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Clients' Experience of Self-Managed Abortion and Perceived Quality of Care by Clinical and Non-Clinical Providers in Urban Slums of Nigeria

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Abstract: ***Background: Unsafe abortion remains an important public health concern in Nigeria, particularly among adolescent girls and young women living in underserved communities. This study assessed experiences of self-managed medication abortion delivered through trained clinical and non-clinical providers and examined perceived quality of care. Methods: Implementation research was conducted among 510 adolescent girls and young women aged 15 to 30 years who accessed medication abortion in selected urban slums of the Federal Capital Territory and Nasarawa State. Participants completed a semi-structured exit questionnaire, and descriptive statistics were used for analysis. In addition, 120 clinical and non-clinical providers underwent pre- and post-training assessment, including assessment of attitudes toward abortion. Results: Participants had a mean age of 24.7 years. Contraceptive use following medication abortion reached 83.2%, while 87.2% of respondents had a positive abortion-perception score. Participants generally reported favourable experiences of confidentiality, respectful treatment, counselling, medication information, and referral support. Mean satisfaction with services was 9.2 out of 10. Provider assessments also indicated improvements in abortion-related knowledge and attitudes following training. Conclusion: The findings suggest that a community-based model involving trained clinical and non-clinical providers is feasible and acceptable for expanding access to medication abortion and related reproductive health services in underserved communities. Further evaluation during scale-up would help establish effectiveness and sustainability.***

Keywords: self-managed abortion, medication abortion, misoprostol, quality of care, task shifting, adolescent girls and young women, Nigeria.

1. Background

Self-Induced medicated abortion is an innovation for informed choice and access for adolescent girls and young women needing this restrictive reproductive health service especially in low- and middle-income countries as Nigeria[1]. The use of medical abortion pills (misoprostol alone or misoprostol in combination with mifepristone), offers a safe and effective method for ending an unintended pregnancy. Safe therapeutic abortion has the potential to both reduce maternal morbidity and mortality from unsafe abortion and to expand the reproductive rights of women. However, the promise of these medicines to improve health and enhance rights can only be realized if information and reliable medicines are available to all women, regardless of their location or the restrictions of their legal system[2].

The health challenge that the research innovation addresses is the lack of access to safe abortion and comprehensive reproductive health information and services for adolescent girls and young women (AGYW), particularly in low-income and hard to reach areas including slums[3]. This challenge is particularly prevalent in countries where there are restrictive laws against abortion, such as Nigeria. The consequences of unsafe abortion are severe and often result in maternal morbidity and mortality[4].

Nigeria bears a disproportionately high burden of maternal mortality, accounting for an estimated 28.5% of global maternal deaths in 2020, with an estimated maternal mortality ratio of 1,047 deaths per 100,000 live births.[5] Unsafe abortion remains an important contributor to maternal morbidity and mortality in the country. Earlier national estimates indicate that unsafe abortion accounted for at least 13% and possibly 30–40% of maternal deaths in Nigeria.[6] The Federal Capital Territory (FCT), including Abuja, faces significant challenges related to access to safe abortion and post-abortion care. Recent evidence from a 2023 study[7] conducted in Abuja and Lagos provides important insight into abortion safety and care-seeking experiences. Among 197 women whose abortion methods could be classified, only 28.4% accessed exclusively clinically safe abortion, while 71.6% reported accessing care from non-clinical and unsafe sources. These findings highlight persistent gaps in access to safe, evidence-based and clinically supported abortion care in Abuja and demonstrate the importance of expanding access to accurate information, quality medication abortion, appropriate referral pathways and post-abortion care. Also, a peer-reviewed national study estimated that 74.3% of abortions among respondents in Nasarawa state were classified as most unsafe.[8] The economic burden is also considerable: post-abortion care in Nigerian hospitals was estimated at US$ 132 per patient, of which US$95 was paid by family members[9]. This demonstrates a clear need for the interventions conducted to address the lack of access to safe abortion and comprehensive reproductive health information and services.

Relevant social, economic, and cultural factors that contribute to this challenge include poverty, gender inequality, limited access to education and healthcare, cultural and religious norms, and stigma associated with abortion. In Nigeria, low-income areas and slums are densely populated with a significant number of people living below the poverty line, thus creating a vicious cycle of poor reproductive health outcomes for AGYW. Barriers to implementing projects relating to access to safe abortion services in Nigeria include

restrictive laws, religious and cultural beliefs. In addressing these barriers, WFI leveraged on the existing support from government, and community gatekeepers to ensure acceptability, success and sustainability of the intervention.

Emerging research[10] suggests that abortion outside the medical setting, or self-managed abortion, is an overall safe and effective way to end a pregnancy. However, significant legal barriers and stigma remain. The safest environment for self-managed abortion is one where accurate information is available, medical care is accessible when needed, and all methods of abortion remain legal.

A previous study[11,12] on the provision of community-based access to Misoprostol (CBAM) by non-clinical providers such as female artisans and facility/store/shop based providers (such as private clinics, proprietary patent medicine vendors (PPMV) and depot holders) was conducted to provide the basis for designing cost-effective, realistic and do-able interventions among adolescent girls and young women (AGYW) in some selected Nigerian urban slums. The findings informed community-based, outside-the-clinic strategies for the uptake of safe abortion and contraceptive services. This study leveraged the methods used in the previous one and conducted similar surveys in more locations to generate contextual information to support arguments for scale up.

The Theory of Change (ToC) premised on the belief that, if AGYW receive quality confidential peer counselling and services from trained and equipped Peers and SFHs operatives with the capacity to provide well-coordinated multi-site community-based access to Misoprostol and Post Procedure Contraceptives (PPC) products and services uninterrupted and affordable; then AGYW will be able to decide on and access unrestricted safe abortion services.

2. Methods

Study Design
The study was implementation research which tested the task shifting potentials of community-based AGYW in vocations and non-clinical workers in the provision of comprehensive sexual and reproductive health services including safe abortion and post-abortion care and contraception.

Setting
The study was conducted in 5 urban slums within the Federal Capital Territory (FCT) and Nasarawa state of Nigeria. These slum dwellers engage in riskier sexual behaviours than their peers in non-slum communities including early sexual debut, transactional sex and multiple sexual partnership[13].

Study Population
The research targeted vulnerable AGYW aged 15 to 30, married/unmarried and residents within the selected slums. The research explored the potentials of female serving community-based operatives namely Tailors, Hair Stylist, Caterers, Female Sex Workers (FSWs), Female Community Health Volunteers (FCHVs) Traditional Birth Attendants (TBAs), Female Relaxation Joint Attendants (FRJAs) - female bar attendant, waitress and event planners) and Market Based Distributors (MBDs) of contraceptive commodities. The intervention also involved Safe Female Homes (SFHs) - mainly designated private hospitals, maternities and Primary Healthcare Centres (PHCs) attending to mainly women.

Sampling Strategy
Due to the sensitive nature of the intervention, a total of 510 AGYW who had used Misoprostol for medication abortion (379) or misoprostol plus mifepristone (131) during the intervention phase and were willing to participate in the study were randomly selected and assessed in the study. Also 120 operatives who were recruited for participation in the implementation research and undergone Value Clarification and Attitudinal Transformation (VCAT) test were assessed.

Intervention
A Proof-of-Concept (POC) implementation research was conducted from December 2020 to November 2022 testing the task shifting and sharing potentials of female non-health community-based AGYW artisans in the vocations to provide comprehensive sexual and reproductive health services including safe abortion and post-abortion care and contraception. This research was a Transition-to-Scale (TTS) conducted in five new urban slums as an expansion beyond the three POC locations to justify the possibility for the model's scalability.

The unique element of the intervention was the “female-to-female Hub-&-spoke cluster model” to drive access for subsidized medication abortion to an estimated poor and marginalized AGYW leveraging opportunities offered by Nigeria’s enlistment of Misoprostol in the Essential Drug List (EDL) for Postpartum Hemorrhage (PPH) and the current task-shifting and sharing policy of Ministry of Health.

A comprehensive training on effective administration of Misoprostol or plus mifepristone for safe abortion and post-abortion care for participating clinical and non-clinical providers was conducted. The training led to an increase in the health providers' knowledge, built their capacities on the drug appropriate dosages for safe abortion, post-abortion care how to handle stigma attached to abortion. The intervention also included the provision and supply of essential commodities (Misoprostol and contraceptives) in selected facilities to ensure that safe abortion services were available when the services are sought by the adolescent girls and young women within the communities. Service delivery data were also collected for a period of 12 months from July 2025 to June 2026. In addition to measuring the previous parameters at POC, clients’ satisfaction was given added attention.

The model worked using findings related to client satisfaction - quality, cost, proximity, availability, accessibility, reliability and sustainability through in-built partnership (referral linkage) with existing private (product & service) and public health (PHC) structures.

Data Collection
Pre and post training assessments were conducted among the providers to test their knowledge, attitude and competency in delivering safe medication and post-abortion care. A validated semi-structured exit questionnaire was also used to assess clients’ experience of the service received. Value

Clarification and Attitudinal Transformation (VCAT) test was conducted on 120 clinical and non-clinical operatives. Data were also extracted from the service registers from operatives' clinics and shops. Clients with missing data were not included in the study. Baseline and Endline surveys were conducted by Women Friendly Initiative (WFI) in 2025 and 2026 respectively to evaluate the changes in knowledge about safe abortion and abortion-related issues including family planning, abortion care-seeking, and service utilization resulting from the intervention.

This report therefore presents the estimates of key project indicators that were measured from 2025 to 2026, providing a summary assessment of significant changes that occurred in knowledge and practice among the adolescent girls and young women targeted with specific focus on the self-managed abortion practice experiences and the quality of care offered by the non-clinical providers.

Data Analysis

Information gathered from service points and monthly reports were disaggregated based on the given indicators like sex, age, location, type of service rendered, categories of service providers and abortion procedure outcomes. Also, information from the questionnaire was cleaned and coded for data entry. It was then entered and analyzed using SPSS software version 26.0. The quantitative data were analyzed for frequency of occurrence and inferential statistics (paired sampled t-test). For the statistical analysis, a p-value less than 0.05 were considered statistically significant. Qualitative information from the clients exit interviews were analyzed for themes and content.

Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee (HREC) of the Federal Capital Territory of Nigeria (Approval Number – FHREC/2021/01/10/08-02-21). The respondents were anonymous; this was done to ensure confidentiality and verbal informed consent was obtained from each of the respondents due to the sensitive nature of the service received. This research did not in any way inflict harm on the respondents and every respondent was treated equally as much as possible. Respondents who refused to participate in the study or could not continue with the interviews were not coerced into the study.

3. Results

Sociodemographic Information of Client Respondents

Respondents' age ranged from 15 to 30 years with the mean age at 24.67±3.7. Sixty percent of the respondents had secondary education, and more than half (55.2%) were self-employed artisans and petty business owners. Respondents' relationship status varied from no partner (8.8%), casual partner (22.0%), steady partner (24.8%), living with partner (20.0%) and married (24.4%).

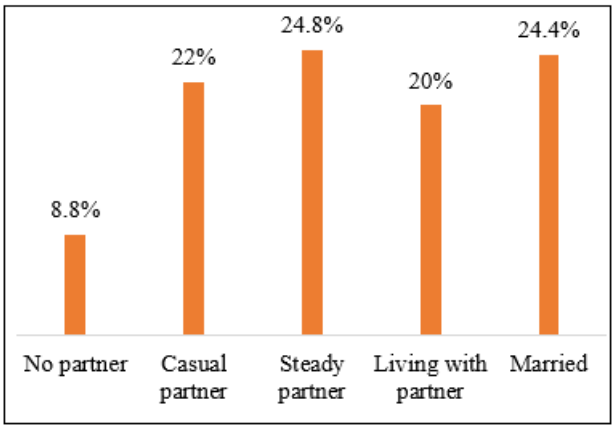

Figure 1: Current Relationship Status

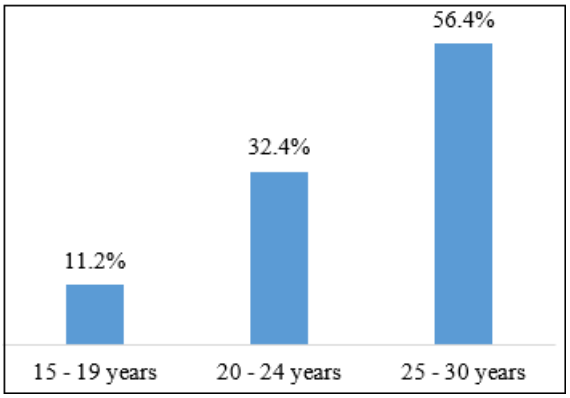

Figure 2: Respondents' Age Group

Sexual and Reproductive Health Knowledge

More than half (60%) of the respondents understood that there were days in a woman's cycle that she is more likely to get pregnant. Also, 54.6% reported that a woman can get pregnant after giving birth before the return of her menstrual period. Majority (78.1%) of the respondents were aware of pills as a family planning method; this was followed by Injectables (75.0%), Male condom (68.5%), Female condom (53.5%), Implant (56.5%), IUD (42.3%), female sterilization (21.2%) and male sterilization (17.7%).

Table 1: Respondents' Sexual and Reproductive Health Knowledge

Variable	N=510
Are there certain days during a woman's cycle when she is more likely to become pregnant?	
Yes	60.00%
No	13.10%
Don't know	26.90%
If yes, when is she most likely to become pregnant?	
Just before her period	4.20%
During her period	0.80%
Right after her period	30.40%
Halfway between periods	17.70%
Don't know	6.90%
Not Applicable	40.00%
After giving birth, can a woman get pregnant before her period returns?	
Yes	54.60%
No	21.90%
Don't know	23.50%
**If yes, which family planning method is most suitable before period returns after giving birth*	
Pills	78.10%

Injectables	75.00%
Male Condom	68.50%
Female Condom	53.50%
Implant	56.50%
IUD	42.30%
Female Sterilization	21.20%
Male Sterilization	17.70%

**Multiple choice answers*

Sexual and Reproductive Health Behaviours

A large percentage (92.7%) of the respondents were sexually active, and the mean age of sexual initiation was 20.4±3.7 years with 26.5% reporting willingness at first sex. Also, 5.8% had sex in exchange for money, food, gifts, drugs, alcohol, other goods or shelter. Few (27.3%) of the respondents used condoms the last time they had sexual intercourse.

Table 2: Respondents' Sexual and Reproductive Health Behaviours

Variable	Percentage
Ever had sexual intercourse	
Yes	92.70%
No	7.30%
Willingness at first sex	
Very willing	26.50%
Somewhat willing	9.20%
Neutral	22.30%
Somewhat unwilling	16.90%
Not willing at all	17.70%
Not Applicable	7.30%
Ever had sex in exchange for money, food, gifts, drugs, alcohol, shelter, or other goods	
Yes	5.80%
No	94.20%

Table 3: Respondents' Number of pregnancies and live births

Number of Pregnancies	N=510
1	37.60%
2	30.40%
3	16.80%
4	10.00%
5	2.80%
6	0.80%
7	1.20%
8	0.40%
Number of live births	
0	36.90%
1	8.50%
2	27.70%
3	11.50%
4	10.80%
5	3.10%
6	0.80%
7	0.80%

History of Contraceptive Use

Majority (64.6%) of the respondents reported lack of readiness for pregnancy and 51.2% of these were using a contraceptive method.

Table 4: Respondents' Family Planning Use

Variable	N=510
Would you like to prevent getting pregnant now?	
Yes – I do not want to get pregnant	64.60%
No – I'm trying to get pregnant now or in the near future	28.80%
No response	6.50%
If yes, are you or your partner currently using any method to delay or avoid getting pregnant?	
Yes	33.10%
No	31.90%
Not Applicable	35.00%
If not using FP, what is the main reason?	
My partner said no family planning	13.80%
The one I used before failed/was giving me problems	3.50%
I don't know where to get family planning	8.10%
I don't know anything about family planning	2.70%
We have not discussed it yet	0.40%
Because I am not yet married	0.80%
Because of the effect	0.40%
No response	70.40%

Contraceptive Use before and after Abortion Procedure

The number of pregnancies per respondent ranged from 1 to 8 with a mean of 2.19±1.3 pregnancies**.** Majority (75.6%) of the respondents did not use any family planning method before the aborted pregnancy. However, current contraceptive use after medication abortion was high among the respondents at 83.2%.

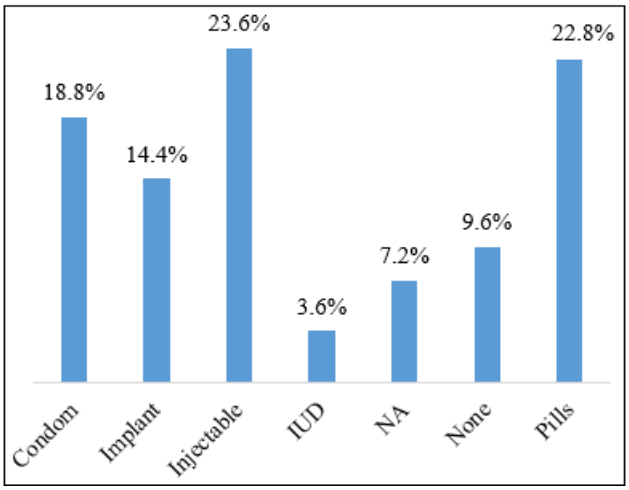

Figure 3: Current contraceptive methods

Knowledge of Abortion

The highest reported abortion method in the target communities was abortion pills from clinic/pharmacy (50.4%), followed by abortion pills from shops (34.6%). Others included: traditional herbs (22.7%), injections (21.2%), surgical procedure from unregistered providers (18.1%), vagina insertion (16.2%) and only 15.0% reported surgical procedure from registered provider.

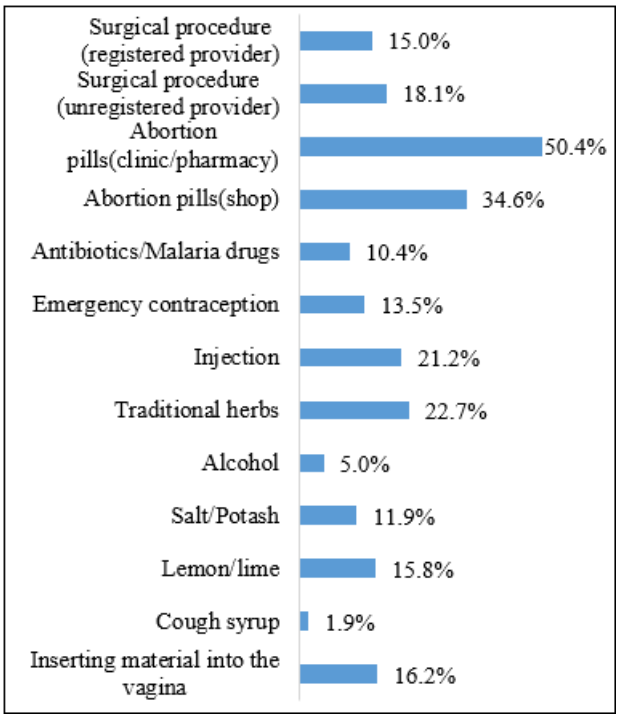

Figure 4: Reported Community Abortion Methods

Perception about Abortion

The perception of the respondents was assessed. The perception score was calculated for each respondent using a 12-point scale. Each positive perception response had a score of 2 while a negative perception response or a neutral response had a score of 0. The scores were then summed up to give a composite perception score for each respondent. The higher the score, the more positive the perception; conversely, the lower the score, the more negative the perception. A score of 0 to 5 was categorized as a negative perception while a score of 6 to 12 was categorized as a positive perception score. The mean perception score at endline was 9.2 ± 3.1 which is indicative of an increased overall positive perception about abortion.

Table 5: Perception of respondents about Abortion.

Variables	A	N	D
It is okay for a woman to remove a pregnancy if continuing the pregnancy puts her health at risk.	94.8%	2.8%	2.4%
It is okay for a woman to remove a pregnancy if the pregnancy is a result of rape.	93.6%	4.0%	2.4%
It is okay for a woman to remove a pregnancy if she cannot afford to raise another child.	84.4%	4.8%	10.8%
It is okay for a woman to remove a pregnancy if she does not want to have a child.	79.6%	6.4%	14.0%
A woman who removes a pregnancy brings shame to her family.	20.8%	28.8%	50.4%
A woman who removes a pregnancy should not tell anyone	23.2%	20.0%	56.8%
Perception Score 0 - 5 (negative) 6 - 12 (positive)		12.8% 87.2%	

A = Agree, N = Neutral, D = Disagree

Abortion Quality of Care Service

The quality of care and service provided by the abortion operatives was assessed and documented. These measures illuminated the extent to which care provided during client-provider interactions align with current evidence on best abortion practices in aspects such as client counselling, provision of accurate information about service to be received, respectful care, privacy, confidentiality, availability, choice and decision-making power by client.

Table 6: Quality of Abortion Service

Variables	Yes (N=510)
I could talk privately during the consultation	80.0%
My abortion was confidential	100.0%
The operative did not judge me, and I was treated with respect	99.2%
I felt I could trust my abortion provider	100.0%
I had enough information about the abortion process and how to take the pills)	90.0%
I trusted the quality of the medications I was taking	80.0%
I knew how and when to take my pills.	70.0%
I was told what to do if I experienced any complications	100.0%
I was counselled on family planning during my abortion visit	74.2%
I took a method of family planning away after my abortion visit	83.2%

Clients' Experience with Misoprostol and Mifepristone Combination

The mean gestation age for the index pregnancy was 8.86 ± 2.2 weeks. Majority (95.5%) of the respondents were first users of the Misoprostol and Mifepristone combination. The time until bleeding after the combination medication ranged from less than 2 hours to 12 hours with more than half (63.6%) reporting moderate bleeding and 27.3% reported heavy bleeding.

Table 7: Duration before bleeding and bleeding level

Variables	Percentage
Duration before bleeding	
Less than 2 hours	27.30%
2 to 6 hours	31.80%
6 to 12 hours	9.10%
More than 12 hours	31.80%
Bleeding level	
Light	9.10%
Moderate	63.60%
Heavy	27.30%

The highest reported level of pain from the combination therapy was moderate (72.7%) with 63.6% using pain medications. Other side effects reported by the respondents were nausea (18.2%), vomiting (50.0%), fever (27.3%), diarrhoea (27.3%) and dizziness (9.1%).

Few respondents (27.3%) reportedly required follow-up visits after the procedure, and 22.7 % required additional treatment during follow-up visits for family planning and when in doubt about the completeness of the procedure. There was a unanimous reported ease of the two - step process for the combination therapy by the users (very easy - 45.5% and easy - 54.5%).

Abortion Referral and Clients' Level of Satisfaction

A significant percentage (90.4%) of the respondents were referred for the abortion service received. Majority (40.8%) of these clients were referred by their friends followed by a health provider (19.6%), neighbour (9.2%), colleague (6.8%), patent medicine vendor (5.2%) and female sibling (4.8%).

Table 8: Information received during referral by clients

Variables	Yes
When in pregnancy I could receive the abortion	71.6%
Where to access the abortion	90.0%
The cost of the abortion	54.4%
Choice of pills or procedure/surgery	27.6%
What happens during the abortion	34.0%

The reported alternative source for abortion without the referral included chemist (45.2%), clinic (13.6%), traditional birth attendant (6.4%) and those with no idea of what to do was 26.8%.

On a scale of 0 to 10, the mean clients' satisfaction level of abortion service received was 9.2±0.8 and the likelihood of recommending the service received to others 8.6±1.3.

Excerpts from Clients Abortion Experience

The clients shared their experiences on the abortion service received, mostly on the circumstances surrounding the need for the abortion. None complained about the quality or dissatisfaction with the services received.

'I was referred by my friend; I would have kept the pregnancy because I didn't know where to access SA services' – **Client**

'I was on injectable but became pregnant because I forgot to take my next shot'- **Client**

'My husband didn't want me to go for family planning because it will make me add weight and I ended up getting pregnant' - **Client**

'*I had a small baby, I was not using any family planning method and I got pregnant. I had to remove the pregnancy'* - **Client**

'A girl was referred for abortion by her school principal who got her pregnant' - **Provider**

'I was not ready for a child and the Misoprostol really helped me. The provider explained everything to me but the pain was very much' - **Client**

I got pregnant because I didn't like family planning, I get bloated and fat. The experience was ok, the provider didn't judge me, it was painful but it took care of the problem for me' - **Client**

'*A 14-year-old girl came in as incomplete abortion, she could not access service in a facility, and she went home and self-medicated so she can receive post -abortion care'* – **Private Clinic Provider**

'*A mother brought her 13-year-old daughter who was impregnated by a 14-year-old boy at school, I had to help her remove it. I cannot invite her for your interview because the mother warned against any disclosure to avoid family problem with the father of the girl…he must never know about it'* - **Provider**

Service Providers Respondents: Safe Abortion and Post-abortion Indicators from Intervention

Providers' Knowledge

A total of 120 operatives (non-clinical – 85 and clinical – 35) were trained on the provision of community-based access to safe medication abortion and post procedure contraceptives.

Table 9: Providers' Pre and Post Training Assessment

Overall Abortion Mean Knowledge Score	Non-Clinical Operatives N=85	Clinical Operatives N=35
Pre-training assessment	32.5%	43.2%
Post-training assessment	65.3%	63.7%
Paired sampled t-test	p<0.001	

Providers' Attitude

With Value Clarification and Attitudinal Transformation (VCAT) test, there was an overall 30.3% positive increase in attitude towards abortion (45.3% to 75.6% pre and post scores).

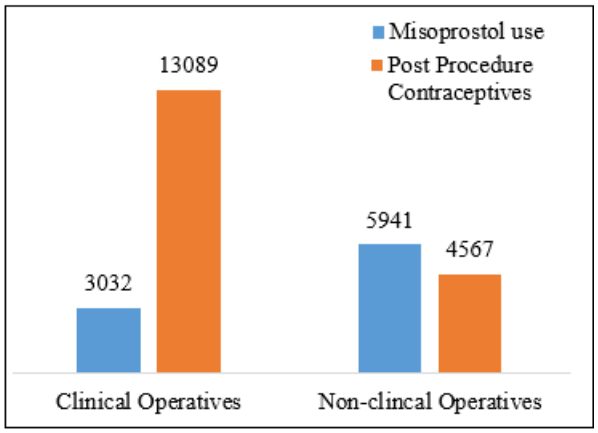

Figure 5: Service delivery data from clinical and non-clinical operatives

4. Discussion

This survey provides a comprehensive analysis of the sexual and reproductive health (SRH) pattern, including potentials of self-managed abortion services among adolescent girls and young women (AGYW) aged 15–30 in selected urban slums of the FCT and Nasarawa State. The findings highlight both opportunities and challenges in improving access to safe abortion, post-abortion care, and family planning services using non-clinical female artisans in the vocations and sundry workers.

Most respondents were in the age group of 25 to 30 years, with secondary education being the most common level attained. A significant proportion of the survey participants were self-employed in informal vocations. This indicates that interventions should be tailored to economically active young women with limited formal education, and those in vulnerable work environments such as bar attendants and sex workers.

The data also showed high exposure to pregnancies, with many women reporting multiple pregnancies and bearing children at a young age. This points to unmet needs for family planning and safe reproductive health services. The increased uptake of post-procedure contraceptive methods was high (pills, injectables, condoms, implants) giving credence to the capability of non-clinical provider's counseling skills which led to change in knowledge, behaviour and practice among the target population. However, there were others who despite going through the procedure, refused to use any method and the common reasons for non-use were fear of side effects and partner opposition. This gap between knowledge and use underscores the need for demand-generation activities, male involvement, and improved accessibility to affordable, youth-friendly SRH services.

Knowledge about abortion was high. This was rooted in the safe medication abortion experience they had as a result of the intervention. Also, there was a recorded high positive attitude and perception towards abortion. Clients having gone through the experience had a change of perspective that safe abortion should be permitted when the pregnancy is posing a risk to the woman's health or when the pregnancy is as a result of sexual assault. There were mixed feelings about the associated stigma (feeling of shame and secretiveness) to having undergone abortion. Decision-making was often secretive, with many not involving partners or family, relying instead on peers for information. This indicates that stigma, fear, and lack of supportive services may impair uptake and calls for awareness on reproductive health rights and justice for women and girls.

The evaluation from the clients' perspective showed high quality of abortion service provided by the trained operatives. The quality of care received translated into high level of clients' satisfaction and high likelihood of recommendation of the service received to others. This suggests trust and confidence in the trained providers and service quality. This is consistent with the core findings from a cross-country study[14,15] which emphasized kindness and respect, information exchange, emotional support, attentive care, privacy, and pain management as essential components of safe abortion.

Programmatic Implications

i. Peer networks are influential in information-sharing, suggesting peer-led interventions could be effective.
ii. Capacity-building for community-based providers (chemists, patent medicine vendors, TBAs) could help reduce unsafe practices.

5. Recommendations

Based on the findings from the survey, the following recommendations are proposed for the promotion and uptake of comprehensive sexual and reproductive health information and services including safe abortion and contraceptives among adolescent girls and young women.

1) **Improved Knowledge and Safe Practices Around Abortion**

a) Implementation of **community sensitization campaigns** and awareness raising events about the danger of unsafe methods such as herbs, potash, alcohol, vaginal insertion, etc.

2) **Enhancing Service Quality and Trust**

a) Training of health workers and volunteers on **non-judgmental counseling, youth-friendly care** to increase trust and service uptake.
b) Monitoring the quality of care and improve commodity supply chains to reduce stock-outs of contraceptives and safe abortion commodities.

3) **Leveraging Peer Influence and Promoting Self Care**

a) Recruitment and training of **peer influencers** among AGYW for the dissemination of accurate SRH information and as holders of abortion and contraceptive medicine depots.
b) Using **vocational centers, relaxation spots, and informal workplaces** (hair salons, tailoring shops, bars, etc.) as safe spaces and platforms for outreach and service delivery.
c) Harnessing digital platforms (WhatsApp, Facebook, TikTok, Telemedicine) to provide consultative and prescriptive confidential SRH education and referrals, in recognition of the influence of technology on AGYW.

6. Conclusion

The findings indicate that trained clinical and non-clinical community-based providers can contribute to acceptable medication abortion, post-abortion care, and contraceptive services for adolescent girls and young women in underserved urban communities. Participants generally reported favourable experiences of confidentiality, respectful care, counselling, and service satisfaction, while post-procedure contraceptive uptake was also high. The community-based and peer-supported model therefore shows promise as an approach for improving access to reproductive health services. Further implementation research with stronger comparative and outcome measures is recommended to assess effectiveness, safety, sustainability, and scalability.

Acknowledgement

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