health and increase the risk of self-induced abortion. Although women were able to give details about performance of illegal abortions for a fee by physicians, these services are clearly much more expensive and appear to

be accessible to far fewer women than self-administration of medications and/or herbs. Women appear to be learning about self-induced abortion more often from uneducated sources like partners, friends and family than from the formal health care system.

Community women perceive that women who undergo abortions are greatly impacted by stigma-related consequences both in the community they live and by providers when they access post-abortion health care. Health care providers perceive that social stigma is present for women having abortions but that the post- abortion care they provide women is adequate.

Health care providers perceive severe abortion morbidity and mortality to be decreasing in Haiti due to the increase use of misoprostol and decreased use of foreign bodies like sticks and metal objects. However, such practices still occur. Community women perceive abortion to carry significant health risks including hemorrhage, infection, infertility, and death. Each focus group had at least one story of a maternal death from abortion by a woman they knew of.

Women in the community perceived both community stigma and health care related stigma, leading to mistreatment, as barriers to receiving timely post-abortion care. Physician providers identified post-abortion services to be adequate however though that privacy issues and community related stigma were barriers for women seeking post-abortion care. Providers at the Justinian University Hospital saw limited resources, like access to medications and blood products, and lack of patient disclosure as potential barriers to providing post-abortion care.

Awareness of methods to induce abortion is high among women in urban Haiti and self-induction of abortion appears to be widely practiced; yet knowledge of the safest self-induction options remains incomplete. This data supports the development of safe abortion education strategies. Such programs would likely be more successful if they addressed efficacy and correct use of misoprostol and antibiotics, worked to breakdown stigma and educated women to seek

timely post-abortion care. Any legalization efforts would likely improve abortion safety by increasing the number of trained professionals that were providing safe abortions. However, self-inducted abortion practices will likely still be more affordable and more private thus, more accessible to the majority of Haitian women. As such, education efforts will remain important. As social stigma and religion play a strong part in Haitian society efforts to form partnerships with important social and religious organizations that will work may also be of enormous value in improving the safety of abortion practices in this region.

As this phase of the research was exclusively qualitative it is unable to provide statistics that many policy makers relay on. In addition, as this was conducted only in Cap Haitien, its finding might not be generalizable to other regions in Haiti, particularly more rural regions. Thus, specific nation-wide conclusions cannot be drawn. However, this study is the first of its kind to explore unsafe abortion practices in Haiti and has great potential to inform future research, interventions and/or improvement projects within the country. Another strength of this study is that it relied on an international multidisciplinary team to conduct thorough yet culturally sensitive research on this complex topic.

The degree of unsafe abortion related mortality in Haiti is yet unknown. However, this research can serve as a starting point to gain understanding in what the prominent practices are and will hopefully lead to further research. A linked project collecting quantitative survey data from women seeking care at JUH completed enrollment early in 2013, the results of which will further inform this qualitative data.

In March 2013 the results of this research and preliminary findings for the survey data was presented at a 4-hour abortion workshop to a diverse audience in Cap Haitien. Audience members included the Minister of Health for the Northern department, the Chief Medical Officer

for Justinian University Hospital, OB/GYN faculty, residents, nurses, community health workers and traditional birth attendants. The Minster of Health reported that this research will be of great use as the country is currently debating whether to ease abortion restrictions to strengthen maternal health. In addition, he reported the ministry of health in Port-au-Prince is interested in strategies to improve abortion related morbidity and mortality. He stated that as there is no other published data, these new findings will serve to educate policy makers and the public health sector nation-wide.

This workshop also yielded rich information on potential next steps and areas for improvement. Based on the workshop activities and these research findings, participants identified the law, religious and social stigma, health care access and patient misinformation as the largest barriers to safer abortion in Haiti. To address the legal aspects, the groups suggested further research be published and presented to the Ministry of Health and policy makers. To combat religious and social stigma, they encouraged formation of partnerships between church groups and health workers to develop more comprehensive sex education programs. They noted that churches would be resistant to discussing abortion safety but thought some might be more open to accurate sex education programs and potentially providing accurate family planning education as well. Improvements in patient privacy and confidentiality were identified as simple steps that may encourage women to seek timely post-abortion care as it might remove fear of being seen by someone they knew and being "outed" as having had an abortion. Hospital-wide education efforts to improved respectful care of patients was also suggested. Although the group did not suggest this, it was clear that many providers in the room were unclear of the best practices for safe use of misoprostol and post-abortion care. Thus, safer abortion educations strategies targeted at health workers, at all levels, would likely be of great value. Developing

programs like these may greatly aid progression to improve maternal health from unsafe abortion in Haiti.

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Appendix 1: Focus Group Discussion Guide

Introductory Statement:. I would like to start out by saying hello and thank you all for coming to this meeting today, my name is _____ and I am a research assistant working on a research project that is being conducted through the Justinian University Hospital, Konbit Sante and Emory University Hospital in the United States.

We are conducting discussion groups as part of a research project on what women's health, pregnancy, family planning and unwanted pregnancies in Haiti. Our research team is going to talk to several groups of women in Cap Haitien and also to health care professionals (like doctors and nurses). We are conducting this research because we feel it is important to hear the views of women in order to document that challenges Haitian women face around health care and pregnancy. We hope that this research will eventually lead to information that will allow Haitian women and families access to improved pregnancy-related health care.

We will be asking questions about pregnancy, fertility control, abortion, use of family planning, and relationships. All of your views are very valuable to us and it is important to tell you that there are no right or wrong answers, so please share your opinions with us. Some of the topics we will discuss are sensitive so we encourage you to talk about community experiences. If sharing experiences about yourself or of another woman you know we encourage you to disguise the identity of the woman you are talking about to keep her information confidential.

Your participation in this group is completely voluntary. Whatever is said here today is completely confidential and will be used only for this research project. Please do not discuss anything we talk about in the group with anyone outside of the group, even if that person is going to be in another focus group. During the discussion_____will be taking notes, and _____will be asking the questions. We will also be tape recording the discussion, so that if we missed some things in the note taking, we can listen to the discussion again and make sure we understood exactly what was said. We will use only your made up names in the discussion, and there will not be any information on here that could identify you. The tapes will not be listed to anyone outside the research team and will not be taken to the United States. Is it ok with everyone here that we tape-record the discussion? We will occasionally ask questions to get the conversation started but hope that this becomes a discussion so please join in whenever you have something to say. We will not be going in any order, and any one can say anything at anytime. However, please speak only one person at a time so we don't miss any of your important input. Remember that this is a discussion, not a test; so if you disagree with someone, please say so. There are no right or wrong answers. It is ok to have different opinions and views here we want to hear from everyone. But please remember to be respectful of each other. This discussion will probably last about two hours. Are there any questions before we begin?

Let's go around the room and introduce ourselves using again our made-up names only, and then please tell us your favorite color.

Introductory Questions

1. What are the best things about being pregnant? Even if you have never been pregnant before let us know what you think the best things are?

2. What are the most difficult things about being pregnant?

3. What influences a woman's decision about when to have a baby?
(when do women have babies? When is having a baby a choice and when is it not a conscious choice?)
(*Prompts- ideal time, does it depend on having a husband? Boyfriend? Age*?)

4. What might be some reason that a women should not have a baby?
    a. her health?
    b. Financial troubles?
    c. Too young/old?
    d. Not in a relationship or no family to help?

Main Questions:

Contraception

What are the consequences/challenges of getting pregnant when you did not want to?
a. is that different in the city as opposed to the village?

What are the consequences/challenges of having a baby outside when you are not ready?

1. If it is not a good time to have a baby, how do women protect themselves from getting pregnancy?
    a. Who do they learn about it from (Doctors? Family members? Friends)
    b. Where do they go?
    c. What methods are commonly used (condoms, mama?, pills, shots, herbs..?)

2. Lets talk about the process a woman must go through to obtain the birth control method she wants?
    a. Is it hard to get birth control for most women?
    b. Who gets it?
    c. Where does she get it?
    d. How common?
    e. What are common methods

Potential cases to discuss:
Carole is a 26-year-old married woman she has two girls ages 4 and 2 and one baby boy who is 8 weeks old. She is very busy and doesn't want to have any more children. Lets talk about her and some of the options available to her?

Sophie is a 20 year old who has a boyfriend.. She is nervous about getting pregnant and doesn't . What are her options?

Abortion Options/Practices

1. When a woman thinks she might be pregnant and does not want to be pregnant what can she do? Tell me about the decision to continue a pregnancy or to have an abortion?
    a. Who might she talk to? (Partner, doctor, family member?)
    b. Where can she get information?
    c. Is abortion an option?
    d. Is adoption an option?

2. What are other terms used for an abortion?

    a. (If need to probe this can give the example that in English speaking communities it can be referred to as "Bringing on a period"? "Menstrual extraction"?)

3. Tell me about why might a woman choose to seek out an abortion?
    a. Relationship status married, single
    b. Age
    c. Education (in school now or wants to be in school?
    d. Financial concerns (unemployed)

4. How do women find information about abortion?

5. Is this an important topic in your community? Why?

6. What are common medicines or herbs used for abortion?

    a. Common herbs? Medications?
    b. Where are the medications sold?
    f. Do women get procedures done?

<u>Potential cases to discuss:</u>
Sabrina is two months late for her period. She did not plan on getting pregnant and feels like she cannot have a baby right now. Lets talk about the process she might go through.

- *Who does she talk to help her make her decision about what to do? (Boyfriend/Husband? Mother? Family members? Doctor?*
- *What might make her feel like she "cannot have a baby" (see 3a-3d)*
- *Lets say she decides she must have an abortion…where does she go to get information about how to have one?*
- *If she decides she wants to have an abortion who might help her?*
- *Has anyone heard of different kinds of medications or herbs that can be bought for this?*

Stigma

3. Tell me some of the opinions people have in your community about abortion? In your community is abortion talked about?
   (prompts.. Is it acceptable for a woman to have an abortion? Under what circumstances? Does it matter if a woman is married? In school? Other factors?)

4. Tell me about some of the challenges women might face when having an abortion?
   a. Physical- risks, morbidity and mortality, impact on future fertility?
   b. Social- mental health perceptions?,
   c. Stigma- telling people, risk of people "finding out"
   d. Financial burden

5. Lets talk about some of the religious or spiritual aspects around having an abortion?

6. What are the laws in Haiti about getting an abortion? Is it ever legal?

7. Now lets talk about getting care at a hospital. In your opinion, if a woman goes to the hospital after having an abortion, how would she talk with her doctor or nurses about this? Tell me about her decision process to disclose or not disclose her abortion.

8. What are some of the health risks to a women who has an abortion?

9. Have you ever know of anyone dying of an abortion?

   (very important not to ask them who but just want to know if this happened in general)

<u>Potential cases to discuss:</u>
Sabrina took medication that caused an abortion.

- *Who would she tell? Would she worry about people "finding out"*
- *If her friends found out, what might their reaction be?*
- *If her family found out what might their reaction be?*
- *If her doctor found out what might his/her reaction be?*

Now lets change focus a little and talk about overall women's health care.

10. What is something you feel the ministry of health could do (or could improve upon to make Haitian women healthier?

Conclusion:
We are getting towards the end of our discussion. Does anyone have any other comments to add to what we have been talking about before we end for the day?

Thank you all very much for coming. We appreciate your contribution to this research project and we hope that the experiences you have shared will help women in the future.

1. I learned of a former medical technician in a village that would help women end their pregnancies for a fee. People knew about him and as far as talk about him went, [no one OR a few women] had to be hospitalized after he would do a procedure on the pregnant women who sought him out. Have you heard about anyone in your community doing this same kind of work?....

2. Did your mother, godmother, or aunts tell you about what women in their time would do to avoid being pregnant or to end a pregnancy? What about your konmè and whether they talk about these things?

3. I have a friend who felt desperate during the pregnancy of her last child. She had to make money through ways she felt were humiliating to feed her other children, and did not think she could cope with another child. She would jump from high places to the ground to shake up her womb, and beat at her stomach to end the pregnancy. I also knew a woman who almost died during her second pregnancy because she had eklampsi and she had mixed feelings when she miscarried her third pregnancy. I didn't know her well enough to ask her what she thought stopped her pregnancy, but I suspected that she took something. Have you ever encountered women in the same situation?

4. One of the granmoun told me about how to use vèvenn to end a pregnancy. She was a midwife and leaf doctor and would share this information once in a while with some of the women in the community. Have you ever heard of such a practice, or one that is similar?

5. I know a pharmacist who provides women with a pill to end their pregnancies. Have you heard of any pharmacists like this in your community, or pill sellers that offer such treatments?

6. In the United States where I live, abortion is legal in most states up until 24 weeks. Abortion was legalized for a number of reasons, one of which was to prevent so many women from dying from procedures they had in illegal conditions, and because of this history, most Americans support legal abortions. Many Americans often say that it should be restricted according to whether the woman became pregnant through rape or if her health or the future baby's health is at risk. More than a third of Americans think that women should be able to have an abortion if they do not feel like they have enough means to raise the child. I need your help in understanding the situation in Haiti because it is so different than in the United States...and I would like to know about your personal ideas...

Appendix 2: In-Depth Interview Guide

Hello, My name is Erin Berry-Bibee, I am an OB/GYN with Emory University in the United States. This research is a partnership with the Justinian University Hospital Emory University and Konbit Sante. As a part of the research we are asking health care providers who work in Cap Haitien to participate in interviews. We are interested in hearing about your experience with patients in the areas of unintended pregnancy, birth control and induced abortion. We will be tape recording the conversation and will be taking some notes. Your name will not be recorded or used in any part of the research. Your confidentiality is of utmost importance to us. Participation is completely voluntary and you may choose to not answer any of the questions or stop the interview at anytime. The interview will last about one hour. Do you have any questions for me?

<u>To get started I would like to get a little bit on information about you.</u>

1. What kind of health care provider are you? (MD, nurse, resident and field of specialty)
2. Tell me about your medical training.
3. How many years have you practiced?
4. Where do you work now? (more than one job?)
5. Describe your patient population.

6. If you could make two changes to Haiti's health care system that could most effectively reduced maternal mortality what would they be?

<u>Contraception</u>

Training

- Tell me about how you learned about family planning methods in your formal education?
- Do you wish you had more, less or the same amount of training on this subject?
- How do you learn about new family planning methods?
- How do you see the role of family planning in women's health?
- What is the role of family planning for maternal morbidity and mortality reduction?

Common Practices

- What methods of family planning do you commonly recommend/prescribe for your patients?
- Tell me about how women and adolescent girls learn about family planning?
- How do women access the family planning methods they need? Tell me about some of the barriers they might face.
- Tell me about the most effective forms of family planning methods available to your patients and what women are candidates for those forms of family planning
- Tell me about your experience with intrauterine devices (IUD's) and implantable condtraceptives (Jadelle)? Who are good candidates for use?

- Tell me about any barriers you perceive to providing the family planning methods you believe your patient need?

Improvements

- If you were in charge of family planning provision for Haiti what changes would you make? What methods would you make available or more available than they are now?

Unintended Pregnancy in Haiti

Training

- Tell me about your exposure to women with unintended pregnancy in your medical training (both medical school and your internship/residency. For nurses in school?

Common Practices

- Tell me about your perceptions of the rate of unintended pregnancy in Cap Haitien?
    - Is that different in rural vs city women
    - Is it different in other parts of Haiti?
- Tell me about your experience with women with unintended pregnancy in your current practice?
    - What have you commonly seen?
    - What do you commonly do?
      Describe the typical patient like this

Abortion

Training

- Tell me about any education or training around abortion and/or post-abortion care in your medical/nursing school? Internship/residency?

Common Practices

- What common methods are used to induce abortion?
- Where do women go to learn information about inducing abortion?
- Tell me about your clinical experience with taking care of women who have induced an abortion? (what methods, what complications, how often do you see it?)
- Tell me about the induced abortion related complications you see in your practice.
- Tell me about the legal environment around abortion in the setting in which you practice? Are there any mandatory reporting requirements or protocols to report in place?

- Would you mind sharing with me one of your most memorable experiences as a practitioner taking care of a woman who had undergone an unsafe abortion?

Improvements

- In your opinion, what changes can and/or should be made in abortion related care in Haiti?
- Is there anything that interferes with or limits your ability to take care of women needing post-abortion care?

Stigma

- Let talk about the how the women who come in with admitted (or suspected) induced abortion are taken care of by the other hospital staff.
    - How is she treated by MD,s nurses, staff? Is it know by others on the ward that she induced an abortion
    -
- Now lets talk about your perceptions of any partner or family member involvement (social support) in the care of women who come in for post-abortion care.
    - Does there appear to be a difference in social support at the hospital for patients with post-abortion care compared to other types of obstetric visits (for example spontaneous abortion, still birth or delivery)?

We are nearing the end of our conversation. Is there any other thing you think I should know about related to family planning or abortion that we haven't already discussed?

Thank you very much for your time and your contribution to this research.

Appendix 3: Provider Recruitment phone script

Hello {name of provider}

My name is _____ and I am calling on behalf of Konbit Sante and Emory University in the United States. We are conducting a research project in collaboration with Justinian University Hospital Do you have a few minutes for me to explain the project and to see if you would be willing to participate?

IF NO→ is there a better time I could call you?_____(write in day and time; if they say no then politely thank them for their time and say goodbye)

IF YES→ Great, this will only take a few minutes. We are conducting research looking at family planning and unintended pregnancy in Cap Haitien. As a part of the study we will be having discussion groups with women in the community and interviews with local health care providers. The interview would last about 1 hour and for your time you will get a small phone card worth 110 HG and we will provide a light snack during the interview. We will ask you questions about your experience taking care of women in Haiti as it relates to family planning, unintended pregnancy and induced abortion practices. Do you think you might be willing to participate?

IF NO→ ok. Any questions I can answer for you? … Thank you for your time.

IF YES→ Great. Thank you. We are looking for providers who work in the area of Women's Health in Cap Haitien and are between the ages of 18-70. We are calling you because we believe you fit those criteria. Is that correct? _____

IF NO→ Ok, Can I ask you how you do not fit those criteria? _____ (write in response, clarify they really do not qualify and if they do not please say→ Thank you so much for your time and I am sorry this could not work out.")

IF Yes→ Great. We will go through the full consent process the day of the interview but do you have any questions for me at this time?
For scheduling purposes what language would you prefer to conduct the interview in French, Haitien Creole or English?_____ (write in)

We are flexible as far and date and time. Tell me what day/time of day works best for you?_____ (please look at interview schedule and sign up for what slot works best. If you cannot find a time please call Dr Berry-Bibee or the research coordinator)