PMA ABORTION SURVEY RESULTS: KINSHASA, DEMOCRATIC REPUBLIC OF CONGO

December 2021 – April 2022

KEY FINDINGS :

Induced abortion is a common reproductive health event in Kinshasa, DRC, with approximately 105 abortions per 1,000 women ages 15-49 in 2021. Most women indicated that they were either too young, unmarried, or without the financial resources to continue a pregnancy.

More than one-third of induced abortions in Kinshasa are unsafe; 35% of women reported using means other than a facility-based surgery or medication abortion pills to end their pregnancy.

Half of women (55%) reported a potential severe complication such as fever, vaginal discharge, or a complication requiring surgery, and only 60% of those women sought postabortion care in a facility.

ABORTION IN DRC: RECENT CHANGES HAVE EXPANDED LEGAL CONDITIONS

Abortion is a common reproductive health event in Kinshasa, Democratic Republic of Congo (DRC), with a 2016 estimated incidence of 55-56 abortions per 1,000 women age 15 to 49.[1, 2] Many of these abortions lead to complications requiring postabortion care, some of which result in maternal deaths. In response to the health concerns surrounding unsafe abortion, the government decriminalized induced abortion in 2018 making it legal in cases of sexual assault, rape, incest, fetal abnormalities, and when continuing the pregnancy endangers the mental or physical health or life of the woman. In 2020, the Ministry of Health approved comprehensive abortion care guidelines in alignment with the Maputo Protocol, which made abortion legal under the previously specified conditions up to 14 weeks of pregnancy and removed key barriers to accessing safe abortion care. The changing legal and abortion practice landscape calls for a re-examining of patterns of abortion incidence and safety to monitor progress and guide ongoing reforms.

THE PMA KINSHASA ABORTION STUDY

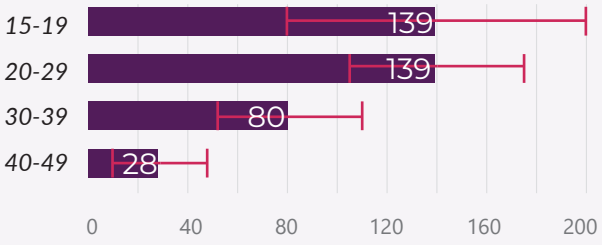
Between December 2021 and April 2022, Performance Monitoring for Action (PMA) conducted a survey to produce updated and more detailed estimates of abortion incidence and safety in Kinshasa. The study used representative data on women of reproductive age (15-49) and their reports of their and their closest female friend's abortion experiences. Additional details regarding the sampling design and information on the survey questions and friend methodology are included at the end of this brief and further described elsewhere.

ABORTION IS A COMMON REPRODUCTIVE EVENT IN KINSHASA, ESPECIALLY AT THE BEGINNING OF A WOMAN'S REPRODUCTIVE LIFESPAN

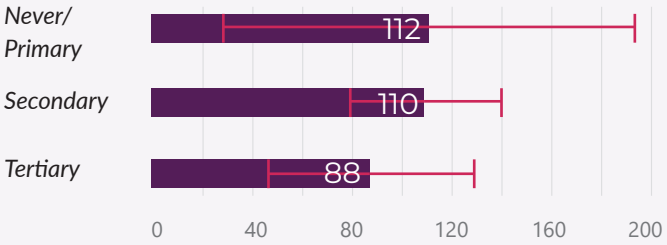
Overall, there were approximately 105 (95% confidence interval (CI) 79-132) abortions per 1,000 women ages 15-49 in Kinshasa, DRC in 2021, equivalent to 344,000 abortions. The incidence is highest among younger women, unmarried women, and women without any children. Past-year intimate partner violence and household violence were somewhat more common among those who reported an abortion in the past year (41% and 21%, respectively) compared to those who did not report an abortion in the past year (36% and 17%, respectively).

ONE-YEAR ABORTION INCIDENCE IN KINSHASA , DRC BY WOMEN'S CHARACTERISTICS, 2021 (N=2,178)

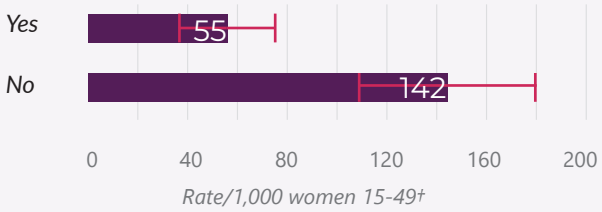
AGE



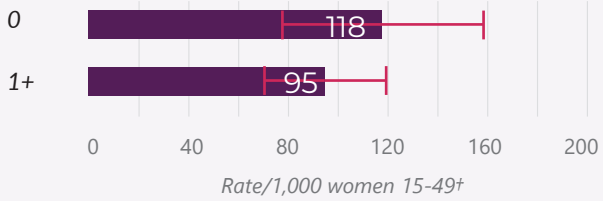
EDUCATION



CURRENTLY MARRIED



PARITY

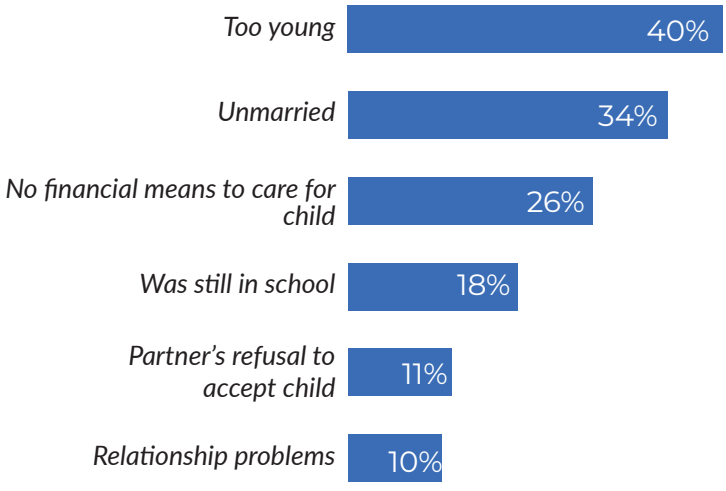


†Abortion incidence estimates come from adjusted friend data.

PRIMARY REASONS FOR ABORTION

Reasons for abortion varied across the lifespan but were often related to accidental pregnancies that occurred when women could not take on parenting responsibilities because they were too young, not in stable partnerships, or not financially prepared.

> ***"I was the oldest in my family, my parents were no longer able to take care of us, my siblings relied on me."***
>
> Woman living with partner, 18 years old and no children at time of abortion

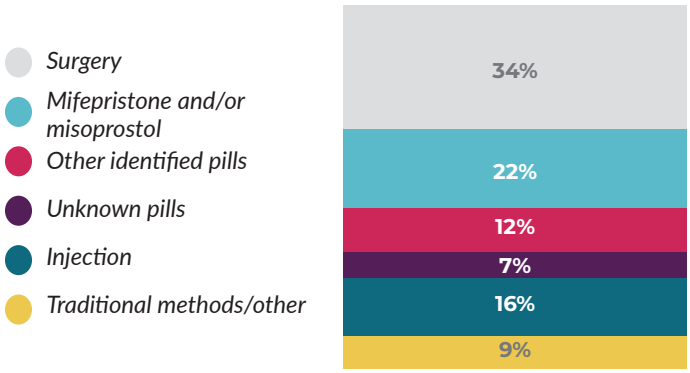


ABORTION TRAJECTORIES OFTEN INFLUENCED BY INCOMPLETE INFORMATION AND A DESIRE FOR PRIVACY

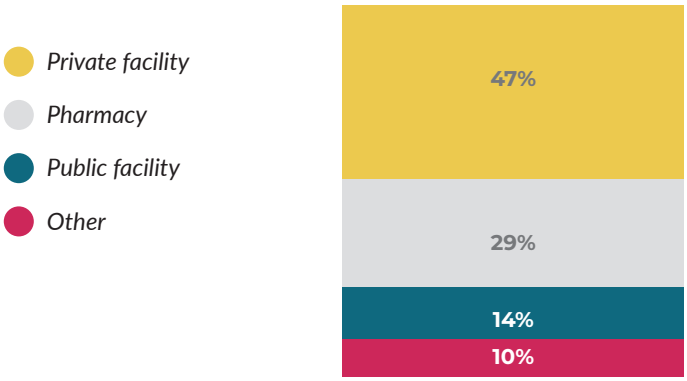
Despite recent legal reform, many women are unaware of the legal grounds for induced abortion in the DRC; only 19% knew that the law allowed legal abortion in certain circumstances, with adolescents, those with little or no education, and the poorest least likely to know. Relatedly, nearly one in four women (23%) were unaware of a safe abortion method (i.e., surgery or medication abortion pills), with adolescents and unmarried women least likely to be aware of a safe method.

Women relied on a variety of abortion methods and sources of care , with 27% reporting using more than one method. Surgery (34%) and abortion pills (22%) were the most common methods used while private facilities (47%) and pharmacies (29%) were the most common sources.

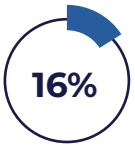
ABORTION METHOD*



ABORTION SOURCE*



*Method and source estimates from respondents (n=307)

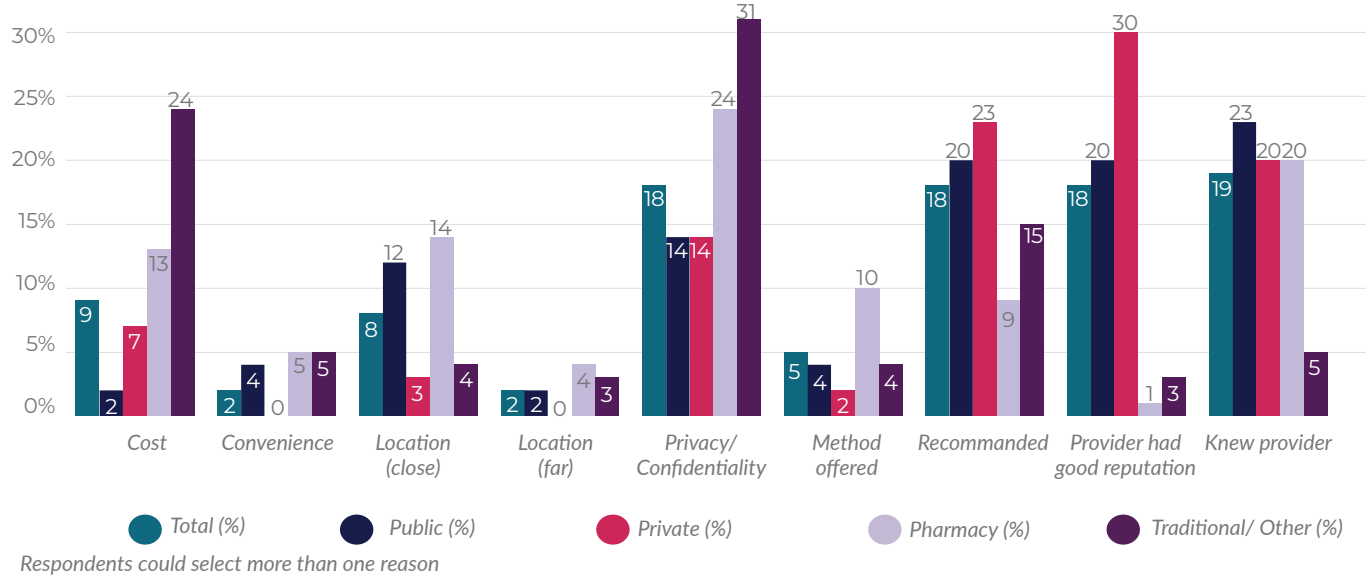


percent of women used medication abortion pills obtained from outside a health facility at some point in their abortion trajectory. These women tended to be more educated and unmarried.

Decision-making

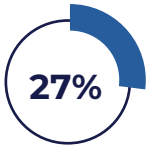
Knowing the abortion provider was the most common reason for choosing an abortion source overall (19%) and for those who went to a public facility (23%), whereas provider reputation was the most common reason for those who went to a private facility (30%) and confidentiality/privacy was the most common for those who went to a traditional/other source (31%) or a pharmacy (24%).

REASONS BY SOURCE

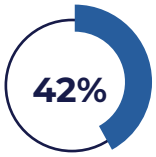


Respondents could select more than one reason

Accessing abortion care is challenging for many women



of women said it was somewhat or very difficult to pay for their abortion. Those who were younger, less educated, and poorer were more likely to report difficulty.

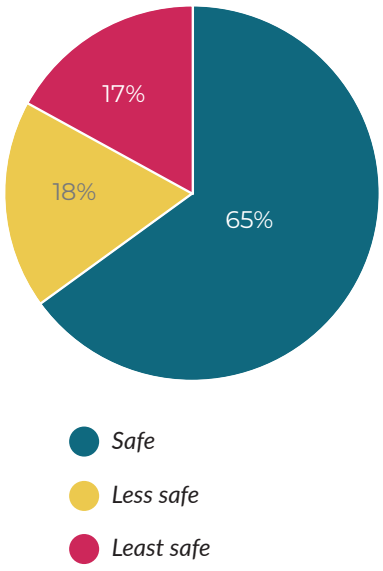


said that part of their payment was a bribe. Paying bribes was more common among those seeking abortion care at private facilities.

DESPITE LEGAL REFORM, MANY ABORTIONS ARE UNSAFE

Over one-third of abortions were unsafe (35%), not involving surgery from a clinical source or medication abortion pills. These estimates are likely an under-representation of unsafe abortion as many women who had surgery or medication abortion described incomplete abortions requiring further treatment. Results suggest that younger women and women with the least financial resources are most likely to have an unsafe abortion.

DISTRIBUTION OF ABORTION SAFETY ACCORDING TO WHO GUIDELINES*



*Estimates of abortion safety from respondents (n=307).

PMA DEFINITIONS OF ABORTION SAFETY

Abortion safety was operationalized into three categories, similar to the World Health Organization (WHO) measurement.[3] This definition reflects recent changes to WHO safe abortion guidelines that include self-managed medication abortion.[4] The safety categories are as follows:

1. Safe: surgery in a clinical setting or medication abortion pills regardless of provider
2. Less safe: surgery from a non-clinical source or non-recommended method from clinical source
3. Least safe: neither a recommended method nor a clinical source

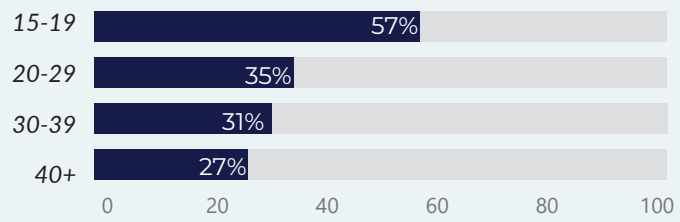
*Less safe and least safe categories combined are considered unsafe abortions.

"Once I arrived I was very afraid since there were rumors that you can lose your life during an abortion, I was even about to give up on the idea but thinking about my situation I told myself that it was the best thing to do."

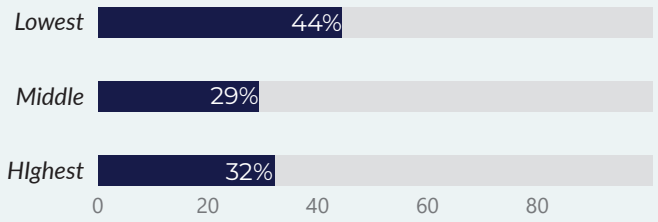
Woman living with her partner, 20 years old and 1 child at the time of the abortion

PERCENT OF INDUCED ABORTIONS CONSIDERED UNSAFE BY SELECT BACKGROUND CHARACTERISTICS (N=307)*

AGE



WEALTH TERTILE



*Abortion safety estimates come from respondent data.

QUALITY POSTABORTION CARE IS NEEDED TO TREAT COMPLICATIONS FROM UNSAFE ABORTION

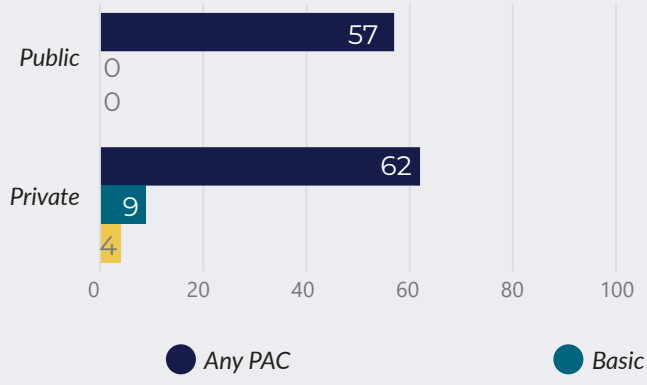
More than half (55%) of women reported a potential severe complication such as fever, vaginal discharge, or complication requiring surgery. Women with only primary level schooling (81%) and those in the lowest wealth tertile (69%) were more likely to experience a potential severe complication. Only 60% of those with severe complications reported obtaining postabortion care (PAC) from a facility.

PAC availability, readiness, and accessibility

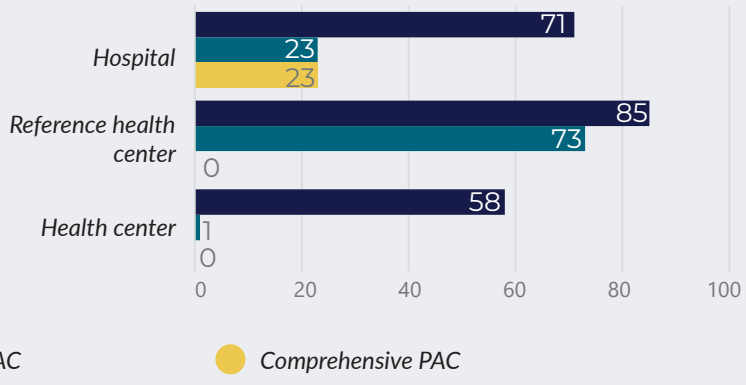
Overall, 61% of health facilities in Kinshasa report treating abortion complications in the last three months. However, only 8% are ready to provide every component of basic PAC*, and only 3% are ready to provide every component of comprehensive PAC**. Though very few had all of the necessary components for PAC, many facilities were able to provide most components.

PERCENTAGE OF FACILITIES PROVIDING BASIC AND COMPREHENSIVE PAC, BY FACILITY CHARACTERISTIC (N=73)

MANAGING AUTHORITY



FACILITY TYPE



Any PAC Basic PAC Comprehensive PAC

*Basic PAC components include: one or more doctor, degree nurse, or degree midwife; obstetric staff present or on call at all times; injectable antibiotics in stock; injectable uterotonics in stock; misoprostol in stock; functioning vacuum aspirator; intravenous fluids in stock; any modern, short-acting contraceptive method in stock. Modern, short-acting methods include oral contraceptive pills, progestin-only oral contraceptive pills, male condoms, female condoms, progestin-only injectable contraceptives, combined injectable contraceptives, and. emergency contraceptive pills.
**Comprehensive PAC components include: all basic PAC components; performed blood transfusion in the last three months; performed a cesarean section in the last three months; one or more doctor(s); any long-acting reversible contraceptive (LARC) in stock. LARCs include implants and intrauterine devices (IUDs). DHS SPA data (2017-2018) were used to obtain PAC estimates.

"My friend told me in the morning that she had experienced the same situation and that she could help me. We went to a pharmacy to buy a medicine whose name I forgot but the pharmacist refused to serve us because it is only for married people and boys only. I bribed the pharmacist by giving him 10,000fc instead of 6,000fc and he served me but told me that if this product has side effects on you it will have nothing to do with me."

Divorced woman, 24 years old and 1 child at the time of the abortion

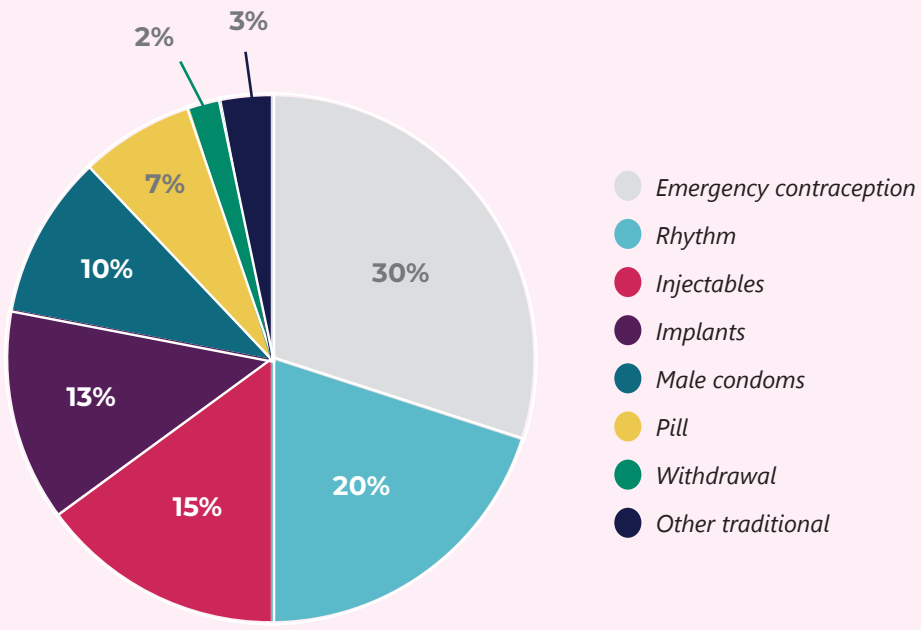
Postabortion contraception

24% of women whose abortion source was a public/private facility or pharmacy were offered postabortion family planning.

46% of all women who reported an abortion adopted a method of contraception postabortion. Those who were unmarried and without children were more likely to adopt postabortion contraception. Most of the contraceptive methods adopted were coital-dependent methods such as emergency contraception (30%), the rhythm method (20%), male condoms (10%) or withdrawal (2%).

Postabortion contraception also significantly varied by the last abortion source used. Nearly nine out of 10 women who relied on a traditional/other last abortion source reported adopting postarbotion contraception.

POSTABORTION METHOD ADOPTED



[1] Chae, S., P. K. Kayembe, J. Philbin, C. Mabika and A. Bankole (2017). "The incidence of induced abortion in Kinshasa, Democratic Republic of Congo, 2016." PLOS ONE 12(10): e0184389; [2]Ishoso, D. K., A. K. Tshefu, T. Delvaux and Y. Coppieters (2019). "Extent of induced abortions and occurrence of complications in Kinshasa, Democratic Republic of the Congo." Reproductive health 16(1): 1-8; [3]Ganatra,B., et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet.2017; 390(10110): 2372-8; [4]World Health Organization (WHO). Abortion care guideline. 2022. Geneva: WHO.

RECOMMENDATIONS

Findings indicate that women in Kinshasa often rely on abortion – often under unsafe conditions – to manage their fertility in the context of experiencing an unwanted pregnancy or pregnancy they are unable to continue. Many women experience complications, even when using recommended methods and receiving care from facilities, and a significant proportion of them don't receive postabortion care. Young women and those from disadvantaged backgrounds are least likely to know safe abortion is legal under many conditions, know a safe abortion method, or have a safe abortion. In light of these results, the following actions could be taken to reduce unsafe abortion and associated negative impacts on maternal health:

- Increase information about family planning methods and services, including in school curriculum, and improve access to contraceptive methods to prevent unintended pregnancies.
- Inform the public and providers about the specific conditions under which abortion is considered legal in the DRC.
- Train providers on abortion services according to recommended guidelines
- Ensure the availability of quality safe abortion and postabortion care services to all women in need to the full extent of the law, particularly at primary care facilities
- Engage providers and the public to increase awareness of the public health consequences of unsafe abortion.

Taken together, these changes can significantly reduce the extent of unsafe abortion, associated complications, and disparities, and reduce the hundreds of preventable unsafe abortion-related maternal deaths that occur each year in the DRC.

Sample Design

In the province of Kinshasa, PMA Democratic Republic of Congo collects information on knowledge, practice, and coverage of family planning services in 58 enumeration areas selected using a two-stage stratified cluster sampling approach at the urban level. The results are representative at the provincial level. PMA Phase 3 data were collected between December 2021 and April 2022 from 1,828 households (95.2% response rate), 2,326 females aged 15-49 (94.0% response rate). For more sampling information and full data sets, visit www.pmadata.org/countries/democratic-republic-congo.

For this phase of data collection we added an abortion module to estimate abortion incidence and safety among respondents and a surrogate sample of their closest female friends. This indirect approach assumes the friend sample is similar to that of the respondents, that the respondents know about their friends' abortions, and that they would be more likely to report them than their own. Additional details on the best friend approach and our abortion module are provided elsewhere [Bell, S. O., M. Shankar, E. Omoluabi, A. Khanna, H. K. Andoh, F. OlaOlorun, D. Ahmad, G. Guiella, S. Ahmed and C. Moreau (2020). "Social network-based measurement of abortion incidence: promising findings from population-based surveys in Nigeria, Cote d'Ivoire, and Rajasthan, India." Population Health Metrics 18(1): 1-15; Bell, S. O., E. Omoluabi, F. OlaOlorun, M. Shankar and C. Moreau (2020). "Inequities in the incidence and safety of abortion in Nigeria." BMJ Global Health 5(1): e001814.]. Data collectors also followed up with and conducted in-depth qualitative interviews with 52 women who reported an abortion in the PMA study and consented to be recontacted. Percentages presented in this factsheet have been rounded and may not add up to 100%.

PMA uses mobile technology and female resident data collectors to support rapid-turnaround surveys to monitor key family planning and health indicators in Africa and Asia. PMA Democratic Republic of Congo is led by the École de Santé Publique de l'Université de Kinshasa. Overall strategy and support is provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins University and Jhpiego. Funding for PMA is provided by the Bill & Melinda Gates Foundation; funding for the abortion module was provided by the Packard Foundation.

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PERFORMANCE MONITORING FOR ACTION

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