



## SEXUAL BEHAVIOUR, UNWANTED PREGNANCY AND TRIPARTITE LEVELS OF DECISION-MAKING REGARDING INDUCED ABORTION AMONG NIGERIAN UNIVERSITY STUDENTS

**John Lekan OYEFARA,**

*Department of Sociology*

*Faculty of Social Sciences*

*University of Lagos*

*Akoka, Yaba, Lagos, Nigeria.*

*E-mails: loyefara@unilag.edu.ng or oyefara@yahoo.com*

### ABSTRACT

*This study examines factors that influence sexual behaviour, unwanted pregnancy and decision-making regarding induced abortion among Nigerian undergraduate students using University of Lagos as the study location. The in-depth interview research method was adopted to achieve the objectives of the study. The findings of the study reveal a high level of sexual networking and unwanted pregnancy among students. In addition, there are three types of decisions to be taken when an unwanted pregnancy is to be terminated by undergraduate students. The three decisions are: the decision to terminate the pregnancy, the decision on the nature of the method to be used to terminate the pregnancy, and the decision on the place where the pregnancy will be terminated. These three decisions are guided by other tripartite factors which are structural, personal, and operational in nature. The study further reveals that most of the decision-making regarding induced abortion by undergraduate students were done without proper consideration of associated operational factors. Consequently, most of the procured induced abortions were carried out in a clandestine, hasty, and unsafe condition. These findings suggest the need to develop appropriate intervention programmes to educate Nigerian undergraduate students that are sexually active on the need to consistently adopt efficient contraceptive methods in order to prevent unwanted pregnancies. In addition, students must be enlightened to consider safety in their decision-making regarding induced abortion.*

**Key words:** *Sexual Behaviour, Unwanted Pregnancy, Decision-making, Induced Abortion, University Students, Nigeria*

### INTRODUCTION AND BACKGROUND OF THE STUDY

Historically and more importantly in the traditional sub-Saharan African society, issues around women fecundity and reproduction are sacred and treated with utmost care and respect. This historical context coupled with negative empirical medical evidence associated with induced abortion has made researchers in the health and behavioural sciences to concentrate and give substantial attention to the various intricacies surrounding the phenomenon of induced abortion in the continent. For the demographers, the incidence and trends of induced abortion have a significant direct impact on the level of fertility, morbidity, mortality, population size and growth rates in general, while in the sociological parlance, the whole gamut of the social structure, relations, interactions, and expectations can be seen as correlates of the phenomenon, as its consequences threaten the whole essence of human beings and the existence of humanity. Globally and instinctively, it has been acknowledged that pregnancy is deemed a desirable phenomenon across socio-cultural divides but a situation where a pregnancy is considered unwanted to the extent that it becomes necessary to terminate the same through induced abortion is antithetical to the notion of its desirability.

Unwanted pregnancy is the sole dominant underlying cause of induced abortion and the incidences of unwanted pregnancy can and do occur among women notwithstanding their social, demographic, and economic background. However, its proportion seems to be significantly high among young unmarried adolescents and youths universally. In sub-Saharan Africa, especially in Nigeria; the most populous country in Africa, unprotected sex is the fundamental cause of



unwanted pregnancy. Consequently, the issue of unprotected sex, unwanted pregnancy, unsafe abortion, and the likely consequent post-abortion complications among university students and students of other institutions of higher learning is indeed a major social, medical, and reproductive health problem in contemporary times in sub-Saharan Africa in general and in Nigeria in particular. Most of these students are young adults or adolescents who just start to discover and explore their sexuality behaviour at the youthful age grade of the human life cycle. This stage is often typified by confusion, mixed messages from different media, peer pressure, exuberance, and a penchant for experimentation especially with drugs, alcohol, and sex. As noted in the literature, for most people, the period of adolescence is critical in the upsurge of sex drives, the development of sexual values, and the initiation of sexual behaviour (Moore & Rosenthal, 1993).

There is a consensus in the literature that people in this age grade engage in high risk sexual behaviour, which predisposes them to different reproductive health challenges, including unwanted pregnancy. Indeed, as Lear (1997) has noted, young adults and college (university) students are more likely to experiment sexually, often with multiple partners without using any form of protection such as condoms on a regular basis. Usman (1997); Harrison (1997); and Oyefara (2011) posit that there is an evidence in the literature that unintended pregnancy, maternal mortality, and sexually transmitted diseases are much higher among this segment than others in various societies. Underscoring this view, Moore & Rosenthal (1993) stated that "youths are among the segments of the population whose sexuality and reproductive health practices are of particular interest because they are known to engage in intense sexual activities." Onwuamanam (1982) listed five types of sexual behaviours identifiable among young adults to include - kissing, breast/genital fondling, embracing, holding, and sexual intercourse. These sort of behaviours are prevalent among many university students in Nigeria.

Alubo (1990) notes that in Nigeria, as indeed in most of Africa, the transition from one period of the life cycle to another, which used to be traditionally marked by the prescribed rite of passage - which involves, above all else, the moral and behavioural code for the next phase of the life cycle - has since been changed by the introduction of Western education and Christianity amongst other factors. The latter frowns at such rites and considers them either barbaric and/or paganistic; enrolment in school meant that most youths were no longer available for such rites of passage as and when they normally should, and may eventually outgrow the appropriate age grade prescribed for such social rituals. Furthermore, education has made it possible to leave home early and this development freed the youths from the overbearing presence of the elders who had hitherto directed and sought to control their behaviour. Education also brought with it new values about life, especially in relation to the individual's choice especially in love and marriage. These new values were different, and in many instances, contradictory to traditional ones. Consequently, values about prohibition of premarital sex and the power of the elders may no longer make much sense in contemporary times to the youths. More recently, the development of satellite broadcasting has given the youths access to a broader marketplace of competing and often contradictory values; widening their individual choice among various unique values bordering on love and marriage.

Sex, in essence plays an important role in young people's (especially adolescents') feelings, fantasies, and relationships. Many young people's pregnancy are the result of inadequate or no contraception (Edjah, 1999). One major factor according to Edjah (1999) and Oyefara (2011) contributing to the high rate of teenage and young people's pregnancy and abortion is the relatively low level of contraceptive use. The authors further identified that, most young females' non-use of preventive measures against unwanted pregnancy is due to their non-use of



contraceptive methods which oftentimes induces them to indulge in induced abortion. To them, abortion becomes the most viable alternative since the pregnancy seems a burden. They therefore suggest the need for people to take active precautionary measures than to get an unwanted pregnancy only to indulge in abortion. This according to them will stem the tide of reproductive health hazards attached to abortion.

The term 'abortion' has been defined expressly by Norton & Walls (2001:13) as "the premature termination of a pregnancy at any stage." Lucas (2000) sees abortion "as the abrupt removal of foetus without completion of its circle" while Pressat (1985) defines it as the termination of pregnancy before the foetus becomes capable of sustaining an independent extra-uterine life i.e. while the foetus is non-viable. Thus, an abortion may occur either spontaneously in the course of a pregnancy, which is known as a miscarriage; or it may be due to a deliberate outside intervention, which is termed as induced abortion. Therefore, whether spontaneous or deliberate, abortion refers to any pregnancy that does not end in a live birth. In contemporary times, abortion is one of the most common gynaecological experiences; induced abortion normally involves a surgical or non-surgical/medicinal procedure that terminates a pregnancy by removing the foetus before the end of the gestation period (Shah & Ahman, 2010).

Decision-making regarding induced abortion within the Nigerian socio-cultural context is complex and remains a big challenge for a woman with an unwanted pregnancy including her sexual partner. There is a paucity of studies in this area in the country most especially among the adolescents and young people in the tertiary institutions of learning, thus the objective of this paper is to provide seminal ideas in this area of study by critically examining those factors that influence decision-making regarding induced abortion among undergraduate students in Nigeria and the possible effects of these factors on whether to seek abortion, where and when to seek abortion, and some of the consequences associated with any decision taking regarding induced abortion among students of tertiary institutions of learning in the country.

### **Brief Literature Review**

Induced abortion is conceived of as a deliberate termination of pregnancy or the intentional expulsion of an unborn child from the womb for a purpose not connected to the removal of dead tissues (Aniekwu, 2003). The foregoing definition suggests that induced abortion is different by its intent and purpose from an abortion performed for the purpose of evacuating dead tissues or carried out for the sole purpose of saving the life of a pregnant woman (Bankole et al., 2006). In most developed societies in Europe and North America, abortion is legal and generally permitted on broad grounds; whereas in many developing countries especially in Africa, abortion laws are highly restricted and permitted only on conditions such as to save a woman's life (World Health Organization, 2012).

However, in many developing countries where abortion is illegal and not generally permitted on broad grounds, evidence indicates that many perform it under surreptitious and sometimes, unsafe conditions, with its associated risks and negative consequences (Bankole et al., 2006). In Nigeria for instance, abortion is illegal and only officially permitted if it is intended to save a woman from the risk of death. Yet, hundreds of thousands of abortions are carried out each year by many private hospitals and clinics; and many others are carried out in unsafe conditions by quasi medical practitioners that do not possess the requisite training (Makinwa-Adebusoye, Singh, & Audam, 1997). Under this condition, women are likely to be exposed to life-threatening post-abortion complications that endanger their reproductive health.



Bankole et al. (2006) observe that induced abortion is widespread in Nigeria, and its practice takes many forms. The authors note that the surreptitious manner in which many abortions are performed makes it somewhat difficult to access reliable official statistics on the phenomenon, but they opined from estimates that among many Nigerian women of reproductive age, one-in-seven or 14 per cent have tried to have an abortion; while 10 per cent actually carried it out and ended an unwanted pregnancy. The authors further revealed that an estimated 760,000 induced abortions occur annually in the country, and that almost nine in 10 Nigerian women who have had an abortion did so before 12 weeks of gestation (Bankole et al., 2006). Abortion has been observed as constituting a worldwide phenomenon and an important method of fertility control which has been in existence from ancient times (Luker, 1975).

Extant literature suggests that abortion occurs in virtually every society; and that for most societies and individual families, abortion has been one of the most frequent responses to population pressure. However, it appears the phenomenon only began to enter scientific discussions only recently, approximately in the late 1960s and early 1970s (Sachdew, 1975). Aniekwu (2003) and Luker (1975) suggest that interest in abortion increased in the course of attempts to examine early or immediate complications, maternal mortality as well as the optimisation of abortion techniques. It can therefore be suggested that during this period, the interest in abortion research was dominated by the need to assess the consequences of induced abortion. An addition to this is Luker's (1975) insistence that abortion at the time was propelled essentially by the need to understand women's attitude towards contraceptives, because many researchers were interested in understanding why some women allow unwanted pregnancy to get to the point of abortion instead of adopting contraceptives. Some other sources maintain that the interest in abortion research was prompted more by its consequences than any other reason. Few researches, if any, considered the issue of the abortion decision-making dynamics, until a few years back (Crock, 2007).

This paper is generally concerned with decision-making regarding abortion. A number of reasons have been adduced on why women carry out abortion. Some of them include, career issues, that is, the likelihood of the pregnancy to disturb the plan or career of the woman; marital status, some women were reported as saying they aborted because they were unmarried and single and would not want to be single parents or give birth to a child out of wedlock; while some indicated that they do not want any more children, thus the need to abort. For others, economic difficulties featured as the main reason for abortion (Bankole et al., 2006; Huber et al., 2016; Mugore et al., 2016).

### **Theoretical and Conceptual Framework of the study**

The explanation of findings of this study is anchored on the Theory of Rational Choice. The rational choice theory is a relatively formal approach to sociological and social science theorising in which it is maintained that social life is principally capable of explaining the "rational choices" of individual actors (Coleman, 1989). As noted by Elster (1989), when faced with several courses of action, people usually do what they believe is likely to have the best overall outcome. This deceptively simple sentence summarises the theory of rational choice. Thus, the idea of "rational action" has generally been taken to imply a conscious social actor engaging in measured calculative schemes. It is a notable argument that human behaviour is not totally spontaneous and free but determined. Rational choice is about choice based on reason. In rational choice theories, individuals are seen as motivated by the needs, wants, or goals that express their preferences (Hollis, 1987). Rational behaviour needs the formulation of a problem that is quantifiable and measureable. Rationality factors in how much information is available. Assertion of rationality without stipulating the background model assumptions describing how the problem



is framed and formulated is meaningless. The rational choice method or model can be used in understanding the decision-making endeavours regarding induced abortion among university students in Nigeria.

Deriving from this theory, the conceptual framework of the study can be seen on Figure 1. As presented in the framework, decision-making regarding induced abortion is multifaceted and multi-dimensional and it is being governed by rational thinking, negotiation and re-negotiation intra-and-between individuals. This decision-making process commences right from the socio-structural and environmental context of sexual behaviour and sexual networking among the students as projected and explicated in the framework.

The university environment globally is a learning one where diverse ideas and people with diverse socio-economic backgrounds and races conglomerate for the purpose of pedagogical, ontological, and epistemological advancement. In addition to intellectual development, there are other social and sexual activities that are peculiar to the ivory tower such as clubbing, aristo, formation and joining of different associations, etc. Invariably, learning will take place through the observation, modelling, imitation, and adoption of new behaviour. At the first stage an individual may decide, after putting various factors into consideration, to have sexual intercourse and not to adopt an efficient contraceptive during sexual intercourse which may result into an unwanted pregnancy.

Unwanted pregnancy is an unplanned, unexpected, and unanticipated phenomenon that the human instincts will desire to make a quick decision about within the context of the short and long term goals, objectives, and aspirations of the individuals in question and more importantly considering the associated stigma of the incidence. The second stage of the decision-making process will involve consideration of the pros and cons on whether to keep the pregnancy or to abort it. The final decision at this stage will be directly influenced by the socio-structural and environmental context of the individual sexual behaviour and sexual networking. It is imperative to note that the social cognitive theory assumes that individuals want to maximise their gains from the environment thus they are motivated to gain the maximum reinforcement and minimum punishment from their environment which will dominate the process of decision-making at this stage. If the decision at this second stage is to abort the pregnancy, this will lead to the third stage of the decision-making process regarding induced abortion. This third stage ordinarily should be guided by reasoned action theory where the attitude toward a behaviour and subjective social norms leads to the formation of intention and actual execution of the behaviour. The decision to abort as presented in the framework ought to be a conscious calculation and consideration of three important factors which are structural, personal, and operational in nature. Decision-making at this stage will inform the nature, location, and expertise of the operator of the induced abortion. Right and appropriate decision-making at this stage will determine whether the abortion will be safe or unsafe. The possible outcomes, if the abortion was unsafe, are social, medical, and psychological in nature as presented in the framework. This conceptual framework will guide various explanations of the findings of the study in the subsequent sections of the article.



## METHODS

### ***Research design and study setting***

The study employed an exploratory research design which entailed of the in-depth interview research method in order to generate both reliable and valid qualitative data that will serve as seminal information on the topic of the study. The adoption of this explorative method was to document initial findings that can lead to larger scale quantitative studies on the topic. The study location is the University of Lagos, Lagos, Nigeria, thus the study utilised data generated from cross-sectional in-depth interviews with students of the university. This university was established in 1962 as a federal institution of higher learning. The detailed planning of the university was assigned to the UNESCO Advisory Commission set up in 1961 at the instance of the Nigerian federal government. The Institution was sited at Yaba (Akoka area) in the then Federal Capital Territory, Lagos. The school started with three faculties namely: Faculties of Medicine, Commerce and Business Administration, and Law. Later in 1964, the discipline of social studies was added to Business Administration. Additional faculties were also established and they were the Faculties of Arts, Education, Engineering, and Sciences. In 1965, the Faculty of Sciences was separated from the Faculty of Engineering and this made room for the Faculty of Social Sciences. Presently, there are eleven faculties and a college in the University of Lagos. These are Faculties of Arts, Business Administration, Education, Engineering, Environmental Sciences, Law, Sciences, Social Sciences, Clinical Sciences, Dental Sciences, Pharmacy, and the College of Medicine. It is instructive to note that faculties of Clinical Sciences, Dental Sciences, Pharmacy, and the College of Medicine are located at Idi-Araba, a distance of some 10km, while the other 8 faculties are located at Akoka. Both locations are within the Lagos metropolis, Nigeria. The campus in Akoka is referred to as the main campus.

### ***Study population and participants' selection***

The study population comprises of both male and female undergraduate students of the University of Lagos. To be eligible, the respondent must have procured at least one induced abortion personally. Thus male respondents are those ones that have procured induced abortion for their female partners, while the female respondents are ladies that had procured abortion personally before. Using purposive and snowballing sampling methods, a total of 40 (24 female and 16 male students) were selected and interviewed for the study. The adopted sampling method allowed us to select our respondents on the basis that they were relevant and available for the study. In the design and selection of the respondents, each of the eleven faculties and the college were represented in the sample. It is essential to further note that since all the respondents had either directly procured induced abortion or had procured induced abortion for their female partners, they were able to share their experiences about the theme of the study.

### ***Research instrument and data collection***

One research instrument was developed to elicit data from the respondents in the study which is an in-depth interview guide. The guide used during the study was designed in such a way that adequate information was collected on the research questions with a view to actualising the purpose and objectives of the study. Specifically, the guide was sub-divided into four sections. Section one consists of questions on the socio-demographic background of the participants. In section two are questions on the nature of sexual behaviour and sexual networking among the university's students. In addition, there are other questions in section 2 that border on the knowledge and use of contraceptive methods among those ones that were sexually active during the period of data collection. The third section contains questions on the rate and frequency of unwanted pregnancy among the university's students, while section four focuses on structural,



personal, and operational factors that influence decision-making regarding induced abortion among students with an unwanted pregnancy. The fieldwork activities of the study were carried out between September and December in the year 2014. Four research assistants were recruited and trained in addition to the principal researcher to conduct the study.

### ***Study limitations and ethical issues***

The major constraint of the study was the fact that many of the students were not ready to be interviewed due to the associated stigma with unwanted pregnancy and induced abortion among unmarried women in the country. Despite these constraints, both reliable and valid data were generated in the study. Considering the medical and social implications of the theme of the study on the respondents, some ethical factors were considered and implemented during the period of data collection. The first ethical issue is the fact that all respondents were promised total confidentiality of the information provided. In addition, there was an “informed consent” form which each of the respondents read through in order to understand the purpose and objectives of the study and finally signed before the commencement of each interview. Furthermore, respondents were completely anonymous in relation to their responses. They were identified in the report by their gender, faculties, or pseudo names in order to hide their real identity. In addition, ten (10) research assistants were engaged to collect the data (5 males and 5 females). In order to enhance the quality of data generated in the study, female research assistants interviewed female respondents, while male research assistants interviewed male respondents.

### ***Data analysis***

Data cleaning, processing, and analysis were done manually using a thematic framework approach. This process involves verbatim transcription of returned tapes by the research assistants after the data collection. The transcripts were screened, edited, and double-checked independently by the principal investigator severally for internal consistency, accuracy, and the elimination of possible spurious responses before further processing of the data and in order to get familiar with the data. The second phase of the analysis involved coding, sorting, and theme identification. The coding log was developed based on the central objectives of the study, the research instrument, and various responses elicited from the respondents. This process led to the development of a final list of themes and sub-themes that are germane to the greater understanding of the topic of the research. After coding, sorting, and theme identification, the generated qualitative data were analysed using the content analysis method. Content analysis is a technique for making inferences by systematically and objectively identifying specified characteristics of messages (Holsti, 1969). Thus, responses on each theme and sub-theme were summarised and important and relevant quotes with expressions by the respondents were reported verbatim to enrich the output of the study and explanatory clarity of the findings.

## **RESULTS**

### ***Participants' socio-demographic profile***

A total of forty (40) respondents were sampled and interviewed in the study as noted in the method section. It is important to note that three-fifth of the respondents were females while, the remaining two-fifth were males. The male respondents had procured induced abortion for their female partners, while the female respondents had procured induced abortion personally for themselves. The respondents originated from different parts of Nigeria: north, east, west and south. This is not unexpected as Lagos has been described as the socio-economic nerve centre and melting pot of all ethnic groups in Nigeria, and the University of Lagos, the study location, has been acknowledged to be the University of First Choice in Nigeria. The overall age distribution was



symmetrical. The mean age of the respondents was 22.1 years; the median age was 22 years. The age distribution was multimodal with the ages 20, 22, 24 years. Christianity and Islam are the two major religions in the country, however majority of the respondents professed Christianity. The respondents were undergraduate students across all the faculties and the college in the institution during the 2013/14 academic session. Furthermore, majority of the respondents were single as at the time of the study.

### **Sexual networking, use of contraception and unwanted pregnancy**

Sexual networking is about the nature and intensity of sexual intercourse in an interconnected cycle of social groups that consist of different categories of people within a given society. It may be for transactional purposes as when a female/male offers her/his body to get money for her/his wants, or when an individual gets into lifestyle of his/her friends who see sex as his/her one of those things that mark an individual rite of passage into adulthood. A 300-level female respondent explains that:

*University students see sex as a common commodity which can be done anywhere, anytime to anybody.*

A 200-level male student puts the matter this way:

*Sexual networking is very high and rampant across universities in Nigeria. Factors responsible for this level are: i) peer group influence (i.e. I would like to be sociable like my friend who has a boyfriend/girlfriend), ii) poor economic situation; and the only means to finance their education is by getting support from a boy/man friend.*

Majority of the respondents described the level of sexual networking as very high on the campus of the University of Lagos. Two respondents gave examples to back their positions:

*In fact, sexual networking is becoming unabatedly high every passing day. One could see the reflection of this if one pays a visit to the undergraduate female hostels, e.g. New Hall, Moremi, at night. Evidence could also be seen at the sports ground/stadium at night as all these undergraduate male and female students will fill the whole place pairing and making love. [A 23 year old 300-level male student during an in-depth interview].*

*[Sexual networking] is becoming increasingly high among university students. There is evidence at the girls' hostels at night as females will be found outside their hostels pairing and making love with their boy/man friend. There is also another evidence of this at the stadium complex at night. [A 27 year old 400-level female student during in-depth interview].*

Clearly the girls' hostels and the stadium complex are prominent sites of sex encounters among the students.

The fact of the onset of strong sexual urges consequent upon adolescence is also important to this discussion. Lahey (2004:341) notes that on account of hormonal changes "activation of sexual desire occurs during adolescence." So, unless the adolescent has been prepared for this phenomenon, they may be unable to handle this sudden activation of sexual desire. It is therefore true as some respondents have noted, that the desire to satisfy sexual desire is partly responsible





for sexual networking. One of the students described it simply as “the urge to enjoy sex;” another said, “They find pleasure in [sex].”

With respect to contraceptive use, the study has found that a reasonable proportion of the respondents are aware of contraception and pregnancy-prevention procedures with a high knowledge of modern contraception. This is not surprising as the study location is a university where the youngsters certainly have been exposed to many ideas about the so-called safe sex methods. It is notable that the contraceptives they knew of mostly is the male condom. Some of the respondents have noted that the condom is not 100% effective to prevent pregnancy. In fact, a 300-level female student stated that:

*No contraceptive is 100% effective. Apart from my personal experiences, there are so many of my friends that had experienced the failure of contraceptive methods with unintended pregnancies as the result of such.*

In a clear attestation to the truth of this statement, two respondents cited instances of where the use of a contraceptive failed to prevent a pregnancy. According to one of them who was in 200-level as at the time of the study:

*I used a contraceptive method, but I still got pregnant.*

The female condom was also mentioned by one of the respondents. Pills and injections were other contraceptives mostly mentioned by the female students. In addition, the postinor pills, an emergency contraceptive method, was mentioned. Other contraceptive procedures cited by the students include the intra-uterine contraceptive device (IUCD) and the relatively permanent procedures called vasectomy and tubaligation.

While many responses might suggest the reasons the students that were sexually active did not use contraception (most especially male condom), the dominant one is the fact that most of them want to maximize the associated enjoyment of the sexual intercourse. In one of such instances, a 400-level male student stated that:

*My partner and I decided not to use any contraception especially the popular condom because we really wanted to enjoy the sex.*

In another case cited by a 100-level female student, the stated reason was:

*I didn't use condom because my boyfriend said it won't feel natural.*

It is important to mention that some of the female respondents have been trained either by personal or vicarious experience on the need to use contraceptive method consistently. A 23-year old 300-level female respondent who got pregnant for the first time at 14 years of age stated that:

*When I had my first pregnancy, I was still young and had no previous knowledge of contraceptive methods. But now, I know what to use, like condoms, pills like postinor 1 and 2, and gynaecosid.*

Another 22 year old 400-level female student who has worked as a call-girl explains her experiences concerning the use of contraception in the following way:



*I always make sure I use the contraceptive method whenever I engage in sexual intercourse. I don't care how much the customer is willing to pay or if it doesn't feel natural to them. Sexually transmitted infections (STIs) are worse off for females, so you need to be smart. But if a pregnancy comes along (which has now and then) I know what to do to terminate it. Why would I want to make myself a single mother at this stage of my life?*

Elicited data from the coding log revealed that many of the male respondents had procured abortion for their female partners more than three times, and a significant number of the female respondents had procured induced abortion for at least two times. In response to the question on how many times she has procured an abortion, a 300-level female student answered:

*I have procured induced abortion numerous times. Because sometimes you can't really be sure if you're pregnant or not, so you just have to make sure the baby doesn't get a chance to grow.*

These responses show that unwanted pregnancy is very high in the university environment in the country due to a high level of sexual networking and a low adoption of modern contraceptive methods.

### **Social dynamics of decision-making regarding induced abortion**

The decision-making process to go for induced abortion among university students in Nigeria is usually complex and traumatic in nature and is always based on tripartite factors namely: structural, personal, and operational. Of the three factors, the dominant ones are majorly the structural and personal factors with little or no attention paid to the operational factors. Major findings on each of these factors were presented in the sections in this article that follow respectively.

#### ***Structural factors in induced abortion decision-making***

The structural factors identified by respondents which guide their decision-making endeavours regarding induced abortion are: the existing legal laws about induced abortion in Nigeria, the nature of their family, the type of parents they have, the nature of support from their sexual partner, the religious orientation/belief system, and the cultural settings of respondents. For instance, a 25-year old 300 level female student explained how the fear of what her parents might do coupled with the unsupportive attitude of the male sexual partner were the main factors behind her first induced abortion. She explained in the following way:

*...the first pregnancy came unexpected when I was in 100 level. I was really fearful of what my parents will do if they get to know about it. In addition, the reaction of my male sexual partner then was highly discouraging. He was not ready to take responsibility for the pregnancy. He told me to take care of myself since both of us were undergraduate students. Considering the whole scenario, I decided to abort the pregnancy.*

Most of the female respondents stated that the reactions of their male sexual partners were generally that of disappointment because perhaps, the male sexual partners were just as unprepared as the females to assume the responsibilities of parenthood. Thus the attitude of the male sexual partner and the consequent stress and feeling of helplessness associated with such



a condition are significant factors that influences decision-making regarding induced abortion among female university students in the country. This is only natural since raising a child is possibly one of the most demanding engagements of a woman. The support of a loving partner can reduce the stress to some extent. But when the woman is left alone, she might have no choice other than to expel the foetus. In this regard, a 29-year old 300-Level student who once had an induced abortion states:

*The attitude of the guy involved is very important especially when one is young and you feel nobody will help in taking care of the baby. This sole factor significantly influenced my decision to abort the pregnancy. I cannot be a single mother at an early stage of my life bringing an innocent baby into this world for an irresponsible man. Thus I had no alternative option than to terminate the pregnancy.*

Culturally, an unwanted pregnancy among unmarried young females and males is usually associated with shame and stigma since such a pregnancy falls short of cultural expectations. In all societies in the country, it is a thing of honour and joy for the parents to give out their daughters in marriage and get wives for their adult sons through a process that culminates in an elaborate wedding ceremony which provides a culturally acceptable framework called marriage that will have both spouses responsible for nurturing their children. Thus, an unwanted pregnancy for both male and female unmarried individuals usually truncates the process that leads to marriage culturally speaking and denies both the parents and affected children their social expectations of ceremonies and an elaborate wedding with diverse reward mechanisms which are manifest in the forms of praises and numerous gifts for both the new couple and their parents. In addition, an unwanted pregnancy is a strong indicator of moral pervasiveness and parental inability to train their children in the principles of self-control, morality, and self-discipline on issues relating to their sexuality and sexual intercourse. Consequently, the shame involved and the stigmatisation that leads to a decision to abort an unwanted pregnancy among unmarried youths may be understood in two dimensions: i) the stigma attached to motherhood/fatherhood outside marriage which the individual female/male student may experience, and ii) the reproach that would come upon the family for having a grandchild from a daughter/son that is not married. These are key issues that strongly influence decision-making regarding induced abortion among university students in Nigeria. One 400-level female respondent explained these factors in the following way during the in-depth interview:

*I have come to understand the need to protect my family name in a situation of an unwanted pregnancy as a young single lady. My mother was even the one that encouraged me to procure the induced abortion in a clandestine manner without the knowledge of my father so as to protect the image and name of the family. Considering what people will say about me and my family as a single parent, my mother and I thought that the pregnancy I had then was a thing of shame and we decided to terminate it. She then educated me on what to do in order to prevent any further unwanted pregnancy. My decision then was born out of the need to protect my family name, my mother's integrity, and to save myself from the shame associated with an unwanted pregnancy of an unmarried youth in our society.*

Another respondent said:



*Well my mother was very disappointed when she discovered that I was pregnant, but she knew if the news ever got to my father he would take his hands off my affairs completely (may be even disown me). So, my mother and my elder sister secretly organised to have the pregnancy taken out.*

Emphasising the role of culture in decision-making regarding induced abortion in Nigeria in contemporary times, a 200-level female student explicates thus:

*The little I know about our culture is that in the traditional setting, marriage was the only social institution where sexual intercourse and pregnancy were socially permitted. Howbeit, things have changed drastically that the two are not necessarily needed to occur solely in marriage. For instance, my parents were not against my decision to have a boyfriend when I was 18 years. They believed that I had reached the age of adulthood in which I am old enough to have a boyfriend and it is a commencement of courtship and a right step in the process of marriage. As you know, in a boyfriend-girlfriend relationship, sexual intercourse is covertly socially permitted. In the process of our boyfriend-girlfriend relationship, I was pregnant and my parents disapproved the pregnancy outrightly on the ground that it occurred outside marriage. To my parents, pregnancy outside marriage is socially wrong and they jointly requested that it should be terminated since I was 19 years old and because of the fact that I and my male sexual partner were not socially and economically ready for parenthood responsibilities. Thus, I agreed with their decision and the pregnancy was terminated.*

The above responses reveal the role of parents in the decision-making process of a young woman/man to procure induced abortion either as a result of their perceived disposition or when they themselves assist with the young woman/man to undertake the abortion. It further shows contradictory social expectations between youths' sexual relationships and the associated outcomes. The society permits young people to go into boyfriend/girlfriend relationships where sexual intercourse is covertly or overtly permissive, and the same society disapproves of premarital pregnancy.

The role of religion as a social institution and belief system on decision-making regarding induced abortion cannot be overemphasised. The two main religions in the country (i.e. Christianity and Islam) have different dos and don'ts and various principles and guidelines on when to initiate sexual intercourse, the people that are permitted to have sexual intercourse, and on the social settings where such sexual relationships are religiously approved. In Nigeria, the two main religions abhor pre-marital sex and it is punishable by the penalty of excommunication. One of the male respondents explained how his religious involvement influenced his decision to abort a pregnancy for his girlfriend. He explained thus:

*In my religion, Christianity, there is no room for sexual perverseness. Intimate sexual intercourse outside marriage for the singles is termed fornication; while such an activity for a married individual outside his/her conjugal union is termed adultery. In my denomination, the two are the greatest sins someone can ever commit. Anyone found to have committed such a sin will be banished from the communion of believers and other church activities. Such an excommunication is usually associated with unbearable shame and stigma. When my girlfriend was pregnant, we quickly decided to abort the pregnancy secretly before anyone gets*



*to know since we have not gotten married officially in the church. We had to do it because of our positions in the congregation and the fact that we were not ready to bear the shame of excommunication.*

The influence of existing laws regarding induced abortion seems to be mild at the initial stage of decision-making regarding induced abortion among the students. Nearly all the respondents claimed to be aware that induced abortion is illegal in the country, but they see the laws as toothless dogs that cannot bite. For those ones that considered the laws before the abortion they undertook, they only did so when they were to decide on the method to adopt and the place where abortion will be procured. The response of a 400 level female encapsulates the role existing laws are playing on decision-making regarding induced abortion among university students in Nigeria:

*I know there are laws against induced abortion in the country but such laws are not potent due to so many reasons. One of such reasons is the fact that abortion is usually done behind close doors. Unless there is a complication, nobody will ever know about it. Consequently, there are millions of abortions that have occurred in the country without any arrest, prosecution, and sanctions. When I was to procure induced abortion, I was mainly looking at the wrong timing and undesirability of the pregnancy, not the laws in the country, I only thought of the laws when I was considering the place where abortion will be procured in order to prevent complications and unnecessary publicity.*

The responses in this section reveal that decision-making regarding the termination of an unwanted pregnancy through induced abortion is strongly influenced by some salient structural factors such as the existing legal laws about induced abortion, the nature of family, type of parents, the nature of support from sexual partner, the religious orientation/belief system of the sexual partners, and the cultural setting of the sexual partners.

### ***Personal factors in induced abortion decision-making***

In addition to the structural factors (exogenous variables) identified in the previous section, there are some other personal factors (endogenous variables) mentioned by the respondents that have a strong influence on the decision-making process regarding induced abortion among university students in the study location. These personal factors are: age as at last birthday, marital status, schooling status, economic/employment status, residential pattern and types of sexual relationship wherein the pregnancy occurred. A further critical examination and synthesis of these reasons shows that a dominant personal reason strongly behind decision-making to procure a non-therapeutic induced abortion is the lack of preparedness in one way or the other. The lack of preparedness may be due to the fact that the woman/man is still in school, too young, or still single or may not have sufficient resources to care for a child.

For instance, a 26-year old undergraduate lady who has aborted a pregnancy a number of times simply says:

*I have procured induced abortion a number of times not because I am too young to be a mother but because I am still single. I had to terminate the pregnancies when there was no serious commitment from the men involved. I don't think the single parent lifestyle is so palatable.*



A 31-year old 400-level undergraduate male respondent who arranged for an abortion on the first of his two occasions at 20 years of age explains how age determined his decision to procure induced abortion for his sexual partner. He stated that:

*To me, the thought of an early mothering responsibility on the part of the females and a fathering responsibility on the part of the males is one of the reasons young people go for induced abortion. I had to arrange for an induced abortion for my first girlfriend because both of us were too young to assume parenting responsibilities coupled with the fear of having children out of wedlock.*

A 200 level female student retorted that:

*I had to quickly decide on induced abortion because the pregnancy came barely few months after my admission into 100 level in the university. I was just 17 years old then, too young and single. How can I explain it? The only option available then was to terminate the pregnancy.*

Coming under the ambit of the lack of preparedness as well is financial capability due to economic/employment status. For instance, a single lady may feel inadequate financially and may opt for an abortion. In the opinion of a 28 years old female respondent who has had induced abortion three times:

*Financial challenges due to poor economic/employment status are the major causes of induced abortion among students in this university. As you can see, majority of us do not have the financial capability because we are still students and are not gainfully employed. It will be extremely difficult to keep any pregnancy as a student, except you have a partner that is financially strong and ready to marry you. I had decided to procure induced abortion on three occasions because I don't want to bring any child into this world, which I will not be able to cater for materially, emotionally, and financially.*

Another personal factor noted by some of the respondents was the love they have for their boyfriends. Thus, it appears that the females seem to factor in the situation of their sexual partners than the males do for theirs. One of the female respondents just seems to have been taken for a ride. She relates:

*My boyfriend was not ready for the pregnancy, so I committed the abortion because I love my boyfriend. I thought aborting the baby will make our love stronger. But I was wrong. He later jilted me and started dating other ladies.*

The summation of the two factors (structural and personal) produces a result (readiness or un-readiness to maintain and sustain the pregnancy - both from the woman's and her male sexual partner's perspectives) that helps in decision-making regarding abortion. The respondents clearly stated that they opted for induced abortion because their pregnancies were unwanted. They were unwanted mainly because they were ill-timed; when the affected individuals were not socially, mentally, and financially ready to assume parenting responsibilities.

### ***Operational factors in induced abortion decision-making***



The operational factors are decisions on when, where and how the abortion will be procured with various considerations on whether to visit a hospital or to do it at home, on the expertise of the operator (skilled, semi-skilled, and unskilled), if it has to be done outside home, on the cost of procurement; the materials required for procurement, and the nature of procurement.

The analysis of the decisions on when the pregnancy should be terminated should be based on deep knowledge of the duration and the key three identified trimesters of a pregnancy. Trimester is a period of three months; especially one of the three three-month periods into which human pregnancy is divided. Thus, the first trimester is a period extending from the first day of the last menstrual period through 12 weeks of gestation; the second trimester is the period extending from the 13th to the 27th week of gestation, while the third trimester is a period extending from the 28th week of gestation until delivery. The responses during the in-depth interviews reveal that most of the induced abortions among the students occurred during the first trimester of the pregnancy. In response to the question of decision-making on when to procure an abortion, a 400-level female student answered:

*No rational person will be waiting until the whole world knows that someone is pregnant, you have to do it immediately you notice any of the symptoms of pregnancy. For me, I cannot really count the number of abortions I have procured because sometimes one can't really be sure if someone is pregnant or not. So you just have to make sure the baby doesn't get a chance to grow by doing the needful.*

Indeed the enormous burden of apprehension engendered by an unwanted pregnancy hampered the ability of most of the affected females to think-through about the implications of various operational factors on their decision-making regarding induced abortion, rather they were eager to use any available method whether safe or unsafe to get rid of the pregnancy. This feeling of apprehension was illustrated by the comment of a 200-level female respondent who said:

*An unwanted pregnancy for a single young lady in the university makes someone feel trapped, and always conscious that someone may know or find out. In such a situation, I was actually ready to use any available method that will assist me in the termination of the pregnancy. My decision was based on how to save my face.*

Another 200-level female student stated that:

*For me, the decision on when the abortion will be procured is usually instant and immediate whenever I notice that I have missed my menstrual period. I am here to read and get a certificate after graduation and not to carry any pregnancy. Within the first month of the pregnancy, it must have been terminated.*

A male respondent who has procured induced abortion for four of his girlfriends explained what usually guides his decisions on when the abortion will be done. He explained thus:

*The moment I hear about the pregnancy, the next thing that will come to my mind is how the pregnancy will be terminated within the next one to three weeks after when I got the information. I will quickly look for the money and other necessary things that will assist both of us. There is no room for delay and keeping what you know you are not ready for. The decision is to have the pregnancy terminated*



*within a month. It is highly embarrassing for people to see someone's girlfriend pregnant when we have not done a wedding.*

The decision-making on where and how the abortion will be procured are highly interwoven and are highly influenced by a number of factors such as the support of a sexual partner, peer influence, and financial resources required to terminated the pregnancy as well as the female sexual partner's age at the time the pregnancy occurs. The location where abortion can be procured can either be in the hospital with the help of a supposedly trained health officer(s) or outside the hospital environment (usually at home/a place of usual abode) without the help of any health officer. Decision-making on where and how the pregnancy will be terminated are a function of the number of abortions ever procured and the experience of the affected individuals on previous abortions. For example, a 400-level female respondent who got pregnant for the first time at 14 years of age said:

*My first abortion was done in a private clinic because my parents were informed and their permission was obtained because I was a minor then. By the time of the second abortion, I have become an undergraduate and I knew what to do myself without visiting any hospital or consulting any medical officer.*

For this respondent, it seemed that consulting a medical doctor is a necessity since a qualified medical practitioner would surely have sought to have the permission of a parent to do such work on a minor. However, as she got mature in age her subsequent abortions were done in a clandestine manner outside the hospital based on her residual knowledge from the first abortion.

There is an array of methods mentioned by the respondents as methods adopted previously to terminate their unwanted pregnancies. These methods include dilatation and curettage (D&C), pills, injections, concoctions, gin and lime, which can be classified into a surgical or nonsurgical/medicinal procedure that terminates a pregnancy by removing the foetus. Medical abortions are non-surgical abortions that use pharmaceutical drugs or other local materials, categorically called abortifacients, while surgical abortions are suction–aspiration or vacuum abortions which can be done manually or electrically. Manual vacuum aspiration (MVA) abortion consists of removing the foetus or embryo, placenta, and membranes by suction using a manual syringe, while Electric Vacuum Aspiration (EVA) abortion uses an electric pump. These techniques are comparable, and differ in the mechanism used to apply suction, including how early in pregnancy they can be used, and whether cervical dilatation is necessary. Electric Vacuum Aspiration (MVA), also known as 'mini-suction' and 'menstrual extraction', can be used in the very early period of pregnancy, and does not require cervical dilation. As earlier stated, surgical techniques are sometimes referred to as 'Suction (or Surgical) Termination of Pregnancy (STOP) and varies depending on the age of the pregnancy. For instance, for first trimesters, it is usual for the embryo to be sucked out by a vacuum pump. This is usually done in a clinic in a short space of time. For the second trimesters, the dismembering of the foetus to extract it from the mother is the needful, a short stay in the hospital is normal. For third trimesters, a major operation such as a hysterotomy - a cutting of the uterus, or womb, to remove the developing child; not to be confused with hysterectomy, a removal of the uterus itself. Since none of the respondents reported having had a hysterotomy, it would mean that none of them carried a pregnancy to the third trimester.

Indeed, for some of them, it is a matter of being on the lookout for the earliest signs of pregnancy, thus many of the respondents were able to use some quick do-it-yourself methods such as using





gin and lime, and a concoction. In fact the respondent who used gin and lime did not even consult any medical professional. However, as would be expected of young aspiring urban professionals, a few number of the females who had procured an abortion consulted a medical professional; at least one of them spoke to a qualified nurse. Another sought the advice of a pharmacist who told her what she could use to terminate the pregnancy. Two of them confessed that they visited quacks. It is proper to emphasise that an appreciable number of the respondents did not consult a medical doctor. It is possible that they felt they could handle the situation themselves perhaps given that the pregnancy was still in the very early phase like those that used simple methods like gin and lime. In any case, it turned out that the decision not to consult a medical doctor resulted from some circumspection considering the legal implications of seeking induced abortion in the country. For instance, a 400-level female respondent who had aborted three times explained how a harsh and un-conducive legal environment inhibits many of the university female students to access safe induced abortion in the country. According to her:

*From my personal experience in this country, it is extremely difficult for any woman to access safe induced abortion in the government hospitals except for therapeutic reasons for a woman. Consequently, the only place where unwanted pregnancy can be terminated in Nigeria is when you visit private hospitals where we have so many quacks. Owing to faulty regulation/control mechanisms and poor performance of oversight functions from the ministries of health at the state and federal levels, the private hospitals in the country are full of semi-skilled and unskilled health officers that can be regarded as quacks. Visiting private hospitals for abortion most of the time is a great risk on the part of the female because you are not sure of the expertise or competence of the officer that will attend to you. My first abortion was done in a clinic here in Lagos, immediately after the D&C I developed a serious complication that was later treated in a government hospital. It was during the post-abortion complication treatment that I got to know that the abortion was not properly done. If not for God, I would have died because of the complication. I had to use appropriate abortifacient drugs for other abortions that I have done since then, and I did not experience or record any complication in any of them.*

Another 200-level female respondent explained how financial constraints made her to decide to procure her first and only abortion at home using abortifacient local materials. She explained in the following way:

*I got pregnant in the early part of my 200-level for my boyfriend. Both of us being undergraduate students, we had limited financial resources. Thus when we decided to abort the unwanted pregnancy, we couldn't raise sufficient money to go for D&C. Someone advised my friend that the pregnancy can be terminated with a concoction made of salt, lime, and potassium. I was instructed to take it early in the morning since the pregnancy was barely a month. I decided to take the concoction since I didn't want people to notice I was pregnant and it worked like magic, before noon of that fateful day it had been terminated.*

The above response tells of the inability of the respondent to access quality care in terms of the monetary sum involved. Considering the amount of money mentioned by respondents during the interview, it took a female an average of N8,833 (US\$55) to procure an abortion while the males paid on the average N8,063 (US\$50) for the ones they procured.



The fact that the women paid more on the average for an abortion may result from inexperience or from a desperate attempt to deal with an inconvenience. For example, a 21-year old 200-level student stated that she paid N20,000 (US\$125) for an abortion to a quack doctor. Indications were also given as to factors affecting the cost of an abortion procedure. A 23-year old 100-level student says:

*The peak period sometimes determines how much the clinic will collect. During the peak period (period when a lot of girls are coming in for abortion), I terminated the first pregnancy with N5,000 (US\$31) and the second was during the off-peak period and I paid N3,000 (US\$19).*

A 400-level male student that has aborted for three of his girl-friends provides some justifications for his decisions on where and how the pregnancies were terminated. According to him:

*I don't think it is necessary to go to any hospital these days for an induced abortion provided someone is quickly aware of the pregnancy at an early stage of the pregnancy. There are many other simple methods that someone can use instead of visiting a hospital. What I usually do is to buy some drugs and other materials (pills such as mestrogen and mix it with alabukun and Schweppes or Sprite (which are soft drinks) or salt solution) which the lady will take with lime. Within 24 hours of taking the concoction, the pregnancy will be terminated. Apart from the fact that the method is cheap, it is also convenient without unnecessary publicity.*

### **Synthesis of the tripartite factors in the induced abortion decision-making process**

There are three major decisions to be taken concerning an unwanted pregnancy. The first one is the decision to terminate the pregnancy; the second decision is to decide on the method to be adopted in order to terminate the pregnancy, while the third decision is about the place where the abortion will be procured. These three decisions are strongly guided by tripartite factors namely: structural, personal, and operational factors. However, findings of this study reveal that most of the decision-making regarding abortion by the respondents were strongly guided mainly by the structural and personal factors with little or no consideration for operational factors. Consequently, induced abortions were observed to be rampant with many social and health consequences among the students. Some of these consequences are discussed in the next section of the paper.

### **Induced abortion decision-making: latent and manifest consequences**

The socio-cultural context of the process of decision-making regarding induced abortion is not without both latent and manifest consequences which are social, psychological, and health related. As reported by the students, most, if not all, of the procured induced abortions were carried out in a clandestine manner, hastily, and in unsafe conditions. Quite many of the respondents were rather careful in order to keep the knowledge of their pregnancy from others; in some cases, only from people who might reprimand them for their conduct. In the cases where the pregnancy got to be known, however, the reactions of people were varied; but in majority of the cases, the first pregnancy of the female respondent met with a negative reaction and a general disapproval. One reported being ignored and treated badly; another said she was insulted and called all manner of names. Then there was the case of one respondent (300-level female student) whose indiscretion exposed her pregnancy and subsequent abortion to others. She reported:



*People got to know that I was pregnant in the course of my procuring the induced abortion; people made jest of my situation and I was labelled divers names. It was a face-me-I-face-you apartment.*

The negative reaction was largely due to the perception that the behaviour ran counter to social expectations associated with the age of the respondent at the time of the first pregnancy. For example, a 300-level female student explicated on how an unwanted pregnancy made her to lose the companionship of people very dear to her coupled with fear of her parents resulted in a clandestine induced abortion:

*My friends were very disappointed in me when they knew about the induced abortion that I procured, and our close relationship was severed. I didn't inform my parents before terminating the pregnancy, as I dreaded the worst from them.*

An examination of the raw data from the coding log shows that an overwhelming proportion of the respondents cited possible damage of the womb and infertility as the consequences of induced abortion, while some mentioned that it can possibly lead to the death of the woman and other health complications. Some of the specific health effects mentioned by respondents include bleeding. For example, in response to the question on the health implication of her abortion, a 21-year old 300-level female student who has had two abortions stated thus:

*Yes, I bled for some days after the induced abortion but to me it was normal bleeding. The bleeding was to let me know the pregnancy has been terminated.*

Another described her own abortion as a near-death experience. According to her:

*I will not deceive you; abortion could lead to a loss of life. I almost died after the whole process. It was not properly done and the whole thing was complicated. It can kill someone quickly please.*

Abortion is a risky procedure especially if not performed by a qualified practitioner. A 28-year old 500-level male student took his sexual partner for an abortion which was carried out by a male nurse, who received N6,000 (US\$38) for it. The operation had this health effect:

*Of course, the operation was accompanied by pain, and there was a little blood oozing from the lady's vagina after the operation, and a little expression of stomach ache, all of which disappeared with the passage of time.*

Another major social consequence of induced abortion centres on stigmatisation leading to shame on the part of the one who has committed abortion and then rejection by the society. This is because the one who commits induced abortion is labelled as irresponsible. A 21-year old 200-level female student who has had two abortions feels that the society is unnecessarily judgemental and impatient with people. According to this respondent:

*People are very judgemental and quick to pass judgement against you instead of waiting to hear your reasons for not keeping the pregnancy. I was labelled a "harlot" and called all manner of names for the induced abortions I had procured. These are the people that do not know how I survive and meet all my social, academic,*



*and economic responsibilities. They want me to have the babies despite the fact that I am not socially and economically ready for motherhood responsibilities.*

Religious institutions are a part of the society. So their teachings and sanctions against socially labelled deviant behaviour often reflect society's own beliefs. The 30-year old 500-level male student said:

*It is better this issue of abortion does not get to any religious institution. When I aborted for my girlfriend, my church frowned at it and I was ostracised from the religious setting and activities. They said I am a defiled person who is not worthy of anything before God. In fact, they even said that they have handed me over to the devil for necessary punishment. It was a terrible experience to the extent that I had to abandon that denomination and run for my dear life.*

Another male respondent, a 31-year old 500-level student who has procured abortion for two out of his numerous sexual partners was of the opinion that:

*It makes the religious body see you as a bad person and somebody who can corrupt the youth in the religious setting. In fact, abortion is a bad pointer to the religious body. I was denied the Holy Communion and removed from the post I held when it was known that my girlfriend was pregnant and that the pregnancy was aborted.*

The reactions of most of the male respondents are generally believed to be influenced by the fear that the woman may no longer be able to have children. In the event that the intended spouse believes that the woman may no longer be able to have children, the relationship may fail since the African society places a great value on children in a conjugal home. In the sub-Saharan African society, the inability to have children either as a result of a shortcoming on the part of the man or the woman places a great strain on a marriage. This fact is borne out by the comment of a 23-year old 200-level male student who has procured two abortions for his girlfriend:

*I am less likely to get married to my girlfriend due to the two abortion experiences she has had. These abortions may have affected her womb, possibly may be her womb has been removed or it has been perforated, our marriage will eventually be broken, because of her inability to have children. So it is better for two of us to go our different ways. Our relationship cannot result into marriage. It is not ideal and rational for me to eventually marry her due to her abortion experiences.*

Some of the respondents cited emotional trauma as the consequences of their decision to procure induced abortion. In most of the cases, the abortion act was regretted, regardless of the fact that it was not widely known, or was not known to friends who were more or less supportive. In some cases, the act was so much regretted that it elicited some kind of penitence on their part-they had to go to confess the act to religious leaders. For others who did not go for any confession, the act was just as regrettable. For example, a 21-year old 300-level male respondent recalls his only instance of procuring an abortion and says:

*Everyday, I feel guilty. I have not been able to pardon myself since then. I keep on wondering everyday why I decided to kill an innocent child. My prayer is that God will eventually forgive me of such a great sin.*



For a 21-year old female respondent who had her only abortion for a guy whom she thought she loved, she ended up disappointed. According to her:

*I really regretted my decision to procure an induced abortion. I thought the guy will appreciate me for aborting for his sake but he left me after the whole thing.*

In this instance, the abortion act was regretted because an anticipated reciprocal behaviour did not materialise. In the case of a 23-year old 300-level female student who recalls that her own only act of abortion regret seems to stem from revulsion at having destroyed a baby that looks so innocent. For her,

*To me, it seems so unfair to snuff out the life of the unborn baby like that. These are innocent and helpless entities that need to be given the chance and opportunity to come and explore this world.*

This strong pro-life stance seems to be reflected in a 30-year old 400-level female student's description of abortion as murder. In her assertion she explained that:

*100%, I wish I had kept the pregnancy then. Abortion indeed does not make a woman not to be pregnant; it only makes her to be the mother of a dead child.*

One of the strongest expressions of the dismissal of abortion as an act of wrongdoing came from a 28-year old 400-level female student. She declares:

*I have already procured three induced abortions and I believe I've done nothing wrong. Aren't there already enough children roaming the streets homeless, poverty stricken, hawking goods; being victims of drug pushers, rapists, and perverted guardians, why do I need to add to that number?*

In summary, women seem to bear more of the abortion burden - they risk a damage of their reproductive organs; they may be dumped by the man responsible for the act; they also bear greater stigmatisation for the act.

## **DISCUSSION**

The findings of this study raised several cogent issues concerning youth sexuality and decision-making regarding induced abortion in Nigeria most especially among those ones in the university. Realities surrounding youth reproductive behaviour, more importantly, decision-making regarding induced abortion in the country are interwoven with attendant multi-dimensional developmental implications. The key issues about these realities were identified and briefly discussed in this section. First, sexual initiation is early. Then, sexual networking is diverse. Adoption of modern contraception among the sexually active university students is rather erratic and very low. These findings corroborate the initial conclusion about sexual behaviour and contraceptive usage of contemporary university students in Nigeria (Oyefara & Bisiriyu, 2007; Olurode & Oyefara, 2010; 2013). Consequently, the average age at which a male got a female pregnant or at which a female got pregnant for the first time was between 20 and 21 years, shortly after they began their sexual experience. Biologically, a pregnancy can occur at the very first experience, but it appears that the students were not properly informed thinking that casual sex, especially for the first time, was not likely to lead to pregnancy. Worthy to note is that the erratic and non-adoption of modern



contraception among these students was due to many personal, social, and economic reasons. For instance, the situation is well captured by the female respondent who asked: “Does anyone who engages in casual sex hope to get pregnant?” To many of the students, casual sex does not connote sexual intercourse without any form of protection from an unwanted pregnancy. Thus, in all of the cases examined, the pregnancy was neither expected nor desired; rather it was usually unintended, unplanned, and absolutely unwanted. This is not unexpected considering the age at which the first pregnancy occurred (majorly immediately after their admission into the university or the early years of their university education) among the students, that they had other priorities which are mostly educational and career development inclined.

The study revealed three intricately connected stages of the typology of decisions that surround the procurement of induced abortion generally. These are: 1.) a decision to terminate a pregnancy, 2.) a decision on a method to be used to terminate the pregnancy, and 3.) a decision on the place where the pregnancy will be terminated/abortion will be procured. These three important decisions are strictly guided by other tripartite factors which are structural, personal, and operational in nature. Key structural factors identified in the study are: the nature of existing legal laws relating to induced abortion in the country, family type, the nature of parents of the affected student, the religious affiliation, and the socio-cultural setting, while the personal factors are: age as at last birthday, marital status, schooling status, economic and employment status, residential pattern and types of sexual relationship within which the pregnancy occurred. A synthesis of the two factors (structural and personal) produces a result (readiness or unreadiness to keep the pregnancy – both from the female’s and her male sexual partner’s perspective). Thus, it is clear from the study that induced abortion is inspired by two principal factors: i) the general feeling of a lack of preparedness due to a number of factors - being still in school, financial constraints on account of lack of support by the sexual partner or others; and ii) the stigma associated with pregnancy out of wedlock - such a stigma experienced by the woman herself and/or her family due to their inability to live up to the required social expectations.

The safety of an abortion lies on the third factor which is operational in nature. Central issues under operational factors are where and how the induced abortion will be procured (medical or surgical induced abortion) with various considerations on whether to visit a hospital or do it at home, the expertise of the operator (skilled, semi-skilled, and unskilled), if it is one that has to be done outside home, cost of procurement, materials required for procurement, and nature of procurement. Ideally, taking a rational decision on the three stages of induced abortion within the tripartite factors will invariably produce a positive desirable outcome – safe induced abortion. However, findings of this study reveal that most of the decision-making regarding induced abortion by the respondents were strongly guided mainly by the structural and personal factors with little or no consideration for operational factors. Consequently, most, if not all, of the procured induced abortions were carried out in a clandestine manner, hastily, and in unsafe conditions without a proper conscious, rational, and calculated thinking-through process about the safety of the adopted operational context which results in a high rate of unsafe induced abortion among the university’s students. The attendant consequences of decisions taken at the various stages are enormous most especially for the ladies who are the primary agents and carriers of the pregnancy. Women bear more of the abortion burden compared to their male sexual partners. Specifically, they risk a damage of their reproductive organs leading to a total pathological sterility/infertility; they may be dumped by the man responsible for the pregnancy and induced abortion; and they bear greater stigmatisation for their action or inaction.



Due to the dominant power dynamics and gender relations in sexuality in the country, female vulnerability has been highlighted in a number of ways in this study: i) On account of their physiological constitution, even when they have protected sex, they are the only ones whose loss of virginity can be known; ii) the females sacrifice more to maintain a relationship than the males, e.g. they yield to sex - sometimes without contraception - to please the males, and they may also abort a pregnancy out of consideration for his situation; iii) if they have unprotected sex, it is worse: as to keep or abort a pregnancy both carry possibly serious consequences. Sometimes, the females are even abandoned after a pregnancy/abortion.

### **Policy Implications and Recommendations:**

Induced abortion is an end point of a set of events and it is strongly affected by various decisions taken at every point/stage of the events. Unguided decision-making at any of the stages may cause permanent social and reproductive health damage for the affected lady or in some cases, cost the lady her dear life due to morbidity associated with incomplete or poorly done induced abortion. Therefore, issues around decision-making regarding induced abortion go beyond mere medical concerns, it is really a developmental issue within the context of maternal morbidity and mortality which goal - 3 of the 17 Sustainable Development Goals (SDGs) and its associated target 1 was developed to address. Thus, all efforts should be put together by government institutions at all levels, national and international development agencies, as well as NGOs and CBOs working on reproductive health, and other stakeholders to, one, educate sexually active students (males and females) on the need to adopt more efficient modern contraceptive methods to prevent most of the unwanted pregnancies. Two, there is an urgent need to design appropriate educational intervention programmes for university students in the country, more importantly, on the need to prevent unsafe abortion and the fact that safety should guide their decision-making in all issues that have to do with their health, especially, issues regarding induced abortion.

### **REFERENCES:**

- Alubo, O. (1990). "Doctoring as Business: A study of Entrepreneurial Medicine in Nigeria." *Medical Anthropology*, 12. Pp. 305-324.
- Aniekwu, N. (2003). Abortion and reproductive rights in Nigeria - A review of criminal laws and legislative policies. *Annals of Biomedical Sciences, College of Medicine*. University of Benin, Nigeria. 2(1). Pp. 1-10.
- Bankole, A., Sedgh, G., Oye-Adeniran, B.A., Adewole, I.F., Hussain, R., & Singh, S. (2004). "Abortion seeking behaviour among Nigerian women." Paper presented at the annual meeting of the Population Association of America, Boston, MA, USA, April 1-3, 2004.
- Bankole, A., Oye-Adeniran, B. A., Singh, S., Adewole, I. F., Wulf, D., Sedgh, G. & Hussain, R. (2006). *Unwanted pregnancy and induced abortion in Nigeria: Causes and consequences*. The Alan Guttmacher Institute (AGI), New York.
- Coleman, (1989). "Rationality and Society." *Rationality and Society*, 1:5-9.
- Crock, J. R. (2007). *Abortion decision-making attitudes of adolescents attending Roman Catholic Schools*. A PhD thesis submitted to the Department of Family Studies and Human Services, Kansas State University. Proquest: Kansas.
- Edjah, K. (1999). "Some aspect of the adolescent sexual behaviour" *Ife Psychologia* 7(2). Pp. 128-138.
- Elster, J. (1989). *Nuts and Bolts for the Social Sciences*. Cambridge: Cambridge University Press.



- Harrison, K. (1997). "Maternal Mortality in Nigeria: The real issues" *African Journal of Reproductive Health* 1(1). Pp. 7-13.
- Hollis, (1987). *The Cunning of Reason*. Cambridge: Cambridge University Press.
- Holsti, O. R. (1969). *Content Analysis for the Social Sciences and Humanities*. Readings, M. A. Addison Wesley.
- Huber, D., Curtis, C., Irani, L., Pappa, S., & Arrington, L. (2016). "Post Abortion Care: 20 Years of Strong Evidence on Emergency Treatment Family Planning and Other Programming Components." *Global Health: Science and Practice* 4(3):481-494.
- Lahey, B. (2004). *Psychology – An Introduction* (8<sup>th</sup> edition). New York: McGraw Hill.
- Lear, D. (1997). *Sex and Sexuality: Risk and relationships in the age of AIDS* (1<sup>st</sup> edition). Fairford: Sage publications.
- Lucas, E. (2000). "Demographic Characteristics, Human Sexuality and Reproductive Control." *Society and Reproductive Health*. Pp. 2-9.
- Luker, K. (1975). *Taking Chances: Abortion and the Decision not to Contracept*. Berkeley, Los Angeles: University of California Press.
- Makinwa-Adebusoye, P., Singh, S. & Audam, S. (1997). Nigerian Health Professionals' Perceptions about Abortion Practice. *International Family Planning Perspectives*. 24(4). Pp.155-161.
- Moore, S. & Rosenthal, D. (1993). *Sexuality in Adolescence*, London: Routledge.
- Mugore, S., Kassouta, N.T.K., Sebikali, B., Lundstrom, L., & Saad, A. (2016). "Improving the Quality of Post Abortion Care Services in Togo Increased Uptake of Contraception." *Global Health: Science and Practice* 4(3):495-505.
- National Population Commission & ORC Macro (2003). *Nigeria Demographic and Health Survey*. Calverton, MD, USA and Abuja.
- Norton, P. & Walls, M.V. (2002). "Perception of Sexual Behaviour, abortion and unwanted pregnancies." *Reproductive Health Journal* (Internet). Pp. 71 - 81.
- Onwuamanam, D.O. (1982). "Sexual Activity of School-going Adolescents in Nigeria". *Adolescence*, 17(65). Pp. 81-87.
- Oyefara, J. L. (2011). *Socio-Cultural Context of Adolescent Fertility in Yoruba Society: Insights from Osun State, Nigeria*. Lagos: Concept Publications Limited.
- Oyefara, J.L and L.A. Bisiriyu (2007). "Knowledge and Attitude of Nigerian Female undergraduate Students toward STIs/HIV/AIDS pandemic: University of Lagos Example". *Gender and Behaviour* 5(2):1340-1359.
- Olurode, L. & J.L. Oyefara (2010). *Issues in Sexual Harassment in Nigeria's Tertiary Institutions: Conspiracy, Compromises and Challenges*. Lagos: Rebonik Publications Ltd
- Olurode, L. & J.L. Oyefara (2013). "Diverse Expressions of Sexuality in Tertiary Institutions in Nigeria: The University of Lagos Example" in Falola, T. and B. Teboh (eds.) *The Power of Gender, The Gender of Power: Women's Labor, Rights, and Responsibilities in Africa*, New Jersey: Africa World Press. Pp. 631-661. (USA).
- Pressat, R. (1985). *The Dictionary of Demography*, Basil Blackwell, Oxford.
- Ritzer, G. (2008) *Sociological Theory* (7<sup>th</sup> edition) New York: McGraw Hill Higher Education.
- Sachdev, S. P. (1975). *Factors relating to the Abortion Decision among Premaritally Pregnant Females*. University of Wisconsin, Madison.
- Sedgh, G. (2012). Induced Abortion: Incidence and Worldwide from 1995 to 2008. *Lancet*. 372(9563). Pp. 1927-1940.





- Shah, I. & Ahman, E. (2010). "Unsafe abortion in 2008: Global and Regional Levels and Trends". *Reproductive Health Matters*. 18(36). Pp. 90-101.
- Sismondo, S. (1993). "Some Social Constructions." *Social Studies of Science*, 23. Pp. 515-523.
- Sule-Odu A. O., Olatunji, A. O. & Akindele, R. A. (2002). Complicated induced abortion in Sagamu, Nigeria. *Journal of Obstetrics and Gynaecology*. 22(1). Pp. 56-61.
- The Alan Guttmacher Institute and Campaign against Unwanted Pregnancy (2003). *Advancing sexual and reproductive health worldwide through research, policy and public education*. AGI: New York.
- United Nations (2011). *World Contraceptive Use 2010*. Department of Economic and Social Affairs, Population Division. New York: UN.
- Usman H. (1997). "Reproductive Health and Rights: The case of Northern Nigerian Hausa women" *African Development XXII* (1). Pp. 79-94.
- Vlassoff, M. (2009). Estimates of Health Care System: Costs of Unsafe Abortion in Africa and Latin America. *International Perspectives on Sexual and Reproductive Health*. 35(3):118-136.
- Winner, L. (1993). "Upon Opening the Black Box and Finding it Empty: Social Constructivism and the Philosophy of Technology." *Science Technology & Human Values*, 18 (3). Pp. 362-378.
- World Health Organization (2011). *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Sixth edition., Geneva: WHO.
- World Health Organization (2012). *Facts on Induced Abortion Worldwide*. Geneva: WHO.

Figure 1: Conceptual Framework on Decision-Making regarding Induced Abortion

