PMA2020 ABORTION SURVEY RESULTS: NIGERIA

April–May 2018

KEY FINDINGS

- In 2017, the annual incidence of abortions in Nigeria was 29.0 per 1,000 women age 15 to 49 based on respondent reporting—more than 1.2 million abortions. When including information related to the experience of respondents' closest confidantes, the number of abortions in Nigeria rose to nearly 2.0 million.[1]
- More than 6 out of 10 abortions were considered most unsafe[2], and 11% of women sought care at a health facility following perceived complications.
- Women living in rural areas, younger women, women with no education, and women who are poor were the most likely to have the most unsafe abortions.
- In Nigeria, most public tertiary facilities provided postabortion care (92%) and safe abortion services to save a woman's life (83%); lower level public facilities and private facilities were much less likely to do so.

An estimated **3 to 5%** of reproductive age women had an abortion in the 12 months prior to this study, indicating that **1.2 to 2.0 million** abortions occur annually in Nigeria.

Abortion in Nigeria

Although Nigeria ratified the Maputo Protocol,[3] an agreement among African Union countries that protects women's and girls' reproductive rights, abortion is only legal to save a woman's life. Prior to this study, recent estimates that relied primarily on facility-based abortion complications data indicated there were approximately 33 abortions per 1,000 women age 15 to 49 in Nigeria in 2012—approximately 1.25 million abortions annually.[4] The majority of these abortions would be considered unsafe.

In 2018, Performance Monitoring and Accountability 2020 (PMA2020) conducted a survey to produce updated and expanded estimates of abortion-related indicators. The survey results provide new insights into the characteristics of women who have an abortion and the pathways leading to abortion within or outside the health care system.

PMA2020 Measurement of Abortion Incidence

Direct and indirect incidence measures

Prior research demonstrates that asking women directly about their experience with abortion results in substantial underestimation of this stigmatized behavior. To generate more valid data, interviewers asked respondents about their closest confidante's experience with abortion prior to asking the respondent about her own experience. The responses were used to produce direct estimates of abortion incidence (self-report) and indirect estimates (confidante). This latter approach draws on the Guttmacher Institute's proposed adaptations of existing social network-based methodologies for abortion measurement.[5,6,7]

In this survey, female interviewers asked 11,106 women age 15 to 49 years two sets of questions on abortion for themselves and their closest confidante: one asked about "pregnancy removal" and the other about "regulating a period when you were worried you were pregnant". Final one-year abortion incidence estimates for respondents and confidantes were calculated by averaging the pregnancy removal and combined (pregnancy removal and period regulation) rates. More detail on the methods are provided elsewhere.[1]

CONFIDANTE:

A confidante is a respondent's closest female friend or relative. A respondent and confidante share very personal information with each other, and similar to the respondent, the confidante lives in Nigeria and is between the ages of 15 and 49.

[1] Bell, S.O., et al. (2020). "Inequities in the incidence and safety of abortion in Nigeria." BMJ Global Health, 5(1): e001814. [2] Bell, S.O., et al. (2019). "Measurement of abortion safety using community-based surveys: Findings from three countries." PLoS ONE, 14(11): e0223146. [3] Adopted by the African Union in the form of a protocol to the African Charter on Human and Peoples' Rights, Relating to the Rights of Women (http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf) [4] Bankole, A., et al. (2015). The incidence of abortion in Nigeria. International Perspectives on Sexual and Reproductive Health, 41(4), 170-181.) [5] Rossier, C., et al. (2006). "Estimating clandestine abortion with the confidants method—results from Ouagadougou, Burkina Faso." Social science & medicine 62(1): 254-266.) [6] Yeatman, S. and J. Trinitapoli (2011). "Best-friend reports: A tool for measuring the prevalence of sensitive behaviors." Am J Public Health 101(9): 1666-1667.) [7] Sedgh, G. and S. Keogh (2019). "Novel approaches to estimating abortion incidence." Reproductive Health, 16(44).

One-year abortion incidence (per 1,000 women) for female respondents and their closest female confidantes[1]

	Respondent	Confidante
Pregnancy removal	18.7	35.1
Period regulation	22.6	28.3
Pregnancy removal + period regulation*	39.4	56.5
Final one-year incidence**	29.0	45.8
Annual number of abortions	1,251,069	1,980,140

*The combined rate is not equal to the sum of the pregnancy removal and period regulation rates as some women reported both a pregnancy removal and a period regulation in the prior year.

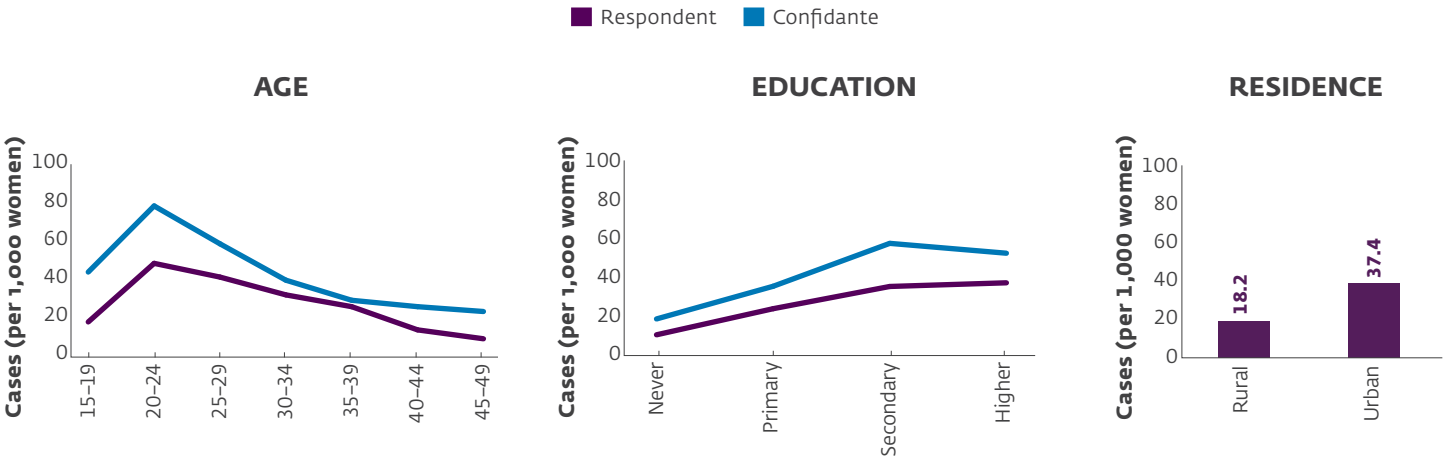
**As described on prior page (and in associated citation), final incidence estimate is an average of the pregnancy removal and combined estimates.

"Nobody can stop anyone from having abortions... If I tell you that it has stopped in this community then I am telling a lie."

— 23-YEAR-OLD UNMARRIED WOMAN

Abortion incidence was highest among women in their 20s, women with secondary education or higher, and women living in urban areas.

One-year abortion incidence among female respondents and their closest female confidantes in Nigeria, by background characteristics[1]

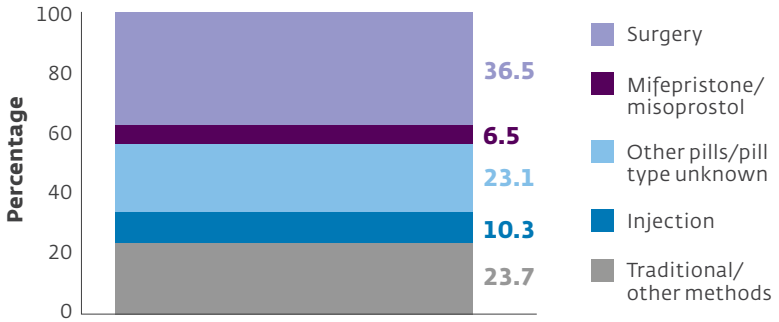


Pathways to Abortion and Abortion Safety

Based on self-reported likely-abortion data (pregnancy removal and period regulation combined), 19% of women indicated they used multiple methods to terminate their pregnancy. Altogether, 36% underwent surgery to ultimately terminate their pregnancy, 7% used mifepristone/misoprostol, and the remaining 57% used other or unspecified medications or traditional methods for their abortion.

Respondents' likely abortion final method

whether one or more methods was used



"I took some drugs hoping it will work but it didn't work. So, while I was waiting for the drugs to remove the pregnancy, time was already ticking. By then I had lost so much time and it was almost two months, so I just decided that it was best I go to the hospital to remove the pregnancy."

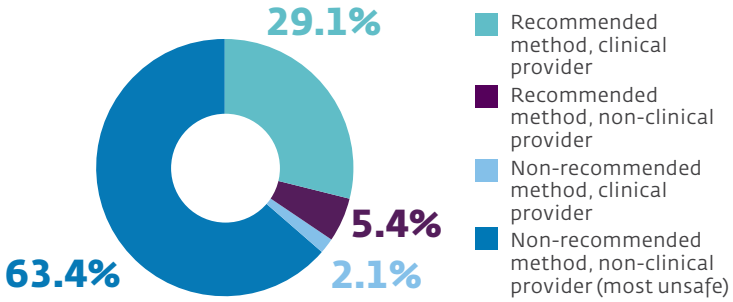
— 30-YEAR-OLD MARRIED WOMAN

More than **6 out of 10** abortions were considered most unsafe, and **11%** of women experienced complications for which they sought postabortion care at a health facility.

Safety of respondents' likely-abortions

pregnancy removals and period regulations combined

Women in rural areas (73%), women with no education (81%), women in the lowest wealth quintile (82%), and girls aged 15-19 (88%) were the most likely to have an abortion that is considered most unsafe.[2]



PMA2020 DEFINITIONS OF ABORTION SAFETY[2]

Abortion safety was operationalized into four categories using abortion method and source data as follows:

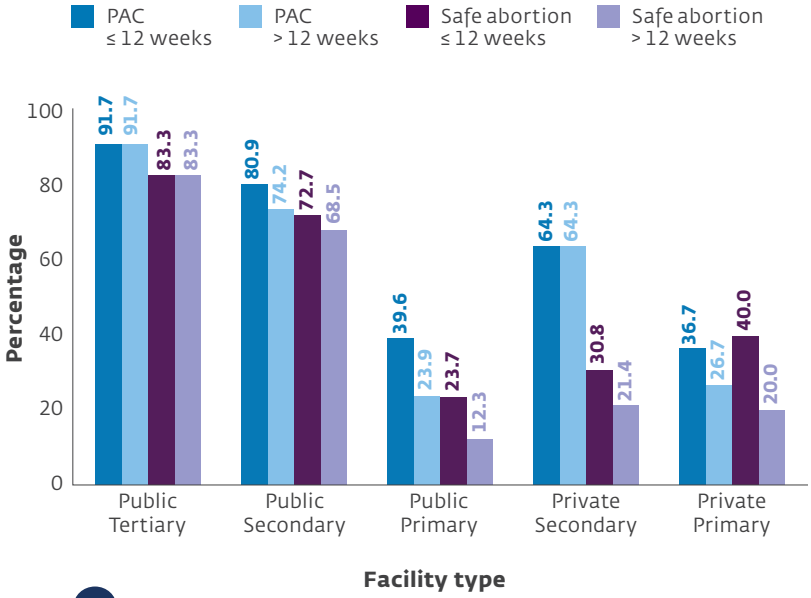
1. Recommended method(s) (i.e. surgery or mifepristone/misoprostol) from clinical source(s) (i.e. public or private healthcare facilities)
2. Recommended method(s) involving non-clinical source(s)
3. Non-recommended method(s) from clinical source(s)
4. Non-recommended method(s) involving non-clinical source(s)

Abortions in the fourth category were deemed most unsafe.

Service Delivery: Postabortion Care (PAC) and Safe Abortion Service Availability

Most public tertiary and secondary facilities provided PAC services, but only 67% of public secondary facilities had the necessary equipment, medicines, and other services (i.e. signal functions) to provide basic PAC. Only 40% of public primary facilities provided any PAC services and significantly fewer had all basic PAC signal functions. Private secondary facilities were less likely than comparable public facilities to provide PAC services.

Percentage of facilities offering PAC and safe abortion services to save a woman's life at 12 weeks or less and more than 12 weeks gestation by facility type (n=429)



Percentage of facilities that have all basic and comprehensive PAC signal functions by facility type (n=429)*

Facility type	Basic	Comprehensive
Public Tertiary	91.7	50.0
Public Secondary	67.4	23.6
Public Primary	26.4	1.8
Private Secondary	50.0	14.3
Private Primary	23.3	3.3

**Basic PAC signal functions include ≤12 weeks gestation removal of retained products, antibiotics, oxytocis, intravenous replacement fluids, and provision of any contraception; comprehensive PAC signal functions include basic PAC signal functions plus >12 weeks removal of retained products, blood transfusion, laparotomy, 24/7 PAC service availability, and provision of long-acting reversible contraception.*

"I had two options. Do or die. That the surgery might take life, or it might not take life. It really made me scared and I said I will not do it. After a while I accepted, I prayed and asked God for forgiveness to grant me safety during the surgery."

— 23-YEAR-OLD UNMARRIED WOMAN

[6] *Ganatra, B., et al. (2017). Global, regional, and subregional classification of abortions by safety, 2010-14: Estimates from a Bayesian hierarchical model. The Lancet, 390(10110), 2372-2381.*

METHODOLOGICAL CONTRIBUTIONS OF THE PMA2020 ABORTION SURVEY

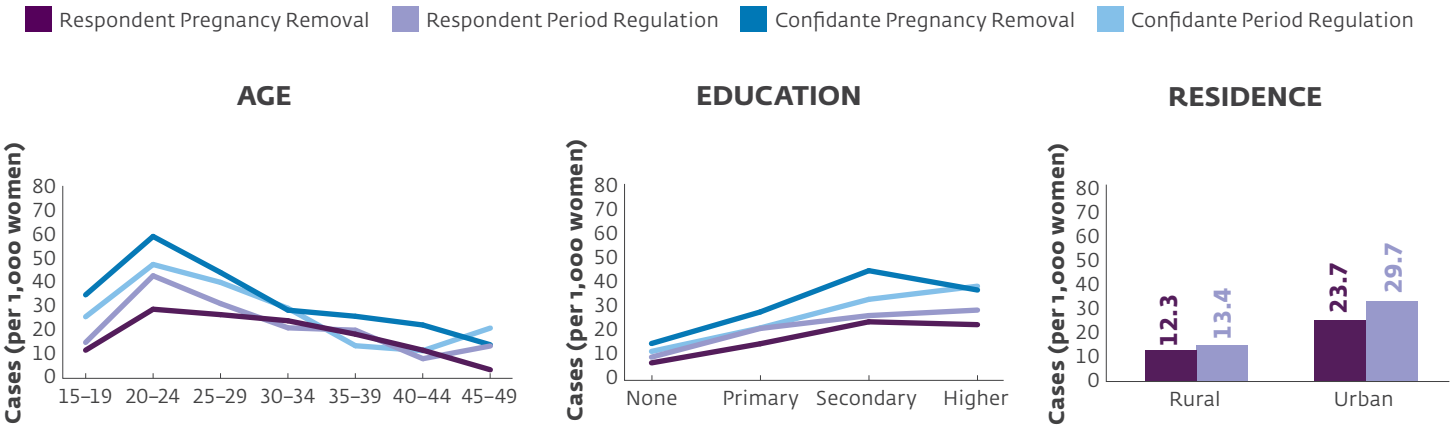
Direct Versus Indirect Estimation of Abortion

Prior to this PMA2020 survey, researchers generated recent Nigeria abortion estimates from facility-based data on abortion complications, then multiplied those data by an inflation factor to account for abortions that likely occurred outside of health facilities (known as the Abortion Incidence Complication Methodology, or AICM).[2] While this indirect approach has proven more useful than an underreported direct measurement of abortion, it is nevertheless important to draw from innovations in the field to further improve direct reporting and other community-based indirect methodologies. These methods can yield rich data on the characteristics of women undergoing abortions and the specifics of their abortion experiences, including for abortions occurring outside of the health care system. PMA2020's community-based data on respondents' and confidantes' abortions seeks to address these limitations.

Pregnancy Removal Versus Period Regulation

Pregnancy removal and period regulation incidences largely follow similar trends by age, education, and residence. However, asking separately about period regulation captures additional likely abortions that would otherwise be missed if asking only about pregnancy termination.

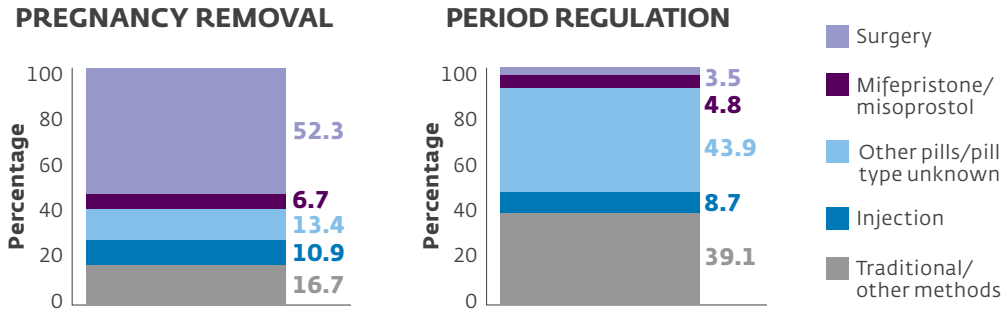
One-year incidence of pregnancy removal and period regulation for respondents and their closest female confidantes by characteristics



Respondents' likely abortion final method

whether one or more methods was used

Respondents more often ultimately removed a pregnancy using surgery, whereas they primarily relied on pills for period regulations at a time when they were worried they were pregnant.



SAMPLE DESIGN

The PMA2018/Nigeria survey used a two-stage cluster design within a sample of seven states. A total of 302 enumeration areas (EAs) were drawn from the National Population Commission's master sampling frame after stratifying by state. In each EA, data collectors listed and mapped households and private health facilities; supervisors randomly selected 35 to 40 households from each EA sampling list. Interviewers surveyed households and invited all eligible females age 15 to 49 to consent for the female survey. The final completed sample included 10,070 households (97.5% response rate), 11,106 de facto females (98.1% response rate), and 429 advanced health facilities (96.6% response rate). Among the female respondents who reported a recent abortion, data collectors followed-up with and conducted in-depth qualitative interviews with 30. The advanced health facilities interviewed included: 12 tertiary facilities, 103 secondary facilities, and 314 primary facilities. Data collection occurred from April through May 2018. The female estimates in this brief reflect weighted values; facility estimates are unweighted.

The PMA2020 project is implemented by local universities and research organizations in 11 countries, deploying a cadre of female resident interviewers trained in mobile-assisted data collection. The Centre for Research, Evaluation Resources and Development (CRERD) and Bayero University Kano (BUK) implement the PMA2020/Nigeria project with overall direction and support provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health. An Anonymous Donor provided funding for the abortion module development, implementation, and analysis. The Nigeria survey is endorsed and supported by the Federal Ministry of Health, the National Population Commission, the National Bureau of Statistics, and State Ministries of Health.