A Customer's Journey:
Knowledge, Procurement, Use and Likely Future Use of Medication Abortion in Ghana and Nigeria

August 2024

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Summary and Background

Understanding how a woman learns about, accesses, and uses medical abortion (MA) is critical to ensuring that the provision of abortion care is more responsive to the preferences and needs of clients. To better understand these 'abortion journeys', **DKT International** partnered with the **Behavioral Insights Lab (BiL)**, in 2024 led by researcher **Sohail Ahga**, to create an innovative digital survey in Ghana and Nigeria. The study is the first population-based survey of its kind on the use of MA in the two respective markets and its findings demonstrate that digital surveys can be effectively deployed to 1) gather insights into women's abortion choices and experiences, and 2) understand market challenges that women may face in accessing abortion care.

DKT International commissioned the study to better understand women's journeys with the use of medical abortion in **Nigeria** and **Ghana**. Operational in both markets since 2012, DKT sells a wide range of high-quality, affordable contraceptives and safe abortion products and technologies, including MA products such as mifepristone and misoprostol. Responses in the study were drawn from those who use digital platforms (specifically Facebook and Instagram) and revealed significant and noteworthy nuances in the awareness, 'ever-purchase,' and 'ever-use' of MA in both markets.

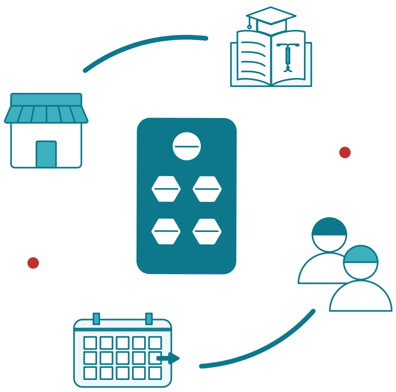
Findings are limited to those who participated in the study and cannot be generalized to the larger population of these geographies. However, the data demonstrates that insights about women's experiences with medical abortion can be gathered via digital platforms efficiently, while ensuring confidentiality of the participants.

The data in this study further confirms that MA remains an important option, primarily in the private sector, when made accessible, available and affordable for those who seek to use it. Perhaps the most noteworthy outcome is that, for the sample size taken in this study, MA awareness, ever-purchase and ever-use is highest amongst the poorest women in both countries, suggesting that medical abortion is a strong pro-poor intervention. To substantiate this finding, a larger study with a more significant sample size would need to be carried out.

Objectives

DKT and the BiL focused on understanding MA-seeking behavior and a customer's journey from knowledge to procurement, as well as procurement sources, usage patterns, and the potential future use of MA.

The study sought to address the following questions:



- **What is the level of awareness of MA amongst both men and women?**
- **Who purchases MA?**
- **Who uses MA?**
- **Who is likely to purchase MA in the future?**
- **Where do users obtain MA from and what does it cost at those points-of-purchase?**

Methodology

The study methodology leveraged social media platforms to capture insights into MA-seeking behavior. Respondents were recruited through social media platforms via ads on Facebook and/or Instagram, and were offered mobile credit as compensation.

The Meta Ads created for the survey targeted primarily women, ages 18-35 (target 80% of respondents), but men, ages 18-35 (target 20% of respondents were also surveyed). Clicking the ad directed respondents to a chat window in Facebook Messenger, explaining the parameters of the study and the structure of compensation. An option to start the survey was then provided. Respondents who completed the first survey received a small compensation in mobile credits (2 Cedis in Ghana and 100 Naira in Nigeria). Qualified respondents were directed to a second survey and (women who used MA) received a larger compensation (5 Cedis in Ghana and 500 Naira in Nigeria).

The study was designed by Ifeanyi Nsofor and data collection was carried out by Sarah Francis, also of the BiL. Informed consent was sought from all participants according to the guidelines. Statistical methods were used to analyze the survey data to identify trends.

Images 1 and 2: Samples of Social Media posts designed to recruit respondents

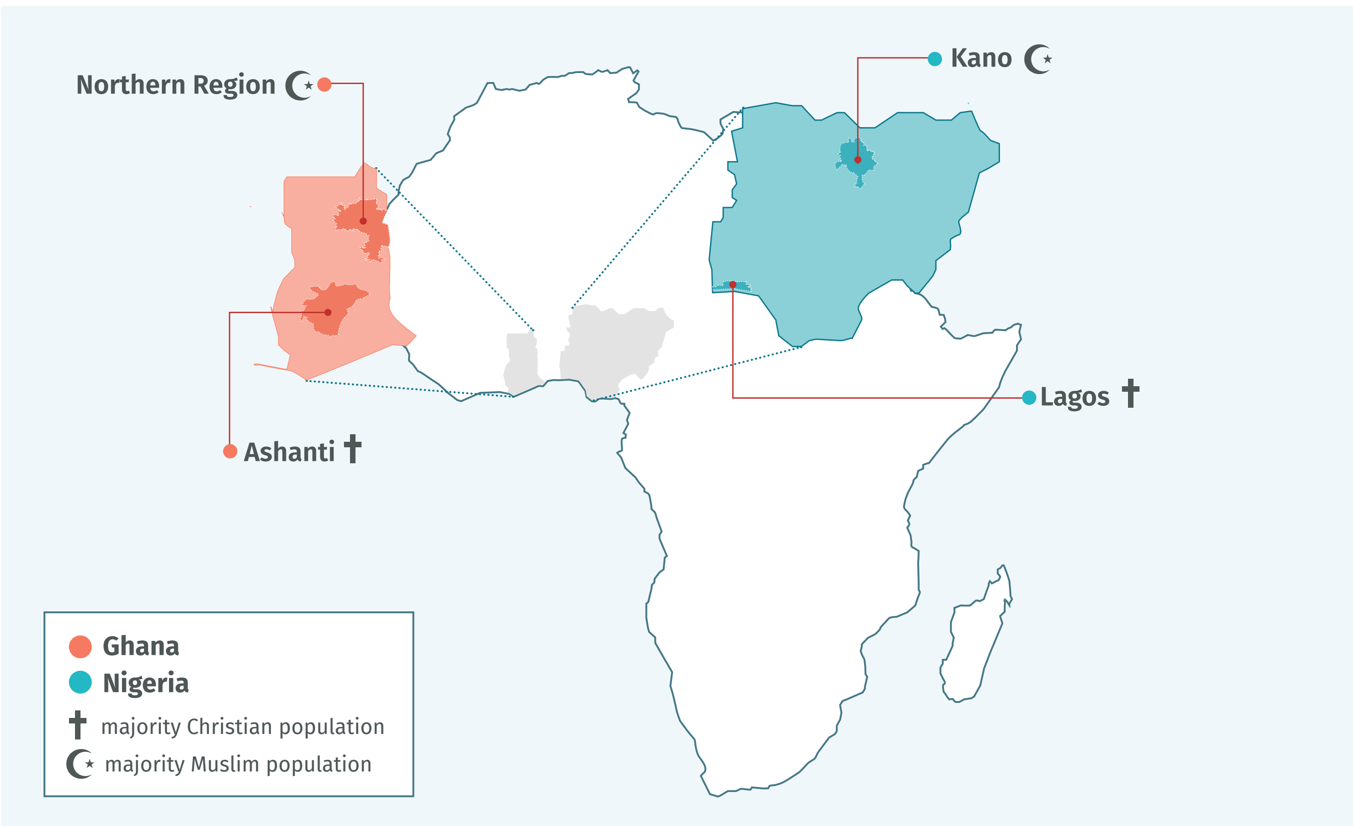
Geography

The study was conducted in the Northern Region and Ashanti in Ghana; and Kano and Lagos in Nigeria, respectively. These regions were selected due to their significance as centers of cultural and economic activity within their countries, as well as to provide a contextual contrast of the lifestyle and religious compositions of both nations.

In Ghana, Ashanti, with its largely Christian population, was contrasted with the Northern Region, where Islam is the predominant religion.

In Nigeria, Lagos, with a significant Christian population, was compared with Kano, which has a majority Muslim population.

The research team used advertising creatives to attract user participation and surveys were distributed in both, local languages and in English. In Ghana, both the ads and surveys were in Twi and English (Ashanti region); and Dagbani and English (Northern region). In Nigeria, the ads and surveys were in English (Lagos State) and Hausa (Kano State).



Sampling Size and Target Population

In Ghana, a total of 1,771 respondents were interviewed for the survey, comprising 1,553 women and 218 men.

For the study conducted in Nigeria, the survey included 2,007 respondents, consisting of 1,625 women and 382 men.

These sample sizes were determined to provide statistically significant data for analyzing awareness, procurement, use, and likely future use of MA in the respective countries. The sample sizes allowed for a comprehensive examination of these factors across different demographic groups and geographic regions within the two countries.

Ghana

1,771 respondents interviewed for the survey

1,553 women **218** men

Nigeria

2,007 respondents interviewed for the survey

1,625 women **382** men

Findings

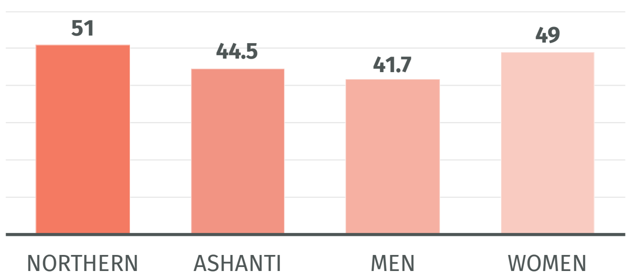
I. Awareness of MA

A. Awareness of MA: Overview

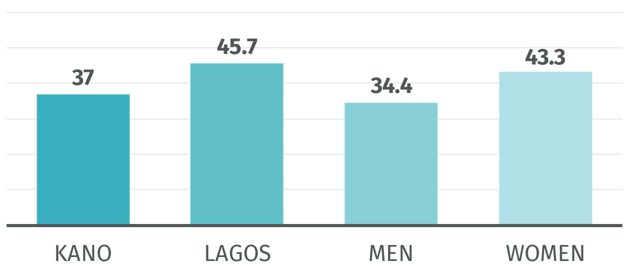
Overall awareness: Awareness of MA was higher among women than men in both Ghana and Nigeria. In Ghana, about 48% of all respondents were aware of MA, with more women (49%) being aware of MA than men (42%). Similarly, in Nigeria, 42% of all respondents were aware of MA, with more women aware than men (43% and 34% respectively).

There was a regional difference in awareness in both countries. In Ghana, awareness was higher in the Northern region (51%) than in the Ashanti region (45%) while in Nigeria, awareness of MA was higher in Lagos (46%) than in Kano (37%).

Awareness of MA: Ghana



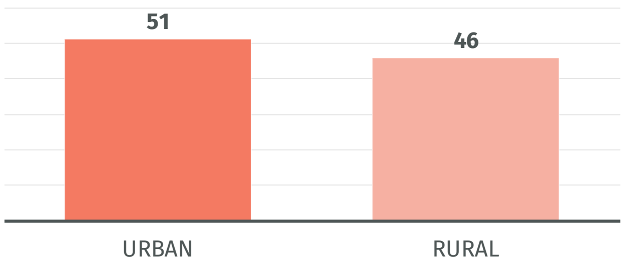
Awareness of MA: Nigeria



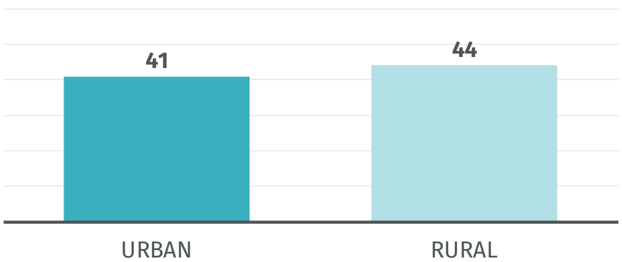
A. Awareness of MA: Urban vs. Rural

In Ghana, awareness was higher in urban (51%) compared to rural areas (46%) while in Nigeria there was a less significant difference in awareness between urban (41%) and rural (44%) respondents.

Urban vs. Rural
Awareness of MA: Ghana

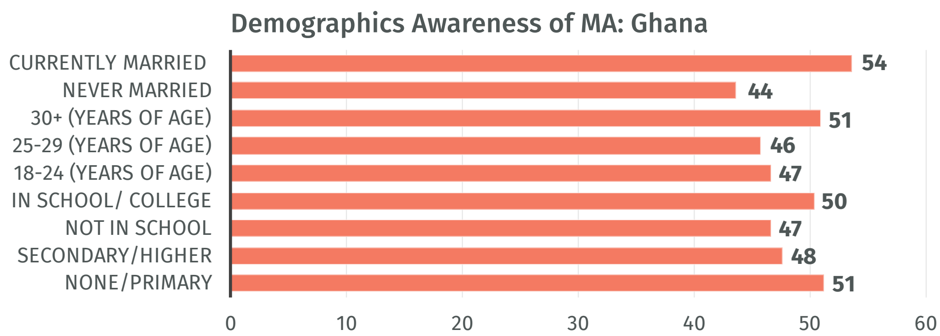


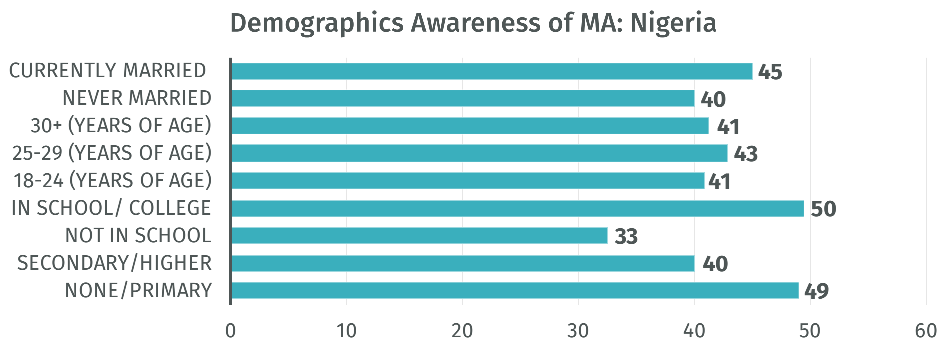
Urban vs. Rural
Awareness of MA: Nigeria



B. Awareness of MA: Demographics

In both countries, currently married women are more likely to be aware of MA than unmarried women (Ghana, 54% vs 44% and Nigeria 45% vs 40% respectively). In Ghana, there was no statistically significant difference in awareness of MA by age or by education, but in Nigeria, women currently in school/college were more likely to be aware of MA (50%) compared to those who are not (33%). Respondents with low education – typically a proxy for poverty – were more likely to be aware of MA than others (49% versus 40%). This indicates that awareness of MA is particularly high amongst the poorest women.





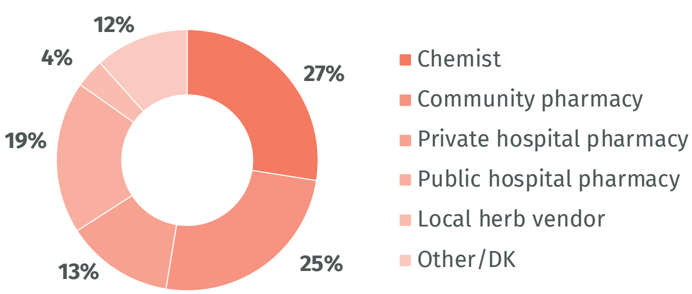
Data from Nigeria showed that respondents with low education – typically a proxy for poverty – were more likely to be aware of MA than others (49% versus 40%)

C. Awareness of MA: Point-of-Purchase

All respondents were asked about the point of purchase for common medications including malaria. The sources for obtaining MA were similar to those reported for acquiring malaria medication in both countries. It should be noted that the denominators for the two questions differed significantly with a question on malaria administered to the entire sample, while the question about MA was restricted to those aware of MA.

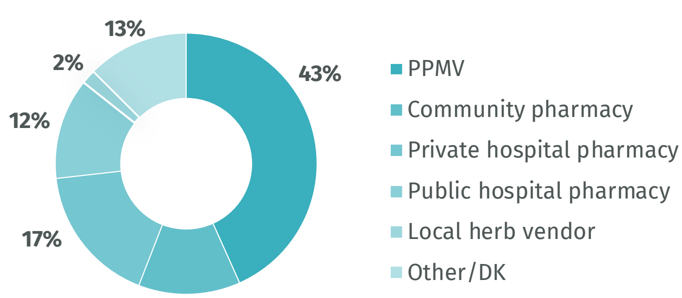
GHANA

Where can medicine to bring back a woman's period be obtained?



NIGERIA

Where can medicine to bring back a woman's period be obtained?

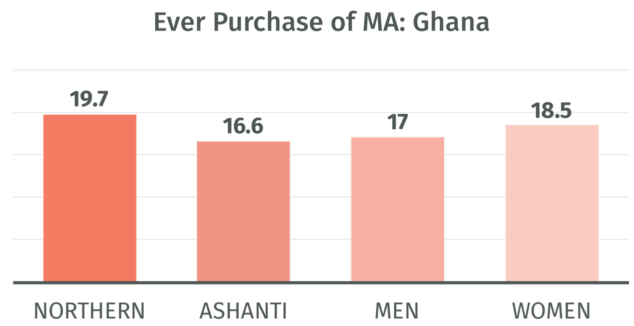


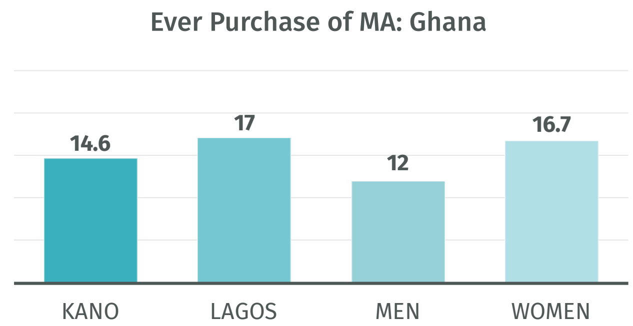
In Ghana, chemists and community pharmacists were the frequently mentioned sources for obtaining "medicine to bring back a woman's period" or MA (28% and 25% respectively). These figures were comparable to frequently mentioned sources for purchasing malaria medication, with about 26% mentioning chemists and 34% citing community pharmacists respectively. Similarly, in Nigeria, 43% mentioned Patent and Proprietary Medicine Vendors (PPMVs) as the source for MA, while 48% of all respondents identified PPMVs as the source for acquiring malaria medication for their households. Thus, the source of MA is the same as the source of purchasing regularly used drugs.

II. Ever-Purchase of MA

A. Ever-Purchase of MA: Overview

Overall, 18% of respondents in Ghana and 16% of respondents in Nigeria had ever-purchased or obtained MA. There was no significant difference in ever-purchase by region in either market. In Ghana, ever-purchase rates were 20% in the Northern region and 17% in Ashanti; whereas, in Nigeria, ever-purchase rates differed slightly between Lagos (17%) and Kano (15%).

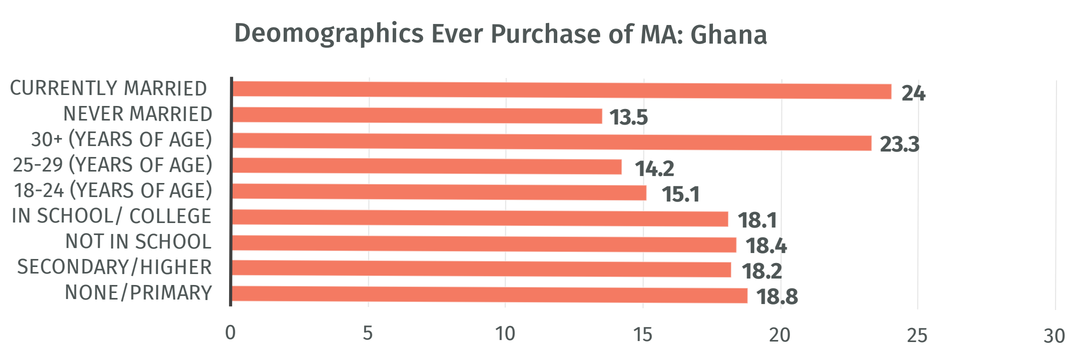


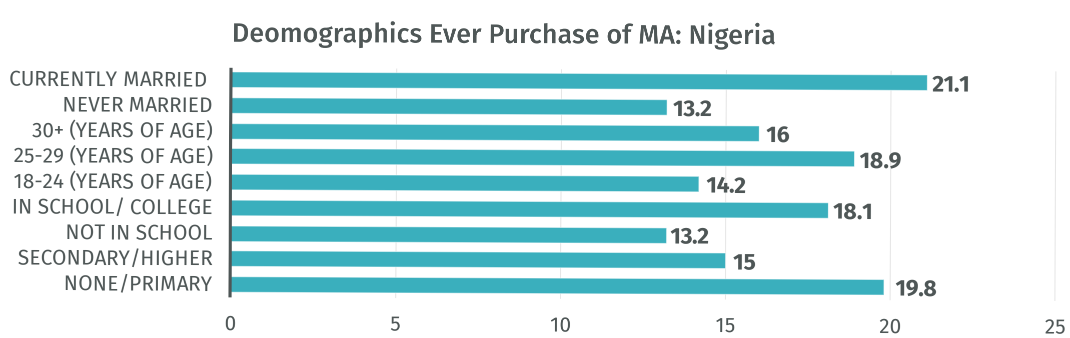


In Ghana, there was no significant difference in ever-purchase by gender (women 19% vs men 17%) while in Nigeria the proportion of women reporting ever-purchase was higher than men (17% and 12% respectively). Notably, the percentage of men reporting ever-purchase was higher than expected, suggesting substantial male involvement in MA purchases in both countries.

B. Ever-Purchase of MA: Urban vs. Rural

Ever-purchase patterns of MA by residence in rural and urban areas revealed contrasting results between the two countries with ever-purchase in Ghana being higher in urban areas compared to rural areas (20% vs 17% respectively) while in Nigeria ever-purchase was higher in rural than urban areas (24% vs 15%).

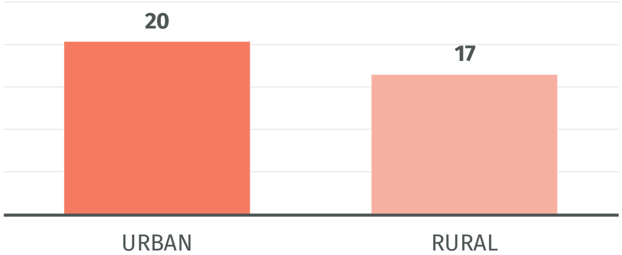




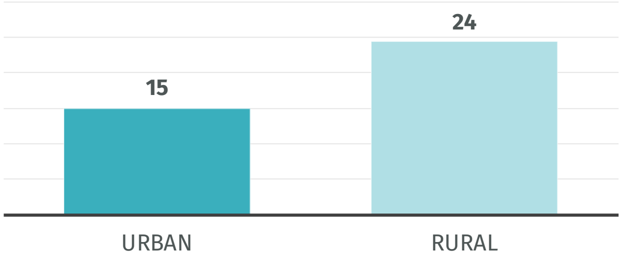
C. Ever-Purchase of MA: Demographics

In Ghana, ever-purchase of MA was higher among those aged 30 and older (23%) compared to those younger than 30. In Nigeria, ever-purchase rates were higher amongst 25- to 29-year-olds (18%) compared to those younger than 25 (13%). In both countries, ever-purchase was higher among currently married respondents compared to others, with 24% vs. 14% in Ghana; and 21% vs. 13% in Nigeria respectively.

Urban Vs. Rural
Ever Purchase of MA: Ghana



Urban Vs. Rural
Ever Purchase of MA: Nigeria



No significant difference in ever-purchase of MA was observed in Ghana between respondents in school/college and other respondents. In contrast, in Nigeria, ever- purchase of MA was higher among the poorest women, or those who indicated they had none or primary education (20%) compared to 15% of women with secondary or higher education.

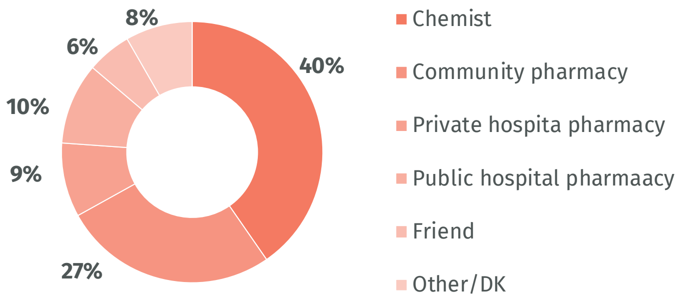
In Nigeria, ever-purchase of MA was higher among the poorest women with none or primary education (20%) compared to 15% of women with secondary or higher education.

III. Sources of Purchase and Pricing of MA*

Ghana

A. Sources of Purchase and Pricing of MA: Source of Medicine

Source of Medicine for MA: Ghana



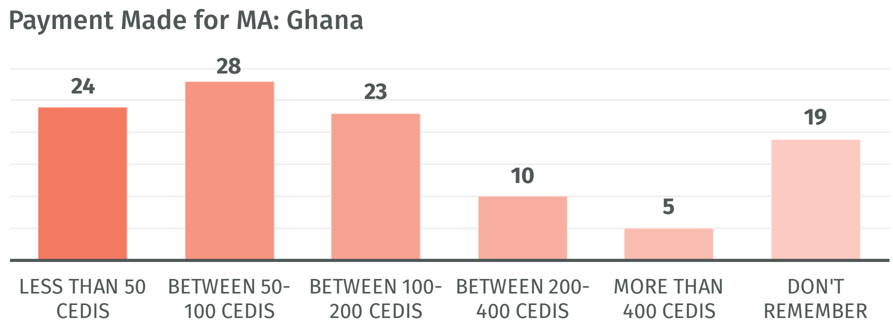
In Ghana, a sizable proportion of ever-users (83%) obtained MA from private sector outlets such as 'chemists', 'Community Pharmacies', and 'private hospital pharmacies' , indicating the accessibility of these vendors for procuring MA. Public hospital pharmacies were less frequently utilized (10%).

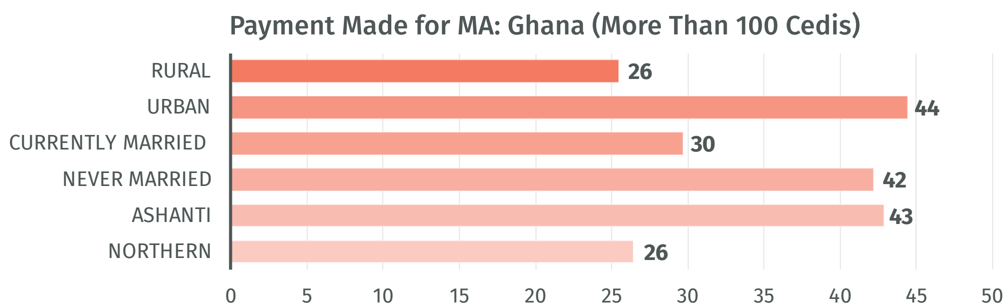
* According to data from the Bank of Ghana and recent financial analyses, the Cedi has depreciated by approximately 27% against major currencies such as the US Dollar and the Euro. This devaluation is attributed to inflationary pressures, fluctuations in commodity prices, and changes in investor sentiment.

By mid-2024, the Naira had declined by 40% to 55% against the U.S. dollar, largely due to factors such as insufficient dollar liquidity, market instability, and ongoing economic challenges. Despite efforts to stabilize the currency, the Naira continued to weaken. This decline has affected the Nigerian economy and contributed to inflation and reduced purchasing power.

B. Sources of Purchase and Pricing of MA: Payment Made For MA

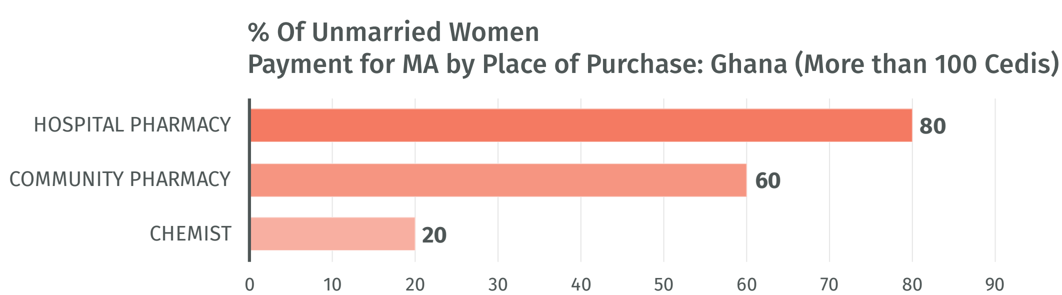
The pricing data in Ghana reveals a range of expenditures among MA users with the majority (52%) paying less than 100 Cedis (approximately $6.50). Only a small percentage (5%) paid 400 Cedis or more for MA; (10%) paid between 200 and 400 Cedis; and (23%) paid between 100 and 200 Cedis.





In Ghana, women in urban areas were more likely to pay 100 Cedis or more for MA than those in rural areas (44% vs 26%). Analysis of regional differences highlights variations in pricing within Ghana. Women in the Ashanti region and urban areas exhibited a higher likelihood of paying more than 100 Cedis for MA compared to other regions and rural areas (43% vs 26% respectively).

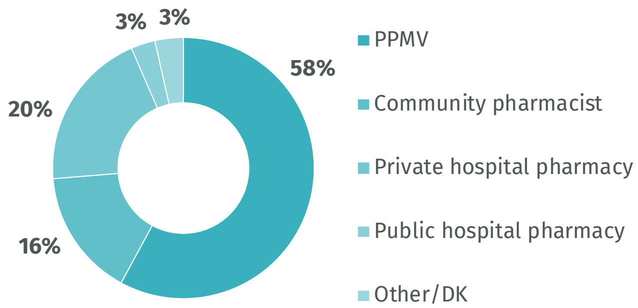
Unmarried women in Ghana encountered higher prices at specific outlets, notably community and hospital pharmacies, where they faced a premium compared to the prices at chemist shops. Specifically, only 20% of unmarried women were charged 100 or more at chemist shops, whereas 60% were charged more than 100 Cedis at community pharmacies and 80% were charged more than 100 Cedis at hospital pharmacies. In Ghana, unmarried women paid more at community and hospital pharmacies. The disparity suggests potential discriminatory pricing practices based on marital status, with unmarried women disproportionately bearing higher costs for MA.



Nigeria

A. Sources of Purchase and Pricing of MA: Source of Medicine

Source of Medicine for MA: Nigeria



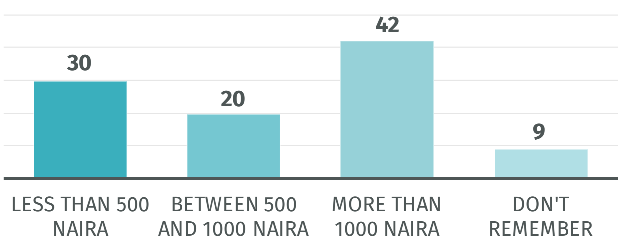
Overall, 93% of Nigerian women obtained MA from private sector outlets.

In Nigeria, the 43% of respondents who were aware of MA reported they could obtain it from Patent and Proprietary Medical Vendors, or PPMVs, indicating the significant role of PPMVs as a primary source for MA in Nigeria. Among ever-users of MA, 58% reported obtaining MA from PPMVs, reinforcing the importance of these outlets in MA access. About 16% of ever-users obtained MA from community pharmacies, while 20% obtained it from private hospital pharmacies, and only 3% from public hospital pharmacies, highlighting the dominance of private sector outlets in MA provision.

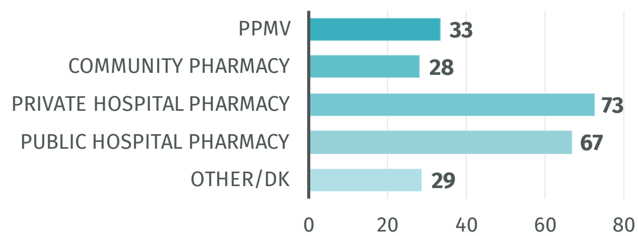
B. Sources of Purchase and Pricing: Payment Made for MA

Only 33% of MA users who accessed PPMVs paid over 1,000 Naira, compared to 73% who purchased it from private hospital pharmacies for over 1,000 Naira. Most ever- users who purchased from community pharmacies paid less and only 28% of ever-users paid more than 1,000 Naira to purchase MA from community pharmacies. It is important to further research why PPMVs and community pharmacists charge lower prices for MA.

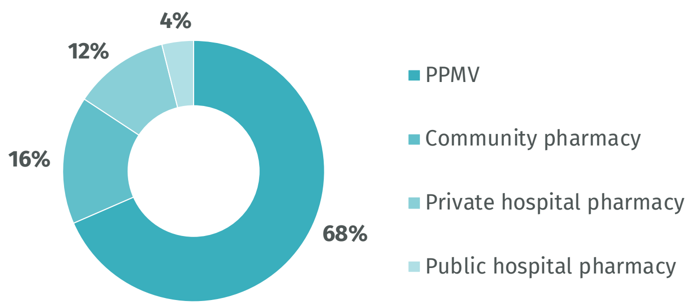
Payment Made for MA: Nigeria



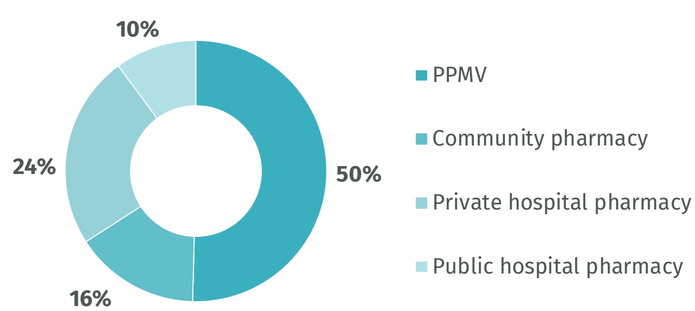
Percent of Users Who Paid More than 1000 Naira by Place of Purchase: Nigeria



Where the Poorest Women Obtain MA: Nigeria



Where Less Poor Women Obtain MA: Nigeria



Interestingly, a higher proportion of poor women (68%) obtained MA from PPMVs compared to less poor women (50%), indicating potential differences in access based on socioeconomic status.

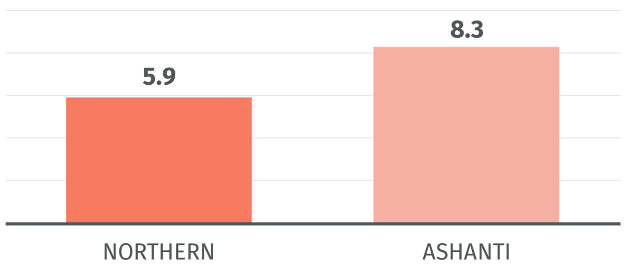
Price differences between outlets prompt further research into potential quality variations, with a clear preference for lower-priced options among the poorest women.

IV. Ever-Use of MA

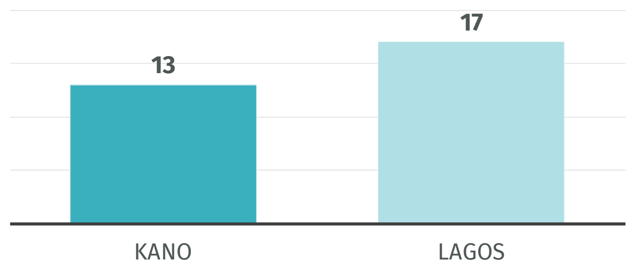
In Ghana the study showed a discrepancy between the reported rates of purchase and use of MA with 19% of women reporting ever-purchase and only 7% overall reporting ever-use. The reason for the large disparity may be due to underreporting particularly among older respondents and those who are married, suggesting a higher stigma associated with MA leading to underreporting. In contrast in Nigeria, there is little difference between ever-use and ever-purchase of MA by women (15% and 17% respectively).

A. Ever-Use of MA: Overview

Ever Use of MA: Ghana



Ever Use of MA: Nigeria



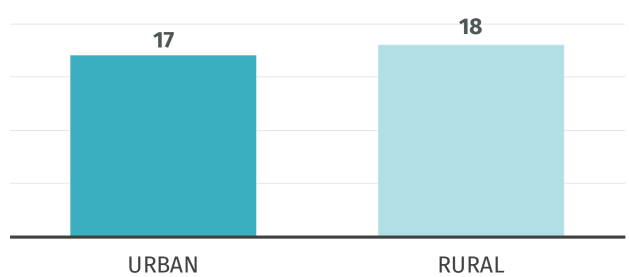
The finding that 1 out of 7 Nigerian women aged 18 and older reported having used MA is noteworthy, but without a population-based survey for comparison, it's challenging to determine its representativeness in Nigeria. Given the nature of the digital survey, it's expected that this percentage might be higher than in the general population of Nigeria.

B. Ever-Use of MA: Urban vs. Rural

Data on regional differences in ever use shows that in Ghana no difference in ever-use was observed by region and residence in urban vs. rural areas (7% for both) while in Nigeria ever-use of MA was higher in Lagos compared to Kano (17% vs. 13%) though no significant difference in ever-use by residence in urban or rural area.

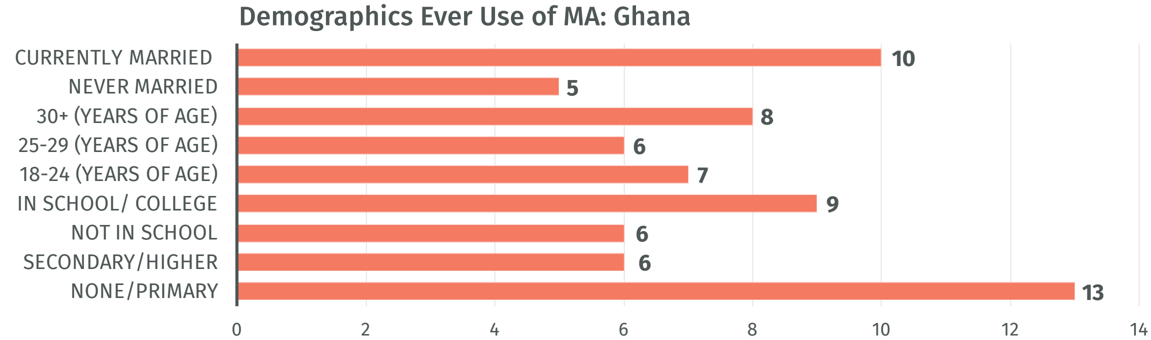
Urban vs. Rural
Ever Use: Ghana

Urban vs. Rural
Ever Use: Nigeria



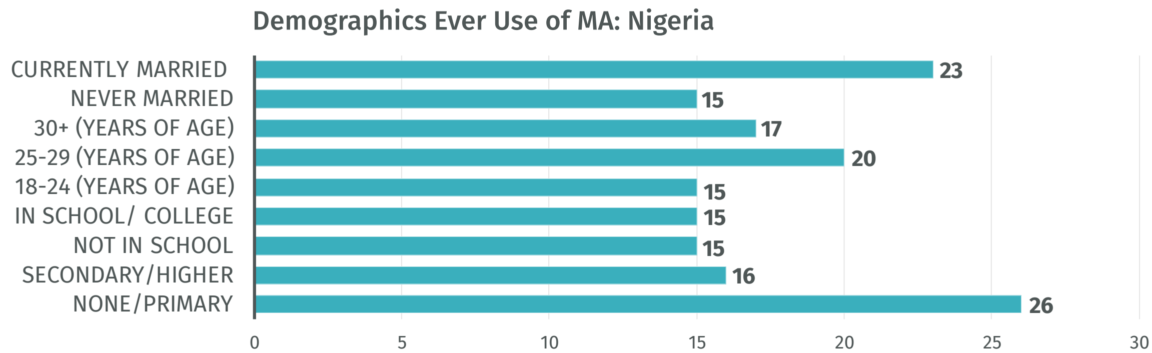
C. Ever-Use of MA: Demographics in Ghana

Regarding the demographic pattern of ever-use, in Ghana, ever-use was slightly higher among women currently in school/ college compared to those who were not (9% versus 6%) and among currently married women compared to those not currently married (10% versus 5%). Notably, ever-use was more than twice as high among the poorest Ghanaian women compared to other women: 13% of women with none/primary education had ever-used MA, compared to 6% of women with secondary or higher education.



D. Ever-Use of MA: Demographics in Nigeria

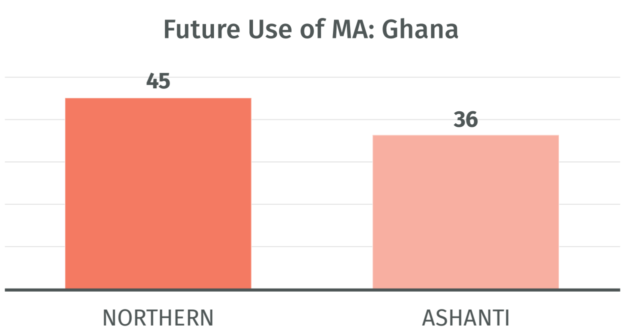
In Nigeria, the patterns of ever-purchase of MA were consistent with the patterns of ever-use of MA. Ever-use was higher among women aged 25-29 (19% vs.13%), those currently in school/college (19% vs. 11%), and currently married women (21% vs. 11%). Ever-use was more than twice as high among the poorest women (29% with non/primary education) compared to women with secondary or higher education (12% each).

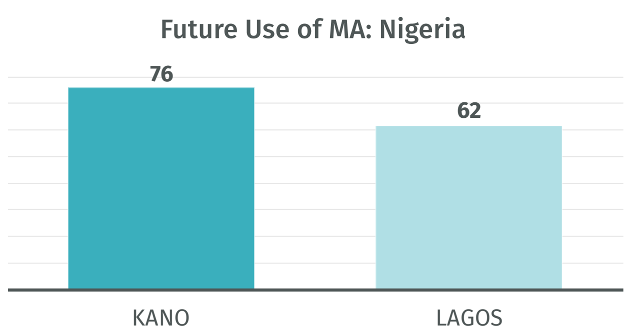


V. Future Use of MA

A. Future Use of MA: Overview

Approximately 41% of all MA ever-users in Ghana and 69% of ever-users of MA in Nigeria reported that they are very likely to use MA again if faced with an undesired pregnancy. In Nigeria, the majority of ever-users express a strong likelihood of future use, especially among those in Kano and school/college.

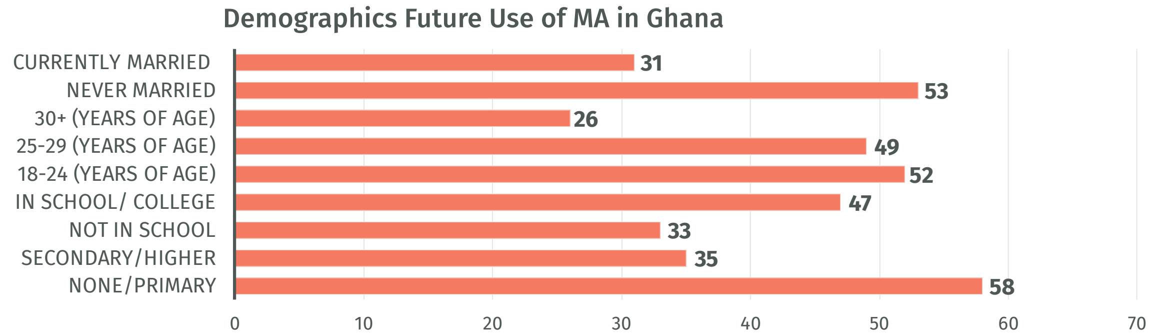




B. Future Use of MA: Demographics

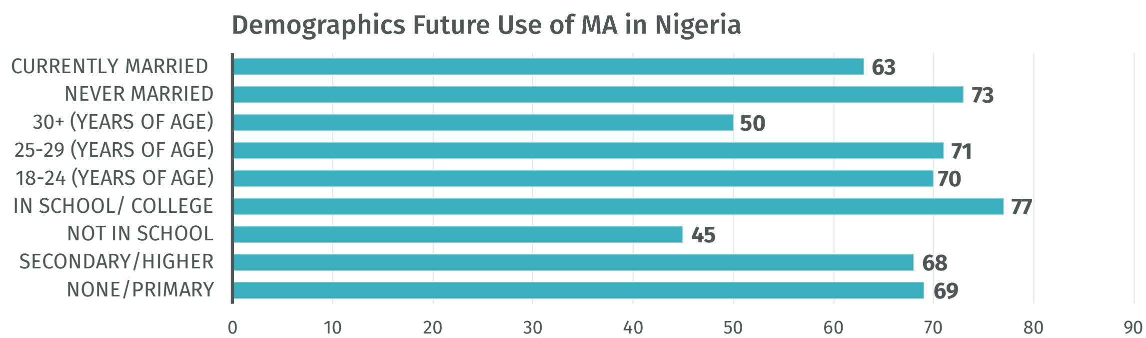
Ghana

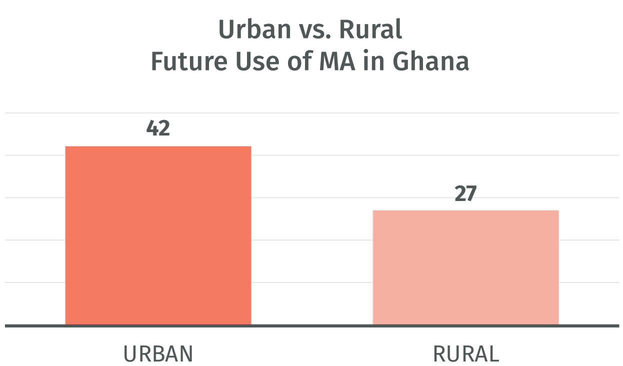
In Ghana, the poorest women, those with no or primary education only, showed a higher likelihood of future MA use (58% versus 35%). Users of MA younger than 30 expressed a greater inclination toward future MA use (around 50% versus 28%). Never-married respondents were more predisposed to future MA use (53% versus 31%).

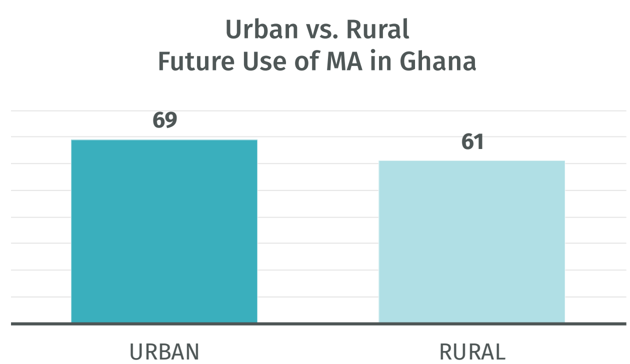


Nigeria

Interestingly in Nigeria, there were no differences by education (none/primary vs secondary) or marital status in ever-use of MA. However, there was a regional difference with women in Kano showing a higher likelihood of future MA use compared to the overall average (76% versus 62%). Ever-users who were currently in school expressed a 32 percentage-point higher likelihood of using MA in the future compared to those who were not in school (71% versus 45%).







Most notable is the revelation that the poorest women, those under 30, and never married women expressed that they were more likely to use MA again in the future. Using a Likert scale combining those "somewhat likely" with those "very likely" to use MA in the future, about 60% of ever users in Ghana and approximately 83% of all MA users in Nigeria indicated a likelihood of future MA use.

Summary and Conclusion

The findings of this study underscore the critical need to understand women's experiences and preferences regarding medical abortion (MA) to enhance the provision of abortion care in Ghana and Nigeria. By leveraging digital surveys through social media platforms, DKT International and the Behavioral Insights Lab (BiL) successfully gathered substantial data on the awareness, purchase, and use of MA, highlighting significant nuances in these processes among different demographic groups.

Key insights reveal that MA awareness is notably higher among women than men, particularly those in urban areas and among the poorest women, indicating that MA has the potential to be considered a "pro-poor" intervention. The study also emphasizes the prominent role of private sector outlets, such as chemists and community pharmacies in Ghana and Patent and Proprietary Medicine Vendors (PPMVs) in Nigeria, as primary sources for MA. The data indicates potential socioeconomic and regional disparities in access and pricing, with poorer women relying more on PPMVs and community pharmacies due to lower costs.

Additionally, findings on the future use of MA suggest a significant likelihood among ever users, especially among the youngest and poorest women, pointing to the necessity for continued support and accessibility of MA products. The potential for discriminatory pricing practices based on marital status in Ghana and the need for further research on quality variations among different outlets in Nigeria are critical considerations for policymakers and healthcare providers.

Overall, **this study demonstrates the effectiveness of digital surveys in capturing valuable insights into women's abortion journeys** and provides a foundation for future research to expand on these findings. Ensuring that MA remains accessible, affordable, and widely available is essential for meeting the needs of women in these regions, particularly the most vulnerable populations.

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