

Reproductive Health Knowledge and Unsafe Induced Abortion in Nigeria

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ABSTRACT: This paper examine reproductive health knowledge and unsafe induce abortion in Nigeria. The study shows that inadequate of reproductive health knowledge greatly contributed to the high incidence of unplanned pregnancies among young adolescent girls which consequently often lead to the fatal decision to abort. Since abortion is not legalized in Nigeria except when a pregnancy poses a serious threat to the life of the woman, findings revealed that most adolescents' girls embark on self-induce abortion due the level of stigmatization that is attached to unwanted pregnancy among other reasons without minding the high risk that is also associated to it. The decision to abort among adolescent girls also often generates dire consequences because they lack the appropriate information and support they need especially from family members and the society at large. Pregnancy among adolescent girls is usually frowned upon by the society especially such society that places a high standard on moral values and education. Qualitative secondary sources of data collection were used for this paper, and theory of planned behaviour was also adopted for the research. Amongst other recommendations, it is recommended that adequate information in respect to reproductive health knowledge and the dire consequences of self-induce abortion should be unveiled to young ladies at the different strata of our educational institutions and the rural communities in Nigeria by trained medical practitioners.

Keywords: Reproductive health, abortion, unsafe abortion, maternal death, Nigeria

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I. INTRODUCTION

It is undisputable truism that as ignorance is darker than night so also the low level of information on reproductive health knowledge can lead to unsafe abortion. Reproductive health has been viewed by scholars as a fundamental aspect of general well-being, constituting a central feature of human development. It reflects one's state of health during childhood, adolescence and adulthood, and sets the stage for health beyond the reproductive years for both women and men and also impacts on the health of the next generation (Kotwal, Gupta and Gupta, 2010). A probable unofficial working definition of reproductive health has been given as the state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health therefore deals with the reproductive processes, functions and system at all stages of life. Sampson (2015) asserts that adolescent proportion of the population is integral to every country's social, political and economic development. Nigeria's development according to this report is compromised by the sexual and reproductive health issues afflicting her youth. Lack of sexual health information and services make young people vulnerable to sexually transmitted infections (STIs) and unintended pregnancy. While intending to protect young people, some adults may limit young people's access to information and health services in fear that information will promote sexual behaviour. Information however are the greatest tool young people needed to protect themselves against reproductive and sexual ill-health.

Unsafe abortion has been defined by the World Health Organization (2015) as a procedure for terminating unwanted pregnancy that is performed by someone lacking the necessary skills or in an environment lacking minimal medical standards or both. Unsafe induce abortions can endanger adolescents' reproductive health and lead to serious, often life-threatening complications. Furthermore, unsafe abortions impose a heavy burden on women and society by virtue of the serious health consequences that often ensue. The Population Reference Bureau (2011) has indicated that nearly one third of Nigeria's total population of over 160 million is between the ages of 10 and 24.

Hence, adolescents terminate unplanned pregnancies for various reasons; these include fear of expulsion from school, unstable relationships, financial instability and lack of support from the partner. In cases where early marriage or single mothers are unaccepted, the pregnancy not only represents an unwanted responsibility but also the end of hope of further education, financial advancement and improved social

opportunities in life. Young women in the university environment are away from home for the first time and become free to experiment sexually especially without any parental supervision. For the young females, there is usually associated coercion from older students and the liberal atmosphere of the university, which are factors that further encourage this experimentation. Coupled with their lack of, or poor knowledge of contraception, quite a few usually end up with unwanted pregnancies and are quite often faced with the predicament of dealing with the problem.

It has however been observed that correct and timely sexual and reproductive health information can make available the requisite knowledge and skill that is needed to make informed choices among adolescent girls. Kuti (2012) unveils that “young people often complain about sexuality; that government and churches fail to convey the right messages about sexuality to them; that there is a lack of communication with their parents especially about sex and HIV and AIDS”. She further stressed that these young people complain that they learn from their peers and suffer considerable peer pressure. It has also been observed by the World Health Organization (2015) that adolescent mothers often lack knowledge, education, experience, income and power relative to older mothers.

In Nigeria many young pregnant ladies often face the harsh consequence of being thrown out of the house by their parents. They are often subjected to rejection and denial by the person who impregnated them and they also face the risk of dropping out of school. Because of the fear of being subjected to shame and ridicule, and because of the family name which is at stake, pregnant adolescent girls may engage in unsafe induced abortion procedures which is usually inimical to their health and can lead to serious reproductive health outcomes, and ultimately, death.

II. CONCEPTUAL CLARIFICATIONS

Reproductive health

Alubo (2011) in the African journal of Reproductive Health defined reproductive health as “the whole array of counsel, information and services required and necessary for safe and healthy sexual expression. It concerns health and illness in relation to the body’s reproductive function”. A working definition of sexual health has been given as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Thus, sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The United Nations Population Information Network defines reproductive health as ‘a state of complete physical, mental and social well-being. It is not merely the absence of disease or infirmity, in all matters relating to the reproductive health system, its function and processes. Young people’s reproductive health is therefore very vital as it forms a strong foundation for them as they transcend from childhood into adulthood, and if not addressed it can lead to poor adolescent health which can tremendously make them vulnerable to diseases and affect their family circumstances thereby reducing on their life expectancy.

Adolescence

United Nations defines adolescence as all persons aged between the ages of 12 to 19 years. However, the age ranges of adolescences trends to vary as per a given society or culture. For example, there are three identified concepts of age; social age, chronological age and biological age. The chronological concept used in Nigeria measures important biological and cultural highlights. A case in point is the measure of the average age prescribed for high school level pupils determined as 13 and 18 years. Children’s Act reveals that a child may consent to his or her medical treatment or surgical operation or that of her/his or child if that child is over the age of 12. Therefore, as highlighted above, the term adolescence as used in this research refers to young girls between the ages of 12 to 18 years.

Adolescent pregnancy, Illegal Abortion and Health Care Providers

Adolescent pregnancy also referred to as teenage pregnancy is the pregnancy that occurs with a teenage girl of 19 years and below and in which case these girls have not reached the legal adulthood age. While, Illegal abortions are procedures that are undertaken by anybody who is not skilled or by skilled health workers under conditions that violate the laws on termination of pregnancy. These include absence of approved clinical environment to provide safe abortions, health workers using poor quality medications and offering abortions beyond 20 week of pregnancy. This can be self-induced or induced by unauthorized person. Because of the conditions in which they are operated, illegal abortions are often linked with life threatening conditions. According to the Mosby’s Medical Nursing and Allied Health Dictionary a health care provider is described as any person who has acquired skills and is certified by a registered and recognized professional body or government organization to provide health services.

Maternal Mortality and Termination of Pregnancy (TOP)

This is referred to the death of a woman during or while giving birth or death within 42 days after delivery, miscarriage or termination of a pregnancy in which case the death of this woman is associated with pregnancy or treatment as opposed to any other cause of death. While, termination of pregnancy also referred to as induced abortion is defined by the legal dictionary 'as the spontaneous or artificially induced expulsion of an embryo or foetus', from the womb before it doable age. In Nigeria termination of pregnancy is illegal. Commonly used method of TOP in the first trimester is by drugs and surgical procedures in a few cases well as the second trimester there is the use of drugs and dilation and evacuation is used. TOP in the third trimester is only allowed in situations that pose a life threat to the life of a pregnant.

III. THEORETICAL BASE

Theory of Planned Behaviour

Ajzen (1991) reveals that the theory of planned behaviour is established on three principles; behavioural beliefs, normative beliefs and control beliefs. Behavioural beliefs acknowledge possible perception of what others view towards the specific behaviour which in many ways can result in social pressure or subjective norm. Lastly control beliefs which regards beliefs about existence of aspects that may aid or hinder performance of a behaviour; such outcomes of the behaviour in question may generate constructive or adverse attitudes towards the behaviour. Normative beliefs on the other hand, relate to one's attitudes which can elevate perceived behavioural control. The attributes above therefore, can direct development of behaviour intentions in human beings. For instance, an individual's rationale to undertake a given action can be persuaded by his or her acquisition of positive attitudes, subjective norms and greater perceived control. This theory therefore, facilitated the research in asserting the attitudes, behaviour and external factors that determine adolescent's preferences for unsafe abortion services.

The planned behaviour theory highlighted above is the basis on which this behaviour model was developed. The use of this model is vital as it helps us to identify, determine and explain why certain behaviours keep reoccurring as well as help in changing appropriate behaviour of a given health problem. In determining the factors that are related to the problem, it helps to explore appropriate interventions which are likely to create positive change. In this study we apply the term 'Behaviour change' to specifically refer to the 'behaviour needs that need to be changed'.

In attempting to understand behaviour for young people, research indicates that sexual and reproductive health and rights (SRHR) initiatives for young people that are contrasted on 'behaviour change models' are bound to be successful. These Change models assert that all problems particularly health and rights problems are deciphered into behaviour. For instance, 'highlighted behaviour of the young pregnant girls at risk' could be a result of the negative 'behaviour of the people in their environment' like the attitudes of healthcare workers towards teenage pregnant girls and their decision to terminate a pregnancy thus turning to unsafe alternatives. This model also helps us analyses why young girls respond negatively towards access to abortion services by differentiating several factors that can affect behaviour.

IV. EMPIRICAL FINDINGS ON REPRODUCTIVE HEALTH KNOWLEDGE

Börjesson, Pedersen and Villa (2014) reveals in their study that in majority of the African countries including Nigeria, many adolescents lack access to correct information about reproductive health issues such as safe abortion and contraception. This is due to the fact that issues on sexuality and reproduction are said to be cultural taboos. Adolescents' lack of appropriate knowledge about their reproductive system and rights therefore, greatly influences their ability to make informed reproductive health choices including their fertility. Even in environments where abortion is liberalized like South Africa, adolescents' still lack appropriate knowledge about their reproductive health system and development like detection or avoidance of pregnancy. Undeniably when young women are ignorant about their reproductive rights and the law thereof, they are susceptible to distorted information within their social networks or gatekeepers. This is evidenced by a study undertaken in Cape Town which submitted that unsafe and illegal abortions were partially encouraged following the misinformation provided to women concerning 'repeat abortions' 170 which is in contradiction with the law.

The major source of information for participants about abortion was from friends and parents and teachers played a minor role in among those participants who were still in school. This result correlates with what Mitchell, Halpern, Kamathi, and Owino (2006) observed in a Kenyan study on knowledge and perceptions of adolescents about abortion, where friends were the main sources of information cited by participants. However, this result contrasts another study which reported that adolescents consider their parents as useful sources of advice on sex matters (Adaji, Warenius, Ong'any and Faxelid, 2010), although other investigators (Correia, Monteiro, Cavalcante, and Maia, 2011) have shown that sexual matters are not discussed freely with parents. Investigating teenage sexual activity among secondary school girls in Brazil, Correia found that the teenagers receive very little sex education from their parents. This could be due to the fact that talking about sex

is still regarded as a taboo in many societies. Since parents and teachers provide little information about abortion and its complications to youths, it is now friends who pass on the information to their peers yet themselves are not necessarily well informed. This was reflected by the different meanings of what abortion participants gave.

From both the quantitative and qualitative aspects of the study of Justin, Sam, Julius and Paul (2013), it shows that participants were aware of complications of induced abortion. An important proportion of participants (60.2%) knew someone who became sick after undergoing an abortion. Also, more than 90% knew at least one complication of an induced abortion. The most commonly mentioned complication was death followed by bleeding, infertility, infection and genital tract trauma. Similar findings were reported in a cross-sectional study in Ethiopia about the knowledge, attitude, behaviour and practice of women on abortion by Senbeto, Alene, Abesno and Yeneneh (2005). This study also showed that awareness about complications of induced abortions was high among female youths with 75% of them knowing the complications of induced abortions. Buga (2002) in a cross-sectional study on attitudes of medical students to induced abortion, asserts that 87.2% of respondents were willing to refer a woman for abortion under certain circumstances such as threat to the mother's life, rape, severely malformed fetus, threat to the mother's mental health, and parental incompetence. Only 12.8% of respondents would not refer colleagues for an abortion under any circumstances. This contrast in the results may be due to the fact that in South Africa abortion is legal and the study population in the two studies was not standardized. However, in the focus group discussions, the few participants who supported abortion and were willing to refer others for abortion provided reasons. This means there is usually a reason why people choose to abort.

Justin, Sam, Julius and Paul (2013) opined that participants who did not have any knowledge about the abortion law in the country and those who would have considered abortion if pregnant at the time of the study were more likely willing to refer others for an abortion. This means lack of knowledge about the abortion law contributes to abortion consideration by female youths. This also means that personal attitude towards induced abortion influences a person's advice toward others regarding abortion. This tendency was reflected in the focus group discussions where participants who were willing to refer others for abortion were also themselves willing to undergo the procedure if pregnant.

V. PREVALENT UNSAFE INDUCED ABORTION IN NIGERIA

Mohee and Mohee (2006) stressed that abortion is the termination of pregnancy before viability. Viability in medical spheres has pegged at 28 weeks of pregnancy but improvements in modern technologies now appear to be changing this (Hesse and Samba, 2006). Abortion is therefore the termination of pregnancy before its 28th week (WHO, 2012). It includes the termination of pregnancies resulting from natural causes or otherwise. Abortion resulting from natural causes is termed as spontaneous abortion, while that resulting from intentional act of human is termed as induced (Worldometers, 2015).

Induced abortions are both legal and illegal depending on their circumstance in which they are undertaken. What constitute legal and illegal abortion varies across countries. Generally, abortion becomes legal when it done within the legal provisions of a country. However, if abortion is done out of the domain or the legal provision, it becomes illegal (Biswas et al, 2012). McKechnie (1983) opined that abortion becomes illegal or criminal when it is outside the provisions of law. What makes abortion criminal is in terms of the legalities and circumstances under which the act is undertaken. For the purpose of this study, criminal abortion refers to any induced abortion undertaken for any reason outside medical or outside legal provisions and supervision within a given jurisdiction.

Almost one-third of Nigerian women of childbearing age have had an unwanted pregnancy. Although Nigerian women and men still want large or midsize families, almost one-third (28%) of women of childbearing age say they have had an unwanted pregnancy.

The proportion is the same in the North and the South, but it is higher among rural women than among their urban counterparts (30% vs. 24%). The proportion is also higher among women with at least four children than among their childless counterparts (29% vs. 23%). This difference largely reflects that women with more children are generally older, which means that they have been exposed to the risk of unwanted pregnancy for a longer time. Due to various reasons, youths are vulnerable to unplanned and unintended early sexual encounters which lead to unwanted pregnancies. They are therefore exposed to seek for induced abortion and candidates to suffer its complications. The adolescent who undergo an induced abortion expose themselves to serious health risks such as haemorrhage, genital injuries, sepsis (Mbonye, 2000; Mirembe, Karanja, Hassan and Faúndes, 2010) and death (Silberschmidt, 2001). In general, in many African countries women younger than 20 years of age represent up to 70% of women treated for abortion complications (Mbonye, 2000; Ahman and Shah, 2011). Nigeria has one of the highest teenage pregnancy rates in the world of 25% (DHS, 2006/07).

VI. FACTORS RESPONSIBLE FOR UNSAFE ABORTION IN NIGERIA

With the fact that abortion is illegal in Nigeria, still safe abortion services are available. Some of the factors that necessitated unsafe abortion in Nigeria are identified and articulated below:

i. Socio-cultural factors

One of the reasons why abortion is unsafe is the stigma within the community attached to the termination of the pregnancy. Women because of confidentiality issue don't discuss the pregnancy with any one for the fear of being exposed. Because of the same fear they delay in seeking healthcare services till the pregnancy is too advanced, and this increases the possibilities of complications. Sometimes they prefer the services of unqualified personnel far from their communities because of stigma in spite the availability of safe procedure in their communities. The idea is that if they go to the qualified personnel, the pregnancy will be known (Henshaw, et al, 2010). Even when a complication arises they remain at home until it becomes worst before they seek health care. All these factors contribute to the reasons why abortions are unsafe.

Religion is another obstacle to obtaining safe abortion in Nigeria, it is considered as a sin by most of the faith based organizations. There was a move to liberalize abortion law by the southern state of Imo, but it met a very high resistance from both religions. The state chairman Christian association was quoted saying "the right to life of the unborn child is inherent to the child and antecedent to all human rights". The catholic women association of Nigeria also believed that, abortion is a murder of the unborn innocent child, which has to be prevented at all cost (Baptist press 2001).

Muslim clerics also were not left behind as one of the Lagos Imams said abortion is manslaughter and any perpetrator should be treated as such. He even quoted a verse from the holy Koran chapter seven verses 31 to 33 where Allah says "kill not your children for fear of what the lord shall provide, sustain them as well as the mother. Verily the killing of them is a great sin." In essence the verse is saying don't kill because of fear you cannot provide for yourself and the child, God is the overall provider. Because of all these religious views, women will find it difficult to procure safe abortion freely in Nigeria (Baptist press, 2001).

ii. Economic reasons

Poverty is one of the reasons female adolescent procure unsafe abortions in spite of the availability of safe abortion methods in the country (Koster, 2010). The cost of abortion services is proportional to the qualification and the skills of the provider. Generally, the cost is higher if a medical doctor or trained nurse provides the services and it is cheaper when provided by traditional healer, non-trained provider or induced by the women themselves (Ibrahim, Jeremiah, Abasi and Adda, 2011).

A study conducted on the perception of health care providers about induced abortion in Nigeria revealed that, the majority of the prosperous women both in the rural and urban areas use the services of qualified health professionals (Adebusoye, Singh and Audam, 1997). While rural and urban poor and adolescents cannot afford the exorbitant cost charged by the professionals, they instead patronize the services of cheap untrained personnel or herbalists for the services. A report by the Guttmacher Institute in 2006 reveals that, only 44% of the poor women patronize the services of trained health care providers against 66% of prosperous women. And 30% of poor women procure the services of traditional healers while only 14% of the non-poor utilized their services (Guttmacher Institute, 2006).

Disparities also exist between the south and the north in terms of safe abortion services affordability. The adolescent and women in the southern part of the country being more prosperous are more likely to be able to afford the services of trained qualified professionals such as doctors, nurses and midwives. On the other hand, the northern adolescent or women being poor cannot afford such professionals, are more likely to use the services of unqualified quacks, traditional healers and chemists (Adebusoye, Singh and Audam 1997).

A study conducted by Henshaw (2008) asserted that unsafe abortion has serious economic consequences for the women, their families and the healthcare setting. In spite abortion being illegal in Nigeria, with available resources women can get a safe abortion in the private hospitals by qualified personnel. The study also indicated that the cost of abortion is directly related with the techniques involved and the type of the provider and many women will find it difficult to afford the services of medically trained providers (Henshaw, et al. 2008). The safety of the procedures involved also determines the cost of the abortion. The Manual Vacuum Aspiration (MVA) is generally considered the safest and most expensive followed by Dilation and Curettage (D&C), while tablets obtained from physicians are generally cheaper (Henshaw et al. 2008).

Age and maturity are also important factors in making abortion unsafe. Married or older women are more prosperous and can afford the services in private hospitals, while young girls in school do not have the privilege to afford such expensive hospital charges (Koster 2010). Also the young girls may not have the experience to recognize pregnancy at an early stage; majority realizes they become pregnant at an advanced stage, mostly in the second trimester. Because of this the young inexperienced are most likely of having

complications of a late unsafe abortion (Henshaw et al. 1998; Koster 2010; Adebuseye, Singh and Audam 1997).

iii. Educational Qualification and Health Care Services

Since education is an eye opener, it plays a vital role in determining the safety of abortion. Evidence has shown that educated adolescent always try to access safe abortion services. Being educated gives them the advantage of differentiating between professional health providers and quacks, and to be aware of the possible complications of unsafe abortions. At the same time, they are more likely to discuss the issue with their friends to obtain a good advice of where to secure safe abortion. Another barrier to accessing safe abortion services in Nigeria is poor quality and non-availability of health services (WHO 2011). The majority of the private hospitals in Nigeria that provide the services are not sufficiently equipped and the doctors or the midwives are not well trained to handle such cases (Henshaw et al. 1998; WHO 2011). One of the safest means of pregnancy termination is the Manual Vacuum Aspiration (MVA), but most of the doctors prefer Dilation and Curettage (D&C) because they don't know how to carry out an MVA. Sometimes the distance women have to travel to access the services is the main barrier to obtaining safe abortion especially in the rural areas (Henshaw et al., 1998).

Healthcare providers, especially medical doctors are supposed to be the advocates of safe abortion services, but this is not always the case in Nigeria. A study conducted in Calabar to explore the knowledge, attitudes and practice of private medical practitioners towards post abortion care reveals that, majority of the doctors said they will not terminate unwanted pregnancy. The reason being it is unethical, religiously wrong, and against the medical profession. But majority of them said they offered assistance to women with post abortion complications (Etuk, Ebong and Okonofua, 2003). Overall the attitude of the staff is one of the main obstacles to accessing safe abortion services for many Nigerian women (Etuk, Ebong and Okonofua, 2003; WHO 2011). Stigmatization of the abortion providers and health facilities by the community are some of the reasons doctors or the nurses are not willing to offer the services.

The distribution of the health facilities shows that most of the private facilities that provide abortions are concentrated in southern Nigeria, while only few in the north do provide such services. Even in the northern part, the majority of the hospitals are located in the urban areas. This disparity leaves the rural dwellers at the mercy of traditional healers (Adebuseye, Singh and Audam, 1997). This further reiterated the reasons why women in the north are more likely to procure unsafe abortion and even worst for those in the rural north.

iv. Legal Restriction

Abortion is legal in Nigeria only to save the life of the mother. Section 228 of the criminal code, states that "any person who with intent to procure miscarriage of a woman, whether she is, or not with a child, unlawfully administers to her or causes her to take any poison, is guilty of felony and is liable to 14 years' imprisonment." Section 229 of the same criminal code gives any woman involved in the crime a minimum of seven years' imprisonment, while according to section 230, the doctor involved will be jailed for three years (Ilumoka, 1991).

However, section 297 states that "A person is not criminally responsible or performing in good faith and with reasonable care and skills a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regards to the patient's state at the time and to all circumstances of the case" (Ilumoka, 1991).

VII. IMPACT OF UNSAFE ABORTIONS ON THE REPRODUCTIVE HEALTH IN NIGERIA

In Nigeria induced unsafe abortion is a serious cause of morbidity and mortality among female adolescent. Although the real magnitude of the problem can only be estimated because only a small proportion (9%) of those complicated cases are presented to the hospitals. Because of the illegality of abortion in the country, most of the pregnancy terminations are carried out by illegal unqualified quacks or by the women themselves. The terminations are by using all sorts of instruments in dirty environments (Okonofua, 1991). Unfortunately, even the registered medical practitioners in the country sometimes lack the necessary skills and motivation to perform the procedures safely. And the worst part of it is that most of the hospitals lack the necessary equipment and skilled personnel to handle such complications when they arise (Okonofua, 1991)

The most common early complications of unsafe abortion are: haemorrhage, sepsis, uterine perforation, bowel perforation, trauma to the cervix mostly by the instruments used, acute renal failure, bladder injury, deep vein thrombosis, tetanus, bowel fistulae and death from anaesthesia (Ibrahim et al 2011; Bankole et al 2006; Okonofua 1991; Rehan 2011). Some of the rationales responsible for most unsafe abortion are: chronic ill health of the adolescent, existing sexually transmitted diseases, skills and experience of the providers, the methods

involved, hygienic conditions, and gestational age of the pregnancy and the legality of the procedure (WHO, 1997).

A study conducted by Guttmacher Institute in Nigeria reveals that one out of every four women that underwent abortion has developed one form of complication or another. With 25% of them developing a serious life threatening complication ranging from severe bleeding, high-grade fever to injury to the visceral organs. These complications warrant admission and about 10% requiring abdominal surgery (Bankole, et al, 2006). The complications are more severe with increasing gestational age of the pregnancy. 58% of the women develop complications if the procedure is performed after 12 weeks, while only 20% will experience complications if the pregnancy is less than 12 weeks. This equals similar results of studies conducted elsewhere (Bankole et al. 2006; Ibrahim et al. 2011; Fetters et al. 2008). The level and severity of the complications also depend on the methods and the skills of the providers. The complications are more severe among women that use traditional remedies (36 %) and less among those that use injections or tablets: (10%) and (19%) respectively (Bankole et al. 2006).

Sepsis is the commonest early complication of unsafe abortion. It normally manifests itself with high-grade fever and purulent or pensive vaginal discharge. It mostly arises due to use of unsterilized instruments by quacks or by the women themselves. It accounts for 50-80% of all complications from illegal abortion in the country. The finding is in line with a study conducted in Niger Delta in 2011, which shows that genital sepsis carried 88.9% of all the complications of unsafe abortions followed by retained products of conception 82.5% (Ibrahim et al. 2011). Sepsis is considered as the main cause of maternal mortality and if the woman survives she might end up with long-term health consequences

VIII. LATE COMPLICATIONS

Late complications of unsafe abortion include: secondary infertility, chronic pelvic pains, chronic pelvic inflammatory diseases and maternal mortality.

i. Secondary infertility

Secondary infertility is one of the serious complications of unsafe abortions worldwide. According to WHO estimate, 20-30% of unsafe abortions cause reproductive tract infections and 20-40% of which is responsible for the upper genital tract infection and secondary infertility (Grimes et al. 2006). Furthermore, the report revealed that 2% of women of childbearing age 15-49 years are infertile as a result of unsafe abortion (Grimes et al. 2006). In spite of the high fertility rate in Nigeria (5.7 children per woman) (NDHS 2008), infertility is still very high and varies among the ethnic groups. It ranges from 10.5 in the north to 14.6 in the southwest and to as high as 19.1 among the Igbo's in the southeastern Nigeria (Araoye 2003).

The growing rate of secondary infertility due to abortion has been attributed to the various methods used by both trained and untrained illegal abortionist, such as inserting different instruments in the uterus. Others are cervical dilatation, introducing chemicals or traditional remedies to induce abortions. Sometimes-foreign bodies such as needles, bones and tree's back are inserted. These result in multiple injuries to the reproductive organs especially the vagina, tubes and the uterus. Such injuries result to various forms of long term complications from vaginal Artesia, uterine syneciae, cervical incompetence and cervical fibrosis to complete tubal blockage that consequently lead to secondary infertility (Eyo, Epuji, and Ukpung 2012). Sometimes infertility results because of complete removal of the uterus to treat complications of unsafe abortions (Okonofua 1991).

ii. Maternal mortality

Maternal mortality is the death of a woman while pregnant or within forty-two days of termination of the pregnancy, irrespective of the site or duration of the pregnancy, from causes that are directly related or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO 2014). Maternal mortality from unsafe abortion is a serious global problem that continues to threaten the lives of many women. World Health Organizations (WHO) reveals that in every eight minutes a woman is dying of unsafe abortion, at the rate of 367 maternal deaths per 100,000 unsafe abortions (Grimes et al. 2006). And more than 97% are in the developing countries with restrictive abortion laws and poorly organized healthcare services. Among those that survive the early complications; over 5 million will suffer serious long-term complications (Haddad 2009).

Unsafe abortion is responsible for about 30-40% of maternal mortality in Nigeria (Henshaw et al. 1998), and the estimate is likely to be higher considering those dying at home and before reaching the health facilities (Henshaw et al. 1998). Another study conducted in some of the hospitals in the country shows that unsafe abortion is responsible for up to 51% of maternal deaths. That study shows that unsafe abortion is one of the leading causes of all maternal mortality in the country. The case fatality rate ranges between 1.0% and 1.5%, which means that, for every 100 illegal abortions performed one woman will die. This is three times higher than the global estimate (Bankole et al. 2006).

iii. Ectopic pregnancy

Another serious long-term complication of unsafe illegal abortion is ectopic pregnancy in subsequent pregnancies “Ectopic pregnancy is pregnancy that occurs outside the uterus which is considered life threatening to the woman” (UMMC 2014). According to the Guttmacher Institute, unsafe abortion increases the chance of ectopic pregnancy, premature labor and recurrent spontaneous abortion in the subsequent pregnancies (Grimes et al. 2006; Okonofua 1991). Another study revealed that, post abortive infection as a result of unsafe illegal abortion increases the chance of ectopic pregnancy five-fold in women that had pelvic abscess and adhesions because of a complicated unsafe abortion (Chung et al. 1982).

iv. Chronic pelvic inflammatory disease

Pelvic inflammatory disease (PID) is “an infection of the woman’s reproductive organs (uterus, fallopian tubes and ovaries) and upper genital tract” (CDC 2014). PID is one of the late complications of unsafe abortions. It normally presents with lower abdominal pains, vaginal discharge and sometimes adnexal tenderness. A study conducted in India shows that, there is a link between induced illegal abortions and PID. The study has further shown that in India 26% of women with PID attending gynaecological clinic has had unsafe abortion, and the same study reported 23% in Pakistan (Patel, Baxi and Diwanji, 2010). PID is a result of an infection already existing in the women’s reproductive tract or introduced by the abortionist through the instruments used to terminate the pregnancy. Sometimes the infection is within the unhygienic environment in which the abortion was performed. And if it is not properly treated can lead to chronic pelvic pain and secondary infertility.

IX. CONCLUSION

United Nations (1981) sees adolescence as all persons aged between the ages of 12 to 19 years. However, the age ranges of adolescences trends to vary as per a given society or culture. For example, there are three identified concepts of age; social age, chronological age and biological age. The chronological concept used in Nigeria measures important biological and cultural highlights. Abortion is the major reproductive problem that affects all women of reproductive age group especially young women and adolescent girls who may prefer induced abortion than other ways. Unsafe abortion is more common among single women, teenagers, students and factory workers (Singh et al., 2018). It is confirmed that unsafe abortion has been one of the three leading causes of maternal mortality along with haemorrhage and sepsis from childbirth along with thousands of disabilities like reproductive tract infections (RTI), pelvic inflammatory disease and infertility. Each year, approximately 21 million unsafe abortions are performed worldwide with a number of negative consequences (WHO, 2011).

X. RECOMMENDATIONS

- Adequate information/education in respect to reproductive health knowledge and the dire consequences of self-induce abortion should be unveiled to young ladies at the different strata of our educational institutions and the rural communities in Nigeria by trained medical practitioners.
- Sex education should be given to young ladies in the family, schools and religious organizations in order to curb the rate of unsafe induce abortion in Nigeria
- The use of contraceptives should be encouraged in order to avoid unwanted pregnancy
- The trained medical practitioners and quacks health care providers who are into the business of illegal abortion in tandem with the victims should be prosecuted and decisively dealt with in order to serve as deterrence to others
- The government should encourage small family size, and the dire consequences of overpopulation should also be revealed to the general public.

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