

Empowering Adolescent Girls and Young Women: A Self-Care Approach to Overcoming Sexual and Reproductive Health Barriers in Nigerian Urban Slums

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Abstract: *Adolescent girls and young women face significant sexual and reproductive health challenges in Nigeria with barriers limiting access to safe therapeutic and post abortion care especially at the grassroots including urban slums. The study evaluated a self care and task shifting intervention to increase access to safe therapeutic and post abortion. A pre and post intervention study between 2021 and 2022 was conducted in 3 urban slums of the Federal Capital Territory of Nigeria. This was followed by an intensive training on modern contraceptives, effective administration of Misoprostol for safe therapeutic and post-abortion care, supply of Misoprostol and contraceptives and; monitoring. Both baseline and endline data were collected using semi-structured questionnaires and interviews. The quantitative data were analyzed for frequency of occurrence. The information from the KIIs were transcribed and analyzed for themes and contents. All respondents were exposed to safe therapeutic abortion and family planning information and services as a result of the intervention with significant increased uptake. There was a significant increase in the knowledge and performance of the respondents in the use of Misoprostol for safe therapeutic abortion and post abortion care family planning methods. Utilization of safe therapeutic abortion service and uptake of modern contraceptives increased at all intervention sites over the duration of the intervention. The self care and task shifting safe therapeutic abortion intervention showed favourable outcomes over the short implementation timeframe. The evaluation demonstrated the potential for sustainability with more efforts and further intervention.*

Keywords: safe abortion, self care, misoprostol, postabortion contraceptives

1. Introduction

Compared to the general public, Adolescent Girls and Young Women (AGYW) aged 15–24 years, have a greater vulnerability to unsafe abortion occasioned by unmet need for family planning and unwanted pregnancies [1]. This is because they are far more likely to enter into sexual relationships and also more likely to delay marriage in order to complete school and become better prepared to join the labour force [2]. Globally, an estimated 121 million unintended pregnancies occur each year among women of reproductive age, and ~60% end in abortion [3]. Nigeria has one of the highest maternal mortality ratios in the world [4], although the government has acknowledged the problem and is committed to improving maternal health, evidence suggests that progress has been limited, and unsafe abortion remains a major contributor to maternal morbidity and mortality. In 2017, according to PMA2020 [5], the annual incidence of likely abortions in Nigeria was 41.8% per 1000 women aged 15-49 (nearly 1.8 million abortions). Literature reviews indicates that unsafe abortion complications accounts for 20%–40% of maternal deaths in Nigeria [6].

WHO 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[7]. In Nigeria abortion is restricted by law, hence, the utilization of unsafe abortion to terminate unwanted pregnancy has become necessary [8]. While contributing to maternal mortality, unsafe abortion results in an estimated 20,000 deaths of women in Nigeria yearly, with majority of the survivors having to live with serious complications including damage to vital organs and infertility[9]. In addition there is the huge burden on the health system as most cases of complications are admitted in the hospital, draining scarce human and material resources.

Globally, medical abortion (MA) has become an increasingly important method for people seeking to terminate a pregnancy [2]. While mifepristone followed by misoprostol is the preferred MA regimen recommended by the WHO, misoprostol alone is recommended as a safe and effective alternative where mifepristone is not available [10]. Medical Abortion (MA) refers to early pregnancy termination using drugs. It is a non-surgical method of abortion administered through the use of the pharmaceutical drugs, mifepristone and misoprostol, or misoprostol alone. Misoprostol is a WHO-approved drug for MA that is widely available in pharmacies in low- and middle-income countries (LMICs) as it has other indications including treatment of gastric ulcers and

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postpartum haemorrhage. Medical abortion (MA) has the potential to expand access to safe abortion services because this method is well-suited for the primary health care setting. Misoprostol is registered in Nigeria but its use in abortion was off-label. Though MA has the potential to expand access to safe services, availability of service providers is a necessary requirement to meeting women's reproductive health needs.

Overall, the delivery of quality FP services across Nigeria depends on the skilled providers and human resource availability at both public and private points of care. Nigeria's Human Resources for Health have been affected by factors ranging from shortage of manpower with attendant burnout, lack of adequate hazard allowance, outstanding Medical Residency Training Fund, etc.; leading to a devastating decline in number of especially skilled health workers attending to an increasing number of clients seeking for medical services. Based on the realization of severe health care worker shortage globally especially in sub-Saharan Africa, Nigeria inclusive, the World Health Organization (WHO) proposed task shifting to improve access to health care services[11]. Task shifting is the name given to a process whereby specific tasks are moved, where appropriate, to health care workers with shorter training and fewer qualifications. Task shifting is considered as a public health initiative that takes a comprehensive approach, with intentions to address the health care workforce requirement of all priority health programmes in the country. In addition, task shifting is among strategies for accelerating the progress towards achievements of the health-related SDGs. As such, the policy focuses on key priority areas such as family and reproductive health and maternal and child health services (RMNCH), as well as HIV, TB, malaria and other communicable and non-communicable diseases in essential health services package [12].

Regarding FP, task sharing is commonly practiced in the public health sector to community healthcare workers but not implemented often in the private sector with CPs and PPMVs despite it being considered a high impact practice in FP[13]. As reported by Dawson et al. (2013)[14], shifting and sharing tasks may increase access to and availability of maternal and reproductive health (MRH) services without compromising performance or patient outcomes which may be cost-effective. Similarly, the task to be shifted is defined and described, and where funding is moved to the new individual assigned to the task in a deliberate manner. Thus, task shifting succeeds with deliberate support for training, services restructuring, mentoring, supervision, and continuous support from existing health system structures[14], [15]. Researches has demonstrated that strengthened collaborations and effective referral linkage between traditional and non-traditional health care providers such as birth attendants, community health workers and women artisan groups to facilitate distribution of contraceptives and abortion medications in the communities is a task-shifting option that could reduce unwanted pregnancy and the associated maternal morbidity and mortality from unsafe clandestine abortion[16].

Health Service provision in Nigeria can be either public or private entities but all primary health care (PHCs) facilities are funded by the government. The private sector also encompasses Private Patent Medicine Vendors (PPMVs) and Community Pharmacies (CPs). PPMVs are only allowed to stock condoms and to re-supply oral contraceptive pills, CPs can dispense pills and in some cases provide injectables while hospitals can offer a greater number of contraceptive methods [17].

1.1 Pre-Intervention

The baseline study[18] which explored the task shifting potentials of non-health community based providers of comprehensive maternal health services in urban slums demonstrated that major gaps exist in knowledge, attitude and practice of family planning and safe therapeutic abortion among out-of-school adolescent girls and young women.

1.2 Intervention

Following the baseline, a comprehensive training on modern contraceptives and effective administration of Misoprostol for safe therapeutic and post-abortion care for selected community health providers and patent medicine vendors was conducted. The training provided an increase in the health providers' knowledge on modern family planning methods, built their capacities on the proper dosage in the administration of Misoprostol for safe abortion and also changed their attitudes in the stigma attached to abortion. The intervention also included the provision and supply of essential commodities (Misoprostol and contraceptives) in selected facilities to ensure that safe abortion services were available when the services are sought by the adolescent girls and young women within the communities.

1.3 Post-Intervention

This end line study targeted the analysis of post-intervention data and evaluates if interventions were adequate and achieved desired objectives. It also established the magnitude of impact of the project interventions. Similarly, the survey evaluated the changes in knowledge about family planning and abortion-related issues, changes in abortion care-seeking, and service utilization as a result of this intervention.

This report therefore presents the estimates of key project indicators that were measured at baseline (2021) and endline (2022), providing a summary assessment of significant changes that occurred in knowledge and practice among the community health providers and adolescent girls and young adults targeted.

2. Methodology

The survey adopted both quantitative and qualitative descriptive research design, and was carried out in three districts of the Federal Capital Territory (FCT) of Nigeria namely Mpape, Kubwa and Nyanya as in the baseline survey.

The data of 200 clients who accessed the safe abortion service in the last one year was collected; Key Informant Interviews (KII) was conducted with 20 trained health providers comprising of community nurse/midwives, community health workers and Private Patent Medicine Vendors).

A total of 15 questions exit-interviewer, semi-structured questionnaire was used to extract clients' information from the clinic records. The questionnaires were divided into two sections; the first section generated information on the socio-demographic data of the respondents; the second section assessed respondents' practice of family planning and safe therapeutic abortion services. Information about adolescent girls and young women who attended the project participating clinics/hospitals and used misoprostol in the last one year was extracted.

A 6- question KII guide on issues relating to reproductive health services including family planning and safe therapeutic abortion/post-abortion care offered, significance of project interventions in service provision for the clinic in general, challenges/limitations faced in service provision and recommendations for the sustainability of service provision. The KII guide contained an introduction of the researcher and full disclosure of the survey, ethical considerations as well as request for consent. All project-trained health providers within the participating clinics/hospital were interviewed.

Information gathered from the questionnaire was cleaned and coded for data entry. It was then entered and analyzed using IBM SPSS software version 26.0. The quantitative data were analyzed for frequency of occurrence. The information from the KIIs were transcribed and analyzed for themes and contents.

Ethical approval was obtained from the Health Research Ethics Committee (HREC) of the Federal Ministry of Health. Participants were recruited during the baseline survey for voluntary participation in the intervention phase of the project. The training modules were informed and developed based on participants' requests and suggestions during the baseline. Also, supplies of misoprotol and contraceptive commodities were distributed to participating clinics/outlets based on requested stock and re-stock.

3. Results

3.1 Findings from Questionnaire Survey

3.1.1 Socio-demographic Characteristics

Age, marital status, educational qualification and vocational status of respondents were some of the key background variables collected from respondents at both baseline and endline. The endline survey identified more women in the age group (between 25-30 years) as well as more married women than the baseline as shown below in Table 1.

Comparing the proportions from the baseline with the endline sample using a test of the difference between two proportions,

the endline survey identified more women in the age group (between 25-30 years) as well as more married women than the baseline survey.

Table 1: Respondents' Socio-demographic Information

Socio-demographic variable	Baseline (%, N=180)	Endline (%, N=200)
Age group		
15– 19	28.9	8.5
20– 24	34.4	21
25 – 30	36.7	49.0*
31 - 45	0	21.5
Mean Age	22.6	26.9
SD	4.3	5.3
Marital Status		
Single	71.7	15.5
Married	28.3	82
Others**	0	2.5
Educational Qualification		
None	1.1	3
Primary	4.4	6
Secondary	69.4	73.5
Tertiary	25.5	17.5
Employment		
Self Employed	84.4	53.5
Apprentice	15	14
Employee	0.6	7
Unemployed	0	25.5

* *Two-sample test of proportions, significance level $p < 0.05$*

***Separated, divorced or widowed*

3.1.2 Knowledge and Attitude for Safe Abortion and Family Planning

Knowledge and attitudinal scores of the health providers were calculated for each respondent. Score for family planning was calculated for each respondent using a 10-point knowledge scale. Each correct answer had a score of 2, an incorrect answer or a no response had a score of 0 and the open-ended questions had a score of 4. The scores were then summed up to give a composite knowledge score for each respondent. The higher the score, the higher the knowledge and vice versa. Similarly, attitudinal score for family planning and safe abortion was calculated for each participant using a 10-point knowledge scale. Each correct answer had a score of 1, an incorrect answer or a no response had a score of 0. The scores were then summed up to give a composite attitudinal score for each respondent. The higher the score, the more positive the attitude and vice versa.

At endline, participant's attitudes toward abortion changed, nearly all participants in the intervention who were interviewed agreed that they should provide safe abortion information to women who request it. Nearly all agreed that healthcare workers deserve respect for providing abortion care and that abortion should be legally available in the country for any woman who needs it (80%). Among those interviewed at endline, 70% reported discussing safe abortion with colleagues since their training and 84% had spoken to a friend or relative about the risks of having an unsafe abortion.

Table 2: Knowledge and Attitudinal Scores for Family Planning and Safe Abortion

Variable	Baseline (%)	Endline (%)
Knowledge score for family planning		
0 – 3 (Low)	25.6	0
4 – 7 (Fair)	54.4	20
8 – 10 (High)	20	80
Knowledge score for Safe Abortion		
0 – 3 (Low)	91.1	0
4 – 7 (Fair)	8.9	30
8 – 10 (High)	0	70
Attitudinal Score		
0 - 5 (negative)	50.6	40
6 - 10 (positive)	49.4	60

3.1.3 Contraceptive Uptake

Modern contraceptive use has increased significantly since the baseline survey. Pill use rose slightly from 2.2% to 3.5%. Use of injectables also increased from 0.6% to 5.0% during this period. LARCs use increased from 1.7% in the baseline to 10.0% at the endline; the increase was much higher for implants compared to IUDs. In the endline survey, 7.5% of the women were using implants, representing a four-fold increase from the 1.7% recorded at baseline. Also the contraceptive method with the highest uptake at the baseline was condom while the use of implants had the highest increase at the endline survey (Table 3). This reflects the access to implants made possible at community level that the project supported

The modern contraceptive uptake rate among currently married women increased significantly from 6.1% to 17.0% as shown in Table 4.

Table 3: Comparison of Contraceptive Methods Use for Baseline and Endline Surveys

Variable	Baseline (%)	Endline (%)
Current Use		
Yes	12.2	23.5*
No	87.8	76.5
Modern Methods		
Condom	6.1	2
Pills	2.2	3.5
Injectables	0.6	5
Implants	1.7	7.5
IUD	0	2.5

*significance level $p < 0.05$

Table 4: Comparison of Modern Contraceptive Uptake by Marital Status

	Current Contraceptive Use				p-value
	Yes		No		
	Baseline (%) (N=180)	Endline (%) (N=200)	Baseline (%) (N=180)	Endline (%) (N=200)	
Marital Status					
Single	6.1	4	65.6	11.5	0.002*
Married	6.1	17	22.2	65	
Others**	0	2.5	0	0	
Total	12.2	23.5	87.8	76.5	

*Chi-square test, significance level $p < 0.05$

**Separated, divorced or widowed

Figure 1 shows steady increase in Family Planning Uptake at non-facility based sites of intervention and a decline at facility-based intervention sites.

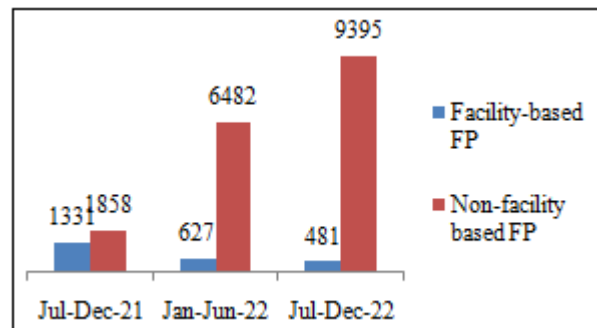


Figure 1: Comparison of Facility-Based and Non-facility based Family Planning Uptake at the intervention sites over a period of 18 months

3.1.4 Post-Abortion Contraceptive Use

Respondents' records showed significant change in the uptake of contraception after safe abortion. The reasons according to the providers included mandatory supply of condoms plus at least one of three other methods of family planning commodities at the end of each procedure. Clinic records showed that 99.9% of clients received post procedure contraception. However, there was poor revisit for re-supply to ascertain continuity.

3.1.5 Misoprostol Use

Figure 2 shows the increase in induce safe therapeutic abortion cases using misoprotol following the onset of the intervention at the endline.

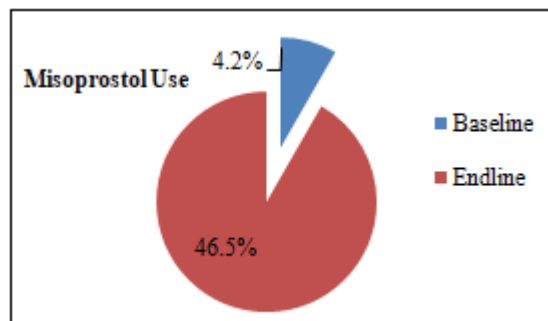


Figure 2: Comparison of the increase in Misoprostol Use for SA at baseline and endline

Figure 3 shows a dramatic rise in the uterine evacuation caseloads following the onset of intervention in a period of 18 months at the three intervention sites. Similarly, Figure 4 shows a comparison of SA request at facility and non facility based intervention sites within the 18 months period

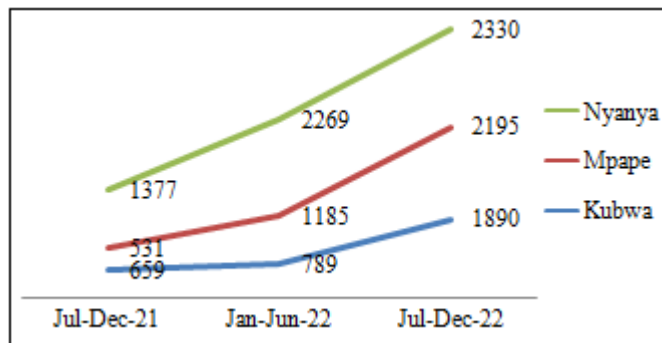


Figure 3: Comparison of the increase in Misoprostol Use for SA at the 3 intervention sites over a period of 18 months

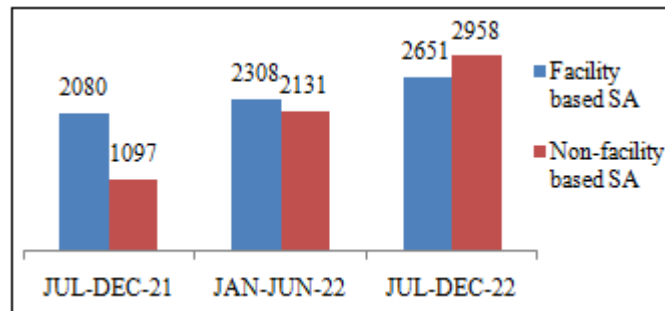


Figure 4: Comparison of Facility-Based and Non-facility based Misoprostol Use for SA at the intervention sites over a period of 18 months

3.2 Results from Interviews

3.2.1 Sexual and Reproductive Health Services Provision in Communities

Post-abortion care and sterilization method of family planning were for referral in public health facilities as at baseline. However at endline, project participating private clinics/hospitals on the other hand can provide such services.

An informant reported that *'we attend to cases of complicated self induced abortion, we first do scan to know if the baby is still there and if not we administer misoprostol and then do manual evacuation of the retained product. We hardly do referral now'*.

Apart from the on-site safe abortion services provided by private health facilities, an informant added that the health providers monitored their clients through follow up and counselling on contraceptives to prevent future occurrence of unwanted pregnancy.

Also, informants from pharmacy and patient medicine store reported that the service provided is mainly counselling on contraception and safe abortion using misoprostol, sale of products and commodities as well as referral linkage to higher level providers. *"I only counsel on family planning and medication abortion and sell products and commodities. "If they require the more services, I refer them to the nearest provider in our partnership map"*.

3.2.2 Family Planning Method Mix in Project Communities

Contraceptive method mix was provided freely in the public health facilities. However at the endline, there were some private clinics offering almost all of the methods ranging from condom, oral pills, injectables, implants to IUDs except sterilization making it easier to access post procedure contraceptives from private clinics. The contraceptive method with the highest uptake at endline was the injectables (40.0%) while implants were a close second at 20.0%. This was the same at the baseline survey. The reason for the high uptake rate for injectables as reported by the respondents at the endline was consistent with the baseline; it was so because it is short term and does not require daily dosage as oral pills which could easily be forgotten thereby losing its efficacy

3.2.3 Safe Therapeutic and Post Abortion Care in Participating Clinics/Hospitals

Following the baseline study, intervention approach which included capacity building, supply of Misoprostol and contraceptives as well as Information, Education and Communication (IEC) Materials were provided in the participating clinics/hospitals. At baseline, majority of the participants reported request for safe abortion among clients with unwanted pregnancy but were refused service. However at endline, the informants from private clinics reported the use of misoprostol for SA.

4. Discussion

Findings from this study has shown that targeted trainings of community health providers, supply of essential commodities, mentoring and monitoring on safe therapeutic abortion and modern contraceptives has the capacity to increase knowledge of these services and its practice in the targeted urban slums. Results from this study were consistent with other studies in Nigeria that found positive impact of training on providers' knowledge[17]. Table 1 confirms earlier studies by Eremutha and Gabriel [19] on recommendations for improving SRH uptake for young people in health facilities within communities to include Community-based facilitated education sessions and Multi-component and multi-sectoral approaches as potential indicators for increasing youth access to SRH.

Table 2 demonstrates that provision of capacity building in addition to IEC materials on contraceptive types/counseling and monitoring/mentoring of service providers has the capacity to improve the knowledge of providers on modern contraceptive and safe abortion as evident from the endline data. Similarly, involvement of AGYW in female focused vocations in the design of the intervention and their training as peer influencers as reported in the survey, improved family planning sales among non – facility based providers (PPMV's) as seen in Figure 1 within targeted slums. AGYW through the provision of peer to peer counseling encouraged and made referrals for the uptake of contraceptive options in the different slums. This further revealed that task shifting and sharing can help in expanding access to essential health care

services to meet the set SDG targets. This finding is in line with the goal statement in the Nigeria Task shifting and Task Sharing (TSTS) policy documents[12].

Figures 2 and 3 demonstrate a sharp increase in self induced medication abortion following capacity building of facility based providers in participating clinics and hospitals. These findings suggest a relatively high level of autonomy for abortion care seeking among women and indicate the important role that community health care providers play as trusted sources of information and providers of therapeutic abortion in underserved settings and restrictive environment as Nigeria. In other studies, it was also concluded that using misoprostol for abortion is a good harm-reduction method in restrictive settings [20], [21]. Similarly, Figures 3 and 4 indicate the important role that PPMVs play as trusted sources of information and providers of MA in undeserved slums. However, the appropriateness of the drug prescriptions and the quality of information provided to women by PPMVs as documented in other studies[22]were not evaluated by this study.

Analysis of the qualitative data indicates that the benefits of capacity building, monitoring and the distribution of IEC materials were significantly associated with achievement of the four outcome measures reported in this survey. These findings are consistent with other studies that found improved outcomes with health worker supervision, audit and feedback, components that were part of the post-training support offered to the providers[23]. Furthermore, there is a remarkable improvement in the knowledge and attitudes of health providers in the provision of family planning and safe therapeutic abortion post training (endline) compared to pre-intervention (baseline) study. Results from this study are consistent with other studies that found positive impact of training on providers' knowledge[24], [25]. This finding is promising for the strategy of task shifting task sharing in underserved settings by expanding the role of non - traditional health workers in safe abortion and contraceptive service delivery in view of the major shortage of skilled providers for delivering these services.

WHO recommends that professionals such as health care workers must learn to separate their personal beliefs and values from their professional practices and treat all women equally and with empathy, regardless of their reproductive behaviours and decisions^[16]. Participants in this study has demonstrated same approach in the provision of sexual and reproductive health services post intervention in line with the WHO recommendation[16].

5. Conclusion

This study has demonstrated that community healthcare providers can be trained to offer safe therapeutic abortion and contraceptive services largely as harm reduction efforts towards lowering incidences of unsafe and clandestine abortion among AGYW and most importantly as a task shifting and task sharing practice towards meeting the

successful implementation of the policy. Their knowledge can be supported through mentoring/ monitoring, IEC materials and commodity support, for the provision of accurate information and quality services. Similarly, there is need for intense advocacy for the lifting of the ban on free access to safe therapeutic abortion in the country, training of more health providers especially at the community levels and regular supply and prioritization of the essential commodities to especially private ensure the quality provision of safe abortion services.

Conflict of Interest

There is no conflict of interest to declare.

Acknowledgements

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