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Clandestine Abortion in Port Harcourt: Providers' Motivations and Experiences

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Abstract

Background: *Abortion is illegal in Nigeria. It is a crime to perform or obtain an abortion except to save a woman's life. In spite of this, several medical practitioners working in profit-oriented private clinics still provide abortion services on demand and on a fee for service basis. This study is to find out the motivations and experiences of these practitioners.*

Methods*: The study was carried out in 15 clinics in Port Harcourt that were known to provide abortion services, using a descriptive, cross-sectional study design. Data were collected using a semi-structured, self-administered questionnaire, followed a few days later by in-depth interview to further explore responses in the questionnaire.*

Results*: A total of 34 doctors, 29 males and 5 females that routinely provide abortion services in the clinics were interviewed. Most of them (79.42%) were below the age of 40 years, married (76.47%), non-specialist doctors (55.88%), and had practiced for less than fifteen years (88.24%). All the owners/ Medical Directors of the clinics were actively engaged in providing abortion services, and most of the clinics (86.67%) had less than ten in-patient beds. All the providers were Christians, but most (85.29%) provided abortion services mainly for the financial benefit. Expertise for the abortion procedures were acquired in private clinics, but most of the providers (61.76%) restricted themselves to terminating pregnancies in which they felt were firmly within their level of competence. All the respondents used manual vacuum aspiration for the termination of pregnancies less than 12 weeks and charge an average of five thousand naira (N5,000. 00) for an 8-week pregnancy.*

Conclusions*: Most abortion providers in Nigeria are lured by the large market and the huge fees collected for the services. Abortion should be formally legalized in Nigeria to at least force down the service charge, and hence make safe abortion accessible to women of low socio-economic class.*

Keywords*: Clandestine abortion, abortion service providers, Port Harcourt*

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Introduction

Abortion is illegal in Nigeria. It is a crime to perform or obtain an abortion except to save a woman's life. Penalties exist for any person who performs an abortion, as well as for any woman who seeks an abortion or attempts to cause her own miscarriage.[1] Nevertheless, women in Nigeria who are faced with unwanted pregnancy still obtain abortion either by their own effort or through clandestine abortion provided by medical practitioners, paramedical workers or traditional medicine practitioners.[2] These abortions are often unsafe.[3] The World Health Organization defines unsafe abortion as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.[4]

The maternal mortality rate in Nigeria is one of the highest in the world at 800 deaths per 100, 000 live births, and unsafe abortion is believed to be one of the largest contributors.[5] Many more women suffer from other complications of unsafe abortion including haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organ, as well as long term sequale like infertility and increased risk of ectopic pregnancy, premature delivery and spontaneous abortions in subsequent pregnancies.[6] Already, hospital based studies have confirmed unsafe abortion as responsible for a large proportion of all gynaecologic admissions in Nigeria.[7]

Even with the present situation, it is predicted that the need for abortion would increase in the immediate future as more Nigerian couples seek to have fewer children, as well as factors related to early sexual activity that often results in out-of-wedlock pregnancies among very young women; the dim prospects for innovative technological advances in the contraceptive field; and the HIV/AIDS pandemic that has encouraged

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the widespread use of contraceptives that are more effective against HIV, but less effective at preventing pregnancy.[8] It is being estimated that women in Nigeria and other developing countries would have an average of one unsafe abortion by the time they are 45 years,[9] possibly with most of the attendant complications.

It is to reverse this trend that medical professionals, women's groups, legal and human rights advocates, amongst others, are advocating for the legalization of abortion.[10] In Nigeria, the Society of Gynaecologists and Obstetricians of Nigeria (SOGON) and the Nigerian Medical Association had been in the forefront in the fight to legalize abortion in Nigeria.[1, 11] Their efforts have now been boosted by favourable changes in the attitude of Nigerians towards the legalization of abortion.[12, 13]

However, several efforts at securing the desired legal amendments have been thwarted mainly by religious pressure groups.[1] These religious groups consistently argue that abortion is murder, placing it outside the realm of what is "morally" correct. There have been reports of violence against abortion service providers in some countries.[14] While this has not been reported in Nigeria; it is believed that pronatalists in Nigeria at least stigmatize and boycott clinics known to provide abortion services, especially as the facilities are never freestanding abortion clinics, but offer a wide range of other medical services. In spite of this hostile situation, several medical practitioners working in these profit-oriented private clinics still provide abortion services.[3, 15] It is estimated that at least 760, 000 abortions are induced in Nigeria annually, with medical doctors working in these clinics providing 40% of them.[7, 15]

This study is to find out the motivations and experiences of these practitioners. The study will provide a fresh insight as it was carried out exclusively on medically qualified abortion service providers. Previous studies in Nigeria often survey a wide-range of health professionals[3]. The study was carried out in Port Harcourt, the capital city of the oil-rich Rivers State of Nigeria.

Materials and methods

Fifteen clinics located in various parts of Port Harcourt and its environs that were known to provide abortion services were used for the study. Informed consents were sought and obtained, first from the owners, or Medical Directors of the clinics, and then from individual doctors in the clinics. All the doctors that provided abortion services in the clinics were interviewed.

A descriptive, cross-sectional study design was used for the study, with a semi-structured, self-administered questionnaire, followed a few days later, with an in-depth interview as the study tools. The data were collected between January and March 2007.

The questionnaire had three parts, and made up of both open and closed ended questions. The first part collected information about the age, sex, marital status, qualification, length of practice, and religious convictions of the respondents. The second part asked the respondents about their motivations for providing abortion services in spite of the legal and religious restrictions; while the third part collected information about the experiences of the respondents, and the set-up in the clinics where they provided the services.

The in-depth interviews were conducted to further explore the respondents' responses to the questionnaire. They were carried out by a doctor of the same status and age group as the respondents, to further increase the validity of the responses.

The collected data were manually checked for consistency and completeness; and then analyzed using a pocket calculator. Summary measures were calculated for each outcome of interest.

Results

A total of 34 doctors, 29 males (85.29%) and 5 females (14.71%) were interviewed in the 15 clinics used for the study; with just 2 doctors declining to be interviewed. Most of the respondents (79.42%) were below the age of 40 years, married (76.47%), non-specialist doctors (55.88%), and had practiced for less than fifteen years (88.24%) Table I.

All the owners/ Medical Directors of the clinics were actively engaged in providing abortion services, and most of the clinics 13 (86.67%) had less than ten in-patient beds.

All the respondents were Christians, and most 31 (91.18%) of them attended religious services at least twice very month, and all expressed the view that their churches were seriously against abortion.

All the respondents had multiple reasons for providing abortion services, Table II, but most of the first ranked reason was the financial benefit (85.29%). However, in spite of these motivations, most of the respondents 23 (67.65%) said they would feel embarrassed if they were openly identified as an abortion service provider.

Most 31 (91.18%) of the respondents terminated at least 14 pregnancies very week, even when only 13

(38.22%) were able to terminate all pregnancies irrespective of the gestational age. Expertise for most abortion procedures were learnt by most of the respondents 33 (97.06%) from senior colleagues in a private clinic.

Because of the legal situation, most of the respondents 21 (61.76%) were able to play safe by restricting themselves to terminating pregnancies in which they believed were safe to handle, and within their level of competence. As a further preventive measure, some (23.53%) of the respondents spoke of encrypt forms of record keeping to protect the provider in the event of any legal action. Only 3 (8.82%) of the respondents had ever had problem with the law enforcement agents, usually following the death of clients. All the cases were settled out of court in the police station.

The service charge for abortion is influenced not only by the gestational age of the pregnancy, but also by the ability of the client to pay the fees. Respondents charge an average of five thousand naira (N5, 000. 00) for an 8-week pregnancy. All the clinics implicitly studied considered patients seeking abortion as the private patients of the doctor that provided the service, and so the service charge was shared to reflect the fact that the provider had to bear the consequences for any complication that arose. Most 10 (75%) of the clinic collected money just for the consumables and the use of the clinic's theater, while 5 (25%) had a fixed amount paid to clinic that varied with the gestational age of the pregnancy terminated.

Discussion

The result of the study showed that in spite of the legal and religious restrictions against abortion in Nigeria, doctors working in private clinics have continued to provide abortion services, especially to cash in on the large number of women seeking abortion. The large market for abortion in Nigeria is fed by the desire for smaller family size, and low level of contraceptive use [16]. The mean desired number of children declined from 5.8 in 1990 to 5.3 in 2003, even as only 7% of married Nigerian women used a modern contraceptive method, with another 6% relying on traditional or folk method [17]. A 2003 survey in Nigeria also found that 40% of respondents were at risk of unwanted pregnancy [16].

The large market and the illegal status of abortion in Nigeria ensured that the fees for abortion services remained very high. Providers in this study took an average of five thousand naira (N5, 000) for the termination of an eight weeks pregnancy. This is exorbitant considering that according to a 2003 Human

Table I: Percentage distribution of respondents by selected characteristics

Characteristic	Number (N= 34)	Percentage (%)
Sex		
Male	29	85.29
Female	5	14.71
Age		
< 30 years	5	14.71
30 – 34 years	8	23.53
35 – 39 years	14	41.18
> 40 years	7	20.59
Marital Status		
Single	8	23.53
Married	26	76.47
Separated, divorced or widowed	0	0.00
Length of practice		
< 5 years	7	20.59
5 – 10 years	11	32.35
11 – 15 years	12	35.29
> 15 years	4	11.76
Qualification		
MBBS	19	55.88
Obstetrics and Gynaecology resident	5	14.71
Resident in other specialties	9	26.47
Consultant, Obstetrician – Gynaecologist	0	0.00
Consultant in other specialties	1	2.94
Religion		
Catholic	1	2.94
Protestant	9	26.47
Pentecostal	24	70.59
Spiritual	0	0.00
Muslim	0	0.00
Traditional Religion	0	0.00
Number of in-patient beds in clinics (N =15)		
/< 5 beds	5	33.33
6 – 10 beds	8	53.33
>/ 10 beds	2	3.33

Table II: Motivations of respondents for providing the services

Motivation	Third ranked (+)	Second ranked (+ +)	First Ranked (+ + +)
Financial benefit	0 (0.00%)	5 (14.71%)	29 (85.29%)
Desire to help a woman in need	3 (11.11%)	3 (8.82)	1 (2.94%)
The exercise of a medical expertise	7 (25.93%)	14 (41.18%)	1 (2.94%)
The desire to prevent a woman from patronizing an unskilled provider	4 (14.81%)	3 (8.82%)	0 (0.00%)
Part of the job description at the clinic	13 (48.15%)	9 (26.47%)	3 (8.82%)
Total	**27**	**34**	**34**

Development Report [18], 70.2% of Nigerian live on less than one dollar (N130) a day. This high fee is not surprising considering that most of the providers in this study were motivated by financial reasons, and the fact that the clinics they operated in were small, points to the possibility that the whole set up was to cash in on the huge profit that could be made from abortion services. Financial motivation distinguished the providers in this study from others in Latin America[19] and Belgium[20] that worked under the same environment. These providers

were motivated mainly by their desire to help women cope with unwanted pregnancies, and the need to achieve a political change in the abortion policy [19,20]

But should the fees for abortion services be kept high to discourage women from it? Studies have shown that women would always seek to terminate their wanted pregnancies irrespective of the prevailing laws, religious proscriptions or social norms [21]. Other studies have shown that high fee for safe abortion has the tendency to drive women to unsafe abortion with its attendant complications[3, 7, 22]. Therefore to ensure that all women desiring of an abortion have a safe one would require making adjustments in both the demand and the supply side of abortion. Chastity and contraception have always been at the top of recommendations to reduce the need for abortion[6], but chastity appears to be a dying virtue in Nigeria, as the age at first sexual intercourse continues to fall to a few years after menarche[17]. Contraception is neither a popular option in Nigeria as many young Nigerians considered it more detrimental to their future reproductive aspiration than abortion [23, 24]. But even as safe abortion has emerged as one of the safest procedures in contemporary medical practice [25], contraception remains the better option for the reproductive health of Nigerian women [4, 6, 7, 16]. Therefore, serious attempt should be made to change this wrong perception.

To address the supply side of abortion might require addressing the legal status of abortion in Nigeria. The illegality of abortion in Nigeria compels providers to raise their fees to at least offset the cost of keeping the law enforcement agents at bay. The freedom from extortion and prosecution that follow the legalization would increase the number of providers, and cause a decrease in the service charge. As reaffirmed by this study, most doctors can easily get beyond the moral and religious stance against abortion, but many are deterred by the possibility of a loss of license to practice, if being charged for medical misconduct by the Medical and Dental Council of Nigeria[26]. The ethical guidelines of the Medical and Dental Council of Nigeria explicitly stated that it is an offence to carry out an abortion, except to save the woman's life[27].

Although making abortion legal in Nigeria would not guarantee that all doctors would be able to provide the service[28]. It will however allow the services to be provided in public hospitals which would reduce the service charge and create more avenues for the training of more doctors on abortion procedures[27]. Respondents in this study had gained their expertise in private clinics because the clinics routinely provided the services; and medical fees in public health facilities in Nigeria are always cheaper.

Conclusion

Most abortion providers in Nigeria are lured by the large market and the huge fees collected for the services. Although their services are relatively safe, the huge fees they collect might have priced out women of low socio-economic class, forcing them into patronizing quacks. Legalizing abortion in Nigeria will go a long way into reducing the service charge, and hence make safe abortion accessible to women of low socio-economic class.

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