

Health care providers' attitudes towards termination of pregnancy: A qualitative study in Western Nigeria*

Mustafa Adelaja Lamina

Department of Obstetrics and Gynaecology, Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria
Email: ademustapha_2003@yahoo.co.uk

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ABSTRACT

Background: Despite restrictive abortion law in Nigeria, women still seek abortion services. Restrictive policies on abortion make it difficult for safe and legal abortion to be obtained. Hence, abortion is provided on clandestine basis in some private health facilities, and where the cost of such service is prohibitory, women resort to unsafe methods, including visiting quacks and self medication, resulting in severe complications including death. In Nigeria, little is known about the personal and professional attitudes of individuals who are currently providing abortion services. Exploring the factors which determine health care providers' involvement in or disengagement from abortion services may facilitate improvement in the planning and provision of future services. **Methods:** Data were collected using qualitative research methods. Thirty-six in-depth interviews and one focus group discussion were conducted between January 2010 and July 2010 with health care providers who were involved in a range of abortion services provision in the Western Nigeria. Data were analysed using a thematic analysis approach. **Results:** Complex patterns of service delivery were prevalent throughout many of the health care facilities. Fragmented levels of service provision operated in order to accommodate health care providers' willingness to be involved in different aspects of abortion provision. Closely linked with this was the urgent need expressed by many providers for liberalization of abortion laws in Nigeria in order to create a supportive environment for both clients and providers. Almost all providers were concerned about the numerous difficulties women faced in seeking an abortion and their general quality of care. An overriding concern was poor pre

and post abortion counselling including contraceptive counselling and provision. **Conclusion:** This is the first known qualitative study undertaken in Nigeria exploring providers' attitudes towards abortion and it adds to the body of information addressing the barriers to safe abortion services. In order to provide an enabling environment and sustain a pool of abortion service providers, a drastic change in Nigerian abortion laws is mandatory, after which policies that both attract prospective abortion service providers and retain existing ones can be developed.

Keywords: Health Care Provider; Attitudes; Abortion

1. BACKGROUND

Unsafe abortion is a major public health problem in Africa and is responsible for the deaths and disabilities of thousands of women each year. Low contraceptive use, restrictive abortion laws, limited availability of safe, elective abortion care and post abortion care, and the poor quality of services contribute to the 13% of maternal deaths attributable to abortion complications in the region [1].

Unsafe clandestine abortion is responsible for estimated 100 - 200,000 deaths among women in developing countries each year and accounts for 25% - 50% of all maternal deaths in some region, especially Latin America [2]. Each year, more than 4.2 million African women undergo unsafe abortion, and an estimated 38,000 of them die from the experience [3]. These women represent over 50% of all women globally who die from abortion-related causes [3]. From a study in Sagamu, Nigeria, maternal deaths from abortion constituted 20% of all maternal deaths [4].

A third of the population of the Third World live in countries where abortion is illegal or permitted only in extreme cases. Mortality from clandestine abortions in

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developing countries may be as high as 400/100,000 procedures compared with 6/200,000 in situations where abortion is legal [2]. Thousands of other women survive the intervention but experience short-term and long-term morbidity, including incomplete abortion, uterine perforation, pelvic infection, haemorrhage, shock, chronic pelvic pain and secondary infertility, emotional sequelae and enormous costs to the health care system for treating abortion complications [2,3]. In addition, many women suffer stigma and isolation imposed by their families and communities.

The legal status of abortion in Nigeria, like many other African countries, is highly restrictive (permitted by law to save a woman's life). Hence, it is the private-sector hospitals and clinics that mostly provide abortion services. Given professed concern with improving maternal health, the refusal of so many governments to liberalize their abortion laws seems inconsistent. Most African (including Nigerian) women have no legal way to terminate an unintended pregnancy, as few countries have health system guidelines for when and how to provide legal abortion, and services are rarely made available in public-sector health facilities. Consequently many unintended pregnancies end in unsafe abortion. Women may induce abortion themselves, sometimes in collusion with a pharmacist or herbalist, or turn to clandestine, unskilled practitioners in unhygienic settings who use techniques likely to cause haemorrhage, infection or other harm to their health [5-8].

There has been little research to date on health providers' attitudes towards abortion in Nigeria. Studies have done elsewhere, including countries where abortion is legal, they have found that various factors shape health professionals' attitudes towards induced abortion [9,10]. Religious beliefs, the reason for seeking an abortion such as rape or incest, age of the abortion seeker, and gestational age were all found to affect attitudes and willingness towards abortion provision. In Nigeria, little is known about the personal and professional attitudes of individuals who are currently working in hospitals/clinics that provide abortion services. Exploring the factors which determine health care providers' involvement or disengagement in services may facilitate improvement in the planning and provision of future services.

This paper reports on results from a qualitative study that explored knowledge, attitudes and opinions of health service providers who are likely to play a critical role in determining access to and the quality of these services.

2. METHODS

2.1. Study Sites

The study was conducted between January 2010 and July 2010 across 16 private and 4 public sector health care

facilities; 16 private hospitals/clinics and 4 public (general and tertiary) hospitals. The private-sector hospitals/clinics provided a range of representative services from pre-abortion counseling and referral, to the provision of first and second trimester abortions, post abortion counseling and contraceptive services.

This study was carried out in Ogun State, Nigeria. Ogun State, located in the western part of the country, is one of the 36 states in Nigeria. Ogun State comprised of four geopolitical areas. Four private hospitals/clinics were randomly selected from the list of the private-sector health facilities which offered abortion services and agreed to participate in the study from each geopolitical area, making a total of 16 health facilities.

The public-sector health facilities provide abortion services only to save the woman's life (therapeutic abortions and management of abortion complications) because of the restrictive abortion law in Nigeria and these services are fee-related. The private-sector health facilities offered abortion services though clandestinely, at a cost, which sometimes may be prohibitive. Doctors provide first and second trimester abortions in the private-sector health facilities. Most first trimester abortions were performed using manual vacuum aspiration (MVA), and a few were done using dilatation and curettage (D & C). All the second trimester abortions were carried out using medical method (a mix of use of vaginal misoprostol (Cytotec) only or with oxytocin and a combination of vaginal misoprostol and intra-cervical catheter). The use of medical method entailed a hospital admission of a few days. The use of dilatation and evacuation (D & E) for second trimester abortion is unpopular in the private-sector health facilities in Ogun State, Nigeria because it is said to be associated with a lot of complications.

2.2. Study Respondents

A total of 36 in-depth interviews and one focus group discussion (comprising of 4 doctors from the public-sector) were conducted with health care providers who were involved in a range of aspects of abortion service provision (see **Table 1**). There were equal numbers of male and female respondents. The median number of years of experience in abortion services was 9 years (range 0 - 30). Participants were selected through purposive sampling. Due to paucity of providers, snow-ball techniques were used to identify both providers and non-providers for the study.

The sample represented a range of health care providers who varied by professional category (including doctors, registered nurses and midwives) and type of provider. These included providers who were trained to perform abortions and were providing the service; providers trained in abortion services but were not providing

Table 1. Background variables associated with TOP service provision.

Study sites	Private hospitals/clinics	16
	Government hospitals (Level 2 & 3)	4
Training status	Providing service—Trained	18
	Providing service—Not trained	0
	Providing service—Health care manager	2
	Providing service—Total	20
	Not providing service—Trained	4
	Not providing service—Not trained	14
	Not providing service—Health care manager	2
	Not providing service—Total	20
Service provider category	Counsellor	2
	Registered Nurse/Nurse-midwife	8
	Community health extension worker	6
	Doctor	20
	Management	4
Median number of years worked in TOP services (range)		9 (0 - 30)
Sex of provider	Male	20
	Female	20
Religious affiliation	Christianity	20
	Islam	2
	Not specified	18

the services; and providers who were not trained in abortion procedures. Other respondents included nurses and counselors who were involved in pre-abortion and post-abortion referral and counseling, and health care managers in facilities providing both abortion and/or reproductive health care services.

2.3. Study Design

Qualitative in-depth interviews were conducted among health care providers and health managers who were working in facilities that provided abortion services in the private and public sectors. Considering the sensitivity of the subject matter and the respect for privacy of participants, individual interviews were deemed the most appropriate method for data collection. Based on the request from 4 participants, a single focused group discussion was held, as they felt more comfortable speaking in a group rather than on individual one-on-one basis. The interview guide was adapted accordingly to facilitate discussion.

Semi-structured, open-ended interview guides with

probes were used. Socio-demographic data which included gender, religious affiliation, training and qualifications, category of provider and years of experience as a provider were collected prior to the interview. A pilot study was conducted to check for appropriateness and understanding. Revisions were made to improve the clarity and flow of the instrument. Interviewers, who had experience in qualitative research methods, conducted the interviews in English. Interviews were held in a private setting and each interview was about an hour in duration. Interviews were diligently recorded and transcribed verbatim.

All participants provided written informed consent. They were assured of confidentiality and anonymity, both of which were ensured. Ethical approval was obtained from the Research Ethics Review Committee of Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State, Nigeria. Approval to conduct the study was obtained from Nigerian Medical Association (NMA) and Association of General Private Medical Practitioners of Nigeria (AGPMPN).

2.4. Data Analysis

Data were analysed using a thematic analysis approach. Initial categories for analysing data were drawn from the interview guide and themes and patterns emerged after reviewing the data. Key themes to emerge were: reasons providers were not willing to provide abortions including individual and health service related barriers, how providers defined or conceptualized abortion, knowledge and understanding of the TOP legislation, and how reasons for seeking an abortion impacted on providers' decisions to be involved in abortion provision.

The computer software package ATLAS ti 5.2 was used to facilitate sorting and data management (Scientific Software Developments, 1998-2008). The author (with the assistance of medical statisticians) developed and refined the codes using the key issues probed. The transcripts were coded by the author and then cross-checked for coder variation. The data were then reviewed for major trends and cross-cutting themes were identified. Issues for further exploration were prioritized for final analysis. No coding discrepancies were encountered.

3. RESULTS

Complex patterns of service delivery were prevalent throughout many of the health care facilities and fragmented levels of service provision seemed to operate in order to accommodate health care providers' willingness to be involved in different aspects of abortion provision. Some providers provided abortions and some assisted with the procedure and/or provided pre-abortion and post-abortion counseling. Others restricted their involvement to tasks solely relating to pre-abortion care, such as performing ultrasounds to determine gestational age and referral to a private health facility they think may offer abortion.

3.1. Knowledge of TOP Legislation

Knowledge of the abortion legislation and the right to "conscientious objection" (refusal on religious or moral grounds to performing an abortion but the requirement to refer to another facility or provider) varied amongst both providers and non-providers.

Providers who were performing abortions were aware of Abortion Act of the Criminal and Penal code. However, some providers who were supportive of a woman's right to choose were not very familiar with the legislation. Non-providers who were opposed to abortion were unclear about the conditions under which abortion can be offered to a woman. When asked about the legislation, a non-provider's response was:

I don't give a dam about what the Abortion Act is all about. All I know is that it is criminal to perform or procure abortion. I have heard here and there that both the

performer and the abortion-seeker will go to prison for number of years I don't know if found guilty.

3.2. Barriers to Service Provision

3.2.1. Policy

All participants agreed by consensus that the government policy on abortion is a major barrier to provision of abortion service. The abortion law in Nigeria is restrictive. Some of the respondents opined that a situation where abortion services are provided when women develop complications of illegal abortions, some of which may be fatal, is not heart-warming.

In the words of one service provider:

It appears callous to wait till a woman carrying unplanned pregnancy is at point of dying before providing abortion services, which if offered earlier (within a permissible legal framework), would have prevented unwarranted life-threatening conditions and deaths.

It is the belief of most of the participants that complications and deaths from abortions can be reduced to the barest minimum if abortion laws are liberal. Regularization and standardization of abortion services will ensure that the services are provided safely rather than the present situation whereby abortion services are provided clandestinely, sometimes by untrained personnel and in unsafe environment.

3.2.2. Conscientious Objection

Many respondents reported an ad hoc interpretation of the right to conscientious objection. They were of the opinion that it often interfered with abortion service provision.

Both the providers and non-providers reported confusion and uncertainty with regards to conscientious objection. There was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke the right to refuse to provide, or even assist in abortion services. According to respondents, it was evident that health services lacked the necessary regulatory structures to deal with conscientious objection among health care providers as a result of "anti-abortion laws" existing in the country presently. Furthermore, there seemed to be very little recognition or support from health service managers regarding effects of conscientious objection on service provision because of the restrictive nature of abortion law in the country. Many providers reported that staff including non-nursing staff such as cleaners and administrative personnel refused to assist or provide basic nursing care to abortion clients. A doctor-provider at a public health care facility narrated how access to care could be denied by a nurse:

The way they attend to patients with abortion complications could be appalling. A patient with septic abortion was groaning in pains, and all that was required was to

administer analgesic. The nurse in-charge of the patient ignored all the yelling of the patient and remarked that “after all I’m not responsible for your problem”. She didn’t give the drug until I accidentally came into the ward and I instructed her to do so immediately.

While all public sector facilities did not provide abortion services except for complications mainly as a result of the law, many private sector facilities did not have providers who were prepared to either perform abortions or to assist those performing abortions. Abortion services were often not provided due to “pro-life doctors not wanting to do anything about abortions” resulting in a few providers from the private sector providing the services. The impact of conscientious objection on service provision included all aspects of the abortion process from refusing to prescribe or administer necessary medications to refusing to assist in the operating room or provide abortions. A nurse in a private sector health facility said:

I’m the only one who is happy assisting fully in abortion care. Other nurses refused to give even the tablets (misoprostol) for the clients. One of them helps in the theatre, making the packs and assisting me with the book work but she refuses to give the tablets. She said she won’t involve herself with it (abortion).

However, some providers noted that when there’s financial compensation, those who refused to be involved with abortion care would assist.

3.2.3. Empowerment and Shifting Role of Mid-Level Provider

Most of the abortion service providers were of the opinion that training of nurses and midwives (as mid-level care providers) in abortion care services including MVA for first trimester pregnancies, will increase the number of abortion care providers in the face of many doctors who may refuse to provide abortion services on the premise of conscientious objection. They also expressed the need for major change in government policy on abortion before this mid-level provider role can materialize. Some nurses working in family planning said they might find the adjustment to be challenging as many colleagues were not willing to change their attitudes towards abortion.

I might find myself in an antagonistic position. Everybody will want to see what is going on but none will be willing to help the patients who come for abortion.

For some nurses who will become mid-level providers, the new context of being able to perform first trimester abortions was seen as “empowering” and an opportunity to broaden their knowledge and skills, and provide a comprehensive service to women with unplanned pregnancies.

A nurse seeks to combine operating room experience

with opportunities for abortion training which will be offered if there is a change in abortion policy. In the event that abortion laws are liberalized and provision made for mid-level providers, being an abortion provider and being able to perform first trimester abortions is perceived as empowering particularly for nurses.

As a nurse-midwife stated:

To be performing TOPs will be an empowering thing for nurse (mid-level) providers, you become more confident, you do a different function aside your normal role, people will look at you differently.

3.3. Influencing Factors in Abortion Provision

3.3.1. Personal Reasons

Reasons for involvement in abortion provision were more often than not influenced by direct and indirect personal experiences. Some see provision of abortion as part of a natural career trajectory, and for others, involvement was linked to prior exposure to mortality and morbidity associated with illegal abortions (performed by quacks) and the recognition of a scarcity of providers willing to provide abortion services.

A nurse-midwife underscored her need to be involved in abortion services this way:

Having nursed very ill and quite distressed patients who were admitted with septic abortion, and subsequently being asked to provide abortion if and when abortion law is revised though may take a space of time, that would be my motivating reason. When the new “liberal abortion law” is implemented and I’m part of it, all has to do with women empowerment.

Other health care providers were of the opinion that involvement in abortion service provision was a vocation requiring passion and commitment. One provider emphasized:

Since some people are very anti-abortion and you cannot force somebody that is totally anti-abortion, to go and work with somebody who is having an abortion, then people must choose to be in that situation.

3.3.2. Moral Reasons

Abortion as a moral issue and how it influenced health care providers’ degree of involvement in services was expressed in different ways. Some providers vehemently disliked abortion care, whereas others were prepared to restrict their involvement to pre and post abortion counseling, basic nursing duties, and were not willing to provide direct abortion care including performing abortions. As a nurse provider stated:

I don’t have anything to do with TOPs. I hate it and continue to hate it till Kingdom comes. I love to enjoy my job as a nurse.

While some non-providers working in the services did

not like abortion, they emphasized that they did not feel that it was “wrong”, or that they were in position to “judge a client”.

Providers not directly involved in abortion services who based their objection to abortion on moral grounds, have different thresholds in terms of their willingness to assist in preparing clients for an abortion. For instance, nurse providers described that they would help with ultrasounds and pre-abortion counseling, or they would set surgical trays, but they preferred not to assist in the procedure itself. Some said that they went as far as absenting themselves from the room during the procedure. One non-provider refused to provide misoprostol to the doctor provider as she believed it was an abortifacient and explained her reason thus:

I refused to provide the misoprostol because I'm an accomplice in starting it off. I don't think it's good to take a life, that's my point of view.

Providers who stated that they were “pro-choice” were more likely to talk about a “woman’s right to choose”. They maintained that a lack of objectivity regarding a woman’s right to choose arose from pre-judging women as irresponsible without thinking of the long-term consequences of an unplanned pregnancy. A nurse-provider felt that it was “sinful” to bring children into the world when they were at risk of being neglected and not adequately catered for. She narrated:

When I talk to anybody about preserving life, I'm referring to the life of the woman. I always remind them of the fact that being pregnant has many options; pregnancy continuation or termination. Women will or people who are there will say “what about the life of the unborn?” Now what would the quality of life be if the unborn was born, and wasn't born into happy circumstances, and where it could be provided with the basic needs of life?

3.3.3. Religious Beliefs

Most health care providers mentioned that they had experienced colleagues’ opposition to abortion based on a mix of religious and moral grounds in the working environment. Many abortion providers were labeled as “murderers” and “baby killers” who were expected to “preserve and not take life”.

Religious beliefs played a role for some providers in deciding not to be involved in abortion services. One service provider expressed herself this way:

As a nurse, I'm also involved in providing family planning services. There's a contrast, being a Catholic. I thought I had to take a stand on issues. So after I chose this position, I made up my mind not to be involved in that. [Referring to abortions]

On the other hand, another provider approached the issue from another angle, stating that:

I'm a practicing Catholic but “had made peace” with my decision to provide abortions despite the fact that I had been ostracized by my religious community.

Despite personal or religious beliefs prohibiting TOP involvement, some providers were able to separate personal values from professional conduct. Providers who described themselves as “pro-choice” favoured a “clinical” over an “emotional” response to abortion, viewing abortion care as “part of the job”, whereas those opposed to abortion found it difficult to separate their personal feelings from professional conduct.

3.4. Reasons for Seeking an Abortion

3.4.1. Rape, Incest and Foetal Abnormality

Whether the reasons why a woman sought an abortion could influence providers’ attitudes towards providing care was explored. Almost all providers perceived an unplanned pregnancy due to rape or incest as different and a legitimate reason to obtain an abortion. The few providers who commented on foetal abnormality suggested that staff generally were more understanding and supportive towards a woman seeking an abortion for what they perceived as a legitimate medical reason. It was assumed that a woman would be more traumatized about giving birth to a baby with a foetal abnormality and therefore deserving of more support, and that this would be forthcoming from staff irrespective of their stance on abortion.

3.4.2. Socio-Economic Reasons

Almost all respondents seemed to be in agreement that many women who sought abortion were pushed to do so by socio-economic hardship. Participants showed a lot of sympathy and understanding, irrespective of the motivating factor, be it last child too young, too poor and young to have a child, disruption of schooling or financial constraints. Reflecting on a possible miserable life for a woman and her child, many respondents were resolute that women should not have a baby they could not afford. Thus, it is important not to delay abortion in these circumstances, as any delay could result in women changing their minds. Comparing their own relatively better socio-economic circumstances to that of many abortion seekers seemed to elicit a sympathetic response from some providers, including those who personally hitherto would have objected to an abortion.

3.4.3. Experiences on Abortion Services

Many respondents opined that effective provision of abortion services is seriously hampered by the restrictive law on abortion in Nigeria. Hence, abortion services are not routinely provided in the public health facilities except to save the life of the woman. Therefore, abortion

services are clandestinely offered by private health facilities. However, for the providers in the private health sector, the provision of abortion services appeared to be contingent on the willingness of staff to be involved in abortion provision. Respondents mentioned that frequently those who were providing abortion services felt stigmatized. Some service providers stopped offering the services as “they could not endure the comments or the attitudes of their colleagues”. A provider described feelings of isolation experienced by some providers:

Colleagues make it difficult for you. They talked about you as if you are a criminal. Very often, you'll find many doctors not providing abortions because of fear of victimization, stigmatization and isolation from their colleagues and also the community itself.

3.4.4. First and Second Trimester Abortions

The respondents recognized the importance of providing second trimester services. However, their attitudes towards it varied, with the majority of the providers feeling distinctly uncomfortable about second trimester abortion provision. While some providers were absolutely opposed to second trimester abortion, others felt it was a procedure they could come to terms with over time. Non-providers who refused to involve themselves in abortion care were particularly vehement in their opposition to second trimester abortions, and in certain instances refused to prescribe or administer misoprostol for women presenting for second trimester abortions. Gestational age was a key indicator of acceptability. Providers found it more traumatic to deal with a termination performed around 16 - 20 weeks, than a termination at 11 weeks, because with the latter, one was dealing with an “embryonic sac” rather than a “formed foetus”.

Providers mentioned the fact that there has been a decrease in the number of second trimester abortions at private facilities. Several respondents attributed this decrease to some providers' refusal to provide second trimester abortion and acceptance by the women to carry on with the pregnancy after being advised to do so by an “unwilling service provider”. Some providers found dealing with clients who requested second trimester abortions frustrating because they wondered why women “waited so long”.

3.4.5. Contraceptive Services

Contraceptive services were described as a failure from two perspectives: failure of the public and private health sector (especially the public health sector) to provide effective services and failure on the part of the clients to use contraceptives. Many respondents opined that the public health sector has the capacity of wider coverage and provision of services at a highly subsidized rate or

even free of charge. Frequently mentioned was the preference of some women to seek abortion as a means of contraception. A common perception among the respondents was that contraceptive services in the public health were essential to the health of women and also preferable to abortion. Yet, there were many barriers to realization of this assertion, including little or no contraceptive counseling, limited contraceptive supply and choice, and judgemental attitudes particularly towards younger women. Post abortion counselling was difficult as the clients were often “in a rush” to leave the clinic/hospital or inadequate time on the part of the providers to provide comprehensive post abortion contraceptive counselling and was easier to tell the clients to continue on the contraceptive they were using previously.

Some providers remarked that there were insufficient numbers of family planning clinics in the public health sector while family planning clinics were almost in-existent in the private health sector and most contraceptive services were provided on ad hoc basis. A provider remarked:

When you ask the young girls what they use to prevent pregnancy, they say emergency contraceptive pills and condom (condom use being commonly promoted as part of strategy to prevent HIV transmission). And when asked how often, they say they use them occasionally. The older women continue with injections, which when failed, they fall pregnant, seek abortion and receive injection again. I love a situation where family planning would be included in the school curriculum.

3.4.6. Repeat Abortions

Many participants expressed a major concern about “repeat abortion” or the possibility that women were using abortion as a contraceptive method and this influenced their decisions concerning abortion provision and care. A woman who returned for a second or third time was identified as coming for a “repeat abortion” and in turn was perceived as sexually irresponsible. Another concern expressed by the participants was the link between failed or no contraception and the break-down in current family planning services including inadequate family planning counselling.

I have seen women coming for second and third abortions. You can see that it's becoming too easy an option to choose. And obviously it's becoming a contraceptive, a position I don't agree with.

However, while it was glaring that a number of participants felt it was unacceptable that clients would use abortion as a contraceptive method, others linked the rise in “repeat abortions” to difficulties in accessing services.

3.4.7. Quality of Services

Discussions on current service provision brought out a

great concern about quality of care within both the public and private health sectors. The concerns expressed by the providers centered on problems associated with a general lack of adequate pre and post abortion counselling, punitive staff attitudes especially towards younger women and fragmented services. In addition to the aforementioned problems, there was acute shortage of providers mainly due to restrictive Nigerian abortion law, and some providers in the private health sector had stopped rendering abortion service for fear of persecution.

A provider described how often large numbers of women were turned away due to shortage of providers and its potential consequences.

Many doctors in the private health sector are unwilling to provide the services and a few of them attend to a small number of clients. Women are often too scared to go elsewhere or can't afford high cost in other facilities, resulting in them seeking a "back street" abortion.

Fear of being labeled as abortionist and limited suitable spaces at the private clinics make it extremely difficult to provide adequate counselling and care.

A respondent from a private sector, a doctor providing reproductive health care services summarised the situation in public sector facilities:

The way patients with abortion complications are treated in government clinics leaves much to be desired. Abortion service is not integrated with other services and it is completely deprived of privacy. The service is suboptimal, that is, not of good quality. Policies of implementation of comprehensive abortion care should be reviewed.

However, there were also positive comments about the services particularly within some private sector clinics where providers felt they had more time for counseling and appropriate infrastructure to provide optimal services and where people who worked there chose to be involved in abortion provision. This was different from what was obtainable from government clinics where TOP services were not integrated into reproductive health care services.

3.4.8. Abortion Training and Values Clarification

Discussion around training showed a conflicting and complex picture of the state of abortion training opportunities and training barriers for providers. While training opportunities appeared to constitute training barriers to some providers on one hand, access to training was unproblematic for those who sought it on the other hand. "They just have to phone NGO like Ipas, and they will get the training as soon as a training group is on ground". Training opportunities were described as sporadic and staff shortages made it difficult for those who wanted to undergo training to be released as there were no staff replacements.

Stigma and fear associated with providing or even assisting with abortion services was recognised as a serious barrier to accessing training, even when it was on offer. Attending abortion training could be particularly fraught with danger for some providers as training could be seen as a "pro-choice" stance, consequently opening oneself to "finger-pointing".

Values clarification workshops were said to be very limited because of the restrictive nature of abortion laws in Nigeria. Values clarification was usually incorporated into comprehensive abortion care workshop programmes, which were facilitated by international NGOs such as Ipas. However, providers expressed an overriding sentiment that values clarification workshops would have a positive impact on service provision, assisting those opposed to abortion "to viewing things differently". Furthermore, providers suggested that value clarification helped them to define their role as facilitators who guided rather than directed a client. This alleviated the decision-making process. A provider remarked:

TOP is not a good thing. Values clarification opens up your mind to realize that you shouldn't judge the woman. She has her reason for doing this and I have to respect her position as a patient.

3.4.9. Possible Intervention Strategies

Most providers spoke about the need for "a radical change in abortion laws" from "restrictive" to "liberal" to create a supportive environment for both clients and providers. In addition, many providers spoke about the need for "dedicated centres for TOPs" or "special abortion clinics". Many saw these as ways of dealing with negative staff attitudes and with providers who refused to be involved in abortion care and provision.

4. DISCUSSION

Providers expressed a broad range of views and understandings about abortion provision and care. The major areas of concern were the providers' and non-providers' frankness in voicing out the difficulties faced by women seeking abortion, and the general quality of care received by these women. Post abortion contraceptive counseling was lacking and this was viewed by providers as a missed opportunity for contraceptive initiation. Women's perceived utilization of abortion services as a contraceptive service was largely linked to "ineffectiveness/failure" in family planning services.

Reported poor contraceptive uptake amongst post abortion clients in a relatively well-resourced area of Nigeria is worrisome. Though Nigeria has a relatively low contraceptive prevalence (11% - 13%) compared to other sub-Saharan African countries, there is high level of sexual activity and widespread awareness of the various

contraceptive methods among Nigerian adolescents and youths, with the Western Nigeria having better overall reproductive health care services than most other areas of Nigeria [11-14].

While religious beliefs were the main reason to some providers for not being involved in abortion provision, others were not deterred from being strong supporters of a woman's reproductive right to choose. Late gestational age abortions were particularly difficult for all providers and had an impact on service provision resulting in some doctors in the private sector turning back such cases.

In Nigeria, the proportion of abortions performed in the second trimester is low. About 10% of abortions are performed at a gestational age greater than 12 weeks. This is comparable to what is obtainable in United States and lower than that of South Africa [9,10,15]. Though this proportion is low, it is still of concern in Nigeria because of higher rate of and more severe complications including death associated with second trimester abortions [4,16]. Restrictive abortion law in Nigeria, health service-related barriers and personal circumstances had been found to contribute to why women delayed seeking an abortion until second trimester of pregnancy [12,17].

Most providers were familiar with Nigerian Abortion Act; the Criminal Code and Penal Code, and the conditions under which abortion care can be offered. However, very few engaged with the complexities and difficulties in decision-making surrounding an unplanned pregnancy and the complex reasons why women seek abortion. Unplanned pregnancies were largely attributed to irresponsible sexual behaviour and to a lesser extent, failed contraception, whereas sexual violence and non-consensual sex were rarely mentioned as possible causes of unplanned pregnancies. This is surprising given the high levels of violence against women reported in Nigeria [18, 19].

The difficulty mentioned by some providers in accessing abortion training is of concern as shortage of providers is not unrelated to providers opting to undergo training. In addition, it will be problematic sustaining a pool of abortion providers if the environment in which they work is unsupportive with lack of recognition of work provided and without incentives.

The emergence of quality of care as an issue is not surprising because it has been reported in other studies in Nigeria within the context of reproductive health services in the private and public health sectors [4,7,20]. Destigmatising issues around abortion for both the clients and providers will go a long way in improving quality of abortion care services.

Values clarification training programmes designed to promote more positive and tolerant attitudes by service providers should be organized and extended to health care providers within the realm of reproductive health

care. Efforts of International NGOs and other partners in organizing programmes around values clarification should be encouraged and sustained. These interventions have impacted positively on the quality and continuity of care, as well as the long-term health outcomes of women seeking abortion care [21].

Since the training and certification of mid-level abortion service providers such as midwives has been identified as a critical step toward making high quality abortion services accessible to all women in other sub-Saharan countries such as South Africa, a drastic change in abortion policy and promulgation of abortion-supportive laws, providing for legal abortion and registered nurses to be permitted to perform first trimester abortions will create a pool of certified abortion providers. A major policy change, recognizing and respecting a woman's right to abortion alone is unlikely to have the desired effect of significantly increasing the pool of providers, and subsequently access to safe, abortion services unless other issues raised by this study are addressed.

5. CONCLUSIONS

This is the first qualitative study carried out in Nigeria exploring providers' attitudes towards abortion and adds to the body of information addressing the barriers to safe abortion services.

A mix of factors among service providers seemed to influence their decisions to become involved in one way or the other with abortion provision. The major factors are the restrictive laws and unsupportive policies on abortion. Others included a combination of personal interest and circumstance. Religious and moral beliefs and fears of being stigmatized and ostracized played an important role in decisions not to be involved in abortion provision. However, despite misgivings about being involved in abortion provision, non-providers were concerned about many difficulties women in Nigeria faced in seeking an abortion and the need for improved contraceptive provision and counseling.

Complex and fragmented levels of service provision in many of the health facilities were consequent upon providers' reluctance to be involved in different aspects of abortion provision. Closely linked to this was the need expressed by many providers for "designated abortion clinics" where people feel "committed and passionate" about what they do and thus creating a more supportive environment for both providers and clients and could contribute to sustaining a pool of abortion care providers.

There was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse to provide, or even assist in abortion services. Moreover, the "conscientious objection" was beclouded by the restrictive Nigerian

abortion law. Health services lacked standardized structures to deal with conscientious objection among health care providers in view of existing abortion law in the country. Furthermore, there seemed to be very little recognition or support from health service managers regarding effects of conscientious objection on service provision because of unsupportive abortion law.

5.1. Limitations

Dearth of abortion service providers and willingness of the few providers to be interviewed, partly as a result of restrictive abortion laws in Nigeria, were the main limitations. However, they were relatively overcome by assuring and ensuring high level of confidentiality and anonymity.

5.2. Recommendations

The recommendations were drawn from the highlights of a number of issues mentioned by the providers interviewed for this study.

There is an urgent need to pursue a drastic change in abortion law in Nigeria from “restrictive” to “liberal” so as to give free hands to few existing service providers to operate and new ones will be encouraged to offer service. In addition, an enabling law will encourage the women to seek abortion services in facilities that provide safer services. Clear policy guidelines need to be formulated for the management and provision of abortion services. The health managers at the facility level need to be actively involved in policy guideline formulation.

Post abortion contraceptive counselling needs to be strengthened and integrated into post abortion care, as this has been shown to increase post abortion contraceptive adherence in developing countries where abortions laws are restrictive [22,23].

There is a need to improve on quality of care. This includes provision of adequate space and infrastructure as well as training and retraining of service providers including health managers. Psychological needs of the providers must be given attention as counselling and support is required for both providers and clients. Values clarification workshops attendance by health care providers needs to be encouraged and strengthened.

There is a need to develop support programmes which attract prospective abortion care providers and retain the existing ones. Financial compensation for abortion providers needs to be considered. There is a need by abortion stake-holders to pursue a legal framework, which will make abortion provision by mid-level providers possible. Recognition of this role as a specialized or scarce skill and monetary compensation needs to be considered. This will encourage more staff to volunteer to provide abortion services.

Finally, there is a need to provide stand-alone abortion clinics as such a setting which will provide a supportive and conducive environment to both providers and clients.

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