



Research Article

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EFFECT OF MARITAL TYPOLOGY, REPRODUCTIVE COERCION, AND CONTRACEPTIVE METHODS IN ABORTION RATE, ISTANBUL 2021

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Abstract

Objectives: Abortion is both a reason for maternal mortality and a consequence of unintended pregnancies. This study aimed to propose the effect of marital typologies, reproductive coercion, and contraception methods on abortion presence among married Turkish women.

Materials and Methods: An observational study including married women was done in the family medicine clinic of a tertiary hospital in İstanbul. It was completed between 15 May 2021 and 15 June 2021. A survey was applied to supply sociodemographic data, asking about contraceptive method use, reproductive coercion scale, and marital typology scale questions.

Results: In the reproductive history of the 199 women whose mean age was 37.32 ± 7.54 years, abortion and unintended pregnancy frequencies were found to be 35.17% and 37.18%. The reproductive coercion score was 0.47 ± 0.82 out of a total of 5 points. The most common contraceptive methods were condom use (59.79%) and withdrawal (41.70%), whose success depended more on the male partner. Logistic regression analyses identified young age, early childbearing mother age and unintended pregnancy presence as predictors of abortion presence (OR=0.914; 95% CI: 0.863-0.968; $p=0.002$, OR=0.862; 95% CI: 0.778-0.954; $p=0.002$ and OR=5.413; 95% CI: 2.487- 11.780; $p<0.001$, respectively).

Conclusion: In light of this study, one out of three married women had a spontaneous or induced abortion history, regardless of the contraceptive method, marital typology, and reproductive coercion score. Therefore, the physician must be aware of the high abortion risk and the information needed for both healthy pregnancy and safe abortion care for a young married woman with an unintended pregnancy.

Keywords: Abortion, coercion, contraception, pregnancy, reproductive history.

Introduction

Worldwide, 26% of women of reproductive age want to prevent or delay pregnancy but do not use any modern method.¹ Although women in Turkey know modern contraception techniques, the prevalence of withdrawal among traditional methods continues to be a general problem for unintended pregnancies.² Legalizing induced abortion by the Population Law in 1983 was a critical and controversial step for Turkey's public health and reproductive rights.³ However, recent evidence suggests that the provision of abortion in public hospitals has diminished significantly.⁴ According to 2020 data, only 10 of 295 public hospitals in Turkey (Ankara, Amasya, Bayburt, Burdur, Hakkari, Şanlıurfa, Tekirdağ, and Tunceli) provide optional abortion services without any conditions.⁴

Complications of abortion are the fourth leading direct cause of maternal mortality globally, accounting for 7.9% of maternal deaths.⁵ It has been reported that unintended pregnancies are mainly caused by not using or falsely using contraceptive methods or extra-marital sex, forced sexual intercourse, sexual violence, exposure to incest and rape, and adolescent marriages, which are directly related to access to family planning centers.⁶ Based on data from the WHO Global Database on Prevalence of Violence Against Women, it was found that 27% of all ever-partnered women aged 15–49 years had experienced physical or sexual intimate partner violence since the age of 15 years.⁷

Researchers have demonstrated mechanisms that may underlie the association between intimate sexual partner violence and poor reproductive health, including forced or coerced sex.⁸ Since contraception knowledge in adolescents is both unknown and undesirable, adolescent marriages commonly cause unintended pregnancies and induced abortions. Therefore, modern and traditional society's marital perspective is an essential distinction in women's reproductive and marital health decisions.⁹

A family medicine specialist is a reproductive health counselor who recognizes the female patient before her pregnancy and has a management role.¹⁰ This present study aimed to explain how marital typologies, reproductive coercion, and contraception methods affect the abortion presence among married Turkish women.

Materials and Methods

A cross-sectional (observational) study was completed, including married women admitted to the family medicine clinic of a Gaziosmanpaşa Training and Research Hospital between 15 May 2021 and 15 June 2021. One hundred ninety-nine participants aged between 18 and 49 years and accepted to participate in this study were included unless pregnant or planning to get pregnant. Female patients under the age of 18 years,

participants without the ability to fill out the online survey by phone, and participants without active sexual life were excluded from the study.

The study sample size was obtained using a single population proportion formula. The estimated rate of abortion based on the literature was accepted at 22.00%, with a power level of 95% and a margin of error of 5%.¹¹ The final sample size required for the study was a minimum of 154 taking a non-response rate of 10%. An online survey link with forty-five questions by phone was applied, including voluntary consent, sociodemographic data, contraceptive method use, reproductive coercion scale, and marital typology scale. The permissions for the use of the scales were obtained from the corresponding authors.

The Marital Typology Scale is a five-point Likert-type scale consisting of 30 items with a Cronbach Alpha coefficient of 0.920 in the validity and reliability analysis. It was conducted by Çatal et al. in 2018 on married individuals in Turkey. Three sub-dimensions are in the scale; the traditional type marriage (TM) subscale consists of questions 2, 6, 8, 14, 16, 19, 25, 27, 30, dependant-autonomous type Marriage (DAM) subscale consists of questions 1, 3, 4, 5, 9, 10, 12, 13, 15, 17, 21, 22, 26, 28 and the autonomous type marriage (AM) subscale consists of questions 7, 11, 18, 20, 23, 24, 29 questions.¹² There is no reverse scoring and no total score on the scale. The sub-scale scores are calculated separately. In TM, couples' views on life are similar. The spouses believe that self-independence must be sacrificed for their marriage. They avoid conflicts and only deal with important issues. In the DAM, openness in marriage life is considered, and the spouses are not pressured to negotiate. Conflict is experienced. The wife and husband believe in the equality of man and woman in the family. AM gives great importance to autonomy. The self-individual development is ahead of her marriage. Partners talk very little about their marriages.¹²

The Reproductive Coercion Scale was developed by McCauley et al. in 2017.⁸ It has a 5-question tool translated into Turkish by Öztürk et al. in 2020. It has a Cronbach Alpha coefficient of 0.720 in its validity and reliability analysis. The total score is calculated as yes (1) points, no (0) points, and the increased score indicates increased reproductive coercion; there is no specific cutoff value.¹³

Statistical Analysis

Data were given as mean, standard deviation, median, frequency, and percentage. Variables with normal distribution between the two groups were analyzed using the t-test in independent groups and the Mann-Whitney U test for those that were not normally distributed. Categorical variables were evaluated with Chi-square tests. Binary logistic regression analysis was performed to determine the variables affecting abortion presence. The limit of significance was taken as $p < 0.05$. Analyzes were performed using the NCSS 10 (2015, Kaysville, Utah, USA) software program.

Results

The reliability coefficients (Cronbach's alpha coefficients) of the marital typology total scale, and TM, DAM, and AM subscales were found to be 0.920, 0.823, 0.889, and 0.729, respectively. The reliability coefficient of the reproductive coercion scale was observed as 0.821. Cronbach's alpha number for all scales used in this study was between 0.700 and 0.950, which is considered reliable.¹⁴

As shown in Figure 1, the most common contraceptive method used was first; condom use (59.79%), second withdrawal (41.70%), and third; oral contraceptive pill (24.62%). Vasectomy was the method never used.

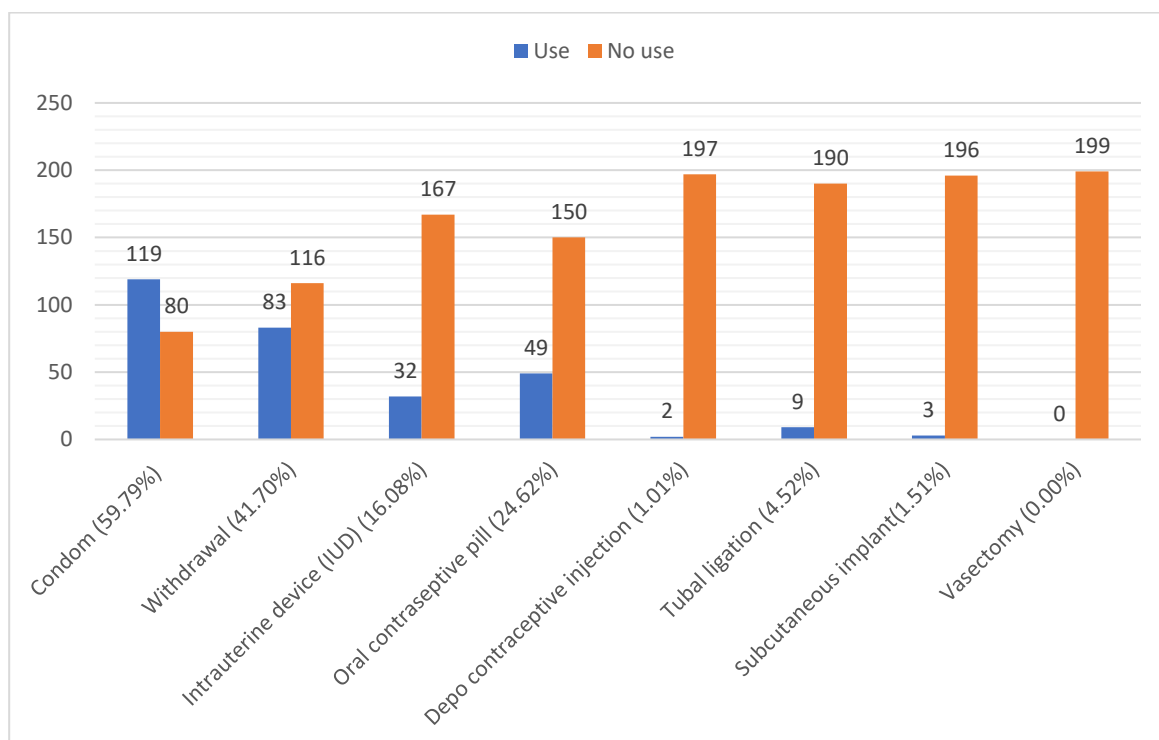


Figure 1. Distribution of the contraceptive methods used by the participants

Data comparison between women with and without abortion history has shown in Table 1. The mean age of the participants was 25.38 ± 3.81 years, 65.79% were university graduates, and 37.14% were housewives. The RC score was 0.47 ± 0.82 out of a total of 5 points. TM score, DAM score, AM score, reproductive coercion score, marital age, and childbearing mother age were statistically similar ($p=0.252$, $p=0.649$, $p=0.251$, $p=0.070$, $p=0.925$, $p=0.073$, respectively). The unintended pregnancy rate in the abortion (+) group (62.86%) was three

times higher than the rate (23.26%) in the abortion (-) group, significantly ($p < 0,001$). Having two or more children was significantly higher in the abortion (+) group than in those with one or no child ($p = 0.023$).

Table 1. Evaluation of the women with and without abortion in obstetric-gynecological health history in terms of family planning

Variables	Total score	Abortion (+) group Mean±SD Median	Abortion (-) group Mean±SD Median	t; Z; X ² value	p-value
Continuous Variables					
Age	37.32±7.54	41.0±7.43	35.33±6.84	t=5.418	<0.001
Marital age	25.38±3.81	25.41±4.49	25.36±3.40	t=0.094	0.925
Childbearing mother age	27.79±4.60	28.62±5.19	27.23±4.09	t=1.806	0.073
Reproductive coercion score	0.47±0.82	0.64±0.98	0.38±7.09	Z=-1.814	0.070
Traditional Type Marriage score	34.64±5.58	34.03±6.04	34.98±5.30	Z=-1.148	0.252
Dependent Autonomous Type Marriage score	57.64±7.84	57.81±8.34	57.55±7.58	Z=-0.649	0.649
Autonomous Type Marriage score	24.53±4.47	24.26±4.08	24.67±4.67	t=-0.628	0.251
Categorical Variables					
	Groups	Abortion (+) group n (%)	Abortion (-) group n (%)	X ² value	p-value
Education level	Primary/Secondary school	11 (15.71%)	9 (6.98%)	3.929	0.140
	High school	13 (18.57%)	24 (18.60%)		
	University	46 (65.79%)	96 (74.42%)		
Occupation	Working	44 (62.86%)	97 (75.19%)	2.773	0.096
	Housewife	26 (37.14%)	32 (24.81%)		
Income level	Low	18 (25.72%)	21 (16.28%)	2.591	0.274
	Medium	33 (47.14%)	70 (54.26%)		
	High	19 (27.14%)	38 (29.46%)		
Pregnancy intend	Intended	26 (37.14%)	99 (76.74%)	30.466	<0.001
	Unintended	44 (62.86%)	30 (23.26%)		
Number of children	No child	7 (10.00%)	32 (24.81%)	7.522	0.023
	One child	27 (38.56%)	50 (38.76%)		
	≥2 children	36 (51.44%)	47 (36.43%)		
Condom use	User	36 (51.42%)	83 (64.34%)	3.147	0.076
	Non-user	34 (48.58%)	46 (35.66%)		
Withdrawal use	User	29 (41.43%)	54 (41.86%)	0.003	0.953
	Non-user	41 (58.57%)	75 (58.14%)		
Oral Contraceptive Pill use	User	19 (27.14%)	30 (23.26%)	0.190	0.663
	Non-user	51 (72.86%)	99 (76.74%)		
Intrauterine Device (IUD)	User	15 (21.43%)	17 (13.18%)	1.718	0.190
	Non-user	55 (78.57%)	112 (86.82%)		
Depo contraceptive injection	User	0 (0.00%)	2 (1.55%)	0.190	0.542
	Non-user	70 (100.00%)	127 (98.45%)		
Tubal ligation	User	4 (5.72%)	5 (3.86%)	0.355	0.723
	Non-user	66 (94.28%)	124 (96.14%)		
Subcutaneous implant	User	1 (1.43)	2 (1.55)	0.005	0.946
	Non-user	69 (98.60%)	127 (98.45%)		

(Chi-square test and Mann-Whitney U test results)

Evaluation of age, RC, and marriage types in Table 2 showed no relationship between RC and TM score, DAM score, AM score ($p=0.473$, $p=0.808$, $p=0.065$, respectively). Although not statistically significant ($p=0.056$, $r=-0.135$), there was a clinically probable correlation between early age and traditional type marriage score.

Predictors of abortion presence have been calculated by logistic regression analysis and are presented in Table 3. It was identified age, childbearing mother age and unintended pregnancy presence as a predictor of abortion presence (OR=0.914; 95% CI: 0.863-0.968; $p=0.002$, OR=0.862; 95% CI: 0.778-0.954; $p=0.002$ and OR=5.413; 95% CI: 2.487- 11.780; $p<0.001$, respectively). As a result, it was observed that the presence of unintended pregnancy increased the risk of abortion by 5.4 times. Additionally, younger age and earlier childbearing mother age were also other abortion risk factors by 1.09 and 1.16 times, respectively.

Table 2. Evaluation of relationships of age, reproductive coercion, and marital typology

Variables	Age	Reproductive coercion score	Traditional Type Marriage score	Dependent-Autonomous Type Marriage score	Autonomous Type Marriage score
Age	-	$r=-0.018$ $p=0.798$	$r=-0.135$ $p=0.056$	$r=-0.125$ $p=0.078$	$r=-0.120$ $p=0.091$
Reproductive coercion score	$r=-0.018$ $p=0.798$	-	$r=-0.051$ $p=0.473$	$r=-0.017$ $p=0.808$	$r=-0.131$ $p=0.065$
Traditional Type Marriage score	$r=-0.135$ $p=0.056$	$r=-0.051$ $p=0.473$	-	$r=0.589$ $p<0.001$	$r=0.544$ $p<0.001$
Dependent-Autonomous Type Marriage score	$r=-0.125$ $p=0.078$	$r=-0.017$ $p=0.808$	$r=0.589$ $p<0.001$	-	$r=0.710$ $p<0.001$
Autonomous Type Marriage score	$r=-0.120$ $p=0.091$	$r=-0.131$ $p=0.065$	$r=0.544$ $p<0.001$	$r=0.710$ $p<0.001$	-

(Spearman correlation test. r: Spearman's rho)

Table 3. Evaluation of risk factors for abortion presence by logistic regression analysis

Variables	P value	OR (95%CI)
Age	0.002	0.914 (0.863-0.968)
Childbearing mother age	0.004	0.862 (0.778-0.954)
Reproductive coercion score	0.091	1.585 (0.929-2.703)
Condom	User	Ref.
	Non-user	0.334 0.684 (0.316-1.478)
Pregnancy intend	Intended	Ref.
	Unintended	<0.001 5.413 (2.487- 11.780)
Occupation	Working	Ref.
	Housewife	0.940 0.962 (0.354-2.615)
Education	Primary/Secondary school	Ref.
	High school	0.302 2.170 (0.498-9.453)
	University	0.353 2.019 (0.458-8.905)
Number of children	No child	Ref.
	One child	0.127 7.884 (0.556- 111.850)
	≥2 children	0.274 4.335 (0.313- 60.059)

(Binary Logistic Regression test, OR: Odds ratio, C.I.: Confidence Interval, Ref: reference value)

Discussion

This present study was conducted with married women admitted to a tertiary hospital outpatient clinic. The relationships and the effects of MT, RC, and contraception methods on women's reproductive health were evaluated. Young age, early childbearing mother age, and unintended pregnancy presence were predictors of abortion. Contraceptive methods such as condoms and withdrawal, whose success depends more on the male partner, were the most used method as a risk for unintended pregnancy that may be related to abortion. MT and RC scores had no effect on abortion or unintended pregnancy rate, and women had a low coercion score in our study.

Among all pregnancies, 85 million unintended pregnancies occurred in the world in 2012, of which 50% resulted in abortion.¹⁵ In the studies of İzmir, Ankara, Kayseri, Hatay, Diyarbakır, Erzurum, and Manisa, it was determined that the rates of unintended pregnancy in women ranged between 15% and 47%.¹⁶ To prevent abortions, unintended pregnancies should be prevented with birth control methods. According to the 2018 data from the Turkey Demographic and Health Surveys (TNSA), the unexpected and unintended pregnancy rate in married women aged 15-49 years is a total of 25.0%.¹⁷ The frequency of using any contraceptive method is 70.0%, rated as 49.0% modern and 21.0% traditional ways. The rates of those using modern methods are as follows: Pill 5.0%, IUD 14.0%, injection 1.0%, condom 19.0%, tubal ligation 10.0%.¹⁷ In a study describing family planning method use among women aged between 15-49 in Samsun province, it was found that modern method use was 68.36% of women's contraception whereas traditional protection method use, such as primarily withdrawal, was 31.64%.¹⁸ In our study, withdrawal as a traditional protection use rate was 41.7%. The most common modern method was the condom. Nearly 60% of participants were using a condom in our study sample. Male-based contraceptive methods may be affected by factors such as infection and premature ejaculation, which is especially high (36%) in Turkey, so male-based contraceptive methods are the risk of unintended pregnancies.¹⁹

On the other hand, sexual partner violence is another risk of condom use in unintended pregnancies. Women aged 18-24 years old, women with restrictive health conditions, pregnant women, and women under financial stress are at high risk for sexual partner violence, which may cause abortions.²⁰ Reproductive coercion is a newly identified but commonly experienced form of domestic violence with potentially severe consequences for women's health. Findings suggest that sexually coercive men may be more attracted to women with characteristics associated with sexual vulnerability. In addition, men perceive women differently based on their attachment styles, and sexually coercive men may perceive women differently than other men.²¹ An Indian study has demonstrated that women's experience of reproductive coercion was associated with poor marital quality at 18 months. Women's experience of sexual partner violence was also negatively associated with men's self-reported marital quality. However, among men, the spouse's marital quality was positively associated with

their own rating of marital quality.²² In light of this search, it was thought that marital typology may be related to reproductive coercion and may cause a high unintended pregnancy rate. But, we did not find a relationship between RC scores and MC scores. Additionally, the analyses of women with and without abortion history were similar on RC and MC scores.

We found both young age and early childbearing mother age are at risk of abortion rate. Early marriage age was not significant in abortion presence; the reason for this result was that early marriages usually occur through religious practices without formal documentation.²³ In adolescent marriages, women are also victims of physical violence.²³ Despite adolescent pregnancies being affected by large families and lower levels of education. Contrary to expectations, pregnant adolescents in Turkey reported no greater incidence of psychological problems. This may be due to a sociocultural perception of the functional value of motherhood in the country and a positive attitude toward adolescent pregnancies.²⁴ In our study, education level or financial status was not risk of abortion rate versus unintended pregnancy, young age, and early childbearing mother age.

Especially the pandemic and the associated economic and social support uncertainties will factor into many women's decisions to obtain an abortion.²⁵ In the following days, unintended pregnancies and related abortions will increase. Therefore, contraception methods and safe abortion services have gained even more importance after the Covid-19 outbreak. As a reproductive counselor in a family medicine center, the family physician should know that a young married woman with an unintended pregnancy needs a healthy pregnancy and safe abortus information depending on her high abortion risk.

Limitations

The result of this search is not a generalizable comment because most women prefer not to talk about abortion history depending on cultural and religious reasons. We had to ask for either spontaneous or induced abortion presence in one question without distinction. Abortion stigma or the negative attributes assigned to women seeking or having had abortions may be an underlying cause.

Ethical Considerations: This study's ethics committee approval was received from the Ministry of Health Istanbul Provincial Health Directorate Gaziosmanpaşa Training and Research Hospital Clinical Research Ethics Committee with the approval letter dated 28/04/2021 and decision numbered 270. Informed consent was obtained from all participants.

Conflict of Interest: The authors declare no conflict of interest.

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References

1. Upadhyay UD, Dworkin SL, Weitz TA, Foster DG. Development and validation of a reproductive autonomy scale. *Studies in family planning*. 2014;45(1):19-41.
2. Nazik F, Mumcu Ş, Sönmez M, YILMAZ AN, Yüksekol ÖD. 15-49 Yaş Evli Kadınların Aile Planlamasına İlişkin Tutumlarının Belirlenmesi. *Ordu Üniversitesi Hemşirelik Çalışmaları Dergisi*.4(3):326-36.
3. Çavlin A, Tezcan S, Ergöçmen B. Kadınların Bakış Açısından Kürtaj. *Nüfusbilim Dergisi*. 2012;34(1):51-67.
4. O'Neil ML, Altuntaş D, Keskin AŞ. Yasal Ancak Ulaşılabilir Değil: Türkiye'deki Kamu Hastanelerinde Kürtaj Hizmetleri-2020 [Internet] <https://dspace.ceid.org.tr/xmlui/bitstream/handle/1/1219/2020-kurtaj-arastirmasi-raporu%20%281%29.pdf?sequence=1&isAllowed=y> (Accessed: 24.09.2022).
5. World Health Organization Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2019 [Internet] <https://apps.who.int/iris/handle/10665/327595> (Accessed: 24.09.2022).
6. Dönmez A, Çoban AÖ, Canbay FÇ. İstenmeyen gebelik ve güvenli olmayan düşüklerin çözümünde ebenin rolü. *TAF Preventive Medicine Bulletin*. 2016;15(5):450-7.
7. Sardinha L, Maheu-Giroux M, Stöckl H, Meyer SR, García-Moreno C. Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet*. 2022;399(10327):803-13.
8. McCauley HL, Silverman JG, Jones KA, et al. Psychometric properties and refinement of the reproductive coercion scale. *Contraception*. 2017;95(3):292-8.
9. Selma Ş, Kavlak O. Çocuk gelinler: Erken yaş evlilikleri ve adölesan gebeliklere yaklaşım. *Sosyal Politika Çalışmaları Dergisi*. 2011;25(25):35-44.
10. Vural ZT. Aile Hekimliğinde Obstetrik Hizmetler. *Türkiye Aile Hekimliği Dergisi*. 2007;1(1):40-2.
11. Çetinkaya M, Mercan Y. Spontaneous and Induced Abortions and Its Determinants in Women Aged 15-49. *Turkish Journal of Family Medicine and Primary Care*. 2021;15(3):490-500.
12. Çatal MT, Kalkan M, BATIK MV. Evlilik tipleri ölçeği: Geçerlik ve güvenilirlik çalışması. *OPUS Uluslararası Toplum Araştırmaları Dergisi*. 2018;9(16):498-523.
13. Öztürk R, Güner Ö. Turkish Validity and Reliability of the Reproductive Coercion Scale. *Turkish Journal of Family Medicine and Primary Care*. 2021;15(1):100-9.
14. Tavakol M, Dennick R. Making sense of Cronbach's alpha. *International journal of medical education*. 2011;2:53.
15. Sedgh G, Singh S, Shah IH, Åhman E, Henshaw SK, Bankole A. Induced abortion: incidence and trends worldwide from 1995 to 2008. *The lancet*. 2012;379(9816):625-32.

16. Savaş N, İnandı T, Arslan E, et al. Unintended pregnancies, induced abortions and risk factors in women admitted to hospitals due to birth or abortion in Hatay. *Turkish Journal of Public Health*. 2017;15(2):85-95.
17. Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü. 2018 Türkiye Nüfus ve Sağlık ve Nüfus Araştırması, 2019 [Internet] http://www.sck.gov.tr/wp-content/uploads/2020/08/TNSA2018_ana_Rapor.pdf TNSA_2018_ana_rapor.pdf. (Accessed: 09.12.2019).
18. Çubukçu M. Samsun ili 15-49 yaş grubu kadınların aile planlaması yöntemlerini kullanım dağılımı. *Ankara Medical Journal*. 2018;18(2):207-14.
19. Gonen M, Kalkan M, Cenker A, Ozkardes H. Prevalence of premature ejaculation in Turkish men with chronic pelvic pain syndrome. *Journal of andrology*. 2005;26(5):601-3.
20. Boxall H, Morgan A. Who is most at risk of physical and sexual partner violence and coercive control during the COVID-19 pandemic? *Trends and Issues in Crime and Criminal Justice*. 2021(618):1-19.
21. Barbaro N, Holub AM, Shackelford TK. Associations of attachment anxiety and avoidance with male-and female-perpetrated sexual coercion in romantic relationships. *Violence and Victims*. 2018;33(6):1176-92.
22. Chatterji S, Johns N, Ghule M, et al. Examining the Longitudinal Relationship between Intimate Partner Violence and Couples' Marital Quality in Rural India. *Journal of Family Violence*. 2022:1-10. (doi: <https://doi.org/10.1007/s10896-022-00363-z>).
23. Cevheroğlu BA, Kışlak Ş. Erken Evlilik Yapan Kadınların Evli Kadın Rolünü Deneyimleme Sürecine İlişkin Nitel Bir Araştırma. *AYNA Klinik Psikoloji Dergisi*.9(1):207-33.
24. Tayfun K, Doğan K, Alyanak B, Akaltun İ. An Evaluation of Sociodemographic Characteristics and Pregnancy-Related Psychological Problems in Pregnant Adolescents. *Ankara Medical Journal*. 2017;17(3):151-9.
25. Hukku S, Ménard A, Kemzang J, Hastings E, Foster AM. "I just was really scared, because it's already such an uncertain time": Exploring women's abortion experiences during the COVID-19 pandemic in Canada. *Contraception*. 2022; 110, 48-55. (doi: <https://doi.org/10.1016/j.contraception.2022.01.014>).