

Understanding Equitable Access to Safe abortion Services in Rural Bihar, India (2022)

1 Introduction and Objectives

Surgo Ventures attempted to generate deep insights on consumer pathways and drivers around abortions in Madhya Pradesh (MP), India. We conducted a cross-sectional representative study to assess the abortion-seeking pathways, decision-making dynamics, enablers, and barriers of safe abortion practices in MP in 2019. We applied unsupervised psycho-behavioural clustering analytics to identify how women who had an abortion in the last 3 years differ in their abortion journeys. Compared to MP, Bihar has a slightly higher abortion incidence rate and the rate of abortions occurring outside health facilities (84%), public facilities not offering abortion-related care (70%) and women who recently had an abortion belonging to rural areas (84%) and backward communities (60%) is higher [1][2]. This indicates that access to safe abortions might be inequitable in the state and available to only some population segments. Therefore, we identified a need to conduct a similar community-based study on abortion pathways and drivers in Bihar to understand the perceptual and contextual barriers that hinder women, especially the marginalized, from accessing safe abortions, timely care, and resources.

Landscape analysis of the abortion space in LMICs such as India highlighted a dearth of literature on equity in seeking and utilizing abortion services both in the pre and post-pandemic period. Further, existing literature on inequities in the uptake of general healthcare services focuses primarily on socio-demographics and standard indicators of health only. Our study will attempt to bridge this gap with the help of the CUBES™ toolkit which takes a holistic approach to abortion decisions and pathways of women by breaking them down into a function of perceptual drivers, contextual drivers and decision influencers. Further, we intend to segment abortion seeking women into cohorts based on their varying abortion-seeking behaviors. We will attempt to discern the inequity in abortion practices by examining which factors make abortion outcomes of such cohorts different from one another. We expect our study to broaden the horizon of evidence available on abortions in Bihar and abortion pathways of women in the state as well as India.

2 Methodology

Sampling and target population: The study will focus on currently married women aged 18-35 years. We are anticipating a proportion of women in the selected age group who are unmarried (thus excluded) but may have sought an abortion at some point. We will therefore also interview a sample of unmarried women, who may be more likely to seek unsafe abortions due to poor awareness and society's negative attitude towards them. Random sampling of women from the community will be core to the methodology to ensure that our sample population represents a variety of abortion instances and does not over-represent a group of women with shared characteristics, such as abortion seekers in the facility or care-seeking only for complications (a bias possible in a non-community-based study setting). The goal is not to generate robust geography level estimates but to be able to include a minimum of 150 target respondents in our sample and meet our research objectives by deploying suitable analytical methods. Towards the study's sample size

objective, we anticipate covering a total of 5000 women in 2 districts of Bihar. We will not screen respondents upfront to identify our target respondents. We did not want the community or women to perceive that a focused study with women who've had an abortion is being conducted as this could impact disclosure and make women feel targeted.

District selection: 2 districts out of 38 districts in Bihar were purposively selected with the objective of finding the highest number of eligible study respondents while ensuring that the community aspect of the study remains sacrosanct. We took the average incidence rates from two data sources and found Nalanda, Jehanabad, Rohtas, and Jamuli as the districts with the highest average induced abortion rates. Nalanda and Jehanabad were selected.

3 Areas of Enquiry, Analyses and Dissemination

Based on the evidence gaps identified through the **CUBES™** toolkit, we developed a comprehensive list of areas of enquiry that look at the FP and abortion behaviours of women as permutation and combinations of contextual drivers, perceptual drivers and influencers. Our Household survey looks to understand the following from eligible women participating in our study:

1. **Demographics:** This captures the demographics of women and their husbands and household composition.
2. **Parity & Birth History:** This section captures pregnancy outcomes of the woman, her parity beliefs, intended family size and her children's age and gender
3. **Family Planning Beliefs and Uptake:** This section of the survey captures family planning awareness, perceptions and use among the 5000 women to be interviewed in the study.
4. **FP Decision Influencers:** This section aims to discern how women interact with family, community, media and FLWs on Family Planning and how they perceive these different types of influencers as sources of information on FP.
5. **Abortion Awareness & Perception:** This section captures detailed information around the abortion perceptions and awareness of various facets of abortions women hold.
6. **Abortion Journey:** This includes a detailed section on the abortion journey of the women, particularly their experiences of discovering pregnancies, seeking help, attempting abortions, and seeking care (including post-abortion care) at facilities (if applicable). We also capture details around abortion methods used, abortion providers involved, quality of care, emotions felt during and after the process and stigma. These questions were asked to only those women who had an abortion in the past 3 years. The eligible women were selected based on a series of questions on pregnancy history asked in the second section of the tool.
7. **Abortion Decision-making influencers:** This section was asked to all women who had an abortion in the past 3 years and covers the key influencers and ultimate decision-makers of the abortion. This section covers 2 main areas, the interaction of

abortion seeking women with HH and community influencers, FLWs and media and their perception of these influencers and channels of information.

8. **Self-Managed Abortion Experience:** This section explores the experience and preferences of women around SMA methods, providers and HCP touchpoint intensity. Parts of this section were asked to everyone. The line of enquiry was modelled after Moseson's study on self-managed abortion [\[3\]](#).
9. **Respondent's Background Characteristics:** This section was asked to all women and captures the household's assets ownership, distance from the nearest health facilities, media exposure and impact of COVID on living conditions and asset holdings. We will capture personality traits of the respondent here.

Our ASHAs, Chemists and TBA survey tool focuses on understanding the following:

1. **General FP and abortion behaviour:** This section captures the perspective of ASHA workers, the Traditional Birth Attendants (TBA) and chemists on general FP and abortion service-related behaviours
2. **Self-Managed Abortions:** This section captures the perspective of ASHA workers, and chemists on self-managed abortions and SMA preferences of abortion seekers
3. **Changes due to Covid 19:** This section captures the perspective of ASHA workers, TBAs and Chemists on changes brought on by the Covid 19 pandemic in FP and abortion uptake

Segmentation Approach

Many existing studies detail the reasons that people could or could not utilize safe abortion services. This study will measure the *different reasons* why people make certain decisions and utilize psycho-behavioural segmentation to understand differences. It will result in distinct and actionable segments that the program can use to target equitable access. While the actual segments will be determined based on the data, we shared a similar example from our MP study above. For more background on how segmentation has been used in other global development programs, see our article [in the Stanford Social Innovation Review](#). Different unsupervised clustering algorithms can be applied depending on the research objective, distribution of the data and other analytical tests.

Utility and dissemination of findings

The primary use of this study is to provide insights that help the stakeholders and the Government in designing more effective interventions addressing the inequitable access to safe abortions in Bihar. Potential interventions could include messaging campaigns, improvements to the health staff training, supporting health staff with tools to support households more efficiently in their abortion journeys and improving supply and quality of services. The results from the study will be widely disseminated with the TAG, other government and relevant organizations and the global SRH community through presentations, webinars, academic papers, blogs, conferences, posters, commentaries, or calls to action. Any resulting reports from this research will not contain identifiable data at the individual level.

References

1. Stillman, M., Alagarajan, M., Moore, A., Singh.S., Ball, H., 2018, Unintended Pregnancy, Abortion and Postabortion Care in Bihar, India-2015, Guttmacher Institute
2. Hussain, S., Shekhar, C., Moore, A., Sahoo.H., Acharya, R., 2018, Unintended Pregnancy, Abortion and Postabortion Care in Madhya Pradesh, India-2015, Guttmacher Institute
3. Moseson H et al., Self-managed abortion: A systematic scoping review, Best Practice & Research Clinical Obstetrics and Gynaecology, <https://doi.org/10.1016/j.bpobgyn.2019.08.002>