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Abortion and Challenges of Teenage Pregnancy in Lagos, Nigeria.

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Abstract

The study examined the influence of abortion on the lives of pregnant teenage girls in Lagos. The study adopted an exploratory and descriptive research design. Copies of a questionnaire were administered on one hundred and five girls selected from Ojo Local Government Area of Lagos State who participated in the study. The study conducted ten in – depth interviews involving medical experts, parents and teenagers who were purposively selected. These data were analysed. Findings of the study supported the outcomes of previous studies that adolescent girls are hesitant to discuss their past exposure to abortion; have divergent perceptions of abortion and display inadequate though varying knowledge of the implications of abortion for their future reproductive health. Moreover, the study found evidences of cultural and religious inhibitions that discourage girls from public discussion of their sexual behaviour. Scared by the disgrace that such an act might cause, most girls deliberately do not access abortion services from specialists. Therefore, the study suggests that government legalises abortion to enable experts handle abortion and post abortion needs of adolescent girls. This will salvage many innocent babies and girls who might be involved in unsafe abortion from experiencing fatality. Otherwise, quackery in the health sector may continue to undermine all progressive health initiative to lay siege on the lives of vulnerable unborn babies and the life chances of their adolescent mothers in Lagos.

Key Words: Adolescent Mothers, Life Chances, Post-Abortion Services, Unborn Babies, Unsafe Abortion.

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1. Introduction

The World Health Organization (WHO) has defined adolescence as progression from the onset of secondary sex characteristics to sexual and reproductive maturity; development of adult mental processes and adult identity and transition from socio-economic dependence to relative independence (WHO, 1975 cited in Population Reports, 1995:3). One third (36.5 million) of Nigeria's total population of 123 million are youth between the ages of 10 and 24 (Population Reference Bureau, 2000). Though the age range of adolescence is culture and purpose specific, in Indonesia many studies on adolescent reproductive health have defined adolescents as young people aged 15-24 years (Yayasan & Kantor, 1993; Utomo, 1997; LD-FEUI, 1999; Situmorang, 2001).

Approximately one billion people—nearly one out of every six persons on the planet — are adolescents; 85 percent live in developing countries (UNFPA. 1997). The sexual vitality of most adolescents puts them at risk of various reproductive health challenges. While about 15 million adolescents aged 15–19 years give birth each year, as many as 4 million obtain an abortion (UNAIDS, 1997). Lack of sexual health information and services for these vulnerable citizens places the young people at risk for pregnancy and unsafe abortion having implications for life and living. If over 16 percent of teenage females reported first sexual intercourse by age 15 (National Population Commission, 2000); a study of 330 female rape victims in Benin

City, Nigeria, reported that a majority of rape victims were females ages 13 to 19; 48 percent were under age 13 and in another study, 75 percent of rape victims were revealed to be unmarried and ages 13 to 19 (Omorodion & Olusanya, 1998), it is urgent that their pregnancy terminating behaviour especially through illegitimate mechanisms deserve some scientific examination and analysis.

Abortion practices remain continuously controversial in many parts of the developing countries of the world because it is intricately linked up with morality than adolescents' liberty to live their lives the way they consider desirable. Many people, especially religious leaders have argued that providing reproductive health information and services to adolescents will encourage them to become promiscuous. As a result, the approach of successive governments to the question of adolescent reproductive health tends to be based on morality, rather than the health need. It is probably for this reason that performing or seeking an abortion has been and still remains illegal in Nigeria, except it is intended to save a woman's life. Irrespective of public policy attachment to moral sentiments, experts estimate that more than 600,000 Nigerian women obtain abortions each year (Henshaw et al., 1998). One study found that one-third of women obtaining abortions were adolescents. Though students also demonstrated an increase in knowledge of contraceptive options (Centre for Communication Programs, 1995), hospital-based studies showed that up to 80 percent of Nigerian patients with abortion-related complications were adolescents (Otoide et al., 2001).

Adolescent unwanted pregnancies often end in abortion. Surveys in developing countries show that up to 60 percent of pregnancies to women below age 20 are mistimed or unwanted (International Council on Management of Population Programmes, 1997). Pregnant students in many developing countries often seek abortions to avoid being expelled from school (Zabin & Kiragu, 1998). Induced abortion often represents a greater risk for adolescents than for older women. In Nigeria, for example, 50–70 percent of women hospitalized for complications of induced abortion are younger than 20; a 13-year review found that complications from unsafe abortion were responsible for 72 percent of maternal deaths among women under age 19 at one university hospital (Unuigbe et al., 1988).

Apart from the sensitivity of the issues, studies in Jakarta found that most parents felt inadequate to talk to their children about issues related to reproductive health (Iskandar, 1995; Utomo, 1997). Parents do not know how to deal with their children's sexuality any better than young people know how to deal with it themselves. Today young people are increasingly tolerant of premarital sex. A study among young people aged 15-24 from various socio-economic backgrounds in 12 cities in Indonesia in 1993, revealed that between 10 to 31 percent of youth reported having engaged in premarital sex (YKB, 1993). Young people, especially those unmarried, seldom use contraception. Sexually active single young people who have sex with a steady partner often claim that intercourse is not the result of premeditated or conscious decisions but just "happens", so they are unlikely to be prepared with contraception (Khisbiyah et al., 1997). In addition, many young people have limited knowledge of contraception (LD-FEUI, 1999).

In Indonesia, as abortion is restricted and childbearing out of wedlock is unacceptable, many premarital pregnancies result in marriage. However, when marriage is not an option, many girls turn to abortion. Since abortion is illegal, it is often performed by unskilled providers in unsafe conditions (Adrina et al., 1998:126; Indraswari, 1999; 131-164). It is estimated that up to half of all pregnancy – related deaths in Indonesia result from the complications of unsafe abortion (Muluk, 1994 cited in Mohamad, 1998:84). Also, a study carried out by the Centre for Health Research at the University of Indonesia in 2000, estimated around 2 million abortion cases per year in Indonesia and roughly 30 percent of them were for adolescents (Utomo, et al., 2001), the situation may not be significantly different in Nigeria.

Unsafe abortions that take place each year are 20 million, mostly in countries where abortion is illegal. World health organisation and Guttmacher Institute (2002) claim abortion is safe in countries where it's legal, but dangerous in countries where it's outlawed and performed clandestinely. According to WHO, nearly all abortions (92 per cent) are safe in developed countries, whereas in developing countries, more than half (55 per cent) are unsafe. As a result, the World Health Organisation recognises unsafe abortion as a

"silent pandemic" and believes safe and legal abortion is a fundamental right of women, irrespective of where they live (WHO & Guttmacher Institute, 2007). Regrettably however, for Nigerian women, abortion is a luxury. For instance, Chapter 21 of Nigerian Criminal Code 'Offences against Morality' criminalises abortion. *Section 228* of The Nigerian Criminal Code provides that any person who, with intent to procure miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable to imprisonment for fourteen years.

Abortion is not a typically Nigerian challenge; it is nonetheless, a dominant social affliction especially in developing societies of the world. A qualitative study in Yogyakarta in 1997 among 44 women who had a premarital pregnancy at age 15-24 had 18 respondents terminating the pregnancy (Khisbiyah et al., 1997:43). Of those who continued the pregnancy, 21 respondents married during their pregnancy and only five respondents remained single. Facing the fact of their pregnancy, most girls who decided to continue their pregnancy had attempted abortion (usually by drinking traditional medicine/jamu) but failed. PKBI reports indicate that for 1998 and 1999, in Indonesia, there were two million abortions each year, and 750,000 (38 percent) of them were requested by single young women (Media Indonesia, 2000).

2. Material and Methods

The study location was Lagos. The survey covered all the state's statutory 20 Local Government Areas. In every local government area, 5 respondents were selected, giving a total of 100 respondents. The study area was chosen for its level of urbanization and diverse characteristics. Lagos derives its demographic importance and prominence from being a premier city having considerable political and economic functions. It has a population of about (9.2m) which accommodates over 6.2 percent of the national population of 140 million (2006 population census figure). At 9 percent per annum growth rate, approximately 300,000 persons per annum or 25,000 per month or 34 persons per hour are added to the existing population (Noah, 2000). Metropolitan Lagos is the most heterogeneous city in the country. It remains the economic nerve centre of the country and industrialized city in the country.

Both qualitative and quantitative methods were used for data gathering. For quantitative data the Questionnaire method was used and for qualitative, In-depth interview was used for the collection of data. In order to make the sample size representative of the whole population in the study area, random sampling technique was used.

3. Data Collection

This study is based on a mixture of qualitative and quantitative approaches. In addition to empirical data collected through in – depth interviews in Lagos, available materials were reviewed for related information. The main data collection techniques for primary data gathering employed in this study are: survey and in – depth interview. One hundred girls were randomly selected from Ojo Local Government Area in Lagos State to participate in the study. For the study, three categories of respondents were selected for five in – depth interviews: two medical experts, two parents (one male and one female) and one teenager who were purposively selected

Five graduating students of Sociology Department of the Lagos State University, comprising three ladies and two men were engaged as assistants who conducted the in – depth interviews and administered copies of the questionnaire with the researcher. These assistants were rigorously trained on the techniques of interviewing people in ways that will prevent respondents from holding any vital information back. Pre interview practice sessions were held to avail the research assistants the competence to administer questionnaire, handle tape recorders and transcribe their contents. These orientation exercises took five days. In all, one hundred copies of a questionnaire were administered, retrieved, correctly completed and analysed for the study.

For qualitative data, five in – depth interviews were conducted to elicit qualitative information about the challenges which the reproductive health of adolescent girls faces in Lagos state. Participants were selected across varying socio – economic backgrounds within the study area. The survey covers the extent of the influence of abortion on the life chances of pregnant adolescent girls in Lagos state. Consent forms were administered to all the participants before the interview. The researcher safely keeps tapes, consent forms and notes taken during the in – depth interview.

4. Data Analysis

Quantitative Data

Returned questionnaires were subjected to thorough

editing. Prior pre-coding of the questionnaire facilitated entry and analysis. Quantitative data collected from this survey were subjected to analysis. This involves an examination of the distribution of the respondents according to particular characteristics. This decision is informed by the assumption that behaviour of individuals in society is, to a large extent, determined by their personal characteristics as well as those of the environment in which they live their daily lives and their abortion behaviour.

5. Results

Socio – Demographic Variables

From table 1, the age pattern of the respondents indicated the proportion of respondents in age group 20 years below is proportionally more than other categories. This implies that majority (48%) of the sample population are in the sexually. While 63% of respondents are single, 25% are married, 8% are divorced and 4% separated. With 48% of respondents having the first school leaving certificate and 44% holding the West African school certificate and 8% holding Ordinary National Diploma, illiteracy could possibly not be advanced as an acceptable premise for adolescent pregnancy and unsafe abortion embracing behaviour of girls in Lagos state. Among respondents, there are more Christians than Muslims. While 58.5% are Christians, 35.5% are Muslims, 3% are traditional believers and 4% belongs to others. The level of ethnicity did not deviate significantly from the expected pattern as 55% are Yoruba, 25.5% Ibos; 9% Hausas and others 11%.

Teenage Pregnancy and Abortion Behaviour

Table 2 reveals that 8% of respondents believed that girls began to experience sexual activity before they were 10years old. While 34% said that girls began between age 10 and 14 years, 58% maintained that it was between age 15 and 18 years. One significant inference from these is that parental influence on girl child morality has manifestly ebbed. Criminalisation of abortion is not a recent legal initiative. The traditional attitude of parents to adolescent pregnancy has always predisposed the pregnant girls to the patronage of all sorts of illegitimate abortion inducing devices.

An old woman respondent said,

The level of moral depravity in contemporary society combines with children's superficial bodily structure to fire the thoughts of members of the opposite sex that result in most of the unsafe pregnancies and the abortion risks that follow.

While 83% of respondents believe that adolescent girls were aware of the legal implication of their actions, only 9% noted that they were unaware and 8% observed that they were indifferent. Adolescent girls have significant decision making power in terms of whether to live with their accidental pregnancies or induce abortion. Fifty nine percent of respondents said partners of the adolescents introduced them to abortion; 19% said friends; 43% said nobody and 13% mentioned parents. That 43% of respondents adjudged adolescent girls as being solely responsible for the decision to induce abortion indicate their decision making skill in what happens to their premature motherhood is not completely outside their control.

A parent respondent said,

Looked at from any angle, pregnant adolescents are decision makers even if they lack required experience that could make going to hospitals for abortion services a wise decision, abortion has two possible social results: it either acts as an eye opener or become a way of life.

Justification for Unsafe Abortion

Pregnant adolescent girls have a multiplicity of reasons for inducing abortion as 29% respondents adduced avoidance of stigma of being accidental mothers; 33% attributed it to avoidance of economic burden; 10% advanced freedom to work as the reason for inducing abortion; 17% ascribed it to the freedom to enjoy themselves; and 11% insisted that it was due to their desire to maintain their girlhood. No matter what the justification for inducing abortion is, *section 229* states that any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years. In addition, *section 230* of the code provides that any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended

to he unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a felony, and is liable to imprisonment for three years. Are pregnant adolescent girls ignorant of the existence of the above anti abortion law?

A male respondent said,
If an adolescent girl is impregnated by someone who is not her boyfriend and is a blood relation, the shame of the event might make the family aid the inducement of abortion because of its incestuous character.

What then could be responsible for this development among adolescents, Devine et al. (1993) found that parental divorce during early adolescence was associated with earlier onset and greater frequency of sexual activity for females, but not for males. Less parental supervision in single-parent homes and modelling of single-parent dating behaviour are among the possible explanations for these tendencies (Dornbusch et al., 1985; Miller & Moore, 1990).

Inherent Dangers of Abortion

Abortion that is induced in controlled environment by an expert could be a safe experience. But the situation alters when it is done in unhealthy condition and handled by quack doctors. Commenting on medical procedure for ensuring this, Dada (2011) noted that there are several ways by which abortion can be done, and there are different stages with their accompanying risks. If for some reason a medical abortion does not work, a woman has the option of getting it done surgically. On the desire to induce abortion, 25% of the respondents said some pregnant adolescent girls will prefer to die to inducing their abortions in the hospital; 35% concluded that out – of – hospital induction of abortion does not instantly lead to death; 30% believed that even adolescent girls who had their abortions induced at the hospital still sometimes die; 7% noted that a person will die when his/her time comes and 3% said pregnant adolescent girls have no reasons whatsoever for inducing their abortions outside orthodox hospitals.

On complications arising from unsafe abortions, a medical doctor respondent said:
Complications which could be either immediate or prolonged included severe blood loss leading to death; infections leading to infertility; uterus perforation; cervical laceration; renal failure; damage to the bladder, intestine perforation and chronic pelvic inflammatory diseases.

Supporting the claim that abortion is a major cause of injury and death among women worldwide, another medical doctor respondent observed:
"In Nigeria, about 25 out of 1,000 pregnancies are aborted, compared to western countries where abortion is legal and done liberally. There, abortion rate is five out of 1,000 pregnancies. Non-legalisation of abortion contributes immensely to maternal deaths. We are losing about 60,000 women every year to abortion and 40 per cent of this figure is caused by complications from induced abortion."

Another medical doctor respondent commenting on complications arising from unsafe abortions said,
Complications could be either immediate or prolonged. These included severe blood loss leading to death; infections leading to infertility; uterus perforation; cervical laceration; renal failure; damage to the bladder and intestine perforation. Prolonged effects of unsafe abortion include infertility and chronic pelvic inflammatory disease.

Prevention and safeguards against teenage abortion

On safeguards against abortion, 43% of respondents recommended the provision of medical and counselling services by government to be the most auspicious panacea; 12% pointed to the direction of recreational facilities; 9% suggested preventive intervention; 3% favoured free education and 33% preferred the deepening of parental socialisation.

On the prevalence of abortion in Nigeria, an in – depth interview respondent said:
A poor family may not have any option than terminate the pregnancy of their teenage daughter who is in school especially when it is apparent that the means of livelihood for both pregnant adolescent and her adolescent 'accidental husband' might be precarious.

Consequently, thirteen percent opted for the need for parents to counsel their young girl children more appropriately; 15% suggested the use of professional counsellors to do the prevention; 35% raised their

thumbs up for improved family life education; 4% believed that improved girl child parenting at home would work wonders while 33% insisted that if parents pay more desirable attention to their growing girl children, the incidence of adolescent girl pregnancy and its tragic twin partner – unsafe induction of abortion will decline.

Another respondent advises co–parents and government,

While we should educate our pregnant adolescent girls, be more intimate with them and their unwanted babies so as to enable them overcome the impact of their traumatic conditions, government, should legalise abortion to prevent unnecessary death of young children.

How then can teenage pregnancies be prevented? Even in the West, the prevention of teen pregnancy has become a subject of great interest to policymakers in recent years. Educational programs delivered in the public schools, often as part of the overall health curriculum, have been among the widespread approaches to the problem (Kirby & Coyle, 1997).

6. Discussion

What option does a helpless pregnant girl have when on realising that she is pregnant; her parents drive her to meet the boy who impregnated her who is still wholly dependent on his own parents? In Nigeria, the fact remains that except abortion is committed to save the life of a pregnant woman; the Criminal Code legislates varying terms of imprisonment from 3-14 years for the person who masterminds an abortion, the woman and the person who supplies the instruments for the abortion. Criminalising abortion legally disenables qualified doctors in Nigeria and leaves the fate of women with unwanted pregnancies in the hands of bizarre quack doctors.

With the rising susceptibility of adolescent girls in Lagos to accidental pregnancy and consequent unsafe abortion, there is a need for a second thought about legalising abortion. To date, almost all parents in the study area are intolerant of adolescent pregnancy and its attendant abortion. Parents are mostly usually involved in abortion arrangement at the level of incest or the health of the pregnant girl is threatened.

While the effects of abortion are insurmountable ranging from physical, social, emotional to psychological effects, some adolescents might be very lucky to go through the process of abortion without complications (Dada, 2011). In spite of the manifest risks involved in the practice, pregnant adolescent girls still induce abortion. What could inform this risky lifestyle? The findings from some studies in the west indicate that children who live with both biological parents are less likely to be sexually active than those from one-parent homes (Flewelling and Bauman, 1990; Forste and Heaton, 1988; Hayes, 1987; Miller and Bingham, 1989; Newcomer and Udry, 1987; Upchurch et al., 1998; Whitbeck et al., 1996) while the sexual activity of children in remarried families usually falls between the first two (Miller & Moore, 1990; Thornton & Camburn, 1987).

7. Conclusion

Nigerian policy makers have no plausible justification for their indifference to youthful pregnancy that ultimately, in most cases, leads to wanton loss of life. Teenage pregnancies and consequent abortion will continue in so far as in some socio – cultural settings, sexual exposure of girls occurs at ages as young as 9 – 12 years as older men seek young girls as sexual partners to protect themselves from STD/HIV infections (Blanc & Way, 1998). To discontinue this unwholesome trend, public policy must urgently consider legalising abortion as a critical health issue rather than a moral question. Liberalising abortion is an issue that is basic to women's reproductive health. Sincerely, it transcends hypocritical morality.

8. Recommendation

It is recommended that government should evolve and implement an adolescent reproductive health policy that would save unborn children from the carnage that abortions subject them. Therefore, the suggestion to give reproductive health information and services to single young people may never be better at any other time than now. It is against this background that the need for improved health and social services aimed at adolescents, including reproductive health services, is not only being advertised by developed countries but should be increasingly recognized throughout the

world.

Policy makers should be committed to a conscious reduction by half, the conception and birth rates among under – 18s. The need for such measures is seldom questioned; in the public imagination (and often in the research literature), there is a belief that teenage pregnancy and childbearing are increasing and that action is necessary to stem the growing numbers of young mothers (FPSC, 1999).

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RESULTS

Table 1: Socio - Demographic Characteristics of Respondents

Characteristics	Frequency	Percent
Sex		
Male	32	32
Female	68	68
Total	100	100
Age		
20 Below	42	42
21- 25	15	15
26 – 30	12	12
31 – 35	10	10
36 – 40	13	13
41 – and above	8	8
Total	100	100
Marital Status		
Single	63	63
Married	25	25
Widowed	8	8
Separated	4	4
Total	100	100
Education		
FSLC	48	48
WASC	44	44
OND	8	8
Total	100	100
Religion		
Christianity	58	58.5
Islam	35	35.5
Traditional	3	3.0
Others	4	4.0
Total	100	100
Ethnic Group		
Ibo	25	25.0
Hausa	9	9.0
Yoruba	55	55.0
Others	11	11.0
Total	100	100

Source: Author's Field Survey, 2011

Table 2: Abortion Behaviour of Pregnant Adolescent Girls in Lagos

Characteristics	Frequency	Percent
Age at which sexual activity begins		
Under Ten Year	8	8
10 – 14 years	34	34
15 – 18 years	58	58
Total	100	100
Awareness that inducing abortion outside the saving of lives was criminal		
Aware	83	83
Not aware	9	9
Indifferent	8	8
Total	100	100
Why teenagers induce abortion		
Avoidance of stigma	29	29
Avoidance of econ. burden	33	33
freedom to work	10	10
Freedom to enjoy themselves	17	17
Desire to maintain girlhood	11	11
Total	100	100
Who introduced adolescents to abortion		
partners	59	59
parents	13	13
friends	19	19
nobody	43	43
Total	100	100
Reasons for abortion outside hospitals		
Cant abort in the hospital	25	25
Out of hospital abortion does not lead to death	35	35
Even in the hospital abotees still die	30	30
A person will die when his time comes	7	7
No reason for inducing abortion outside hospitals	3	3
Total	100	100
Prevention of teenage pregnancies		
Parents to counsel young girls	13	13
Use professional counsellors	15	15
Improve family life education	35	35
Improve girl child parenting	4	4
Pay more attention to growing girl children	33	33
Total	100	100
Safeguards against teenage abortion		
Medical & counselling services	43	43
Recreational facilities	12	12
Preventive facilities	9	9
Free education	3	3
Parental socialisation	33	33
Total	100	100

Source: Author's Field Survey, 2011