



The Burden of Unsafe Abortion in Humanitarian Settings in Nigeria: A case study on the Incidence of Unsafe Abortion in **Borno State**

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Executive Summary

Since 2009, the Northeast Nigeria geo-political zone has faced a violent insurgency led by fundamentalist extremists, including the militant terrorist group Boko Haram and associated fractured groups. Borno state is one of the states most seriously affected by the insurgency in Northeast Nigeria with an estimated 1.7 million women and girls of reproductive age have been displaced, and two-thirds of health facilities have been destroyed.

Ipas Nigeria Health Foundation works to ensure women and girls have bodily autonomy and can self-determine their sexual and reproductive health and rights. As partners for reproductive justice, we build collective action that transform societies to enable women girls and vulnerable persons manage their fertility and realize their full potential. In 2022, Ipas Nigeria supported the Borno state government and local organizations to successfully advocate for passage of the Violence Against Persons Prohibition (VAPP) law. Ipas also went further to collaborate with the State Ministry of Health to train healthcare workers on the provision of care and treatment for victims of violence in the state in line with the VAPP law standard and guidelines.

Given the myriad barriers to Sexual Reproductive Health (SRH) and safe abortion care for women and girls in Borno state, Ipas Nigeria Health Foundation conducted an assessment to determine the burden of unsafe abortion and related complications as well as the availability of post-abortion care services in private and public health facilities in Borno state. Three objectives were outlined:

01

Estimate the incidence of induced and spontaneous/incomplete abortions and the burden of unsafe abortion.

02

Assess the availability and accessibility of abortion services across public and private facilities in Borno state.

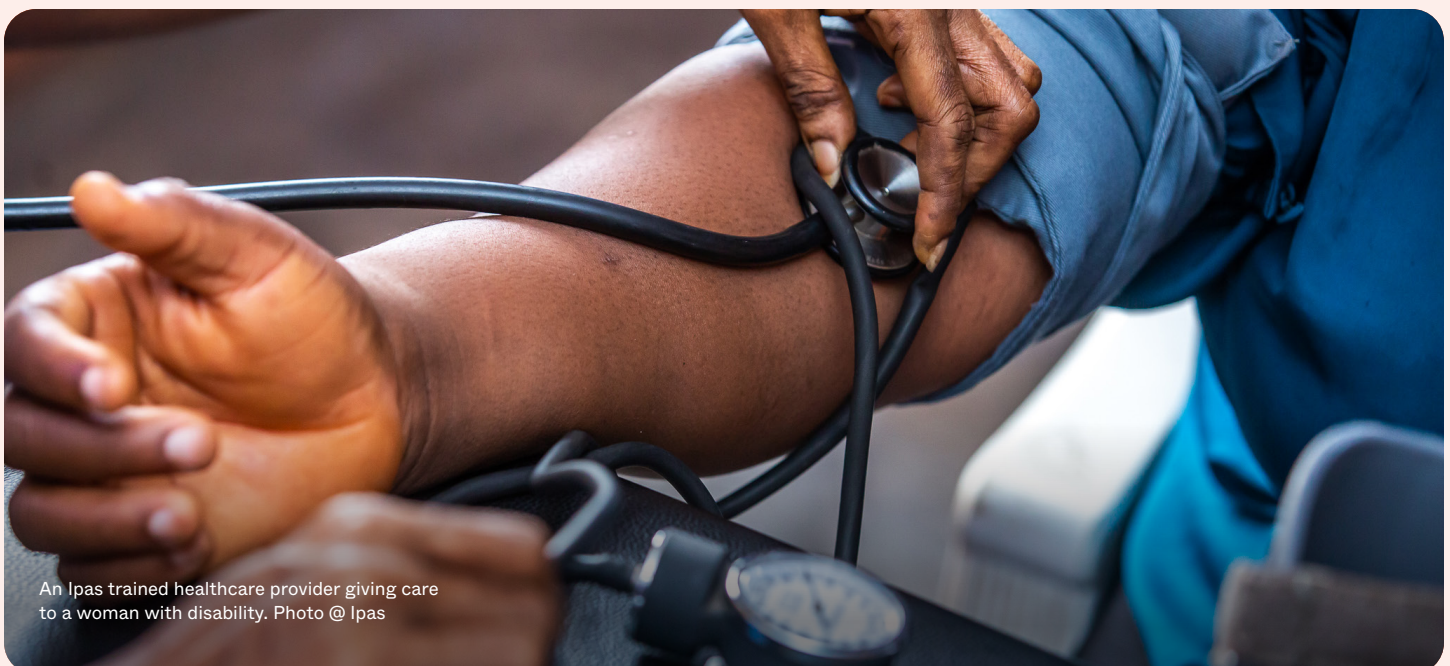
03

Identify factors contributing to unsafe abortions in the state and opportunities to address gaps in service provision and quality.

To accomplish the objectives and research questions outlined in this study, we utilized a hybrid approach that integrated both quantitative and qualitative research methods. Our quantitative component centered on the collection and analysis of service data from health facilities across the state; 24 health facilities comprising 1 tertiary, 8 secondary, and 15 primary healthcare facilities were physically visited across Maiduguri, Jere and Konduga LGAs. An electronic records search was conducted on the state's District Health Information System (DHIS) platform for the periods 2016 – 2023. The facility records were assessed to record the incidence of unsafe/abortion cases and related complications reported in the state. Data on abortion for periods earlier than 2016 was not available as the state only commenced reporting abortion data on the DHIS in 2016.

Generally, the reported data on abortion prevalence in Borno State, disaggregated by type and complications, reveals a somewhat inconsistent trend over the years spanning from 2016 to 2023. This inconsistency may be attributed to the fact that although reporting on the DHIS platform commenced in 2010 in the state, data specifically on abortion was first reported in 2016. The absence of data for the three years before the insurgency (2006 - 2009) limits a comprehensive review of abortion trends pre-conflict versus post-conflict.

However, from 2017 to 2023, a significant increase in total abortions was observed, reaching its peak in 2021 at 6,680 cases. The relatively high proportion of abortions reported as induced abortion from 2016 to 2020 can be attributed to the lack of clarity in the NHMIS version 2013 tools, which were in use until 2020 in Borno state. Furthermore, notable differences between abortion statistics reported on the DHIS2 and findings from facility data audits were observed for all indices. For instance, a total of 837 cases of abortion were extracted from the facility records, while only 301 cases were reported for those same facilities on the DHIS2 for the same period.



Key Findings



1. Abortion incidence in Borno 2021 reveals a rate of **73 abortions per 1000** women of reproductive age (WRA). This refined estimate provides a more likely accurate reflection of the state's abortion landscape compared to the broader regional rate of 41 per 1000 WRA in 2012.



2. Impact-2 modeling for 2021 estimated that the tangible consequences of untreated abortion cases in Borno state were approximately **1,300** maternal Disability Adjusted Life Years (DALYs) along with an estimated healthcare expenditure of **120,000 USD** directly related to untreated abortion cases. Translated into local currency at an exchange rate of **1,531 USD/naira**, this amounts to **N183,720,000**, highlighting the substantial financial burden that could have been redirected towards other healthcare priorities.



3. While the direct impact of the insurgency on abortion could not definitively be ascertained, data extracted from the state's DHIS2 and facility records spanning from 2019 to 2022/23 suggest a significant effect of the insurgency on the abortion landscape in the state. Conducting a comprehensive facility records audit statewide would provide further insights into this phenomenon.



4. Notable disparity between DHIS2 data and facility records was observed for the 3 LGAs where physical visits were made to facilities, underscoring the need for improved quality of abortion service reporting practices.



5. The prevailing sentiment among interview respondents is that induced abortions are primarily accessible in private hospitals for those who can afford them, followed by Patent Medicine stores (Chemists) and pharmacies. Other sources of abortion services were indicated which largely could be categorized as unsafe providers.



6. In general, participants in the focus group discussions (FGDs) agreed that post-abortion care can be obtained in government hospitals, although some healthcare providers are reported to refuse care if they suspect an incomplete abortion resulting from self-inducement.

Key factors driving unsafe abortions in the state



Lack of empowerment and decision-making ability among women, rendering them vulnerable to sexual exploitation

The low contraceptive prevalence rate, currently at **5.4% [7]**, leading to a higher incidence of unintended pregnancies.

The insurgency and subsequent displacement of families, exacerbating the vulnerability of women and girls to sexual assault and exploitation, thereby increasing the likelihood of unintended pregnancies.

Key Recommendations



Program planners and implementers must adopt a more innovative approach to engage policy makers and health managers in the development and implementation of harm reduction strategies within the context of abortion services. Despite the stringent legal framework surrounding abortion services, our findings indicate a prevalent occurrence of unsafe abortions in the state.



To gain a deeper understanding of the true burden of abortion in the state, a more extensive study encompassing additional Local Government Areas (LGAs) and facilities is warranted. This expanded research effort should include an examination of facilities records predating 2010 when the state-initiated reporting on the DHIS2 platform. Such an endeavor would provide invaluable insights into the actual scope of abortion-related issues in the state and shed light on the potential impact of the insurgency on the abortion landscape.



The low Contraceptive Prevalence Rate (CPR) in the state, compounded by heightened Gender-Based Violence (GBV) resulting from the insurgency, presents an opportune moment for the design and implementation of comprehensive Sexual and Reproductive Health and Rights (SRHR) interventions. These interventions should be strategically designed to mobilize various stakeholder groups, including governmental bodies, civil society organizations, and community structures such as traditional and religious organizations. Furthermore, the recent enactment of the VAPP law in the state serves as a powerful tool for mobilizing these diverse stakeholders towards collective action.



Addressing gaps in the DHIS reporting of abortion services, which encompass all forms of abortion, is imperative. Advocacy efforts at the national level are necessary to provide clarity on abortion indicators and to ensure that providers are equipped with updated knowledge and practices for accurate capture and documentation.

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List of Abbreviations

AICM- Abortion Incidence Complications Method

CAC- Comprehensive Abortion Care

CSO- Civil Society Organization

DALYS- Disability Adjusted Life Years

DHIS- District Health Information System

EC- Emergency Contraceptive

FGD- Focus Group Discussion

FP- Family Planning

IA- Induced Abortion

IDP- Internally Displaced Person

IRC- International Refugee Council

JR- Jere Local Government Area

KII- Key Informant Interview

KD- Konduga Local Government Area

LARC- Long-Acting Reversible Contraceptives

LGA- Local Government Area

MMC- Maiduguri Municipal Council

NHMIS- National Health Management Information System

NGO- Non-Governmental Organization

PHC- Primary Healthcare Center

PAC- Postabortion Care

RAs- Research Assistants

SA- Spontaneous Abortion

SAC- Safe Abortion Care

SMOH- State Ministry of Health

SRH- Sexual Reproductive Health

SRHR- Sexual Reproductive Health & Rights

WRC- Women's Refugee Council

WRA- Women of Reproductive Age

SPHCDB- State Primary Healthcare Development Board

Introduction



◀ Internally Displaced People in the outskirts of Maiduguri, Borno State, Northeastern Nigeria. Stefan Heunis/AFP/Getty Images

Since 2009, the Northeast Nigeria geo-political zone has faced a violent insurgency led by fundamentalist extremists, including the militant terrorist group Boko Haram and associated fractured groups. Borno state is one of the states most seriously affected by the insurgency in Northeast Nigeria. An estimated 1.7 million women and girls of reproductive age have been displaced, and two-thirds of health facilities have been destroyed. The humanitarian crisis ensuing from this conflict has created a critical need for sexual and reproductive health (SRH) services, including contraceptive services, for people affected by the conflict. [1]

The need for comprehensive Sexual and Reproductive Health (SRH) care can be especially acute during humanitarian crises, as women and girls are at increased vulnerability of experiencing sexual violence, unintended pregnancy, and pregnancy-

related complications. The chaos resulting from displacement and basic survival as seen in Borno state fundamentally supplants the importance of SRH care, and women and girls experience diminished access to health care services [2]. Abortion and abortion-related care are particularly limited in humanitarian contexts because of a number of barriers beyond the lack of infrastructure, supplies and trained staff: For example, abortion care practitioners in emergency settings may perceive or face legal complications or loss of funding due to their provision of abortion services, institutions and governments may lack timely data on and underestimate the true volume of abortion demand among internally displaced persons, and providers may hold a perception that providing abortion care in such crisis settings may be too difficult to attempt. [2]

Ipas Nigeria Health Foundation works to empower

women and girls to have bodily autonomy and exercise their sexual reproductive health and rights. As partners for reproductive justice, we build collective action that transforms societies to enable women, girls and vulnerable persons to manage their fertility and realize their full potential. In 2022, Ipas Nigeria supported the Borno state government and local organizations to successfully advocate for passage of the VAPP law. Ipas also went further to collaborate with the state ministry of health to train healthcare workers on the provision of care and treatment for victims of violence in the state in line with the VAPP law standard and guidelines.

Given the myriad barriers to SRH and safe abortion care for women and girls in Borno state, Ipas Nigeria Health Foundation aims to conduct an assessment to determine the burden of unsafe abortion and related complications as well as the availability of post-abortion care services in private and public health facilities in Borno state.

The aim of the study was to determine the burden of unsafe abortion and related complications as well as the availability of post-abortion care services in private and public health facilities in Borno state. To achieve this, the following specific objectives and research questions were outlined:

Objective

01

Estimate the incidence of induced and spontaneous/incomplete abortions and the burden of unsafe abortion.

1.1

What is the reported abortions trend in Borno state 3 years before the insurgency, 3 years after and the last 18 months preceding the study (Disaggregated by abortion type- Induced, spontaneous and total number of women treated for abortion complications)?

1.2

Did the insurgency have any impact on the prevalence and/or reporting of abortion in Borno state?

1.3

What is the estimated incidence of induced abortions in Borno state?

1.4

Are there marked differences in the data on abortion reported on the DHIS versus findings from facility data audits?

Objective

02

Assess the availability and accessibility of abortion services across public and private facilities in Borno state.

2.1

Are abortion services readily available across public and private health facilities in Borno state?

2.2

Where do women and girls prefer to get abortion care by type?

2.3

What factors affect/influence the accessibility of abortion care by women and girls in Borno health facilities?

Objective

03

Identify factors contributing to unsafe abortions in the state and opportunities to address gaps in service provision and quality.

3.1

What are the drivers of unsafe abortion and complications in Borno state?

3.2

What are key recommendations to improve the availability and quality of abortion care across public and private facilities in Borno state?

Literature Review

In order to gain comprehensive understanding of the available knowledge on the assessment of the burden of unsafe abortion in the state, a literature review was integrated into the study. An extensive online search using Google was conducted to identify relevant literature on the topic. Additionally, efforts were made to reach out to other credible sources to gather information on any existing body of knowledge.

The Google search yielded only one study titled “Gap between Supply and Demand for Contraceptives in North East Nigeria; a Case Study” published by the Women’s Refugee Commission (WRC) in May 2020 [1]. Furthermore, a key informant mentioned the existence of an unpublished study on Safe Abortion

Care (SAC) commissioned by the International Rescue Committee (IRC) Nigeria office. However, it is important to note that this unpublished study could not be cited as part of the literature review due to its status as unpublished work.

The Case Study by the WRC was commissioned and funded by the Bill & Melinda Gates Foundation, conducted in June 2019 focused on contraceptive service delivery in Maiduguri and Jere Local Government Areas (LGAs) in Borno State. It documented the important work that humanitarian actors, the government of Nigeria, and other stakeholders are undertaking to provide contraceptive services to internally displaced persons



Ipas Nigeria Peer Educator in Benue State sharing Sexual and Reproductive Health Information with her peers. Photo @Ipas

(IDPs) and host communities as well as challenges, how some of these challenges were addressed, and recommendations.

The case study employed mixed methods, including Key Informant Interviews (KIIs) with the United Nations Population Fund (UNFPA) and nongovernmental organization (NGO) health and

SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys with service providers; focus group discussions (FGDs) with IDPs and community members; and a review of service delivery data from UNFPA and partner implementing agencies. Some key findings of the study were:



1. *Overall knowledge of the importance of child spacing and contraceptive methods was high, especially among women, although lower for men and adolescents*



2. *Although short-acting contraceptive methods were widely available, LARCs were much less available and PAC services were even less available.*



3. *Emergency contraceptives (EC) were also less available than short-acting methods and mostly provided to victims of sexual assault.*



4. *In addition to the insecurity, provider turnover and shortage of skilled personnel, commodity stockouts continue to negatively affect overall availability of contraceptive methods and PAC services.*

Whereas this study was on contraceptives supply and demand gaps, some of the findings are strongly linked to the issue of unsafe abortions. For instance, contraceptive prevalence and unmet need for family planning are directly linked to the issue of unplanned pregnancies and ultimately the need for termination

of pregnancies. Provider turnover and inadequate supply of skilled personnel which had been a perennial challenge of health care delivery system in Nigeria was exacerbated by the insurgency with negative consequences for the availability of and access to safe abortion.

Methodology

The study coverage was Borno state. A desk review of all reported data in the state DHIS from 2016 – 2023 was undertaken. In addition, facility visits were conducted to 24 facilities in 3 LGAs - Maiduguri, Jere and Konduga. This was done to ensure alignment

with the current reality in the state, where most of the population accesses healthcare services in Maiduguri and its environs, due largely to the inaccessibility of other LGAs resulting from the ongoing insurgency.

Study Design

To accomplish the objectives and research questions outlined in this study, a hybrid approach that integrated both quantitative and qualitative research methods. Our quantitative component centered on the collection and analysis of service data from facilities across the state; 24 health facilities comprising 1 tertiary, 8 secondary, and 15 primary healthcare facilities were physically visited in the 3 focus LGAs. We also conducted an electronic records search on the state's District Health Information System (DHIS) platform for the periods 2016 – 2023. The facility records were assessed to record

the incidence of unsafe/abortion cases and related complications reported in the state. Data on abortion for periods earlier than 2016 was not available as the state commenced reporting of abortion data on the DHIS in 2016.

Our temporal scope covered a period of six years, encompassing three years before and three years after the insurgency event. The assessment also included a snapshot of the incidence of abortion related care and services within the last 18 months prior to the study. We subjected service data



Ipas training for police workers on women's sexual and reproductive health and rights.
Photo @lpas

to rigorous analysis, with a particular focus on estimating Disability-Adjusted Life Years (DALYs) and other critical health indicators using the Impact-2 model to gain more understanding of the impact of the insurgency on healthcare outcomes in Borno state.

The incidence of induced and spontaneous/incomplete abortions and the burden of unsafe abortion were estimated using a combination of quantitative and qualitative research methods. Recognizing the limitations associated with obtaining service data related to induced abortion, our primary focus for this objective was centered on generating data concerning both induced and incomplete abortion (Post-Abortion Care - PAC) within the selected facilities. We extracted data from service records from both public and private healthcare facilities.

We analyzed service data extracted from the District Health Information System (DHIS) records as well as those obtained from the relevant facility registers, to determine the incidence of spontaneous abortion. Estimation of induced abortion cases was based on the Abortion Incidence Complications Methodology (AICM), an indirect approach that has been used to estimate the incidence of abortion in more than 15 countries including Nigeria. [3] This methodology relied on data collected through the two surveys: a Health Facilities Survey, which gathered information from facilities that treated postabortion patients (i.e., women with complications from induced or

spontaneous abortions), and a Health Professionals Survey, which collected information about abortion provision from service providers in facilities visited, as knowledgeable key informants through in-depth interviews with the service providers.

Insights gathered from the perspective of service users through focus group discussions (FGDs) with women of reproductive age (WRA) and in-depth interviews with service providers were used to assess the availability and accessibility of abortion services across public and private health facilities. Their shared experiences and perceptions provided an understanding of service availability and accessibility including the myriad of issues that affect access and utilization of services. This approach was opted for rather than a beneficiary assessment, because of the sensitivity surrounding safe abortion services and the attendant difficulty in speaking directly to those who have had the service.

Our qualitative research techniques also helped us to explore the underlying causes and mechanisms in identifying factors contributing to unsafe abortions in the state and opportunities to address gaps in service provision and quality service delivery. Through key informant interviews (KIIs) involving a diverse spectrum of stakeholders - relevant policy makers, program planners and implementers, and civil society organizations (CSOs) actively engaged in Sexual and Reproductive Health and Rights (SRHR) programming, we gained valuable insights into the multifaceted issues surrounding unsafe abortions and avenues for improving service delivery.

Sampling considerations

As described above, the quantitative data comprised of facility records review of abortion service provision in select facilities as well as abortion related data and

indicators collated from the state's DHIS records. A total of 24 facilities spread across 3 LGAs were visited.

LGA	Public Facilities						Private Facilities			
	Public Facility		Secondary Facility		Primary health Centres		Primary		Secondary/ Specialist	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Maiduguri	2	0	3	3	5	5	5	4	5	2
Konduga	0	0	2	1	3	3	1	0	1	0
Jere	0	1	2	1	3	3	1	0	1	1
Totals	2	1	7	5	11	11	7	4	7	3

A major factor responsible for the deviation was the devastating effect of the insurgency on infrastructure including healthcare facilities in the state. Some of the facilities we planned to visit were either destroyed or inoperable at the time of the visits.

Qualitative data collection

A total of 12 FGDs with different groups of WRA (4 per LGA) and 30 KIIs (16 in MMC and 7 in each of Konduga and Jere LGAs) were conducted.

Training of the research team

A three-day training of interviewers and field manager (supervisor) was conducted in Maiduguri,

from December 5 - 7, 2023.

In attendance were 10 RAs, 1 supervisor and one staff member of a collaborating NGO. Others in attendance included key officials of the State Ministry of Health (SMoH) and State Primary Health Care Development Board (SPHCDB) lead by - Dr. Goni Abba (Director Primary Health, Borno SMoH). The following were key sessions/issues covered during the training:

- 1 Overview of the project, research ethics and interview
- 2 Review of study protocol, location and selection criteria, quality assurance
- 3 Review of Questionnaire and discussion guide
- 4 Introduction to FP & PAC
- 5 Simulation – extracting FP & PAC data from facility
- 6 Simulations – conducting FGDs and KIIs
- 7 Data transcription
- 8 Ethical issues in research
- 9 Work plan development
- 10 Fieldwork logistics and communication

Fieldwork and data management

The supervisor coordinated with the collaborating NGO and community agents to plan, mobilize participants and secure conducive venues suitable for conduct of the FGDs in each of the selected LGAs. The KIIs were also conducted in a secure location of participant's choice. The FGDs and KIIs were conducted by a team comprising one moderator and one note taker. The sessions were recorded through digital audio recorders with the permission of the respondents. The average duration of each interview session was documented as part of the transcription. Interviews were conducted in English, Hausa or Kanuri based on the respondent's preference. At the end of each day, the moderator working with the note taker reviewed notes. The data analyst also provided daily feedback based on his review of submitted data to the RAs and supervisor using the WhatsApp platform that was created.

Supervision and data quality management

One field supervisor was engaged to provide overall quality assurance through accompaniment (accompanying interviewer) to health facilities as well as observing qualitative interview sessions at a safe distance from the group to ensure confidentiality. The supervisor coordinated with the data analyst to review submitted data real-time and provide feedback to the interviewers.

Data safety and confidentiality

All data collected were stored in a secured cloud sever developed to restrict access. A coding system

was agreed for use during the training. This ensured that reported data was traceable to the various RAs for the purpose of follow-up and correction. However, all forms of Personal Identifiable Information were removed before submission. Data access was strictly restricted to the study team.

Ethical Consideration

Ethical approval (SHREC No: 158/2023) was secured from SMOH State Research Ethics Review Committee before the commencement of the study. A consent form was also developed and administered to every respondent. In addition, Ipas provided letters of introduction to each RA for their use in the field. All Data collectors were provided a brief orientation on research ethics. Data collection was conducted in accordance with the principle of respect for persons, benevolence, and Justice, ensuring Confidentiality and Informed consent.

▼ Ipas trained healthcare providers delivering sexual and reproductive healthcare in the facility. Photo @ Ipas



Results

In this section, we present the findings of the study and provide a detailed analysis of the data collected. The aim is to ease understanding through an objective presentation of the outcomes of the study in a clear manner and organized around the three study objectives.

Objective

01

Estimate the incidence of induced and spontaneous/incomplete abortions and the burden of unsafe abortion.

Total Abortion	21	255	1169	1145	1725	6680	2602	1397
Abortion - Induced- n(%)	12(57)	204(80)	847(72)	727(63)	265(15)	921(14)	363(14)	502(21)
% Maternal Deaths Due to Abortion	2	4	5	6	4	12	4	2
Variable	2016	2017	2018	2019	2020	2021	2022	2023

Table 1: Reported frequencies of abortions in Borno state
(Source: NHMIS-DHIS2 Nigeria)

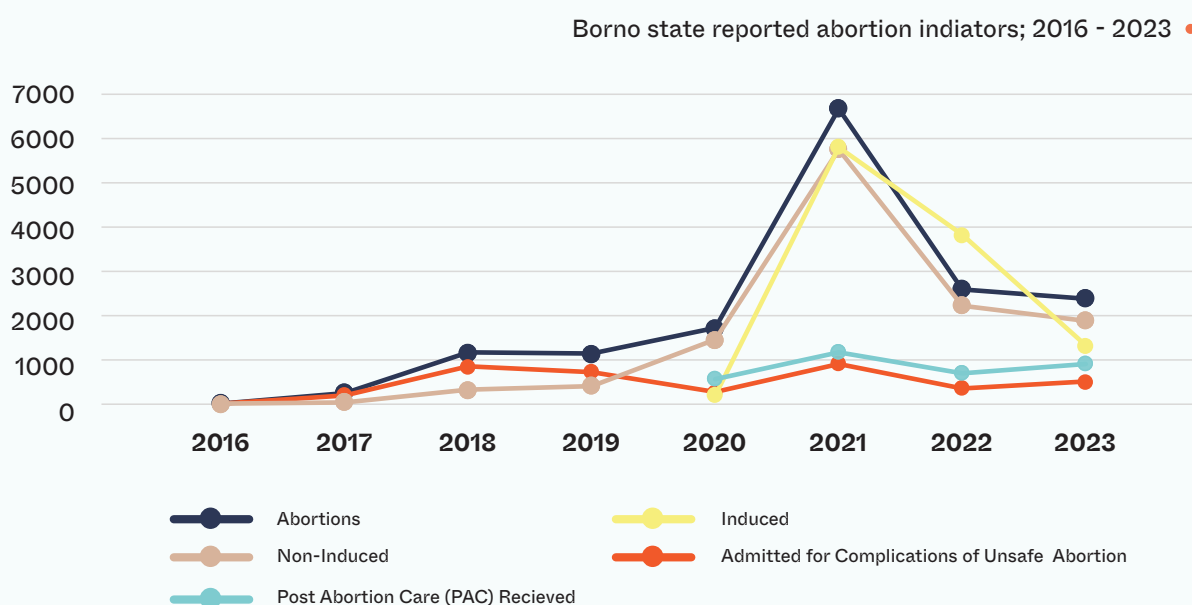


Figure 1: Yearly reported abortion indicators (Source- DHIS2 Nigeria)

The reported data on abortion prevalence in Borno State, disaggregated by type and complications, reveals somewhat inconsistent trend over the years (2016-2023). Although reporting of data on the DHIS platform commenced in 2010 in the state but abortion data was first reported in 2016. Though this study sought to review abortion trends pre-conflict versus post-conflict, the absence of data for the three years before the insurgency (2006 - 2009) limits such a comprehensive analysis. However, from 2017 to 2023, there is a significant increase in total abortions, reaching its peak in 2021 at 6,680 cases. The relatively high proportion of abortions reported as induced abortion from 2016 to 2020 is attributable to the lack of clarity in the NHMIS version 2013 tools which were in use till

2020 in Borno state. Similar misrepresentation of induced abortion figures was found in a recent rapid National data quality assessment conducted by Ipas and the FMoH. Despite concerns of underreporting expressed by many facility staff and managers, the data highlights a notable rise in abortion care cases, emphasizing the importance of comprehensive healthcare services. Maternal deaths due to abortion and admissions for complications of unsafe abortion exhibit varying patterns, suggesting fluctuations in the severity of cases over the years. Overall, while the data offers insights into post-2016 trends, the missing data from three years before the insurgency limits a thorough understanding and conclusions on impact of the insurgency on abortion cases.

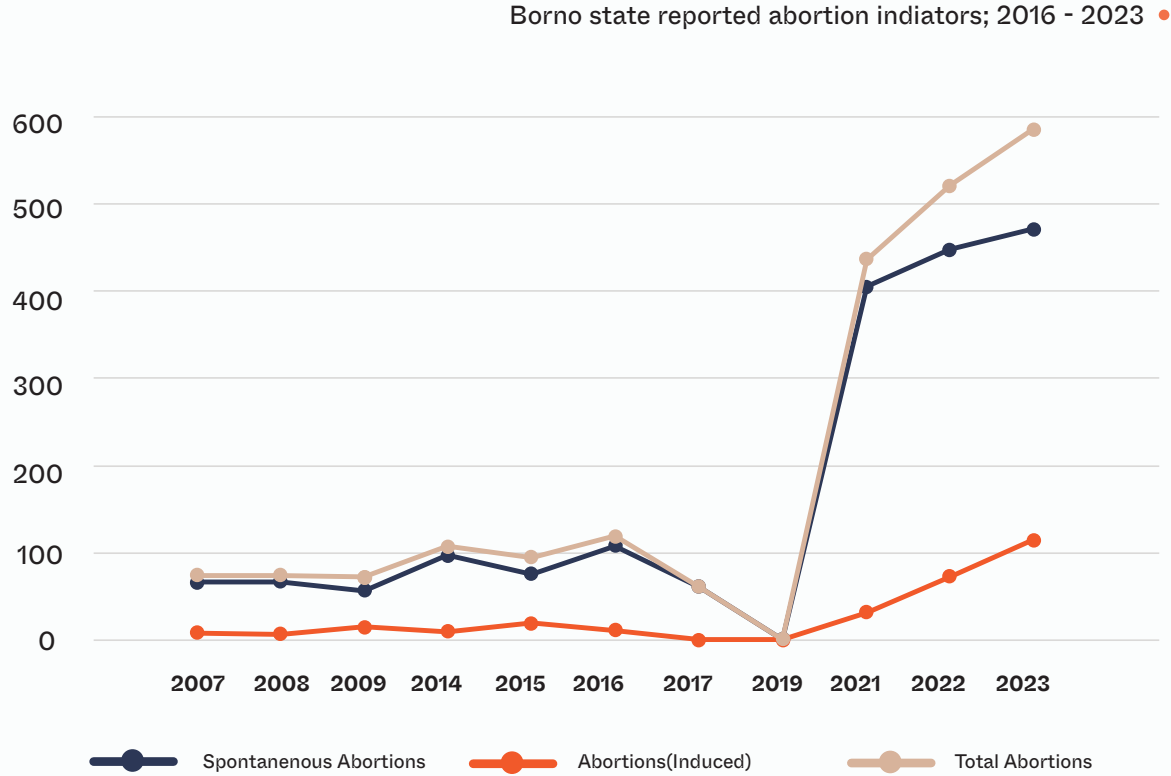


Figure 2: Observed facility-based abortion care records (Source- facility NHMIS records)

From the review of physical records from a sample of facilities from 3 LGAs in Borno (figure 2 above), we were able to extract data for the period before the insurgency. This suggests the possibility of existence more abortion data in facilities pre-2010 when the

state began reporting on the DHIS platform. From the figure above, the abortion trend from 2007 to 2016 does not show any significant increase. There was a decline in abortion data between 2017 and 2019. However, the significant jump between 2019

to 2023 seems to corroborate the trend observed in the state DHIS data for the period 2019 to 2022. This no doubt gives a clue as to how the insurgency might have impacted on abortion incidence in the state.

The sharp decline in reported abortions from 2016 to 2017, especially induced abortions, and the subsequent increase from 2019 to 2023 might reflect disruptions in reporting mechanisms or healthcare access during the peak of the insurgency, followed by improvements in the post-insurgency period.

Overall, the limited available data does suggest some association between the insurgency and abortion trends. This is further corroborated by a statement from one health provider that participated in the KII.

“Ah abortion cases eh is a bit increasing, (I: Ok), its increasing right? Yess.”

The use of “a bit” may suggest that while the increase is noticeable, it may not be extremely large, but it is significant enough to be mentioned.

Comparison of facility records Vs DHIS2 data for 3 LGAs •

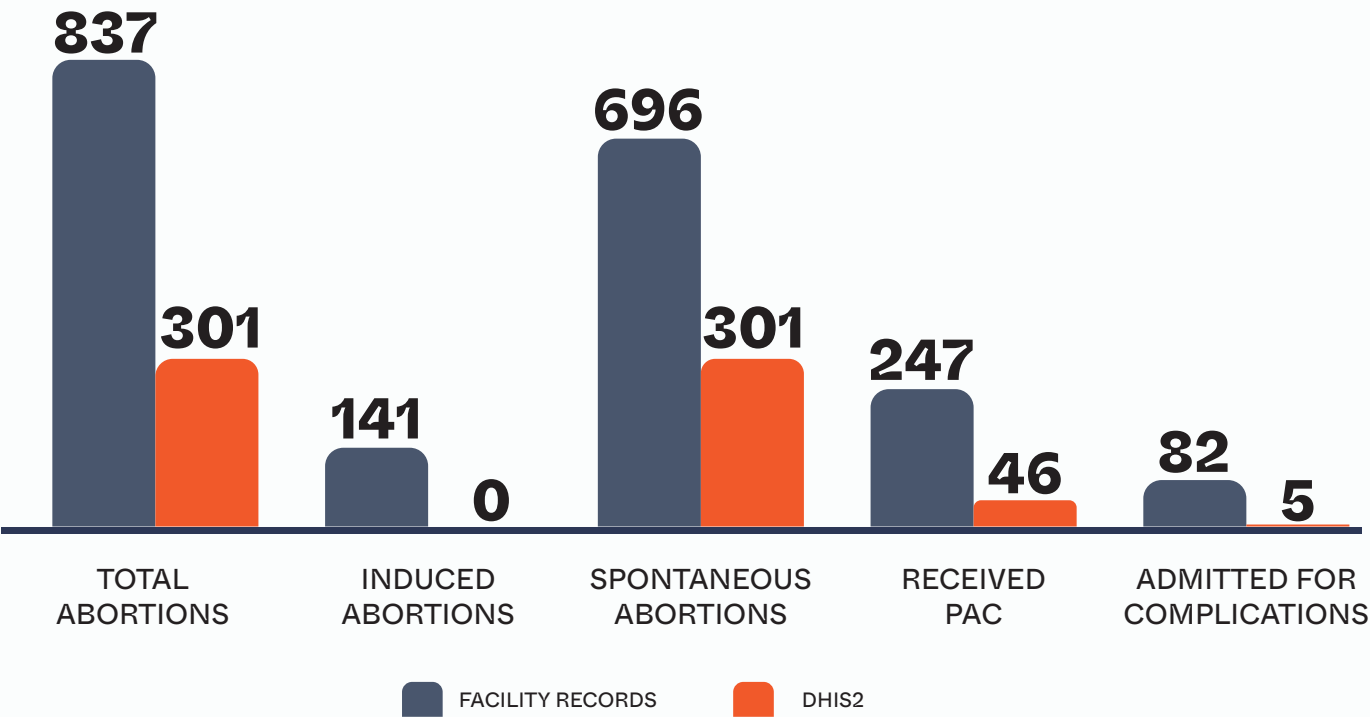


Figure 3: Observed facility records vs reported abortion data for the last 18 months preceding study.

From figure 3 above, there are notable differences between abortion statistics reported on the District Health Information System (DHIS2) and findings from facility data audits, for all indices. For example, a total of 837 cases of abortion were extracted from the facilities records while 301 cases were reported for those same facilities on the DHIS2 for the same period. This is a substantial discrepancy in the

overall abortion numbers. This no doubt is a pointer to existing challenges in the reporting mechanisms. These significant contrasts raise questions around completeness and accuracy of reporting. It also raises issues around data management systems in terms of responsibilities for audit, data use and feedback.

The differences in reporting for spontaneous abortions, where 696 cases were extracted from facilities records as against 301 cases in the DHIS2 is suggestive of discrepancies in the identification and reporting of spontaneous abortions, raising the need for standardization and consistency in data recording practices. Same goes for the discrepancies in post-abortion care (PAC) cases; 242 from facilities records as against 46 on the DHIS2 platform as well as admissions due to abortion complications with facilities records showing 82 cases and the DHIS2 records only 5 cases. Response from one of the providers interviewed indicated that not all facilities use standardized systems:

“Is reporting done through NHMIS and DHIS 2 platform? No.”

The lack of utilization of these platforms suggests

that there may be inconsistencies in how services are documented and reported, which can obscure the true picture of abortion service availability.

According to another respondent, staffing is a major challenge that directly impacts service documentation:

“The problem that we have, before we don’t have enough staffs for this documentation, is only in the facility we have only 5 trained staff.”

With such limited staffing, it is challenging to meet the demand for services, particularly for post-abortion care which requires specialized training and attention.

Archiving records is another area of concern, as noted:

“No we don’t have it because almost these records I be keeping in my office, sometimes in ward that we are consulting.”

The absence of a formal archiving system suggests potential difficulties in maintaining long-term records of care provided, which is crucial for assessing service availability and planning for future needs.

The interview also touched upon the challenges with documentation and reporting at health facilities, which can impact the tracking and improvement of service availability.

“Ahn there is some challenges, like



▲ Patent Medicine vendor offering sexual health services. Photo @lpas

sometimes when you come you would find out that the register has been move to admin, you could not find it here and at the end you end of forgetting to input the data.”

Estimating abortion Incidence

In geographies where abortion is highly legally restricted, and even in some countries where it is legal and accessible, documenting incidence is extremely difficult [4]. One of the most important constraints to measuring the incidence of induced abortion is the stigma surrounding it, which translates into women’s unwillingness to report having had one, particularly in face-to-face interviews. In addition, in settings where abortion is highly legally restricted, identifying and interviewing a representative sample of abortion providers is very difficult. As evident from the results discussed above, challenges in the accurate capture and reporting of abortion data along with the legal restrictions on abortion makes it challenging to estimate the burden of abortion in Borno state.

The Abortion Incidence Complications Method (AICM) is an indirect approach that builds on the number of women treated in medical facilities for abortion complications to eventually arrive at the total number of abortions. The goal of the AICM is to produce estimates of the incidence of abortion in settings where the procedure is highly restricted or where abortion may be permitted under broad criteria but its practice is still unsafe for many reasons (e.g., safe medical services are inadequate, unaffordable or inaccessible). The method provides estimates of the following three indicators: a) the number of induced abortions occurring each year

(incidence); b) the abortion rate (the number of abortions per 1,000 women); and c) the abortion ratio (the number of abortions per 100 live births). The method can generate the above three indicators for major geographic regions. However, for smaller administrative units such as states, departments or provinces, the method can be applied depending on what data are collected and their quality.

To estimate the abortion incidence for Borno state, we utilized data from a Health Facility Survey, a Health Providers Survey, and data from the National Health Information Management System, a DHIS 2 based portal where all National Health Service data is entered across the country. Our estimation of the Incidence of abortion in Borno state is modelled after the application of the AICM in Uganda [5] and the abortion incidence estimate study by Guttmacher Institute (2015) [6].

Using data from the NHMIS, 5818 women were reportedly admitted and treated in 2021 for complications of unsafe abortion. We assumed this figure to be representative of women needing treatment after an induced abortion. To account for women who have complications from unsafe abortion but not serious enough to require treatment in health facilities we estimated that only 40% of women who had an abortion in 2021 had complications warranting treatment in a facility.

This meant that a total of 14545 women had complications from induced abortion in Borno state in 2021. We then used a multiplier of 7.2 to account for women who would not have complications and hence need no treatment [6].

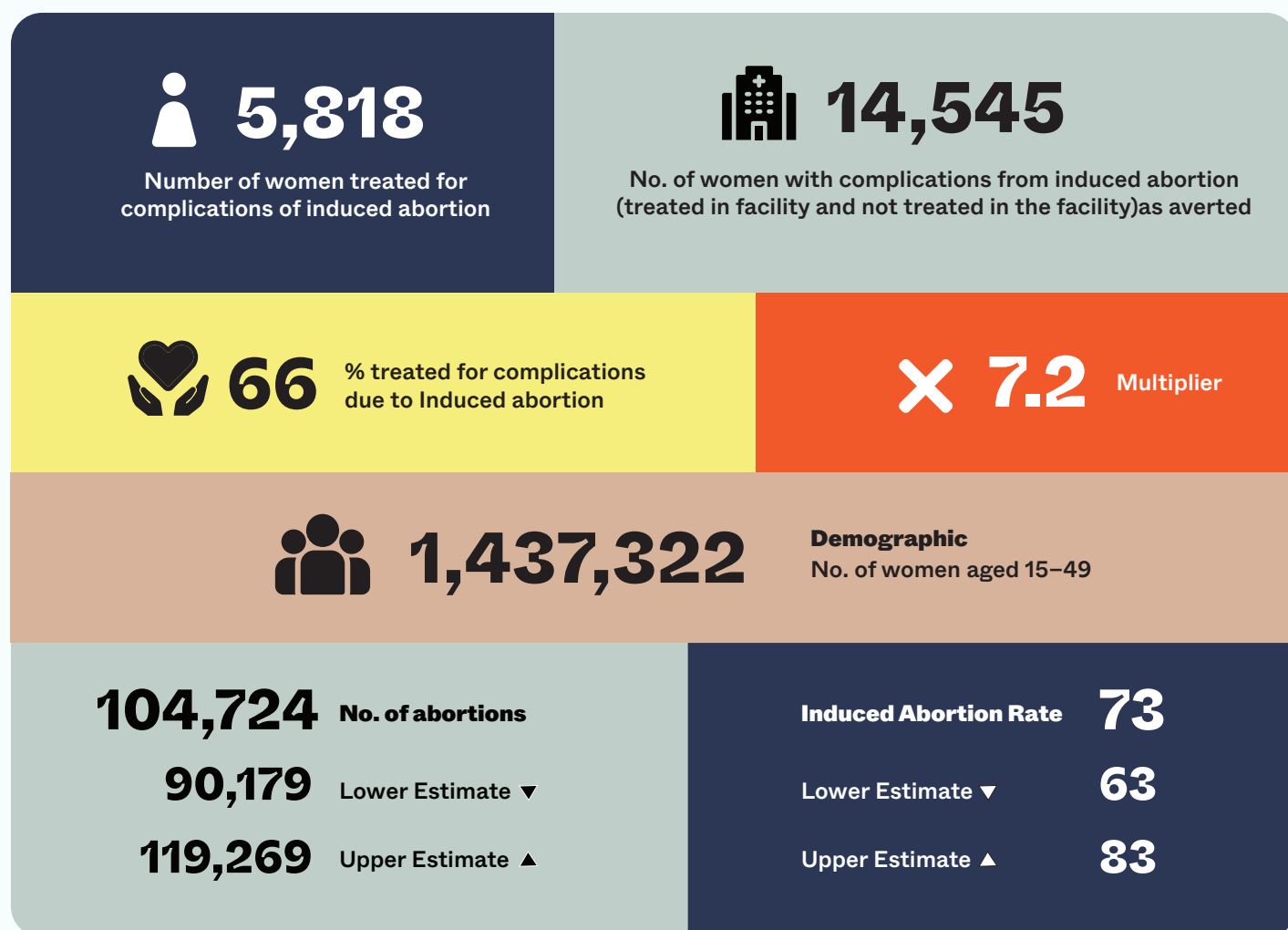


Table 2: Measures used to estimate Borno state Abortion Incidence and key indicators

We estimate that a total of 104,724 abortions took place in Borno in the year 2021. This translates to 73 abortions per 1000 women of reproductive age. For the upper and lower limit estimates we used 1 point below and above the multiplier. We chose data from 2021 because it represented the year with the highest reporting rate and also followed an intervention to improve the capture and reporting of reproductive health indicators on the DHIS platform in Borno state. However, as indicated previously, there continues to be considerable gaps in the actual versus reported data on the DHIS platform. When we estimate that only about 60% of actual cases treated in facilities are reported, the abortion incidence rises to 175,000

abortions (between 105 to 138 abortions per 1000 women of reproductive age. This indicates a need to ensure the consistent availability and access to quality comprehensive abortion care services.

We also sought to estimate the burden of abortion to the health system using the MSI impact-2 calculator. In 2021, the proportion of abortions not treated led to an estimated 1,300 maternal DALYs (Disability Adjusted life Years) and an estimated 120,000 USD in direct healthcare spending.

Though 12 abortion-related maternal deaths were reported in 2021 on the NHMIS platform, the model also estimated that an additional 24 preventable maternal deaths took place within the year.

Considering the limitations of abortion incidence estimation methods including the one used in this study, we also collated qualitative data from health care providers with experience providing abortion care as well as health administrators. The findings of the in-depth interviews also corroborate an increase in the incidence of abortions in Borno state during the period of the insurgency.

Most participants in the FGDs for women of reproductive age mentioned the increasing rate of abortions, citing many examples from their communities including from young unmarried women and victims of sexual violence.

*Hmm...it [abortion] is rising seriously, it's rising..... most of them have unplanned pregnancy and they would terminate the pregnancy because they have not planned for that pregnancy, whether married or unmarried.....most of them go to chemist, it is in the chemist they do give them the drug
.....Healthcare Provider*

*“most at time if this happened, they will go, when they know there's nurse in they community but they will go when they notice no one is seeing them, i know of some people that did abortion and their husband didn't know about it, if you ask them why they will say they don't know when they get pregnant and they are not ready to keep this pregnancy”
.....Married Woman (20-24)*

*.....and some of time if this happened they will go to chemist, they went there because they don't want to go to hospital because if they go the doctor may be from their community or some workers will know that the wife of that man has come to our hospital and this is what she did, so mostly they go to big chemist toh when they go there the worker there will give you either some drugs and some (.) but mostly is in the chemist they normally do it.....
Married Woman (20-24)*

In addition, healthcare providers in secondary and tertiary public facilities affirmed they had experienced an increase in cases of incomplete abortions arising from induced abortions which would often be reported as PAC. Across the 24 facilities sampled, health care providers estimate a total of between 30-50 women were admitted for complications of unsafe (induced) abortion monthly. One health worker provided a rough estimate of the frequency of such cases:

“Weekly they could reach like 15, while monthly they could reach up to like 40 or 50 like that, for yearly they could reach like up to 100.”

These estimates suggest that there is a considerable demand for abortion-related services within the state, and they likely represent only a fraction of the actual incidence due to underreporting and the reluctance of women to seek care for fear of stigmatization or legal repercussions.

Objective 02

Assess the availability and accessibility of abortion services across public and private facilities in Borno state.

In 2021, 97 facilities reported provision of abortion care services in Borno state including the 48 that reported providing induced abortion. The number of facilities reporting dropped considerably in 2022 and 2023 (Table 3). This seems to be due to a decline in the capture and reporting of abortion data elements on the NHMIS platform. Generally, it is likely some of the inconsistencies in the documentation of induced

versus spontaneous abortion is because health workers do not understand the correct and consistent capture of abortion indicators on the NHMIS registers and summary form. This is also similar to previous findings by Ipas in other states across the country that revealed a pattern of inconsistency in the understanding and documentation of abortion indicators on the NHMIS platform.

	SA	IA
2016	21(8)	10(5)
2017	255(34)	204(29)
2018	1168(44)	846(36)
2019	1145(58)	727(39)
2020	978(48)	109(10)
2021	5057(97)	860(48)
2022	1891(63)	311(30)
2023	1521(64)	489(34)

Key

SA Safe Abortion

IA Induced Abortion

Table 3: Facilities providing and reporting abortion care provision 2016-2023 (Source- DHIS 2 Nigeria)

As indicated previously, deducing availability and accessibility of abortion service in a restrictive legal environment, with the attendant stigma around abortion, is always somewhat difficult. Thus, we opted to speak to a spectrum of stakeholders -

women of reproductive age of various categories, health care providers, CSO staff and government health administrators.

Across the categories of women of reproductive

age interviewed, the overwhelming majority felt abortions (Induced) are only available and accessible in private hospitals for those with the means and then in Patent Medicine stores (Chemist), pharmacies, nursing homes, Community-based Health Workers (qualified or unqualified), medicine vendors and knowledge of traditional/herbal methods.

The references to community-based health workers include traditional CHEWs, nurses, or other unqualified categories like health assistants, auxiliary nurses, environmental health workers and others known to provide treatment advice or services within the communities.

some do take drugs most especially.....even flagyl can be used to abort pregnancy, those white flagyl in the chemist also is being used to abort pregnancy.....
WRA(single) 15-19

*Well, in my understanding, if you go to a hospital, as a spinster, they will not carry out abortion for you, that's why they patronize the chemists....if you get to chemist, for instance if the drugs costs N4000, you can decide to offer N7000 for you to meet your needs. These are the challenges we get from the chemist, if you go to buy from them, you will just add the money and double the actual price, they will just give you without asking what you will do with it, and they will just give you.....*WRA(married) 20-24

.....some you will see that it is the parents who will give traditional strategies for terminating the pregnancy,there are traditional herbs for abortion and there's that of the hospital....
WRA(married) 20-24

....some if they do not want to keep the pregnancy there is are traditional herbs they will take, bitter things like bile when they take it, it will abort the pregnancy, some who have money will go to the private hospital where they don't follow instructions since in the constitution abortion is not allow.....
WRA(married) 15-19

*chemist too it's been done there and big pharmacies.....*WRA(single) 15-19

*....they normally go outside the community to where they are not popular or hospitals so that they won't be noticedsome especially in the chemist, they have someone with whom they liaise, who brings them abortion pills, yes we do have such cases in small chemist like that.....[mentions name of a chemist].....*WRA(married) 25-49

There were also references to availability of abortion information through peers and the internet especially among young women though the information is inaccurate and often directs to unsafe abortion.

*mostly such things for instance, ladies who go to school; they have knowledge on these things, they don't have to visit any chemist or related places, they would just browse the internet to get the names of the drugs. From there they will just go and say, give me such and such drugs, they will just come and take.....*WRA(single) 15-19

...some women can discuss within themselves and take measures while others will discuss with their husbands, some can go to chemist and get drugs, and sometime they can go to hospital and explain. Sometimes they would advise them to keep it and

sometimes not.....WRA (married) 25-49

Generally, most women agreed that postabortion services can be accessed in government hospitals though some providers are known to reject providing care if they suspect an incomplete abortion resulting from self-inducement.

....if you get there with blood they will attend to you even if they can't they will refer you to the big hospital [general hospital].....WRA (20-24)

... If it's a miscarriage, we can easily go to our community hospital, but I heard the health worker will ask if you took something before she can attend to you.....WRA (married) 25-49

In most cases, the decision by women to procure an abortion outside of health facilities is driven by poverty, lack of information, stigma, and the prevailing legal restrictions to abortion.

If a woman is known or suspected to have aborted a pregnancy in a community, there is a way she is looked at and spoken about.....so women will rather go to quack doctors as a last resort.....CSO official

factors responsible is, number one factors is the poverty, especially all those that are coming for those abortion are teenage, between ages 15, to 16, to 18 those are the most of the people that are coming with unsafe abortion [complications].....and also a they are not literate on what they would face, they are not educated on the complication of the all these problems.....HCP MD

For all health providers interviewed in all facilities visited, Postabortion care was available and provided to women requiring such services. There were health workers who had received training on abortion care provision in most of the facilities. In public facilities, health workers corroborated the fact that abortion on demand isn't available but such women are advised to desist from seeking abortion though in most cases they do not return.

.....they don't come because they know we will ask them questions so they will go and look for how to abort it.....HCP KD

The availability and accessibility of abortion services vary across health facilities, with some stakeholders reporting the presence of trained staff and essential drugs, while others highlight a lack of awareness and low patronage of services. For example, a Director from Jere Local Government admits:

“Ok, for PAC services actually there is low awareness in the community, yes and [um] though we have trained staff at all our facilities to cater for that services, we have the essential drugs to treat the patient but there is low awareness so there is low patronage in our facilities regarding PAC.”

Objective 03

Identify factors contributing to unsafe abortions in the state and opportunities to address gaps in service provision and quality.

Factors contributing to the prevalence of unsafe abortions in the state are complex and multifaceted. In addition to the lack of access highlighted above, many respondents referenced the lack of empowerment and decision-making ability of women which makes them vulnerable to sexual exploitation. With a contraceptive prevalence rate of 5.4% [7], unintended pregnancies were also identified as a contributory factor to the increasing rate of abortions and related complications. The insurgency and the attendant displacement of families made women and girls more vulnerable to sexual assault and exploitation which in many cases led to unintended pregnancies.

We have poverty, ignorance, teenage pregnancy, early marriage and all this increased during insurgency..... sometimes when there is no food at home the young girls will sleep with men in other to

get food and it can cause pregnancy and we have seen a lot of them, even us we see it and that is gender based violence and this is another factor.....
HCP MD

With our growing children they should get them something doing or business so that they won't find themselves in conditions many are in today, that's what we are pleading with the government today.....WRA (married) 20-24

.....basically the main causes include lack of enlightenment and poor sex education..... Ignorance on the part of the parent as children grow without exposing them to sex education making them to know the signs and the implications of what they may be seen in life, that's the main cause..... ignorance, poverty, with socio-economic status contribute to the majority of the issues.....HCP MMC



Ipas training for police workers on women's sexual and reproductive health and rights.
Photo @Ipas

.....Actually, i can say that it has worsen because you won't hear most of such things in the past..... Today you could hear of teenage pregnancy even those of 12 and less of age have all been victimized of such things, but before the insurgency in our community, there were no such things.....WRA (Single) 15-19

.....Mmmmmm most of them do have unplanned pregnancies,..... they often terminate the pregnancy because they have not planned for that pregnancy. Whether married or unmarried.....HCP MD

We have high number of cases because of the insurgency. You know the security personnel in charge and the camp managers, they contributed. Some they are giving something special to the ladies, they always use their body to exchange for what they want. And causing this thing [abortions] to increase.....CSO Official MD

The reported high number of complications from unsafe abortion are most common in the secondary health facilities.

A lot of them [complications] are because they are afraid to come to the hospital on time because they may have illegally induced the thing [pregnancy].....HCP KD

In response to these challenges, stakeholders provide several recommendations for improving the situation. This includes greater community engagement and education, improved access to contraception, training of health workers and equipping health facilities.

"I will recommend more sensitization and creation of awareness."Government Official

I will also recommend supporting NGOs to conduct advocacy to key community stakeholders of the communities.....Then on the community level i will also recommend.....creation of awareness, and eh you know convincing people or will i say persuading people to know the benefit of side child spacing, especially in the part of the ladies.....Child spacing helps a lot, and eh it mitigates some health challenges.....CSO staff

I would love the recommendation to start from the higher level, let it be that poverty is addressed, the socio-economic status of an individual is also considered, and sex education also.....HCP MMC

To address these issues we need....."sensitization, and advocacy.....all the health educators should enter community and sensitize them on issues like early marriage, and to stop little children from hawking.....HCP JRE

Discussion

In this section, we provide an in-depth analysis and interpretation of the results presented in the preceding section. We critically evaluate our findings elucidating their significance in relation to the study objectives.

A recent review of maternal mortality trends in Borno state revealed the maternal mortality stood at about 1074 deaths per 100,000 live births. The main causes are preventable including abortions which accounted for about 10% of the cases [8]. Since 1996, 4 studies have estimated the incidence of abortion in Nigeria all at the National and Regional levels [9] [6] [10]. These national or regional estimates make it difficult to thoroughly understand state specific peculiarities and burden in a local context.

In terms of objective 1 of the study - estimate the incidence of induced and spontaneous/incomplete abortions and the burden of unsafe abortion;

In 2012, the reported incidence of abortion in the Northeast region, which includes Borno state, was 41 abortions per 1000 women of reproductive age (WRA) [6]. Our updated estimation for 2021 reveals a more nuanced perspective, indicating an incidence rate of 73 abortions per 1000 WRA in Borno state. This refined estimate provides a likely more accurate reflection of the state's abortion landscape compared to the broader regional rate of 41 per 1000 WRA in 2012.

Furthermore, our Impact-2 estimate for 2021 illustrates the tangible consequences of untreated abortion cases in Borno state. It reveals that

approximately 1,300 maternal Disability Adjusted Life Years (DALYs) were incurred, along with an estimated healthcare expenditure of 120,000 USD directly related to untreated abortion cases. Translated into local currency at an exchange rate of 1,531 USD/naira, this amounts to N183,720,000, highlighting the substantial financial burden that could have been redirected towards other healthcare priorities.

Data extracted from the state's DHIS2 and facility records spanning from 2019 to 2022/23 including qualitative data from interviews with women, health workers and administrators suggest a significant effect of the insurgency on the abortion landscape in the state. Conducting a comprehensive facility records audit statewide would provide further insights into this phenomenon. However, it is essential to acknowledge that the notable disparity between DHIS2 data and facility records serves as a limitation in this study, underscoring the need for improved quality of abortion service reporting practices. Despite the limitations with service documentation and the ability to indicate a clear trend, multiple statements from health workers, women of reproductive age and health administrators show that the insurgency has directly led to an increase in sexual violence, unintended pregnancies and the incidence of abortions most of which were unsafe.

On the second objective - assess the availability and accessibility of abortion services across public and private facilities in Borno state – our findings from the interviews (FGDs with WRA and KIIs with health providers, implementers and government

officials) indicate that the prevailing sentiment among participants is that induced abortions are primarily accessible in private hospitals for those who can afford them, followed by Patent Medicine stores (Chemists) and pharmacies. Other mentioned sources of abortion services include nursing homes, Community-based Health Workers (whether qualified or unqualified), medicine vendors, and traditional/herbal methods. Community-based health workers encompass various categories such as traditional CHEWs, nurses, and other unqualified individuals like health assistants, auxiliary nurses, and environmental health workers, known to provide treatment advice or services within communities. Additionally, participants noted that peers and the internet serve as sources of abortion information, albeit often inaccurate, leading to unsafe abortion practices, especially among young women.

In general, participants in the focus group discussions (FGDs) agreed that post-abortion care can be obtained in government hospitals, although some healthcare providers are known to refuse care if they suspect an incomplete abortion resulting from

self-inducement. Our review of NHMIS records and discussion with health administrators indicate that Postabortion care is available across Government secondary facilities and referral PHCs but not widely across PHCs with maternal health services. This means the availability of abortion care services isn't decentralized enough leading to inaccessibility in terms of distance to certain geographies especially rural and hard to reach/ inaccessible settings as a result of security. Abortion services therefore cannot be said to be widely available.

In conclusion, our findings suggest that abortion services are limited in the state and induced abortion is mostly only accessible in the private and out-of-Facility settings. However, the primary concern lies in the quality and safety of these services across the majority of the identified sources.

Our study's examination of the third objective - identifying factors contributing to unsafe abortions in the state and opportunities to address service provision and quality gaps - revealed the following key factors:



Healthcare worker providing training on Post Abortion Care through the On-the-Job Training approach. Photo @Ipas

1. *Lack of empowerment and decision-making ability among women, rendering them vulnerable to sexual exploitation*
2. *The low contraceptive prevalence rate, currently at **5.4%** [7], leading to a higher incidence of unintended pregnancies*
3. *The insurgency and subsequent displacement of families, exacerbating the vulnerability of women and girls to sexual assault and exploitation, thereby increasing the likelihood of unintended pregnancies*



Conclusion and Recommendation

In this section, we distill key insights gleaned from our analysis to provide actionable recommendations aimed at addressing identified challenges and leveraging opportunities. Our aim is to suggest how the study findings could translate to tangible actionable strategies to inform decision-makers, program planners & implementers, and other key stakeholders on effective pathways for addressing the issues raised in this report.

This study and its findings is a significant contribution to available knowledge on unsafe

abortion situation in Borno state. Whereas the study team acknowledges key limitations of this study which include unavailability of data for periods before the insurgency, limited scope of coverage (3 LGAs) of physical visits to facilities, findings from this study do corroborate anecdotal evidence on unsafe abortion service delivery, nexus of the insurgency with rising GBV issues and by extension, unwanted pregnancies and unsafe abortions. It also highlights the critical issue of perennial weaknesses of state mechanisms for health data (including abortion services) management.



Ipas values clarification and attitudes transformation session to drive social norms change on sexual and reproductive health. Photo @ Ipas

In view of the foregoing, the following recommendations are proffered:

1. Program planners and implementers must adopt a more innovative approach to engage policy makers and health managers in the development and implementation of harm reduction strategies within the context of abortion services. Despite the stringent legal framework surrounding abortion services, our findings indicate a prevalent occurrence of unsafe abortions in the state.

2. To gain a deeper understanding of the true burden of abortion in the state, a more extensive study encompassing additional Local Government Areas (LGAs) and facilities is warranted. This expanded research effort should include an examination of facilities records predating 2010 when the state initiated reporting on the DHIS2 platform. Such an endeavor would provide invaluable insights into the actual scope of abortion-related issues in the state and shed light on the potential impact of the insurgency on the abortion landscape.

3. The low Contraceptive Prevalence Rate (CPR) in the state, compounded by heightened

Gender-Based Violence (GBV) resulting from the insurgency, presents an opportune moment for the design and implementation of comprehensive Sexual and Reproductive Health and Rights (SRHR) interventions. These interventions should be strategically designed to mobilize various stakeholder groups, including governmental bodies, civil society organizations, and community structures such as traditional and religious organizations. Furthermore, the recent enactment of the VAPP law in the state serves as a powerful tool for mobilizing these diverse stakeholders towards collective action.

4. Addressing gaps in the reporting of abortion services, which encompass all forms of abortion, is imperative. Advocacy efforts at the national level are necessary to provide clarity on abortion indicators and to ensure that providers are equipped with updated knowledge and practices for accurate capture and documentation.

5. By addressing these critical areas, stakeholders can work collaboratively towards enhancing the provision of safe and accessible abortion services while mitigating the risks associated with unsafe abortions in the state.

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Appendix

Please use the guidance below to conduct focused group discussion with different groups of WRA in the selected LGAs

Name of FGD Facilitator:				Focus Group ID: FGD-LGA-Group-01			
Name of FGD Notetaker: !							
Group Codes- Adolescent Girls-single (ADOS) Adolescent Girls-married (ADOM) Women of Reproductive age (WRA2024) Women of Reproductive age (WRA25+)							
Focus Group Discussion Participant Log							
<i>Directions: Please fill out the following information <u>before every GD</u>, after informed consent has been obtained. Ask all participants individually to provide the personal information in the table below - please remind them that this information is confidential and to please be honest about their opinions. This needs to be administered by either the facilitator or note taker to ensure that correct codes are used.</i>							
LGA:				State:			
Community:							
Type of FGD:							
START Time of Discussion:				END Time of Discussion:			
Language(s) used during FGD:				Auto-generated file name from recorder:			
				Recorder Label:			
	Participant Code Prefix Guidance- Focus Group Id-Participant S/No				Please use codes below to complete these three columns.		
Participant #	Participant Code	LGA	Resides in Rural or Urban area?	Participant's Age	Marital Status	Education level	Religious affiliation
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							

Discussion Guide

Introductions and welcome (10 mins)

Introductions to everyone in the room – quick ice-breaker activity!

Thank you for participating – your opinions are important and will help us better understand PAC situation in your community. Please feel free to speak up if you have a different opinion -- these discussions are extremely valuable, and we will all be respectful of each other's opinions. We will be recording the session to be sure we don't miss any feedback. No one will have access to the recording except Ipas NHF staff and consultants, and it will be destroyed after it has been reviewed and analyzed.

Questions

K1.

- a. What are the common health challenges women and girls face in this community?
- b. Do you think that issues like STIs, rape, teenage pregnancy, miscarriage are part of the health challenges faced by women and girls in this community?
- c. Do you know about any child spacing methods for women and girls? What are the common methods in this community?
- d. Are those methods readily accessible for women and girls in this community?
- e. Where do women and girls usually access these methods?
- f. Are there any barriers to women and girls accessing child spacing methods in this community?

K2.

- a. Are there instances where a woman or a girl gets pregnant and they do not want to keep it? What do they do? Where do they go?
- b. Have you ever heard of a situation where a woman or girl attempting to terminate a pregnancy that resulted in complications – injury or death? How often does this happen in this community?
- c. Why do you think women and girls patronize quack providers?
- d. Do you think that women and girls were exposed to increased sexual harassment/exploitation during the insurgency? What were the issues?
- e. Were there cases of pregnancies resulting from these exploitations? How were those pregnancies resolved?
- f. Do you think that a woman or girl who became pregnant as a result of rape or incest should be allowed to terminate the pregnancy if they choose to do that?

K3.

- a. In your community, do you know where a woman can get safe post-abortion care? Please discuss all sources known (Please clarify sources of postabortion vs induced abortion care).
- b. Have you or anyone you know in your community received abortion care in some of the facilities in your localities? What were your/their experiences?
- c. What are the challenges women face in accessing safe abortion care in your community?
- d. What in your opinion are the drivers/causes of unsafe abortion and related complications in your communities?
- e. What do you recommend government and other stakeholders should do to address these issues?

Please use the guidance below to interview identified key informants including health care providers and administrators.

Facility Name:	LGA:
Facility Type:	Facility Level:
Geo-Coordinates	
Type of records reviewed (NHMIS, State-specific Registers, Facility/make-shift records)	
Key Informant Name: Unique ID: (TBD)	Position:
Cadre:	No. of years of service:
No. of years served at the facility:	

1. Please tell us briefly about your experience at this facility especially with providing child spacing and post-abortion related care? Where you trained to provide post-safe abortion care? What type of training did you receive and when? Probe for provision of Induced abortion, and missed abortion care. Does the hospital have adequate equipment to provide these services?
2. How are services documented and reported in the facility?
 - a. Is reporting done through the NHMIS and DHIS 2 platforms?
 - b. What are the challenges with documentation?
 - c. How are records archived in the facility (is there a system in place for archiving records)?
3. Frequency of service provision- Based on your experience at this facility, thinking about the past year, can you estimate the number of women that were provided with the following services weekly/monthly/yearly (estimates)?
 - a. PAC for – spontaneous abortion, incomplete abortion, missed abortion?
 - b. Number of women who present with complications from unsafe abortion?
 - c. Induced abortion
 - d. How many women are admitted for treatment as a result of incomplete abortion?
 - e. How many are admitted as a result of complications from unsafe abortion?
 - f. How many women have died as a result of unsafe abortion related complications in the past year?
 - g. Where services provided are mainly reported as PAC, in your opinion, what proportion of these services are suspected induced abortions?
 - h. Thinking about previous years, in your opinion is abortion incidence on the rise or declining?
 - i. What in your opinion are the drivers (factors responsible) of unsafe abortion among women?
 - j. Are you aware of unsafe practices or unsafe sources of abortion in this facility's catchment area? How does this drive the presentation of cases in the facility?
 - k. What do you recommend government and other stakeholders should do to address these issues?

Please use the guidance below to interview identified key informants [government officials & NGO/ CSO representatives] in the LGAs selected.

Organization Name:	LGA:
Geo-Coordinates	
Key Informant Name:	Position:
# of years of service:	

1. Please tell us briefly about your role in this organization.
2. How is your organization responding to the SRHR needs of women and girls? Probe for specific activities/programs that address – child spacing, PAC, GBV
3. Do you know about other organizations in the state that are involved in programming for SRHR needs of women and girls in the state?
4. How would you describe the situation of women and girls in terms of access to PAC services in the state?
5. Unsafe abortion is one of the drivers of maternal mortality in Nigeria; what would you say is the situation in the state?
6. How would you describe the availability and accessibility of PAC services in the state? Probe for:
 - a. Availability of trained providers at primary and secondary levels
 - b. Are facilities adequately equipped?
 - c. Which donor programs support provision of PAC services in the state? Can you mention them?
7. What in your opinion, is responsible for women visiting quacks for their abortion needs?
8. How did the insurgency impact on the need for and availability of PAC services in the state; would you say it had any effect? What was it?
9. Are you aware of any existing government policies in the state, that address the SRHR needs of women and girls? Example the VAPP law, VAPP law S&G protocol, etc?
10. What other factors do you think affect women's access to PAC services in the state?
11. What would you recommend as key actions to address unsafe abortion situation in the state on the part of:
 - a. Government
 - b. NGO program planners & implementers including CSOs
 - c. Community gatekeepers

INFORMED CONSENT FORM _ FGDS AND KIIS

CONSENT for participation in Ipas NHF Assessment

FGDs and Interviews with WRA, Health Providers, Government and NGO/CSO Officials

Study Title: An Assessment of the Burden of Unsafe Abortion Services in Public and Private Health Facilities in Borno State

Introduction

Hello, my name is _____ and I work as a Research Assistant for Ipas. I would like to invite you to participate in a study to better understand the burden of unsafe abortion in Borno state and the impact on the health and wellbeing of women and girls. This study is sponsored by Ipas Nigeria Health Foundation in collaboration with the Borno state Ministry of Health.

This assent form will provide you with some information about the study. It may contain words that you do not understand. Please ask me to explain any word or information that you do not clearly understand as we go through the form.

Procedure

If you agree to participate in the study, an interviewer will speak with you. Before you begin, the interviewer will ask you to assent to participate and will give you the opportunity to ask any question about the study. In case of underage participants, the adult/guardian here with you today will also be asked to give his/her consent for you to participate in the study. You cannot participate unless the adult/guardian gives his/her consent. Once he/she does that, you will participate in the discussion alone.

The interviewer will then ask you a series of questions related to your experience and knowledge of SRHR especially post-abortion care provision and the interview will likely last about 30-45 minutes – it may last a little longer or shorter depending on the conversations. You will be asked some questions about yourself, your profession and professional experience providing SRHR care and/or opinions of the burden of unsafe abortion. You do not have to answer any of the questions that make you uncomfortable and you can stop participating in the discussion at any time. At the end of the discussion, the interviewer will give you the opportunity to ask any remaining questions that you might have.

During the discussion, we will not ask any information that can identify you such as your name or where you live. During the discussion, the facilitators will take notes and record the conversation on an audio recorder, this is so that we can later listen to it, take more notes and analyze your responses. As soon as the discussion is finished, we will put the interview on a computer with a password that only the study team can access and lock the paper questionnaire in a cabinet. You do not have to answer any questions you do not want to answer and you may ask to stop participating in the discussion at any time.

Risks

The risks associated with participation in this study are minimal and not different from what the participants

would have been exposed to in the absence of this research especially since we are only seeking information. You may feel uncomfortable discussing some of the topics included in the questions or they may bring up emotional experiences. If such happens, you will be referred to a counselor if you would like to speak more in-depth to a professional about such issues. We realize that there are social risks associated with discussing personal experiences and information if such information were to be known outside of the interview. We will do our best to protect the information you share by holding the discussion in a private place; the interviewers have been trained to maintain your confidentiality and we will keep all the data in securely passworded mobile devices. Besides, personal identifiers such as name and phone number will not be collected attached to information from you. Although, the relevant Health Research Ethics Committee can request to view the confidential data, the data will still not be shared with anyone else. Your decision to take part in this study will not influence any of the health care services you receive or might receive. There may be uncommon or previously unknown risks. You should report any problems to the researchers.

Benefits

You may not benefit personally from being in this study. You may benefit from knowing that the information you share with us today will be used to make sure that women have better access to SRHR services in your community.

Confidentiality

All of your responses will be kept confidential. Your name will not be associated with any of your responses to the questions that you answered during the discussion. We will keep the discussion recordings and notes in a secure location and computer devices. Only members of the study team will have access to the information you share with us in this in this discussion.

Questions

Ipas	Samsu Gombwer, Senior Advisor, Programs, Ipas Nigeria Health Foundation. GombwerS@Ipas.org
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Signatures

If you don't have any/any more questions and agree to participate in the study, I ask you to sign this form stating that I, the interviewer, have informed you of your rights as a participant and that you have agreed to participate. This is the only place where your name will be recorded. We thank you for your time. I have read the information in this assent/consent form (or it has been read to me orally). All my questions about the study and my participation in it have been answered. I understand what my involvement in the

study means, and I voluntarily agree to participate. I understand my participation is voluntary and I can refuse to participate at any moment, for any reason, without penalty.

Participant Name (Please print)

Participant Signature

Date

Adult/Guardian (Please print)

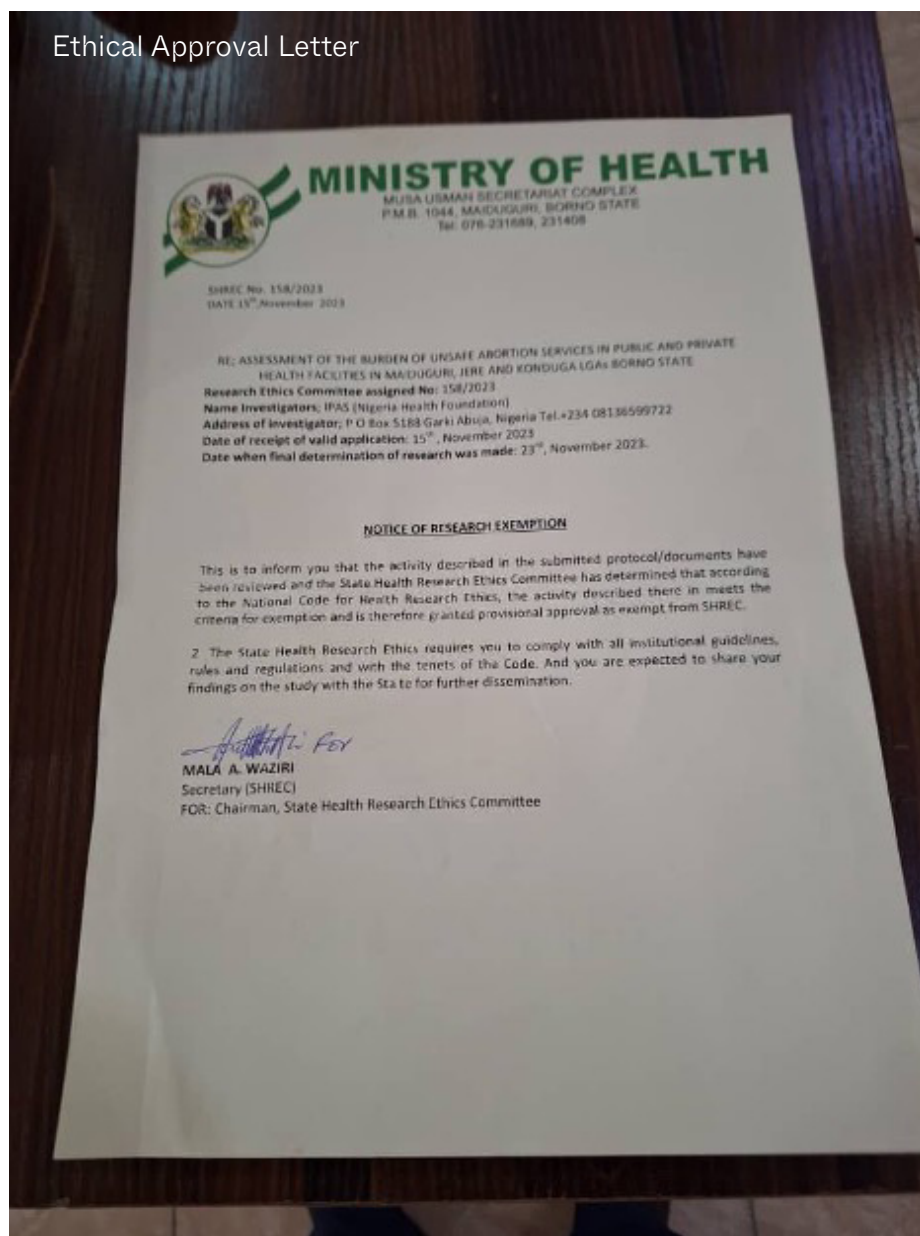
Adult/Guardian Signature

Date

Interviewer Name (Please print)

Interviewer Signature

Date



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