Nigerian Journal of Clinical Practice
December 2009 Vol. 12 (4):443-449

PERCEPTIONS AND ATTITUDES OF A RURAL COMMUNITY TO ABORTION IN THE NIGER-DELTA REGION OF NIGERIA

***LO Omo-Aghoja, **VW Omo-Aghoja, ***FE Okonofua, ****O Aghedo, *****C Umueri, ******R Otayohwo, *******P Feyi-Waboso, ********CO Esume**

*Departments of Obstetrics and Gynaecology, *College of Health Sciences, Delta State University, Abraka, ** Oral and Maxillofacial Surgery, University of Benin Teaching Hospital, Benin city, *** College of Medical Sciences, University of Benin, Benin City, ****SERAC, Lagos, *****Central Hospital, Sapele, ******State School of midwifery, Amukpe, ******* Abia State University Teaching Hospital , Aba, ******** Pharmacology, College of Health Sciences, Delta State University, Abraka, Nigeria.*

ABSTRACT

Objective: To determine the perceptions and beliefs relating to unwanted pregnancy, family planning and abortion, and identify issues that can be leveraged to initiate positive attitudes towards family planning and abortion in the area.

Materials and Methods: Focus group discussions (FGDs) and in-depth interviews (IDIs) were conducted in Amukpe, Delta State, Nigeria. A highly motivated and well-trained team versed in the local language and culture conducted the FGDs and IDIs.

Results: There was unanimity that unwanted pregnancies was quite common amongst women of reproductive age group and constitute a significant problem in the community. Abortion, particularly in the hands of quacks was a major option to handling an unwanted pregnancy. Almost all agreed that their culture and religion abhors abortion, yet widely practiced because of the odium associated with an unwanted pregnancy in the community. The knowledge of the Nigeria National abortion law even amongst the health workers and teachers was generally poor. The participants agreed that there were problems and complications (often severe) including death associated with abortion in the community. It was largely agreed that contraceptive knowledge and usage was poor. The reasons adduced for this include lack of knowledge, lack of spousal consent, socio-cultural taboos and misconceptions, as well as economic reasons. It was suggested that imbibing positive family values by parents in their wards and government leveraging the socio-economic status of the community will go a long way to stemming the tide.

Conclusion: Unwanted pregnancy, unsafe abortion and abortion complications are reported to be common amongst women of reproductive age group in Amukpe community, whilst contraceptive awareness and usage is poor.

Key Words: Perception and attitudes, rural community, Abortion *(Accepted 17 December 2008)*

INTRODUCTION

Unsafe abortion continues to be a major public health issue that evokes social, cultural and religious sentiments and debates in all societies. This is particularly so in countries with restrictive abortion laws[1,2]. It is one of the leading causes of maternal mortality and morbidities[3,4]. As many as 53 million pregnancies are estimated to be terminated each year by induced abortion worldwide[5], while in Nigeria an estimated 610,000 abortions are performed yearly[5]. Many of these abortions are unsafe as they are performed by unskilled abortion care providers[6], and these unsafe abortions remain a major reproductive health concern in Nigeria and indeed most other parts of the developing world[7]. They are also a major contributor to maternal mortality, accounting for as many as 30-40% of maternal deaths in Nigeria and one in eight maternal deaths in the West Africa sub-region as a whole[7-9]. The provision of quality and accessible family planning services and post abortion care will contribute immensely to obviating the problems of unwanted pregnancy as well as reduction of maternal mortality and morbidity due to unsafe abortion. However, there are reports that clearly indicate that by the very way contraception and abortion are perceived, community involvement and participation is the gold standard to the initiation of an effective debate towards acceptance as seen with programmes aimed at reducing maternal mortality[10,11]. This is further buttressed by the fact that community practices and cultural beliefs play significant roles in decision making vital to women's reproductive health[12]. Community practices, cultural

Correspondence: Dr L O Omo -Aghoja
E mail:eguono_2000@yahoo.com

perceptions and beliefs are better explored using community based (in particular rural) ethnographic studies[13,14]. Oye-Adeniran et al[15,16] in their community based studies across urban and rural centers in Lagos and Edo states of Nigeria, revealed that Unwanted pregnancy and abortion constitutes a significant problem even at the community level. Analysis of the data revealed a high prevalence of unwanted pregnancy and abortion both in the rural and urban areas particularly among the youths (school girls), married women and single women. Data from Edo state revealed that the incidence of unwanted pregnancy was less common in rural areas compared to urban areas. It also revealed that unwanted pregnancy and abortion tends to be more rampant amongst the youths, particularly school girls. The implication of this disparity in behavior needs to be explored in further studies to seek the reasons for this variance. Additionally, the findings of the community and hospital based surveys undertaken by the *Campaign Against Unwanted Pregnancy* (CAUP) in collaboration with the *Guttmacher Institute (GI)* across eight states of the country revealed comparable enormity of the burden of unwanted pregnancy and abortion.[17] Clearly all these studies recommended the need for further researches across different communities to properly situate the dimensions and the issues involved, as there can only be effective debate and advocacy for safe abortion practices in manner that will not offend the respective sentiments expressed on abortion by various Nigeria communities if their attitudes and perceptions are clearly understood. It is against the foregoing background that we decided to embark on this study with a view to adding to the existing body of evidence and information on the views and perceptions of relevant *rural* community stakeholders in the Niger-Delta region of Nigeria relating to contraception, unwanted pregnancy and unsafe abortion. Such information will be useful for identifying relevant and culturally appropriate interventions for resolving the problem of unsafe abortion and increased uptake of contraceptive usage. In particular, programs that identify abortion as a community problem and that seek community participation in diagnosing the extent of the problem and designing relevant approaches for addressing the problem are more likely to be successful on the long term.

POPULATION AND METHODS

Project Site and Population

The study was conducted at Amukpe (an Okpe community in Sapele Local Government Area) in Delta Central Senatorial district of Delta State in the Niger-Delta region of Nigeria. The study took place between December 2005 and July 2006 with support from the Macarthur Foundation.

The settlement is rural with a few semi-urban enclaves, and has a population of nearly 71,356 people based on the 2002 National Population Commission census figures, with female population being 31,206. Women of reproductive age group (15-49 years) including adolescents comprise 60% of the female population. The only available government health facility is a comprehensive health center that is ill equipped and understaffed. Additionally, there are two other private clinics that rarely render family planning and safe abortion services. The main occupation here consists of factory work, fishing, hunting, subsistence farming and trading as well as low cadre civil service. Also, there is active commercial sex activity going on in the community. The unit of social organization is the family, which is patrilineal and patriarchal. The man is the head of the family and its breadwinner, while the woman is the procreator and housekeeper. Group of families who claim same ancestral descent or origin forms a kindred (or *ekwa*) and many kindreds form the village (or *okoh*). The Amukpe community is made up of fifteen *okohs* and the community is overseen by a community development Association made up of male representatives of the 15 villages from amongst whom an executive committee is elected.The Community Development Association is answerable to the paramount ruler of the Okpe Kingdom (the Orodje of Okpe) whose palace is located at Orerokpe, the administrative headquarters of the Okpe people to which the Amukpe community belongs. Other associations in the community include the women leaders group, the youth association and associations of the various trade groups. The opinion of the community development association supersedes every other group and final on community issues that arises from time to time, except in cases of appeals against any decision that are referred to the *Orodje*. Members of the community development association act as the gatekeepers to the community and they must grant permission for entrance into the community for any study of this nature. Local tradition and culture typical of the Okpe people dominates the reproductive practices in the study community.

METHODS

We conducted ten focus group discussions (FGDs) with different major segments and interest groups in the community. The groups were the leaders of the community men, the leaders of the community women, market women's group, motor bike riders group, the in school adolescents' group, out of school adolescents' group, the religious leader's group, health workers group, teachers and the oil workers group. There were between 5-10 participants in each focus group discussion and each lasted 45 minutes to one hour. Subjects were recruited from those

responding to a printed invitation displayed at the central community hall and or public announcement by a local town announcer. Participants were stratified by age, educational and marital status. The FGDs helped identify perceptions and beliefs relating to the opinions that are held about unwanted pregnancy, family planning and abortion, and identify issues that can be leveraged to bring about positive attitudes towards family planning and abortion in the community. Ten In-depth interviews (IDI) were held with the head person of the various groups, and these included: community leaders, religious leaders, women leaders and heads of major health institutions. The IDIs lasted an average of 45 minutes each. This helped determine the quality and availability of services for family planning and abortion care in the area. Additionally, it helped identify key persons that could be used as political entrepreneurs to build community consensus for increasing women's access to family planning and abortion care in the area. It also provided greater insight into community practices, reproductive beliefs and customs. Leaders and or officers of the various groups were recruited for the IDIs, while other members were recruited for the FGDs. This was done to forestall domination of the FGDs by the officers and or leaders and to get more in-depth views and perceptions of the leaders. All FGDs were led by the same moderator and observer. In order to ensure active and informed participation in this study, visits were made to the traditional rulers and opinion leaders in the communities. The nature and rational for the study was fully explained to them. In order to avoid violation of participants rights, due consent was obtained from participants and permission from community leaders before recruitment. Study was approved by the ethics committee of Delta State University Teaching Hospital. Written consent from the State's Ministry of Health was also obtained. A topic-guide containing ten semi-structured, open-ended questions about knowledge, experiences, attitudes and reflections on unwanted pregnancy, family planning and abortion was used. A highly motivated and well-trained team versed in the local language and culture conducted both the FGDs and the in-depth interviews. All FGDs and in-depth discussions were led by same moderator and 2 observers (taking field-notes). They were conducted in the local language or Pidgin English as appropriate, and audiotaped. All participants were informed about the purpose of the study and the basic rules of discussion. To facilitate analysis, the moderator and the observers at the end of each session summarized the statements made to confirm that they had understood participants correctly and to allow an opportunity for clarification. The audiotaped discussions were then transcribed and analyzed for both content and form. In particular, we triangulated the results obtained from FGDs and the in-depth interviews, to make inferences and conclusions about the socio-cultural perceptions and attitudes towards family planning and abortion in the local community.

Analysis

The data were analyzed by manifest content analysis[18]. A number of major themes and ideas emerged from the data, which was discussed and confirmed by the research team. A coding frame was developed to identify the repeating themes. Quotations are used to illustrate and illuminate the findings being discussed. Once consensus was reached on theme codes, the investigators reread the transcripts, compared their theme codes and discussed any difference in opinion. Themes/codes were compared across groups and were ranked in priority order, higher priority being given to issues expressed by the majority of participants or less commonly held views that generated a lot of discussion.

RESULTS

Two main themes and 6 sub-themes were identified and are presented in table 1 below. This is followed by the text of the sub-themes.

Knowledge, Experiences and Attitudes: Unwanted pregnancy

The participants in the respective FGDs and the respondents in the respective IDIs were in unanimity that an unwanted pregnancy was quite common amongst women of reproductive age group and constituted a significant problem in the community. All the groups discussed the fate of an unwanted pregnancy and the options of managing the situation. Three modalities of resolving an unwanted pregnancy mentioned were: that abortion was the commonest option resorted to, a few others will deliver and raise the child as a single parent and yet a third group will choose to abandon the babies. The adolescents did not think that the issue of single parenthood was a big issue as they all seem to express the position that after all their parents help in upbringing and care of the child. But on the contrary the respective adult groups were quite worried about the trend because of the added burden in particular that of financial demand it places on them and that it is a shameful act that brings the family name to disrepute. The enormity of unwanted pregnancy and its consequences were commonly summed up by the participants and respondents in the respective groups in the phrases captioned below as consensus views expressed. *"Unwanted pregnancy is major problem plaguing our girls and women, indeed a lot of them still find themselves in this situation despite the associated consequences"*. *"Single parenthood is extremely common and constitutes a serious problem that can be likened to an epidemic as most of the*

youths in the community have children without being married". "Sometime ago a woman picked up a child wrapped in a piece of cloth in the bush with deep cuts all over him and was already invaded by giant bush ants". "A woman was once found bleeding with retained placenta in the bush after she had delivered herself of a baby and neatly buried him". "We pick up abandoned babies by the side of our popular burrow pit almost on a daily basis.

Abortion

The participants and the respondents reported that abortion was a major problem in the community and consistently in all the groups they mentioned that it was one of the main means of resolving the issue of an unwanted pregnancy. Common places where abortion was undertaken was mentioned to include private clinics, chemists, nurses private homes, doctors private homes and homes of traditional medical care providers as well as those of traditional birth attendants. While a few of the abortion seekers use various forms of local and orthodox medications to attempt self procurement of abortion. Respondents in majority of the groups reported the very painful way a law school student who is a daughter of a prominent community chief died following self-procurement of abortion and it was succinctly put this way *"only about a month ago, a daughter of one of our chiefs took a lot of local gin mixed with camphor to terminate an unwanted pregnancy, she lapsed into unconsciousness and died on the way while being rushed to hospital".*

All groups discussed advantages, disadvantages and complications of abortion. Some respondents particularly amongst the out of school adolescents and the community leaders (men and women) thought abortion was beneficial and a means of family planning and indeed consider it as safer than family planning drugs and devices. While a larger proportion of the respondents in the different groups knew abortion was associated with complications and often severe. Complications mentioned were: infection, incomplete abortion, bleeding, abdominal pain and swelling as well as death. Others are Vesico vaginal fistula (*a nursing superintendent in charge of the comprehensive health center situated in the community reported seeing a case of junior secondary school girl where the entire anterior vaginal wall had been removed*), infertility, amenorrhea and other menstrual disturbances, anemia, uterine injury/damage with hysterectomy in some cases.When the religious and cultural perceptions about abortion were discussed, it was a general consensus amongst the respondents that their various religious affiliations see abortion as a bad act, and that the tenets of each faction either orthodox or traditional abhor it. The participants from the respective groups also reported that culturally abortion is seriously frowned at and before Westernization, it was considered a taboo of the highest form. But the adult groups in particular the community leaders (men and women) are quick to add that when their wards do get pregnant and they don't want it particularly when the child is likely to be illegitimate, they go ahead to terminate it because of the odium associated with such scenario. Only a few individuals consider abortion as beneficial and have nothing against it. The participant's knowledge of the Nigeria National abortion law was poor. Only some respondents from the health workers and teachers groups knew about the law. *"Most of the respondents queried that how can there be a law governing abortion in the country, when it is freely done by all and sundry while a few others across all groups believed that the law permits abortion to be done".* Only a few of the respondents even amongst the health workers and teachers group were aware that the law was restrictive and called for its liberalization.

Contraception

Contraception as means of preventing unwanted pregnancy was discussed. Participants in the respective adult groups (teachers, health workers, market women, leaders of community men, leaders of community women and religious leaders as well as motor bike riders group) reported that the contraceptive awareness in the community was poor. On the contrary but interestingly, the female adolescents (in-school and out-of-school) reported that contraceptive awareness was high in the community while the male adolescent had very little input in this regards. However, a more detailed discussion unveiled limited knowledge of correct contraceptive methods. The mentioned agents wrongly listed as contraceptives by the adolescents include bitter lemon drink, local gin and spirits, quinine bisulphate, Andrew's liver salt as well as becodeine tablets amongst others. Additionally, it was a consensus amongst respondents of the respective FGDs and IDIs that contraceptive usage was poor. The reasons adduced for this include lack of knowledge, lack of spousal consent, cultural taboo (*"the generality of the participants insisted that contraception is cutting short the number of children freely given by God and hence the person runs the risk of bareness when reincarnated in subsequent lives"*), desire for large family size (*the religious leaders unanimously echoed that "indeed we don't dear preach about limited family size and contraceptive usage as it is against their culture"*), an only child syndrome (the female respondents particularly in the community leaders group, retorted by saying *that when their husbands is an only child, that the onus is on them to bear all the brothers and sisters he did not have from his parents*), and fear of side effects (a market woman leader who had only secondary school education put it this way: *"We were told that*

contraceptives destroy the womb & prevent women from having children later in life" and a female school teacher puts it this way "I am aware that it causes a lot of other health problems in women"). Other reasons include religious impediments, wrong information by neighbors, friends and relations, cost/financial incapability, family planning drugs /devices are believed to induce infertility and paucity of family planning service delivery outlets. A few indeed believe that abortion is safer than family planning drugs/devices and some say that repeated pregnancy is a means of assessing their continued fertility.

Gender perspective

The female adolescents expressed extreme worry about unwanted pregnancy and abortion. Because they all agreed that these have often resulted in severe health complications including infertility in the long term, and a possibility of drop out of school thereby leaving them in a deeper level of poverty than that which had led them to engage in premarital sex to make ends meet. The society also brand girls with unwanted pregnancy as tramps or slut and the family looked at them with disdain. On the other hand, a boy that is dating several girls and causing unwanted pregnancies might be branded a "player" or a macho man, but he would still gain respect. The male adolescents (in-school and out-of-school) had poor knowledge of family planning methods and they were unanimous in expressing unwillingness to use condoms when this was discussed. The expressed attitude by them is that of not being bothered as they do not bare the brunt of unwanted pregnancies. Majority of the male adolescent participants asserted that they would not marry girls who have had an unwanted pregnancy or known to have had an abortion previously.

Suggested interventions

The general opinion was that there was an urgent need for intervention to help address the poor reproductive health status in this community. Participants emphasized the importance of these interventions to be at two levels- interventions at the community level and governmental interventions.

Community interventions

The consensus of participants of all groups is that the community needs to start encouraging and promoting the concept of couples limiting the size of their family from the present trend of large family size to the number they can effectively cater for. Proper parental child upbringing and imbibing of positive values by example by parents was emphasized, in particular cultural and religious tenets that abhor fornication.

Governmental interventions

All focus groups and in-depth interviews agreed that the government needs to complement the community interventions for meaningful impact to be made. The overall suggested interventions for government include - provision and creation of jobs to economically empower the community inhabitants, creation of enabling environment for individuals and multinationals to set up industries and business concerns, enunciating policies and programmes that creates room for gender equity in employment, free education and or subsidized education by way of bursary or scholarships (in particular to the girl child) and provision of free skills acquisition centers for out of school adolescents in a manner akin to the free education policy.

Additionally, government should sponsor community mobilization and sensitization programmes aimed at passing appropriate sexual and reproductive health information to the public (with particular emphasis on the men folk as to why they should encourage the use of contraceptives by their wives and daughters), inclusion of sexual and reproductive health education in the secondary school curriculum, provision of more health centers and establishment of functional, accessible as well as affordable family planning service delivery outlets.

DISCUSSION

This study clearly demonstrates that unwanted pregnancy and unsafe abortion are widespread in this community, despite the reported high incidence of far reaching reproductive health sequelae including mortality. This is not different from the reports of the surveys undertaken in Nigeria by Oye-Adeniran et al and *Campaign Against Unwanted Pregnancy (CAUP)* in collaboration with the *Guttmacher Institute (GI)* across several states of Nigeria[15-17,] and also consistent with the findings of the qualitative surveys undertaken in India, Pakistan and Zambia[19-21]. This gives further credence to the well established view that abortion is one of the neglected problems of health care in developing countries[22].From the respective focus group discussions and in-depth interviews, what came out unambiguously was that abortion in this community is a response to an unwanted pregnancy which is consistent with reports from other surveys[22-29].Interestingly the leading reasons adduced as to why people seek abortion, are highly amenable to consistent and proper contraceptive usage. Unfortunately, it is equally reported by the respondents that for a number of largely social, cultural and

Table 1: **Identified Main Themes and Sub-Themes.**

Theme	Sub-theme
Knowledge, experiences and attitudes	Unwanted pregnancy
	Abortion
	Contraception
	Gender perspective
Suggested interventions	Community level intervention
	Governmental intervention

religious reasons, members of this community are dissuaded from practicing and using contraception. This is similar to reports from other studies[30,31]. This underscores the fact that a comprehensive sexuality education with a well articulated contraceptive program in this largely under-served community is a sine quanon. Additionally, the operative dynamics of abortion in this community from the responses given by the participants of the respective FGD and IDI shows that it is consistent with that from a milieu of restrictive abortion laws. WHO[32] had reported in 2000 that it is characterized by inadequacy of skills on the part of the provider and use of hazardous techniques and unsatisfactory facilities. Concluding that women who resort to clandestine facilities and /or unqualified providers put their health and life at risk. This is the ugly scenario in this community. Again it must be said that best available evidence[33], have not demonstrated that restrictive laws prevents abortion or reduce the incidence rather it only succeeds in driving it underground with backstreet professionals taking the center stage with significant havoc inflicted on the women folk[34,35], as clearly exemplified by reports from this community survey.

Compounding this situation further, is the negative impact of cultural and religious beliefs on the usage of contraception which is an age long established mode of preventing unwanted pregnancy and therefore a primary prevention against abortion. Incidentally, despite the perceived religious and cultural persuasion upon which non-usage of contraception is based, the respondents were in unanimity that if their wards get pregnant, they were more likely to opt for abortion as a result of the odium associated with unwanted pregnancy. It therefore implies that if developing countries particularly sub-Saharan Africa must achieve the target of the millennium development goal of reducing maternal death by 75% by 2015 then there must be concerted efforts at putting in place a well thought out cultural and religious sensitive interventions aimed at breaking the conspiracy of silence over these norms that have remained impediments over the years. These would largely be in line with the suggestions of the respondents that there was a need for sustained community sensitization, mobilization and educative programmes that would optimize the reproductive health outcomes of women in largely underserved communities of developing nations. In summary, it was a general consensus by all that there is an urgent need for far-reaching social changes that will aim at increasing female autonomy, female economic power and the value of the girl child as the pivot that are likely to make a significant impact on the sexualand reproductive health of women in this community.

This is certainly advocated for high priority attention. To arrive at this point the duo of government and the community are advised to work in consonance to arrest these highly preventable plaques of unwanted pregnancy and unsafe abortion. Community acceptance of small family size (which is a function of contraceptive usage), and imbibing positive cultural values in their children are also recommended by the respondents. In, particular concerted and deliberate efforts at re-orienting the community's (especially men's) perception of family planning and improved usage will tremendously assuage the problems sequel to unwanted pregnancy and unsafe abortion.

ACKNOWLEDGEMENT

We are extremely grateful to the Macarthur Foundation for providing the funds with which this study was undertaken. However, the findings and interpretations therein were in no way influenced by the Foundation. We would also like to thank Mr. Kingsley Iriferi who was instrumental to our linkages, smooth entrance into the community and indeed served as interpreter on a number of occasions.

REFERENCES

1. **Chandrasekhar S.** Indian's Abortion Experience. Denton: University of North Texas Press; 1994.

2. **Mundigo AI**. Determinants of unsafe induced abortion in developing countries. In: preventing Unsafe Abortion and its Consequences: Priorities for Research and Action. Warriner IK and Shah IH (eds). New York: AGI; 2006: 51 - 72).

3. World Health Organization. Global and Regional Estimates of Unsafe Abortion and Associated mortality in 2000. 4th ed. Geneva: World Health Organization; 2004.

4. **Alan Guttmacher Institute** (AGI). Sharing Responsibilities: Women, Society and Abortion Worldwide. New York: AGI; 1999.

5. **Henshaw SK, Singh S, Oye-Adeniran BA, Adewole IF, Iwere N, Cuca YP.** The incidence of induced abortion in Nigeria. Int. Family Plan Perspect 1998; 24 (4): 156-164.

6. **Oye-Adeniran B, Umoh AV, Nnatu SNN**. Complications of unsafe abortion: A Case Study and the Need for Abortion Law Reform in Nigeria. Reproductive Health Matters 2002; 10(19):18-21.

7. **Adewale IF.** Trends in postabortal mortality and morbidity in Ibadan, Nigeria. Int. J. Gynecol Obstet 1992; 38 (2): 115-8.

8. **Okonofua FE, Odimegwu C, Ajabor H, Daru PH, Johnson A.** Assessing the prevalence and determinants of unwanted pregnancy and induced abortion in Nigeria. Stud Fam Plann 1999; 30:67-77.

9. **Whitaker C, German A.** Safe abortion in Africa: ending the silence and starting a movement. Afr. J. Reprod. Health 1999; 3 (2): 7-10.

10. **Maine D.** Safe motherhood programmes. Options and Issues. 1991; Pp 37-40.

11. Shehu DJ. Community participation and mobilization in the prevention of maternal mortality in kebbi, North Western Nigeria. In: Safe motherhood initiatives: Critical Issues, (1st edition). Berer M and Sundari TK (eds). Ravindian.

12. **Odimegwu C, Adewuyi A, Odebiyi T, Aina B, Adesina Y, Olatubara O et al**. Men's Role in Emergency Obstetric Care in Osun State of Nigeria. Afr. J. Reprod. Health 2005; Vol. 9 (3): 59-71.

13. **Krueger RA, Casey MA.** Focus Groups: A Practical Guide for Applied Research (third edition), by Richard A. Krueger and Mary Anne Casey, 1988; Newbury Park: Sage Publications.

14. **Debus M, Porter Novelli** Handbook for Excellence in Focus Group Research, Washington: (1986) Academy for Educational Development, Healthcom.

15. **Oye-Adeniran BA, Adewale IF, Umoh AV, Ekanem EE, Gbadegesin A, Iwere N.** Community-based survey of unwanted pregnancy in southwestern Nigeria. Afr J Reprod Health. 2004 Dec: 8 (3): 103-115.

16. **Oye-Adeniran BA, Adewale IF, Umoh AV, Iwere N, Gbadegesin A**. Induced abortion in Nigeria: findings from focus group discussion. Afr J Reprod Health. 2005 Apr: 9 (1): 133-141.

17. **Bankole A, Oye-Adeniran BA, Singh S, Adewale IF, Wulf D, Sedgh D et al.** Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences, New York: Guttmacher Institute, 2006

.18. **Burnard P.** A method of analyzing interview transcript in qualitative research. Nurse Educ Today 1991; 11:461-6.

19. **Varkey P, Baakrishna PP, Prasad JH, Abraham S, Joseph A.** The reality of unsafe abortion in a rural community in South India. Reproductive Health Matters 2000; 8(16): 83 - 91.

20. **Koster-Oyekan W.** Why resort to illegal abortion in Zambia? Findings of a community-based study in Western Province. Social Science and Medicine 1998, 46 (10): 1303-1312.

21. **Saleem S, Fikree F.** A community and hospital based study to examine the magnitude of induced abortion and associated gynaecological morbidity in Karachi, Pakistan. Population council 1998, 1 Dag hammarakjold plaza, New York, NY 10017.

22. **Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al**. Unsafe Abortion: the preventable pandemic. Lancet. 2006: 25; 368 (9550): 1908-19.

23. United Nations Population Fund. The State of the World Population 1997. New York: UNFPA; 1997.

24. United Nations Development Program. Levels and trends of contraceptive use as assessed in 1998. New York: UNDP; 1998.

25. **Westoff CF, Bankole A.** Trends in the demand for family limitation in developing countries. Int Fam Plan Perspect 2000; 26(2): 5662, 97.

26. **Otoide VO, Oronsanye F, Okonofua FE**. Why Nigerian adolescents seek abortion rather than contraception: evidence from focus group discussions. Int Fam Plann Persp 2001;27(2):77-81.

27. **Keele JJ, Forste R, Flake DF.** Hearing native voices: contraceptive use in Matewe village, East Africa. Afr J Reprod Health 2005; 9(1):3241.

28. **Black T.** Impediments to effective fertility reduction. Br Med J 1999; 319:932-33.

29. **Marston C, Cleland J**. Relationships between contraception and abortion: a review of the evidence. Int Fam Plan Perspect 2003; 29(1):613).

30. **Ba-Thike, Katherine.** Abortion: A Public Health Problem in Myanmar Reproductive Health Matters. May 1997. No. 9. P. 94-100. Location: SNDT Churchgate.

31. **Bankole A, Singh S, Haas T.** Reasons why women have induced abortions: evidence from 27 countries. Int Fam Plann Perspect 1998; 24:117-27 and 152.

32. World Health Organization. Unsafe abortion: global and regional estimates of the incidence unsafe abortion and associated mortality in 2000. 4th edition. Geneva Switzerland: world Health 2004.

33. **Allan Guttmacher Institute.** Issue in Brief. An overview of clandestine abortion in Latin America. 2000.

34. **Ganatra B, Johnston HB.** Reducing abortion-related mortality in South Asia: a review of constraints and a road map for change. J Am Med Women's Assoc 2002; 57**:**159-64.

35. **Graham WJ, Campbell OM.** Maternal health and the measurement trap. Soc Sci Med 1992; 35:967-77.