KNOWLEDGE, ATTITUDES, PRACTICES, AND BEHAVIORS AMONG PROVIDERS OF ABORTION-RELATED CARE

A referral maternity hospital in Jigawa state, Nigeria, a fragile setting – Results of the AMoCo Study

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INTRODUCTION

Evidence on the burden of abortion-related complications in fragile and conflict-affected settings is still limited even though the need for sexual and reproductive health (SRH) care, including both postabortion care (PAC) and safe abortion care (SAC), is likely increased in these settings. The demand for services is high due to disruptions in contraceptive use and access and increased exposure to sexual violence or transactional sex among a population with a high level of displacement while service availability is low due to under-resourced health systems (1). In these settings, reducing unsafe abortion is even more critical because women may have difficulty accessing quality postabortion care due to security risks, migration, and a lack of community and family support important for accessing health care (2).

Access to timely and high-quality comprehensive abortion care (CAC) can decrease the magnitude and severity of abortion-related complications (3) and health care providers have important roles in providing this care (4). Many elements have been identified that influence the provision and quality of CAC by health care workers. These include insufficient training and gaps in clinical skills (4), a lack of awareness of regulations and legality of abortion (5), personal convictions and conscientious objection based on moral, religious beliefs or stigma, and negative attitudes of health professionals surrounding abortion leading to discrimination during facility-based care (6). However, little is known about these elements related to providers in humanitarian settings.

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This evidence brief presents selected results of one component of the AMoCo Study (**A**bortion-related **Mo**rbidity and Mortality in **Co**nflict-affected and Fragile Settings). This knowledge, attitudes, practices, and behaviors (KAPB) survey was given to health professionals providing abortion-related care. The primary objective of the KAPB survey was to describe the knowledge, attitudes, practices, and behaviors of PAC-providing health care workers in the hospital. The secondary objectives were to identify provider-related barriers in the pathway of care that limit women from receiving adequate CAC and to identify points for improvement in the provision and accessibility of CAC.

STUDY SETTING

This study took place in the MSF-supported maternity in Jigawa state, Nigeria, a state which had one of the world's highest maternal mortality ratios (MMR), at 1,012 maternal deaths per 100,000 live births in 2017 (7). The national MMR for Nigeria at this time was much lower, estimated to be 917/100,000 live births, still very high by global standards (8); an estimated 75% of Nigeria's maternal deaths occurred in the North (9). Abortion-related complications in Nigeria accounted for 7.8% of maternal deaths according to one national cross- sectional study involving 42 tertiary hospitals conducted in 2012-3 (10). Wider proportions of maternal deaths due to abortion complications were reported in other regional studies (23.8% in Ile-Ife (11), 11.8% in Enugu (12)), but there is little evidence on abortion complications specifically from northern Nigeria. One national study on the incidence of abortion in Nigeria based their analysis on surveys estimating the numbers of women treated for complications of spontaneous or induced abortion reported in each of the six geopolitical zones in the country. According to that study, the Northwest zone (where Jigawa state is located) cared for nearly 20% of women seeking care for abortion complications in the country in 2012 (13). In 2019, the 168-bed facility in this study recorded over 9,100 deliveries and assisted almost 500 women seeking postabortion care.

METHODS

The KAPB survey consisted of a standardized anonymous questionnaire self-administered in November-December 2019 to health professionals, including physicians, midwives, clinical officers, medical officers, nurses, and midwife/nurse aids, who were involved in abortion care at the study site and were literate in English. The only exclusion criterion was refusal to participate. One hundred forty (140) of the 141 eligible staff participated for a 99% response rate. One did not participate due to delayed submission of the questionnaire.

Thirty percent (30%) of providers were midwives, 29% were nurses, 32% were assistants and only 9% were physicians or medical officers. Seventy-one percent (71%) of providers were female.

Most of the respondents were female midwives, nurses and assistants.

	Total (N=140)	Female (N=99) *	Male (N=34) *	Professional Experience
	n (%)	n (%)	n (%)	Years (mean)
Midwives	41 (30)	41 (41)	0 (0)	6.3
Nurses	39 (29)	23 (23)	15 (44)	3.9
Assistant Nurses & Midwives	44 (32)	35 (35)	8 (23)	4.0
Physicians and medical officers	12 (9)	0 (0)	11 (31)	6.5

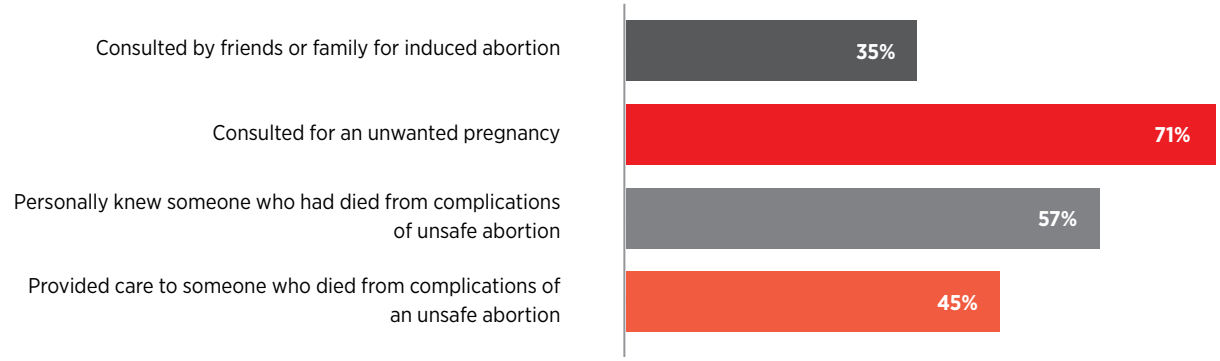
*7 preferred not to disclose gender or missing

KEY FINDINGS

Personal experiences with abortion complications and consultations

- About half of the respondents had personal experience with abortion complications: 57% personally knew a woman who died from complications of abortion while 45% had ever cared for a woman who died from complications of abortion.
- Seventy-one percent (71%) had been consulted regarded an unwanted pregnancy, while 35% had been consulted by friends or family for induced abortion.

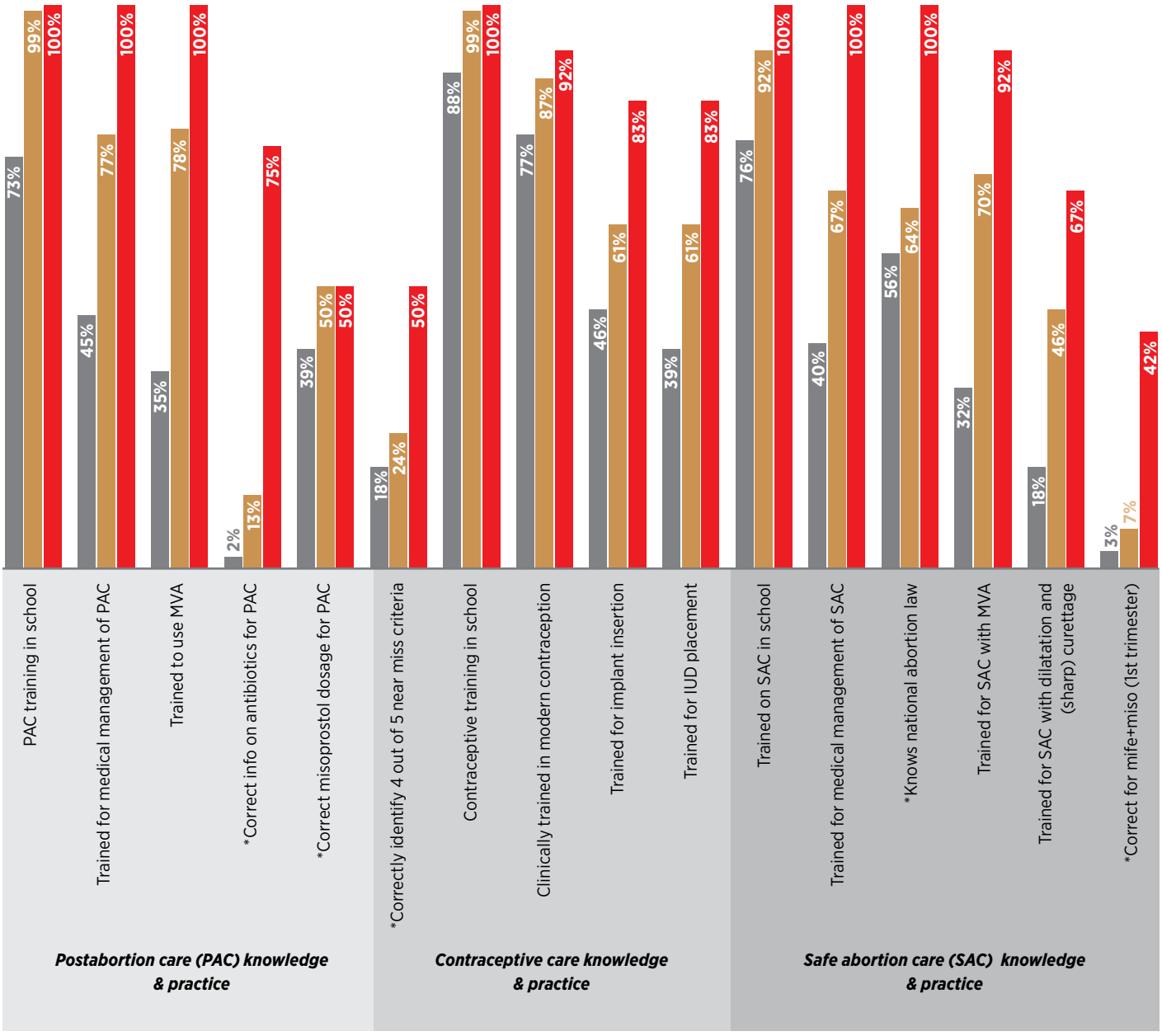
Health care workers have personal experience & knowledge of unsafe abortion



Knowledge

- Ninety-one percent (91%) of participants reported having had training on PAC, but only 24% of respondents correctly identified 4 out of 5 of the abortion-related near miss criteria (severity criteria).
- While 85% reported training on contraception, only 57% and 55% were trained in the insertion of implants and IUDs respectively.
- Sixty percent (60%) of participants reported having had training on medication abortion, yet only 9% knew the correct dosage for the combined regimen of mifepristone and misoprostol and none knew the correct misoprostol alone regimen.

Experience and *knowledge of PAC and contraception was high overall, but was lower for SAC



Attitudes

- Despite the restrictive legal environment for abortion in the country, seventy-nine percent (79%) considered PAC and 74% considered SAC to be the right of every woman in Nigeria.
- Sixty-four (64%) percent expressed agreement with the statement that health professionals should refer patients to another provider if they have objections to SAC provision.
- Only 51% agreed that any woman who presents with signs of an induced abortion should not be reported to the authorities and only 38% agree with the statement "women should always have the rights to have an induced abortion in case of unwanted pregnancy".

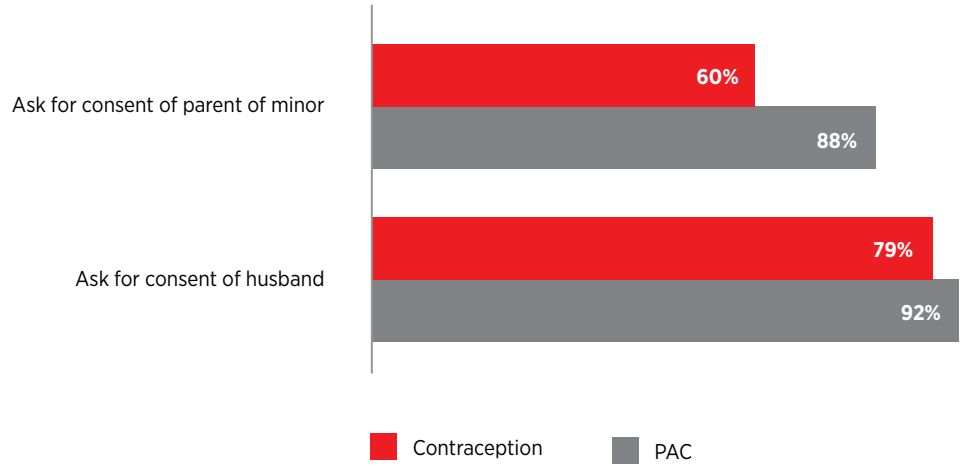
Practices

- Over one-third, 34% of respondents, providing PAC and 36% providing SAC reported using dilatation and curettage (D&C) despite the method no longer being recommended by WHO clinical guidelines.
- An estimated 34% of respondents had personally provided an induced abortion at least once in their career while 29% reported having referred at least one woman for safe abortion care in their current position.

Behaviours

- Among those providing PAC services, 92% would ask for husband's consent before providing PAC, and 88% would ask for parental consent if the patient is a minor.
- Among those providing contraception, 79% would ask for husband's consent before providing contraception, and 60% would ask for parental consent before providing contraception to a minor.
- In response to the question, "Would you feel comfortable to provide SAC personally in some circumstances?", 87% answered yes, with 97% selecting "the life of the woman is at risk" as the most acceptable indication, "when the woman's physical health is at risk" next at 84%, "in case of confirmed fetal abnormality" 77%, and only 5% indicating they would provide SAC for any reason.

Significant percentages of providers seek permission of others for provision of PAC and Contraception



CONCLUSIONS

Most health professionals in this facility have a supportive attitude regarding comprehensive abortion care, especially for the global provision of PAC and contraception. More diverse opinions were seen for the provision of safe abortion care and contraception to minors. Nevertheless, their **knowledge and practices still reflect shortcomings.**

Knowledge about the national legal framework of third-party consent, the protocols to provide contraception to minors, the placement of implants and intrauterine devices and the near-miss criteria to evaluate severity of complications need to be further strengthened by continuous campaigns, trainings and clinical mentoring. Additionally, low levels of knowledge about the WHO-recommended regimens of misoprostol and mifepristone or misoprostol alone for induced abortion, and for misoprostol for PAC indicate a high-priority area for improvement.

One crucial area for action is the high number of staff (49%) considering reporting to the authorities any woman who presents with signs of an induced abortion. This is a problem of values and attitudes and clashes both with medical ethics and MSF principles.

Continuing ongoing improvement efforts will sustain and strengthen the facility's advances towards the provision of the full range of comprehensive abortion care. These efforts include regular workshops on Values Clarification for Action and Transformation (VCAT) about abortion (14) and to strengthen confidentiality and non-reporting to authorities; organizing continuous education of all staff about current protocols for PAC and SAC; providing up-to-date information on legislation and regulations; simplifying the near-miss approach; and expanding the contraceptive method mix. As the WHO guideline on CAC encourages task shifting of abortion and contraceptive care from doctors to midwives, nurses and assistants (4), focused training to strengthen contraception and abortion provision capacity among these cadres is recommended to secure stable and quality CAC provision.

While contraceptive and abortion-related care is traditionally centered in the facility, accurate information, including dispelling myths and misinformation, also needs to be prioritized and occur in communities. Self-care strategies for contraception and abortion are now recommended by the WHO and can be supported to increase choice and autonomy for patients and to relieve over-burdened health systems (4, 15). Indeed, up-to-date protocols and regulatory information, continuing education including VCAT sessions, task-sharing, robust contraceptive method mix, and supporting self-care interventions are likely to strengthen comprehensive abortion care in facilities beyond this one. More research is needed about the factors associated with health professionals' positive attitudes, behaviors, and practices towards each component of CAC, including the potential impact of their personal experiences with unsafe induced abortion, as well as on the long-term impact of VCAT workshops (14).

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