

〈共同研究〉

「アフリカン・イニシアティブとその展望」

Characteristics of Women Who Had Voluntary Termination of Pregnancy (Induced Abortion) in Lagos, Nigeria

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Summary

The study was done in Lagos between 1st June and 31st December, 2003. Four hundred and forty women who had had a previous termination of pregnancy completed the questionnaire. The mean age of these women was 31.1 ± 7.8 years and the mean parity was 1.87 ± 2.0 . Almost 85% of them were single when they terminated their first pregnancy. The mean age at first coitus was 17.7 ± 2.4 years while the mean age at which they terminated their first pregnancy was 28.1 ± 4.8 years. Among the providers 64.8% were non-gynaecologist doctors. The contraceptive prevalence among them was 21.7%. There was a positive correlation between the age at first intercourse and the number of pregnancy terminated ($r^2 = 0.06$).

Introduction

The World Health Organization (WHO) defines reproductive health as a condition in which the reproductive process is accomplished in a state of complete physical, mental, and spiritual well-being and not merely the absence of disease or disorder of the reproductive process. It therefore implies that people have the ability to reproduce, to regulate their fertility, and to practice and enjoy sexual relationship. The International Conference on Population and Development in Cairo (1994), and subsequently the 4th World Conference on Women in Beijing (1995) brought into focus the importance of reproductive health for the social and economic development of a nation. Unsafe abortion, its prevention and management is one of the components of reproductive health (Akande 2002). In Nigeria, induced abortion accounts for 13% of maternal mortality, which is death of a woman while pregnant or within 42 days of termination irrespective of the duration or site of pregnancy, from any causes related to or aggravated by pregnancy or its management. The maternal mortality rate in Nigeria has been estimated to be over 500 per 100,000 deliveries (Okpere 2003).

A sizeable proportion of pregnancies undergo voluntary termination, hence, induced abortion is by no means alien to Nigeria. According to the Nigerian criminal code, it is illegal to perform an abortion unless the pregnancy threatens the woman's life and the penalties for such an offence are severe (United Nations Department of Economic and Social Development 1993). About 12% of pregnancies in Nigeria end

in induced abortion and 9% result in unplanned birth (Henshaw et al. 1998). There is very little research into the characteristics of the women who obtained voluntary termination of pregnancy in Nigeria and the various reasons for terminating the pregnancy. Most studies on abortion in Nigeria were based on women admitted into major hospitals in urban centres for abortion complications (Okonofua et al. 1992, Archibong 1991). The major reasons why adolescents seek termination of pregnancy were found to be: the need not to interfere with schooling; not being old enough to get married; fear of family members knowing; not planning to marry the partner; being jilted by a fiancé; following rape or incest and not knowing the actual father (Otoide et al. 2001). In addition to the legal issue raised above, ethical and moral issues have contributed to the paucity of data and they also make research difficult.

Reproductive preferences and behaviour often vary across socio-economic and demographic sub-groups. The intention to have more children and actual fertility are usually higher among rural women and women without any formal education than among their urban and better-educated counterparts (Bankole and Westoff 1995, Bankole et al. 1999).

Almost all induced abortions result from unintended pregnancies from non-use of contraception or contraceptive failure (Bankole et al. 1998). A study in Lagos showed 56.6% of pregnancies from failed contraception requested for termination (Ogedengbe et al. 1991). Unsafe abortion is often the end result of an unwanted pregnancy. This trend of pregnancy is most profoundly demonstrated among adolescents (Otoide et al. 2001). Hospital-based studies have shown that in Nigeria up to 80% of patients with abortion related complications are adolescents (Okonofua et al. 1992, Adewole 1992). Similarly a community-based study of abortion prevalence found that one third of women who obtained abortion were adolescents (Otoide et al. 2001).

Where women have opportunities for education, employment and career development, younger and unmarried women are the most likely to postpone childbearing and obtain abortion. In contrast, where women marry young and are expected to have a child soon after marriage abortion will be infrequent (Bankole et al. 1999).

In some sub-Saharan African countries a girl must leave school if she is pregnant and abortions tended to be most common among young, unmarried women who wish to continue their education (Salter et al. 1997). There is evidence to show that Christians more than Muslim women resolve unwanted pregnancy by abortion (Ahiadeke 2001, Okonofua et al. 1996). Some studies showed women who are employed tend to be more likely to obtain abortion than those who are not working (Agadjanian and Qian 1997).

In Nigeria, apart from abortion being illegal, it is also affected by religion, ethical, and moral values yet many women go to extreme measures to avoid an unwanted birth. These measures often involve clandestine abortion, performed under unsanitary conditions and by unskilled personnel using dangerous techniques.

The problems related to abortion are multifactorial for adolescent women (Adetoro et al. 1991). With many families are leaving their rural settlement for urban areas and parental control and supervision becomes lax, and with increasing Westernisation, young people are exposed to modern influences that

encourage sexual activity in casual relationships. Contraceptive knowledge among women is low in Nigeria, particularly among the adolescents. Their utilization of both traditional and modern methods of contraception has been shown to be poor. The 1990 National Demographic and Health Survey (NDHS) found that only 1% of the sexually active women aged 15-19 years ever used any contraceptive method (Otoide et al. 2001). Access to the service is poor and unintended pregnancies are common among these young, unmarried women (Henshaw et al. 1998).

This study was conducted to examine the various characteristics of women who obtained voluntary termination of pregnancy. A better understanding of the women's background and characteristics could improve our ability to target those who are in the greatest need of effective contraception. This information will be vital in family planning programs and policymaking.

Methodology

This study was conducted over a period of six months. It is presumed that most women that would agree to participate in this study would provide accurate information. A structured questionnaire was administered to women who had voluntarily terminated pregnancy and were attending gynaecological and antenatal clinics of various hospitals in Lagos. The questionnaire was designed to obtain such information as age, parity, number of pregnancies that had been terminated, age at which the first termination was obtained, usage of contraception at the time of termination of the first pregnancy. Women who had miscarried or who had evacuation or dilatation and curettage for conditions such as incomplete abortion or missed abortion were excluded from this study.

All information obtained was collated and computer-analysed using EPIINFO version 2002 statistical program designed for Windows. Results are presented as tables and figures.

Results

Four hundred and forty women who had voluntarily terminated pregnancy consented to complete the questionnaire. The age of the participants ranged from 16 to 60 years with a mean of 31.2 ± 7.89 years and they had a mean parity of 1.87 ± 2.0 with a range of 0 to 9. A total of 35.4% of these women were nulliparous when they had their first induced abortion. Table 1 shows the frequency of age at which they experienced coitus for the first time. The mean age at first coitus was 17.7 ± 2.4 years. There is a positive correlation between the age at first intercourse and the number of pregnancies terminated ($r^2 = 0.06$ $P = 0.000001$).

Table 2 shows the frequency of age at which these women had their first induced abortion; the mean age was 21.8 ± 4.8 years with a range of 15-44 years. Of these women 37% of them were adolescents.

The mean number of pregnancies terminated by these women was 2.0 ± 1.8 with a range of 1-10. Of these women 46.6% had only one termination. The gestational age at which abortion was induced declined with an increasing number of terminations. Of these women 45.8% had their first induced abortion at

between 8-13 weeks gestation, as compared to 86.7% of those having their third induced abortion taking place at less than eight weeks gestation. (Table 3)

Figure 1 shows marital status at first termination of pregnancy. About 85% of them were single, and 66% were still in school of which 47.5% were in secondary school. Of those in employment, 76% were apprentices, traders and businesswomen.

The providers of these abortions are shown in Table 4. Almost 65% of these women obtained their pregnancy termination from non-gynaecologist doctors, and 5.9% of these women purportedly performed the abortion themselves using various agents like menstrual inducing agents like menstrogen, a combination of ethinyl estradiol and ethisterone, gynecosid, a hormonal preparation, quinine, illicit gin, codeine, lime and a brand of aspirin "alabukun" singly or in combination. In 77.7% of cases the procedure was performed in a private hospital and 14.8% of these women experienced complications such as abdominal pain and vaginal bleeding.

Although contraceptive awareness was 42.6% the prevalence was 21.7% at the time they terminated their first pregnancy. Most of those using contraception at the time they had their first abortion used emergency contraception. (Figure 3)

Other characteristics observed included religion, where 70.5% were Christians and 29.5% were Muslims. Figure 2 shows the various Christian denominations. Pentecostals and Catholics were 34.1% and 31.1% respectively.

Table 1. Frequency of age at first intercourse

Age (years)	Frequency	Per cent (%)
14-19	344	78.2
20-25	95	21.6
26-31	1	0.2

Mean: 17.72

SD: 2.40

Range: 14-29

(SD=Standard Deviation)

Table 2. Frequency age at first termination of pregnancy

Age (years)	Frequency	Per cent (%)
15-19	165	37.5
20-25	199	45.2
26-31	50	11.4
32-34	21	4.8
35-44	5	1.1

Mean: 21.81

SD: 4.87

Range: 15-44

Table 3. Frequency of gestational age at which pregnancies were terminated

Gestational age	First pregnancy	Second pregnancy	Third pregnancy	Fourth pregnancy
< 8 weeks	145 (32.2%)	172 (80.4%)	85 (86.7%)	37 (88.1)
8-13 weeks	194 (45.8%)	36 (16.8)	6 (6.1%)	5 (11.9%)
> 13 weeks	85 (20%)	6 (2.8%)	7 (7.1%)	-
Total	424	214	98	42

Table 4. The providers of the abortions

Providers	Frequency	Per cent (%)
Gynaecologist	65	14.8
Non-gynaecologist Doctor	285	64.8
Nurse	33	7.5
Pharmacist	8	1.8
Herbalist/Quack	12	2.7
I do not know	11	2.5
Myself	26	5.9

Figure 1. Marital status when the first pregnancy was terminated

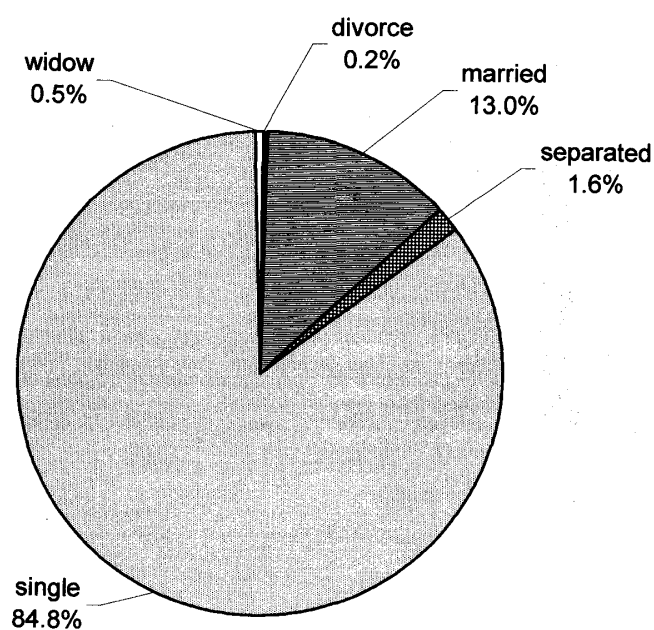


Figure 2. Christian Denominations

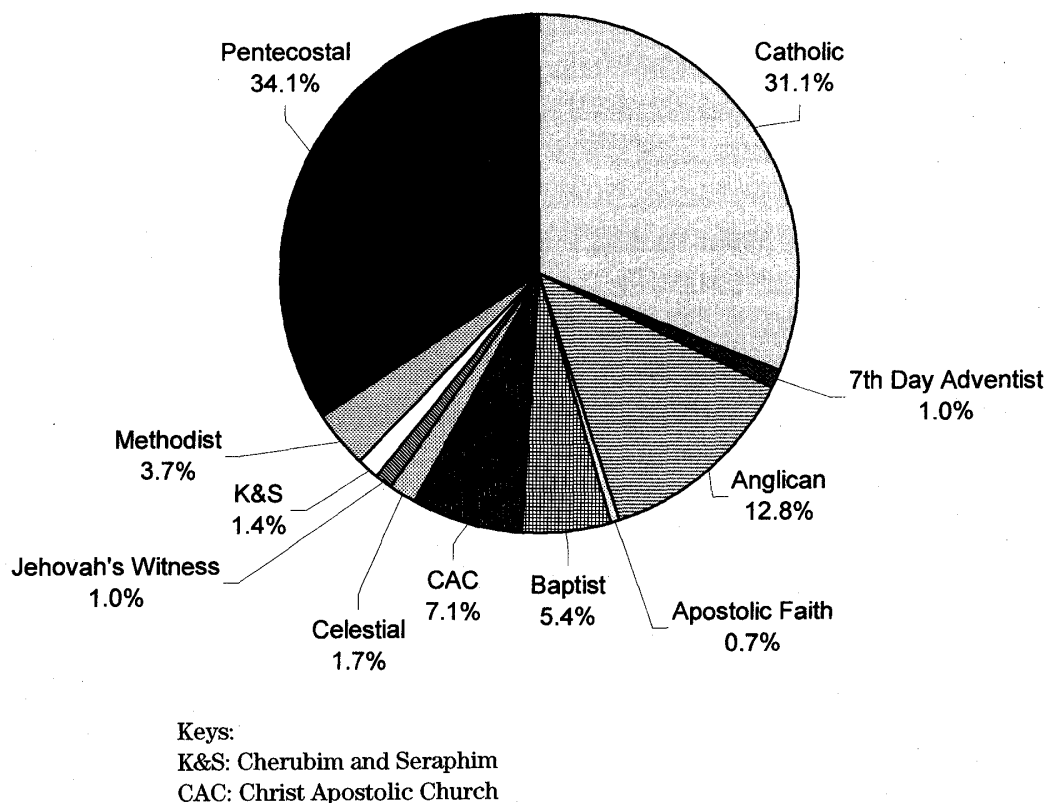
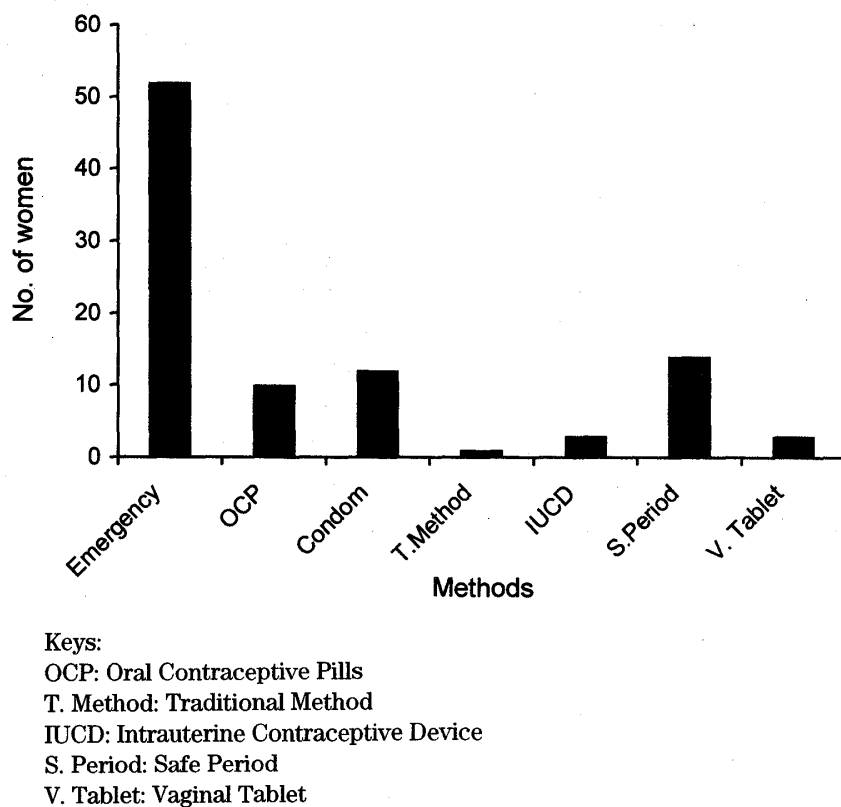


Figure 3. Methods of contraception they were using when they got pregnant



Discussion

Demographic influences such as age and parity as well as values such as education, marital status and religion that may influence the choice of any woman terminating pregnancy were examined. Abortion like unplanned pregnancy cuts across virtually all societies. Regardless of the legal status in that society, the majority of unwanted pregnancies would be resolved by abortion.

The largest proportions of these women were in their youth (15-24 years) though a significant proportion had their first abortion during adolescence. It has been suggested that women in their twenties are likely to be sexually active, fecund and married (Otoide et al. 2001). This is in contrast with the findings in this study. Of the total women who participated in this study 84.8% were unmarried and 54% of them were in their twenties. This can be explained by the social reprisals of out-of-wedlock pregnancy (Makinwa-Adebusoye 1999), also, the level of contraceptive usage among these categories of women is very low. It is the view in Nigerian society that any unmarried woman seeking contraception is promiscuous. Information from the 1990 NDHS suggests that low level of knowledge of modern contraceptive and method source as well as poor access to the source and supply contribute to women's need to seek abortion (Makinwa-Adebusoye et al. 1997). Married women are more likely to use contraception than unmarried women. A study showed that government hospitals and designated family planning clinics are the only source of contraception known by women. Perception among the adolescents that modern methods of contraception has a sustained interference with fertility may also account for their low use of contraceptives (Okonofua et al. 1996). Effective sex education among the adolescents, improved access to contraception, such as encouraging private hospitals to provide family planning services and counselling and the creation of adolescent friendly health services are strategies that can be used in targeting the at-risk women, particularly the adolescents. Clinical and behavioural research has found a positive association between early age at first intercourse and subsequent sexual health (Gueye et al. 2001). In this study a positive association was found between the early age at first intercourse and the number of pregnancies terminated ($r^2 = 0.06$, $P = 0.000001$). Therefore, sex education should be incorporated into the school curriculum beginning from the primary school before Nigerian adolescents are exposed to unwanted pregnancy and its adverse consequences.

It was noted that the gestational age at which these women terminated their pregnancies decreased with succeeding pregnancies. This might be explained by the initial lack of experience and delay in making a decision. However, after the first abortion, they are able to recognise pregnancy at the very early stage and the fate of such pregnancy is determined promptly. Sex education and adolescent friendly clinics will also assist with this. Mid-trimester abortions commonly procured by adolescents are associated with high morbidity and mortality. Early termination has been shown to be safe and less costly (Ahiadeke 2001).

About a third of these women had no living child at the time they terminated their first pregnancy; this is similar to what was found in earlier studies (Okonofua et al. 1996). The influence of education and preservation of a career on the choice of termination of pregnancy has been demonstrated. These women may have opted for abortion because they were unmarried or in favour of their education, since significant proportion of them were still in school, or because of career obligations at work. When abortion is

induced after the first child, it may have been for child spacing or limitation of their family size. Limiting family size and child spacing has been shown to be indications for termination of pregnancy in another study, thus termination of pregnancy is the only option due to ignorance about contraception (Okonofua et al. 1996).

This study showed a large proportion of these women to be Christian the majority of which were Catholic and Pentecostal. This may be explained by the fact that both of these Christian denominations do not encourage the use of contraception. The predominance of Christians over Muslims may be accounted by the fact that the former being more liberal with religion accommodates the influence of Westernisation, which is liberal with pre-marital sex, unlike the Muslims.

As in most studies from Nigeria, where unsafe abortion is common, complications resulting from induced abortion among these women were high and it is likely to be related to the place where the abortion was obtained and the lack of a skilled provider. Most of these women had their abortion in private hospitals but some had theirs from quacks, nurses or "pharmacists". Some women claimed that they performed the pregnancy termination themselves using various agents. These agents are mostly known to be abortifacients and there was a possibility that they may not have actually been pregnant; however, the intent was there. These are the consequences of a restrictive abortion law, which prevent women from having safe services. Apart from the mortality associated with unsafe abortion, there may be delayed complications such as secondary infertility, ectopic pregnancy, secondary amenorrhoea, chronic pelvic inflammatory diseases, spontaneous abortion and prematurity in Nigerian women (Okonofua et al. 1996).

Conclusion and Recommendation

Information on demographic and social characteristics relating to induce abortion can be an important means of improving our understanding of the circumstances surrounding a woman's decision to obtain an abortion. Studies of these characteristics can help to identify the sub-group such as adolescents both in school and out-of-school, single and married adults, who are in need of counselling and services to prevent unplanned pregnancy.

Specific needs of the adolescent must be met through comprehensive policy on adolescent reproductive health education, which should be incorporated early into the school curriculum before they initiate sexual activity since the mean age at first coitus was found to be about 17 years. Abstinence skills should be promoted, but where it fails, adequate information, counselling and provision of contraceptives will be important in adolescents' acceptance of methods of contraception and their use at intercourse.

Liberalisation of the abortion law will enable any woman who needs a termination of pregnancy under such conditions such as rape, the presence of an abnormal fetus or failed contraception to use a skilled provider in appropriate centres. This will reduce maternal morbidity and mortality related to abortion since the restrictive law has done little or nothing to stem the abortion related morbidity and mortality.

Training in Post-abortion Care (PAC) providers is very crucial to this initiative, so that the required skills to terminate pregnancy in the safest way and the required contraceptive and reproductive health counselling and services will be available.

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