PERFORMANCE MONITORING FOR ACTION

PMA ABORTION SURVEY RESULTS: KONGO CENTRAL, DEMOCRATIC REPUBLIC OF CONGO

December 2021 – April 2022

KEY FINDINGS :

Induced abortion is a common reproductive health event in Kongo Central, DRC, with approximately 44 abortions per 1,000 women ages 15-49 in 2021. Most women indicated that they were either unmarried, too young, or without the financial resources to continue a pregnancy.

42% of abortions were unsafe, using means other than a facility-based surgery or medication abortion pills to end the pregnancy.

Six out of 10 women who had an abortion reported a potential severe complication such as fever, vaginal discharge, or a complication requiring surgery, and only 63% of those women sought postabortion care in a facility.

ABORTION IN DRC: RECENT CHANGES HAVE EXPANDED LEGAL CONDITIONS

Abortion is a common reproductive health event in the Democratic Republic of Congo (DRC), with a 2016 estimated incidence of 55-56 abortions per 1,000 women ages 15 to 49 in Kinshasa;[1,2] no similar estimates exist for Kongo Central. Many abortions in the DRC lead to complications requiring postabortion care, some of which result in maternal deaths. In response to the health concerns surrounding unsafe abortion, the government decriminalized induced abortion in 2018 making it legal in cases of sexual assault, rape, incest, fetal abnormalities, and when continuing the pregnancy endangers the mental or physical health or life of the woman. In 2020, the Ministry of Health approved comprehensive abortion care guidelines in alignment with the Maputo Protocol, which made abortion legal under the previously specified conditions up to 14 weeks of pregnancy and removed key barriers to accessing safe abortion care. The changing legal and abortion practice landscape calls for a re-examining of patterns of abortion incidence and safety to monitor progress and guide ongoing reforms.

THE PMA KONGO CENTRAL ABORTION STUDY

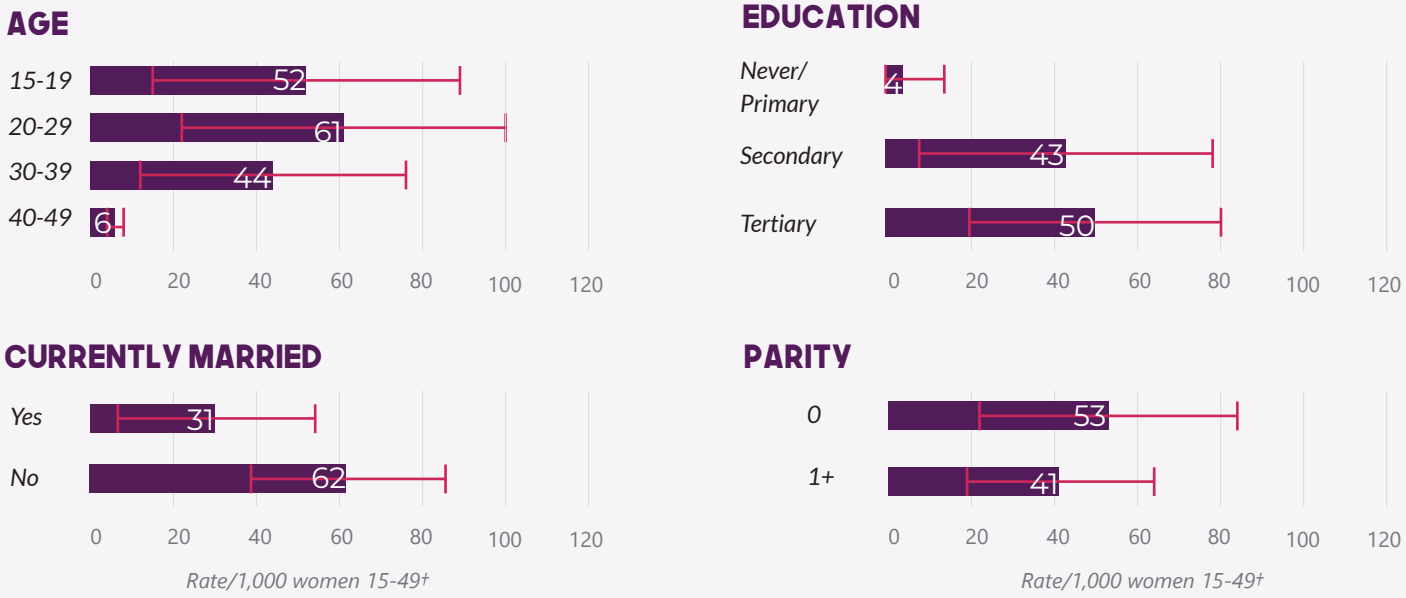
Between December 2021 and April 2022, Performance Monitoring for Action (PMA) conducted a survey to produce estimates of abortion incidence and safety in Kongo Central. The study used representative data on women of reproductive age (15-49) and their reports of their and their closest female friend's abortion experiences. Additional details regarding the sampling design and information on the survey questions and friend methodology are included at the end of this brief and further described elsewhere.

ABORTION IS A COMMON REPRODUCTIVE EVENT IN KONGO CENTRAL

Overall, there were approximately 44 (95% confidence interval (CI) 23-66) abortions per 1,000 women ages 15-49 in Kongo Central, DRC in 2021. This is equivalent to 51,000 abortions. The incidence is highest among women with higher levels of education, unmarried women, and women without any children.

Past-year intimate partner violence and household violence were more common among those who reported an abortion in the past year (67% and 24%, respectively) compared to those who did not report an abortion in the past year (20% and 15%, respectively).

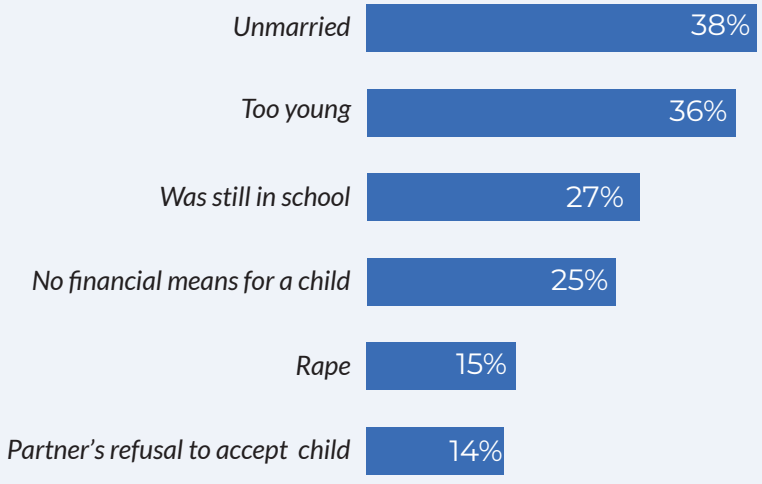
ONE-YEAR ABORTION INCIDENCE IN KONGO CENTRAL, DRC BY WOMEN'S CHARACTERISTICS, 2021 (N=1,586)



†Abortion incidence estimates come from adjusted friend data

PRIMARY REASONS FOR ABORTION

Reasons for abortion varied across the lifespan but were often related to accidental pregnancies that occurred when women could not take on parenting responsibilities because they were unmarried, too young or not financially prepared. Additional reasons involved experiences of sexual violence or issues in their partnerships.

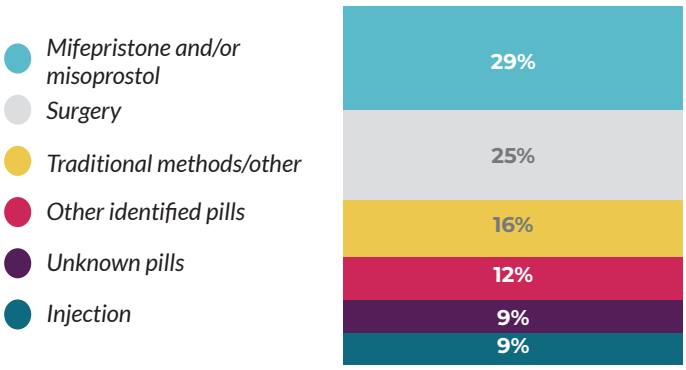


ABORTION TRAJECTORIES OFTEN INFLUENCED BY INCOMPLETE INFORMATION AND COSTS OF TERMINATING

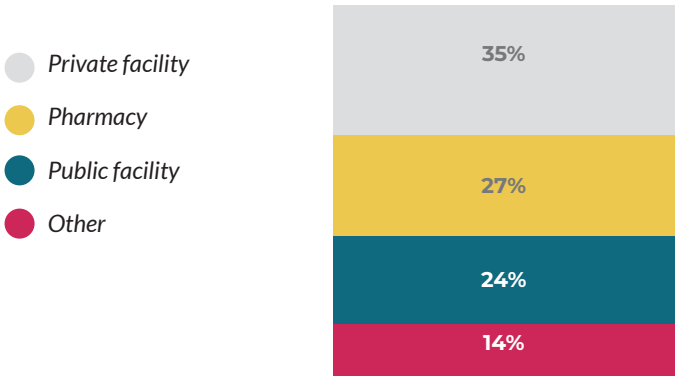
Despite recent legal reform, a third of women were unaware the law allowed legal abortion in certain circumstances, with adolescents, those with little or no education, and those with no children least likely to know. Relatedly, 42% of women were unaware of a safe abortion method (i.e., surgery or medication abortion pills); adolescents, women with little or no education, married women, and poorer women were least likely to be aware of a safe method.

Women relied on a variety of abortion methods and sources of care, with 44% reporting using more than one method. Abortion pills (29%) and sugery (25%) were the most common methods used while pharmacies (35%) and private facilities (27%) were the most common sources.

ABORTION METHOD*



ABORTION SOURCE*



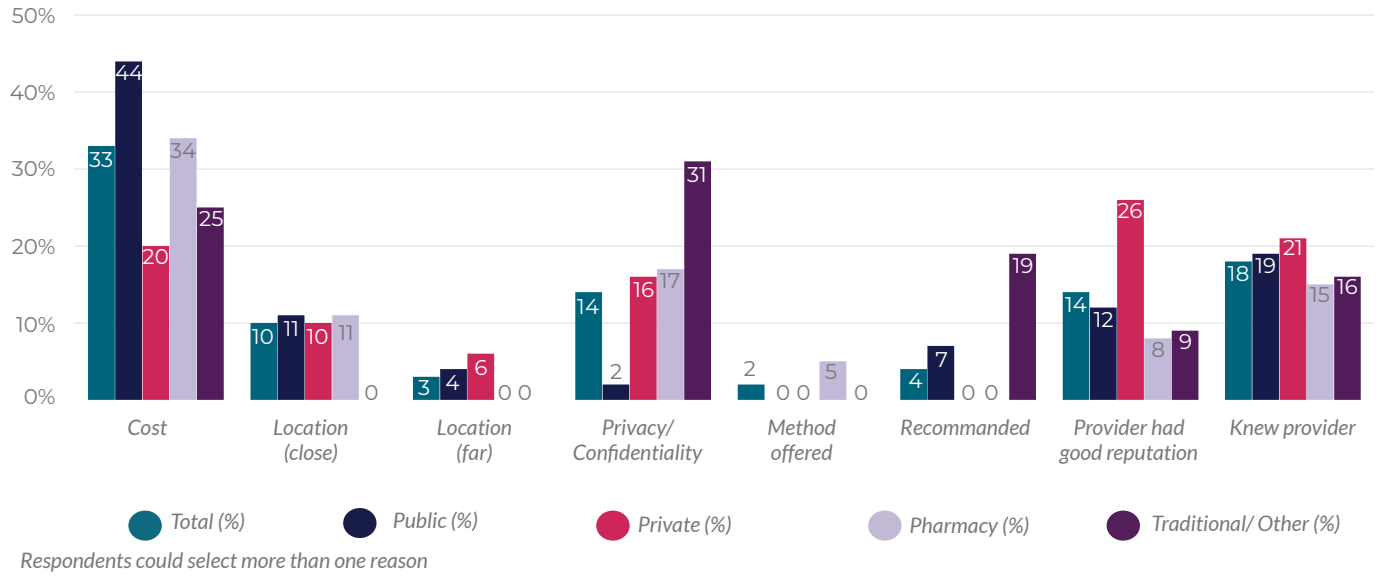
Method and source estimates from respondents (n=148)

percent of women self-managed their abortion using medication abortion pills obtained from outside a health facility at some point in their abortion trajectory. These women tended to be more educated, unmarried, and without children.

Decision-making

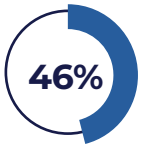
Cost was the most common reason for choosing an abortion source overall (33%) and for those who went to a public facility (44%) or a pharmacy (34%), whereas provider reputation was the most common reason for those who went to a private facility (26%). Confidentiality/privacy was the most common for those who went to a traditional/other source (31%).

REASONS BY SOURCE

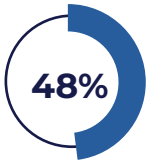


Respondents could select more than one reason

Accessing abortion care is challenging for many women



of women said it was somewhat or very difficult to pay for their abortion. Those who were less educated and poorer were more likely to report difficulty.

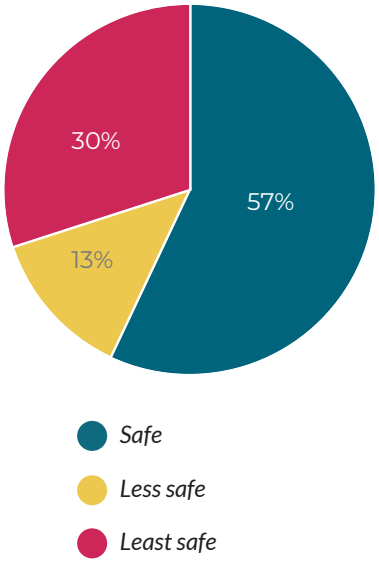


said that part of their payment was a bribe. Paying bribes was more common among those seeking abortion care at public facilities.

DESPITE LEGAL REFORM, MANY ABORTIONS ARE UNSAFE

Nearly half of abortions were unsafe (43%), not involving surgery from a clinical source or medication abortion pills. These estimates are likely an under-representation of unsafe abortion as many women in the DRC who had surgery or medication abortion described incomplete abortions requiring further treatment. Results suggest that women with less education and unmarried women are most likely to have an unsafe abortion.

DISTRIBUTION OF ABORTION SAFETY ACCORDING TO WHO GUIDELINES*



*Estimates of abortion safety from respondents (n=148).

PMA DEFINITIONS OF ABORTION SAFETY

Abortion safety was operationalized into three categories, similar to the World Health Organization (WHO) measurement.[3] This definition reflects recent changes to WHO safe abortion guidelines that include self-managed medication abortion.[4] The safety categories are as follows:

1. Safe: surgery in a clinical setting or medication abortion pills regardless of provider
2. Less safe: surgery from a non-clinical source or non-recommended method from clinical source
3. Least safe: neither a recommended method nor a clinical source

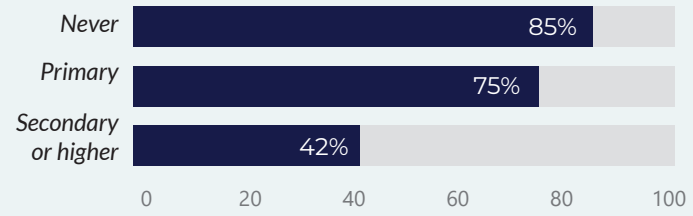
*Less safe and least safe categories combined are considered unsafe abortions.

"I knew that abortion had such risks that I can die; I can bleed too much."

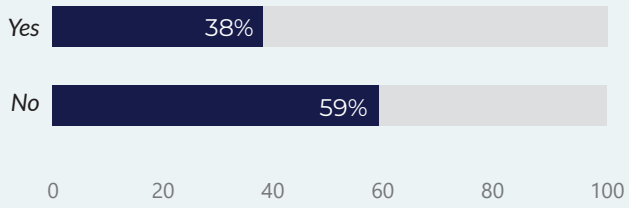
Woman living with her partner, 25 years old and 2 children at the time of the abortion

PERCENT OF INDUCED ABORTIONS CONSIDERED UNSAFE BY SELECT BACKGROUND CHARACTERISTICS (N=156)*

EDUCATION



CURRENTLY MARRIED



*Abortion safety estimates come from adjusted friend data.

QUALITY POSTABORTION CARE IS NEEDED TO TREAT COMPLICATIONS FROM UNSAFE ABORTION

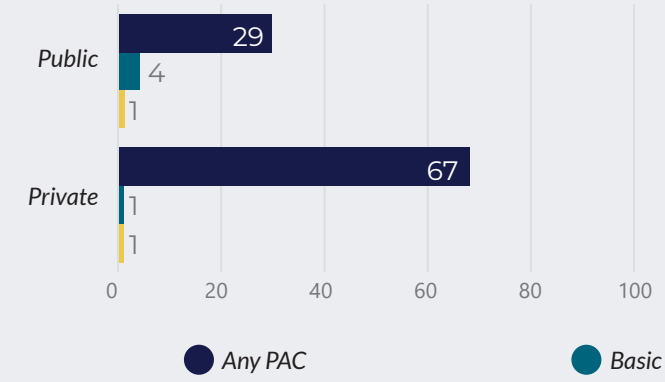
61% of women reported a potential severe complication such as fever, vaginal discharge, or complication requiring surgery. Women with no formal schooling were more likely to experience a potential severe complication. Only 63% of those with severe complications reported obtaining postabortion care (PAC) from a facility.

PAC Availability

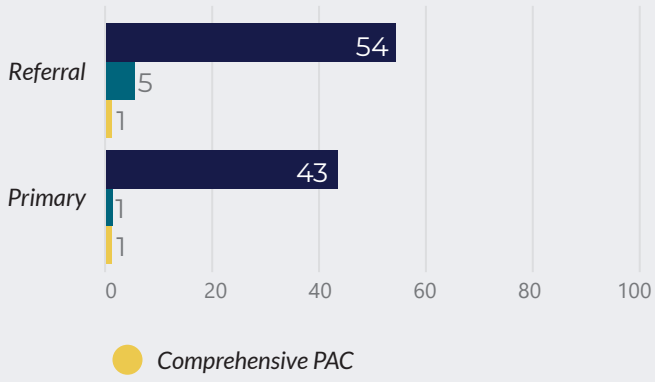
Overall, 47% of health facilities in Kongo Central report treating abortion complications in the last three months. However, only 2% are ready to provide every component of basic PAC*, and only 1% are ready to provide every component of comprehensive PAC**. Though very few had all of the necessary components for PAC, many facilities were able to provide most components.

PERCENTAGE OF FACILITIES PROVIDING BASIC AND COMPREHENSIVE PAC, BY FACILITY CHARACTERISTIC (N=80)

MANAGING AUTHORITY



FACILITY TYPE



Any PAC Basic PAC Comprehensive PAC

*Basic PAC components include: one or more doctor, degree nurse, or degree midwife; obstetric staff present or on call at all times; injectable antibiotics; injectable uterotonics; misoprostol; functioning vacuum aspirator; intravenous fluids; any modern, short-acting contraceptive method in stock. Modern, short-acting methods include oral contraceptive pills, progestin-only oral contraceptive pills, male condoms, female condoms, progestin-only injectable contraceptives, combined injectable contraceptives, and. emergency contraceptive pills.
**Comprehensive PAC components include: all basic PAC components; performed blood transfusion in the last three months; performed a cesarean section in the last three months; one or more doctor(s); any long-acting reversible contraceptive (LARC) in stock. LARCs include implants and intrauterine devices (IUDs).
DHS SPA data (2017-2018) were used to obtain PAC estimates.

"When I noticed that I was pregnant, I told myself that with what I earn now, I would not be able to take care of this child. I still needed to work to make enough money and this pregnancy could make me lose my job. So it was a choice between keeping my job and letting the pregnancy continue."

Woman living with her partner, 18 years old and no children at the time of the abortion

"It was poor quality. He was giving out no-name pills, he had no sense of follow-through, basically he didn't care about my health at all, all he cared about was his money."

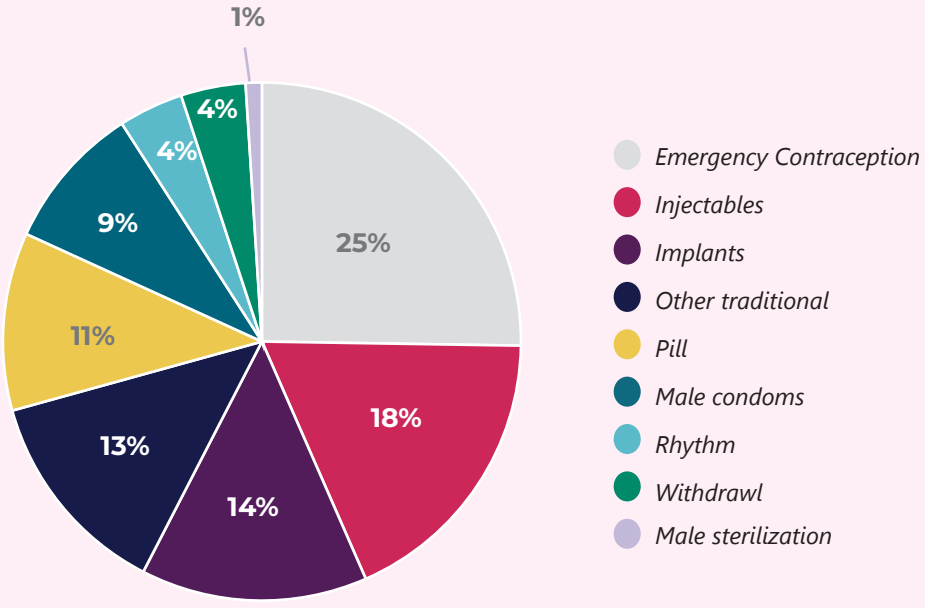
Woman living with her partner, 23 years old and 1 child at the time of the abortion

Postabortion contraception

Only 26% of women whose abortion source was a public/private facility or pharmacy were offered postabortion family planning.

35% of all women who reported an abortion adopted a method of contraception postabortion. Those who were unmarried, without children, and wealthier were more likely to adopt postabortion contraception. The most common contraceptive methods adopted were emergency contraception (25%) and injectables (18%), followed by implants (14%) and traditional methods (13%). Those whose last abortion source was a public facility had the highest postabortion contraceptive uptake (51%), followed by those who went to a pharmacy (40%).

POSTABORTION METHOD ADOPTED



[1] Chae, S., P. K. Kayembe, J. Philbin, C. Mabika and A. Bankole (2017). "The incidence of induced abortion in Kinshasa, Democratic Republic of Congo, 2016." PLOS ONE 12(10): e0184389; [2]Ishoso, D. K., A. K. Tshefu, T. Delvaux and Y. Coppieters (2019). "Extent of induced abortions and occurrence of complications in Kinshasa, Democratic Republic of the Congo." Reproductive health 16(1): 1-8; [3]Ganatra,B., et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet.2017; 390(10110): 2372-8; [4]World Health Organization (WHO). Abortion care guideline. 2022. Geneva: WHO.

RECOMMENDATIONS

Findings indicate that women in Kongo Central often rely on abortion – often under unsafe conditions – to manage their fertility in the context of experiencing an unwanted pregnancy or pregnancy they are unable to continue. Many women experience complications, even when using recommended methods and receiving care from facilities, and a significant proportion of them don't receive postabortion care. Young women and those from disadvantaged backgrounds are least likely to know safe abortion is legal under many conditions, know a safe abortion method, or have a safe abortion. In light of these results, the following actions could be taken to reduce unsafe abortion and associated negative impacts on maternal health:

- Increase information about family planning methods and services, including in school curriculum, and improve access to contraceptive methods to prevent unintended pregnancies.
- Inform the public and providers about the specific conditions under which abortion is considered legal in the DRC.
- Train providers on abortion services according to recommended guidelines
- Ensure the availability of quality safe abortion and postabortion care services to all women in need to the full extent of the law, particularly at primary care facilities
- Engage providers and the public to increase awareness of the public health consequences of unsafe abortion.

Taken together, these changes can significantly reduce the extent of unsafe abortion, associated complications, and disparities, and reduce the hundreds of preventable unsafe abortion-related maternal deaths that occur each year in the DRC.

Sample Design

In the province of Kongo Central, PMA Democratic Republic of Congo collects information on knowledge, practice, and coverage of family planning services in 57 enumeration areas selected using a two-stage stratified cluster sampling approach at the urban level. The results are representative at the provincial level. PMA Phase 3 data were collected between December 2021 and April 2022 from 1,861 households (98.6% response rate), 1,856 females aged 15-49 (97.8% response rate). For more sampling information and full data sets, visit www.pmadata.org/countries/democratic-republic-congo.

For this phase of data collection we added an abortion module to estimate abortion incidence and safety among respondents and a surrogate sample of their closest female friends. This indirect approach assumes the friend sample is similar to that of the respondents, that the respondents know about their friends' abortions, and that they would be more likely to report them than their own. Additional details on the best friend approach and our abortion module are provided elsewhere [Bell, S. O., M. Shankar, E. Omoluabi, A. Khanna, H. K. Andoh, F. OlaOlorun, D. Ahmad, G. Guiella, S. Ahmed and C. Moreau (2020). "Social network-based measurement of abortion incidence: promising findings from population-based surveys in Nigeria, Cote d'Ivoire, and Rajasthan, India." Population Health Metrics 18(1): 1-15; Bell, S. O., E. Omoluabi, F. OlaOlorun, M. Shankar and C. Moreau (2020). "Inequities in the incidence and safety of abortion in Nigeria." BMJ Global Health 5(1): e001814.]. Data collectors also followed up with and conducted in-depth qualitative interviews with 52 women who reported an abortion in the PMA study and consented to be recontacted. Percentages presented in this factsheet have been rounded and may not add up to 100%.

PMA uses mobile technology and female resident data collectors to support rapid-turnaround surveys to monitor key family planning and health indicators in Africa and Asia. PMA Democratic Republic of Congo is led by the École de Santé Publique de l'Université de Kinshasa. Overall strategy and support is provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins University and Jhpiego. Funding for PMA is provided by the Bill & Melinda Gates Foundation; funding for the abortion module was provided by the Packard Foundation.

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