

FAMILY SIZE DYNAMICS AND INDUCED ABORTION AMONG WOMEN IN RURAL NIGERIA

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Abstract

Induced abortion is legally restricted in Nigeria; it is permitted only to save the life of the woman. Despite the restrictive abortion law, several reports indicate that induced abortion is widespread in some countries and that it is associated with high rates of maternal morbidity and mortality. The general objective is to empirically examine the effect of family size on the incidence of induced abortion among the women in the study area. The study was anchored on the theory of Symbolic Interactionism. The survey method was adopted for this study. The population of married women aged 15 – 49 years in Ogube is estimated at 2,500. The sample size was 240 respondents drawn from the six villages in Ogube through simple random sampling method. The questionnaire was used for data collection. Data collected were analyzed through frequency tables and the chi square. The following results emerged: a majority of the respondents (69.5%) are below 32 years; a majority of the respondents are currently married (88.5%); about half of the respondents (50.0%) were Catholics; a mean age at first marriage of 23 years and median age of 23.5 years . there is significant association between the number of children already had and incidence of induced abortion; there is significant association between the number of sons already had and involvement in induced abortion; there is significant relationship between sex of children already had an incidence of induced abortion among married women in the study area. The study recommends greater awareness on contraception among women in the study area and a scale up of general services on reproductive health.

Key words; Family size, Induced abortion, Women, Rural Nigeria

Introduction

Fertility decision making is a very crucial aspect of reproductive health in particular and studies in human population in general. The incidence of induced abortion has been recognized as a proximate determinant of human fertility. A woman's decision to be involved in induced abortion is not just a reproductive health decision but a crucial fertility decision. The present study interrogated the extent to which family size is implicated in such crucial decision.

In Nigeria, induced abortion is legally restricted yet women with unmet need for family planning go out of their way to procure services for induced abortion. In the literature, several factors are implicated for the above action but this study concentrated on family size. This is because the Igbo of Southeastern Nigeria are pronatalist and whatever factor that challenges their pronatalist inclination deserves an empirical investigation.

Background and Problem Statement

Induced abortion is legally restricted in Nigeria; it is permitted only to save the life of the woman and, in the southern states of the country, also for physical and mental health reasons. Despite the restrictive abortion law, several reports (Okonofua, 1997; Fletcher, 2014; Erdman, 2014, Jones, Jacqueline and Henshaw, 2002) indicate that induced abortion is widespread in some countries and that it is associated with high rates of maternal morbidity and mortality. World Health Organization (WHO) reports show that in developing countries one woman dies of complications of unsafe abortion every eight minutes (Manandher, El Ayadi, Butrick Husang and Miller, 2015).

Abortion is the termination of pregnancy before the embryo/fetus (baby in the womb) attains the age of viability (maturity) WHO (2003). In most developing Country like Nigeria, the age of viability is accepted to be 28 weeks of gestation i.e. seven months. Okoye (2006) noted that abortion is the termination of pregnancy before the fetus attains birth weight of 500gm or a gestational period (age of 20 weeks). The latter is applicable in developed countries where advanced technology is employed in salvaging much younger fetuses.

. Medically, abortion can be classified into three (3) groups based on the surrounding circumstance that lead to it; they are;

- i. Spontaneous abortion
- ii. Therapeutic abortion
- iii. Induced abortion

Spontaneous abortion is defined as natural or unaided termination of pregnancy before fatal maturity. This type of abortion is commonly referred to as miscarriage. This type of abortion rate increases when the maternal and natal care is insufficient.

Therapeutic abortion is said to be therapeutic when there is a medical reason for it to be done and it must be permitted by existing law of the country. It is a planned termination of pregnancy in an approved hospital setting. This implies that there are exceptional cases, where abortion maybe allowed by both the medical governing body and the law. Under this clause however, the conditions for this to take place includes life threatening health conditions in the mother such as cancer, heart failure, kidney failure and other debilitating ill health.

Induced abortion is the type that is commonly referred to as abortion both by religious and non-religious people. It is defined as an artificial or intentional act of terminating pregnancy using any method against laws of the country. This may include the use of drugs, mechanical devices, manipulations or instrumentations (Okoye, 2006:8). Because of the illegal status of the procedure, public health facilities often do not provide safe abortion services and only a few offer evidence-based post-abortion care. (Bankole et al, 2015). The immediate explanation that women often give for seeking induced abortion is that the pregnancy was unplanned or unwanted. However, the myriad social, economic and health circumstances that underlie such explanations have not yet been fully explored. (Bankole et al 2015)

The general objective is to empirically examine the effect of family size on the incidence of induced abortion among the women in the study area.

This was measured by asking respondents questions on the number of live births ever had, their sex as well as involvement in induced abortion

The study area (ogube-ihube) is located in Okigwe Local Government area of Imo state. The study area is along Enugu-Port Harcourt express road whose boundary from the east is Leru in Umunneochi Local Government area and Uturu in Isuikwuato Local Government area, both in Abia State from the west and south with Amagu Ihube autonomous community and in the north with Agbala in Ihitte Ihube autonomous community both in Okigwe Local Government area. Ogube is known as “Ogube ala nkume na ala uzuzu” (stone and sandy area); Ogube is made up of six villages; they are: Ndielugwu, Ndiagbo, Umuche, Umualia, Umuonyebiara and Umurogwo.

Review of Literature

Scholars have identified some factors associated with family size preference. One is the economic utility preference; sons are more likely than daughters to provide family labour on the farm or in a family business, to earn wages, and to support their parents during old age, although there is some recognition that sons are no longer a dependable source of old age support (Bardhan, 1985). Upon marriage, a son brings a daughter-in-law into his family, and she provides additional help around the house. Another important advantage of having sons is their socio-cultural utility. In the context of having a son is imperative for the continuation of the family line, and many sons provide additional status to the family (Caldwell, Reddy and Caldwell, 2009). Finally, the utility of having sons arises from the important religious functions that only sons can provide. Among the Igbo tradition, sons are needed to perform the funeral rites of their deceased parents and to help in the salvation of their souls.

A cultural preference for sons (Okonofua, 2005) may be a factor driving recourse to induced abortion in Nigeria, as women carrying female fetuses may decide to terminate their pregnancies. A variety of factors influence couple to have male children, such as continuation of family lineage, ritual and religious purpose, economic reasons, old age dependence, upward social mobility, and source of power (Ahiadeke, 2001).

Sex-selective abortion accounts for roughly 11 percent of late-term unsafe abortions (Agrawal, 2004). Sex-selective abortion, however, is not only the result of an unintended or unwanted pregnancy. Indeed, it is the gendered preference for a certain type of pregnancy that guides the decision to undergo sex-selective abortion (Mallik, 2002). The pressure to have sons has intensified as couples strive simultaneously to reduce family size and ensure the birth of the desired number of sons, leading to increased acceptance of and reliance on the use of sex-selection strategies to achieve those results. The use of coercive measures in implementing population policies particularly undue emphasis on the use of permanent methods can easily lead to an intensifying trend toward sex determination and sex-selective abortion (Mallik, 2002). The World Health Organization and UNICEF(WHO, 2007), and with other United Nations Agencies, have found that measures to reduce access to abortion are much less effective at reducing sex-selective abortions than measures to reduce gender in equality.

In the study by Izugbara and Ezeh (2010), it was observed that the respondents were of the view that serving Allah with one's fertility is exemplary behaviour for good Muslims hence Islam mandates that its adherents perpetuate the religion by having many children among other ways

Okonofua (2005) looked at abortion and maternal mortality in the developing world using data from WHO which indicate that the risk of dying from unsafe abortion is highest in Africa. Induced and unsafe abortion is an important public health problem and a significant cause of maternal mortality in developing countries. He contributed that application of a public health approach based on primary, secondary, and tertiary prevention can reduce morbidity and mortality associated with unsafe abortion in developing countries. Efforts to address these problems will contribute both to reducing maternal mortality associated with induced abortion and to achieving the Millennium Development Goals in developing countries.

Shah and Ahman (2009) examined unsafe abortion a global and regional incidence, trends, consequences, and challenges. Their aims were to provide the latest global and regional estimates of the incidence and trends in induced abortion, both safe and unsafe. A related objective is to document maternal mortality due to unsafe abortion. The legal context of abortion and the international discourse on preventing unsafe abortion are reviewed to highlight policy implications and challenges in preventing unsafe abortion. Their data was obtained using the database on unsafe abortion maintained by the World Health Organization. Additional data from the Demographic and Health Surveys and the United Nations Population Division are used for further analysis of abortion and mortality estimates. Their results shows that each year 42 million abortions are estimated to take place; 22 million safely and 20 million unsafely. Maternal mortality ratios (number of maternal deaths per 100,000 live births) due to complications of unsafe abortion are higher in regions with restricted abortion laws than in regions with no or few restrictions on access to safe and legal abortion. They concluded that legal restrictions on safe abortion do

not reduce the incidence of abortion. Providing information and services for modern contraception is the primary prevention strategy to eliminate unplanned pregnancy. Providing safe abortion will prevent unsafe abortion. In all cases, women should have access to post-abortion care, including services for family planning. The Millennium Development Goal to improve maternal health cannot be achieved without addressing unsafe abortion and associated mortality and morbidity.

Sedgh, Singh, Henshaw and Bankole (2012) were of the view that unsafe abortion has a significant impact on women's health in Guatemala. Comprehensive government programs are needed to address the issues of intended pregnancy and unsafe abortion, with attention to regional differences.

Lawrence (2005) experimented on reasons U.S. women have abortions a quantitative and qualitative perspectives. Their data was collected using a structured survey that was completed by 1,209 abortion patients at 11 large providers, and in-depth interviews were conducted with 38 women at four sites. The data was analyzed using multivariate logistic regression models and examined the differences in the reasons for abortion across subgroups. Their results shows that the reasons most frequently cited were that having a child would interfere with a woman's education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%). Nearly four in 10 women said they had completed their childbearing, and almost one-third were not ready to have a child. Less than 1% said their parent's or partners desire for them to have an abortion was the most important reason. Younger women often reported that they were unprepared for the transition to motherhood, while older women regularly cited their responsibility to dependents. They concluded that decision to have an abortion is typically motivated by multiple, diverse and interrelated reasons. The themes of responsibility to others and resource limitations, such as financial constraints and lack of partner support, recurred throughout the study.

Sedgh et al (2012) examined induced abortion: incidence and trends worldwide from 1995 to 2008. They explained that data of abortion incidence and trends are needed to monitor progress toward improvement of maternal health and access to family planning. Their estimates for safe and unsafe abortion worldwide were made only for 1995 and 2003. They used the standard WHO definition of unsafe abortions. Their estimates for safe abortion were based largely on official statistics and national representative surveys and estimates for unsafe abortion were based primarily on information from published studies, hospital records, and surveys of women additional sources where used and also systematic approaches to make corrections and projections as needed where data that were misreported, incomplete, or from earlier years. The data was analyzed using linear regression models to explore the association of the legal status of abortion with the abortion rate across sub-regions of the world in 2008. Their results shows that global abortion rate was stable between 2003 and 2008, with rates of 29 and 28 abortion per 1000 women aged 15 – 44 years, respectively, following a period of decline from 35 abortion per 1000 women in 1995. The average annual percent change in the rate was nearly 2.4% between 1995 and 2003 and 0.3% between 2003 and 2008. Worldwide, 49% of abortions were unsafe in 2008, compared to 44% in 1995. About one in five pregnancies ended in abortion in 2008. The abortion rate is lower in sub regions where more women live under liberal abortion laws.

Agrawal (2004) studied the determinants of induced abortion among women in India and examine the consequences of induced abortion on women's reproductive health. The analysis was done based on 90,303 ever married women or reproductive age, 15 – 49 years, included in India's second national family health survey, conducted in 1998 – 99. The necessary variable he used was sex composition of living children, sex preference, women's age at effective marriage, urban/rural residence, religion, caste/tribe, couples education, couples working status, media exposure, wealth status, and women's autonomy. Binary logistic regression methods were used to examine the association between induced abortion and possible determinant, as well as consequences of induced abortion on women's reproductive health. His results shows that at the nation level, sex composition of living children, women's autonomy, urban residence, couples education, and wealth status were found to be significantly associated with experience of induced abortion among women. Although sex composition of living children and couples education were the major factors for induced abortion in the states, wealth status and caste/tribe were the major factors too. He concluded that women's desire to limit family size with preferred sex composition of children as an

important determinant of induced abortion in India. The study also suggests that induced abortions may have negative consequences for women’s reproductive health. In general, the more children a woman has, the higher the likelihood that she does not want another child (NPC and ICF, 2019).

Theoretical Framework

This paper is anchored on Symbolic Interactionism. Going by the tenets of Symbolic Interaction, the number of children a woman bears is an outcome of the value which she places on family size. Also, the relationship between family size and induced abortion depends on those ideas, beliefs, values, ethos and norms which people concerned hold sacred. For instance, an individual who places high value on large family, will bear as many children as possible to attain desired family size, on the other hand, an individual that places high value on small family size will adopt family planning method, use of contraceptive and induced abortion to achieve desired family size. Symbolic Interaction is considered appropriate as an anchor for this work because family size and induced abortion are aspects of social action which are greatly influenced by ideas, values and beliefs or interpretation the individual or group of people give them.

Methods

The survey method was adopted for this study. The study covers six areas within Ogube – Ihube Autonomous Community which are; Ndielugwu, Ndiagbo, Umuche, Umualia, Umuonyebiara and Umurogwo. It explores the relationship between family size and incidence of induced abortion among married women aged 15 – 49 years in the study area.

The population of the study is made up of married women in Ogube, Okigwe Local Government Area of Imo State. It has a population of more than 10,000 with the exception of those residing abroad. The population of married women aged 15 – 49 years in Ogube is estimated as 2,500. The sample size was 240 respondents drawn from the six villages in Ogube through simple random sampling method. The register of Ogube Development Union (women wing) kept by each of these six villages served as the sampling frame. The questionnaire was used for data collection. Data collected were analyzed through frequency tables and the chi square.

Results

Socio-Demographic Characteristics of Respondents

Table 1: Distribution of Respondents According to Age in intervals

AGE INTERVALS	FREQUENCY	PERCENTAGE (%)
14 – 19	51	25.5%
20 – 25	39	19.5%
26 – 31	50	25.0%
32 and above	60	30.0%
TOTAL	200	100%

The data in table 1 shows that a majority of the respondents (69.5%) are below 32 years ; women between the age of 32 years and above formed 30.0% of the respondents.

Table 2: Distribution of Respondents by Marital Status

MARITAL STATUS	FREQUENCY	PERCENTAGE
Currently Married	177	88.5
Divorced/separated	13	6.5
Widowed	10	5.0
TOTAL	200	100

Table 2 reveals that a majority of the respondents are currently married (88.5%). This helps the study to get information from respondents who were currently involved in reproductive experience

Table 3: Distribution of Respondents by Religious Affiliation

RELIGIOUS AFFILIATION	FREQUENCY	PERCENTAGE
Catholic	100	50.0%
Protestant	70	35.0%
Other	30	15.0%
TOTAL	200	100%

Data in table 3 show that about half of the respondents (50.0%) were Catholics and Protestants were 35.0%. The data also reveal that those who are members of uncategorized religious group are 15.0%. This shows that majority of the respondents are Catholic and also Catholic dominate the area.

Table 4: Distribution of Respondents by Educational Qualifications

EDUCATIONAL STATUS	FREQUENCY	PERCENTAGE
Primary Education	50	25.0%
Secondary Education	84	42.0%
Tertiary Education	25	12.5%
No Formal Education	41	20.5%
TOTAL	200	100%

The data in table 4 show that, 25.0% of the respondents have at least primary school education, while 42.0% had secondary school education; it is only 12.5% that attained tertiary education and the remaining 20.5% have no formal education. This means that a majority of the respondents had at least basic education.

Table 5: Distribution of Respondents by Occupational Status

OCCUPATIONAL STATUS	FREQUENCY	PERCENTAGE
Civil Servant	20	10.0%
Self Employment	40	20.0%
Farmers	90	45.0%
Unemployment	14	7.0%
Others	36	18.0%
TOTAL	200	100%

The data on table 5 show that 45.0% of the respondents are farmers, followed by 20.0% who are self employed, the data also revealed that it is only 7.0% that are unemployed and another 10.0% who are civil servants, while the remaining 18.0% belong to other unclassified occupation.

Table 6: Distribution of Respondents by Age at first Marriage

AGE AT FIRST MARRIAGE	FREQUENCY	PERCENTAGE
15 – 20 years	45	22.5%
21 – 25 years	110	55.0%
26 – 30 years	25	12.5%
31 years above	20	10.5%
TOTAL	200	100%

In table 6 the data show that more than half of the respondents,(55.0%) were married within the age 21 – 25 years; 22.5% of the respondents got married between the age bracket of 15 – 20 years; 12.5% got married at the age 26 – 30 years; while 10.5% falls between the age bracket of 31 years and above. This

means that majority of the respondents got married between the age bracket of 21 – 25 years with a mean age at first marriage of 23 years and median age of 23.5 years .

Test of Hypotheses

Table 7: Association between Number of Children already had and Incidence of Induced Abortion

NUMBER OF CHILDREN	INCIDENCE OF INDUCED ABORTION		
	YES	NO	TOTAL
Below 6 children	43	16	59
6 children	37	28	65
Above 6 children	34	42	76
TOTAL	114	86	200

The calculated χ^2 value (10.735) is greater than the tabulated value (5.99), we accept the alternate hypothesis (H_1) and reject the null (H_0) hypothesis This is an indication that there is significant association between the number of children already had and incidence of induced abortion.

In some societies, the most commonly reported reason why women often seek for induced abortion is that the pregnancy was unplanned or unwanted (Bankole, Singh and Haas 1998). However, the myriad social, economic and health circumstances that underline such explanations have not yet been fully explored, analysis reveals that education, place of residence, age at first birth, desired family size, mass media, NGOs activities, number of children ever born, complications during pregnancy, decision making autonomy power, inadequate number of antenatal care services during pregnancy period was found significant on induced abortion. (Agrawal, 2004). The incidence of induced abortion in relation to parity has been studied in Sweden (Tullberg and Lummaa, 2001) The reason for an abortion may differ between younger and older women. For instance, older women may be more likely than younger ones to choose an abortion because they already have the number of children they desire. It is therefore necessary to control for age and for the number of previous children.

According to the conventional demographic theory, fertility decline occurs once rising level of urbanization and education, changes in the economy, and declined mortality lead parents to desire a smaller number of births. To implement these desires, parents rely on contraceptives, induced abortion and family planning programs accelerate their adoption.

Table 8: Association between the Number of Sons already had and Involvement in Induced Abortion

Number of Sons Had	Involvement in Induced Abortion		
	Yes	No	Total
1 – 2	35	15	50
3 – 4	41	49	90
5 – 6	25	35	60
Total	101	99	200

Since the calculated χ^2 value (10.3578) is greater than ($>$) the tabulated value (5.99), we accept the alternate hypothesis. This is an indication that there is significant association between the number of sons already had and involvement in induced abortion.

Table 9: Association between Sex of Children already had and Incidence of Induced Abortion

Sex of Children	Involvement in Induced Abortion		
	Yes	No	Total
Boys	80	40	120
Girls	35	45	80
Total	115	85	200

The calculated chi-square value (10.3144) is greater than (>) the tabulated value (3.841), we reject the null hypothesis (H_0) and accept the alternate hypothesis (H_1). This indicates that there is significant relationship between sex of children already had an incidence of induced abortion among married women in the study area.

According to Shuzhuo, Yan and Marcus (2005), the risk of having an induced abortion to end the next pregnancy is significantly higher for those whose first child is a daughter than for those whose first child is a son. This result reveals that sex-selective abortion is widely prevalent.

The preference theory, is of the view that fertility effect of these gender preferences in a particular society is not easily estimated because it depends on the structure of parental preferences for gender composition of their families, on the way parents reconcile conflicting preferences for gender composition, on the degree to which these preferences are implemented by effective use of birth control and also relying on sex-selective abortion.

Discussion of Findings

In interrogating the factors that influence induced abortion, family size of respondents have been implicated. With a mean age of 23 years and median age of 23.5 years, respondents’ views on the subject matter are germane.

There is significant association between the number of sons already had and involvement in induced abortion. Going by the theoretical framework, symbolic interactionism, the number of sons a woman bears is an outcome of the value which is placed on the male child. Also, the association between the number of sons and involvement in induced abortion are those ideas, beliefs and values which people hold sacred.

According to Okonofua (2005), a cultural preference for sons may be a factor driving recourse to induced abortion in Nigeria, as women carrying female fetuses may decide to terminate their pregnancy. There is significant relationship between sex of children already had and incidence of induced abortion among married women in the study area. According to Shuzhuo, Yan and Marcus (2005), the risk of having an induced abortion to end the next pregnancy is significantly higher for those whose first child is a daughter than for those whose first child is a son. This result reveals that sex-selective abortion is widely prevalent.

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In addition to the above findings, the study observed that among the respondents education as a socio-economic variable neither reduces fertility nor predisposes the women with a favourable attitude towards the use of contraceptives and affirmed that majority of them have never used contraceptives in spite of their awareness and education.

It is observed that these women, both the educated and non-educated, find expression and happiness in having many children as a result that the use of contraceptives according to them is interfering with God (gods) work, who alone gives children. It was also observed that their religious beliefs, do not encourage abortion; because it is believed that such individual have committed “murder” there exists nothing to guarantee that induced abortion would give the expected result of reducing the fertility of women.

We suspect that in spite of the availability of contraceptives and abortion facilities, where legal or illegal, there seems to exist a moral element among married women, perhaps determined by their customs and traditions that spur them to undertake high fertility.

Conclusion

Collecting information on reasons for abortion has its challenges. This is because it requires asking women to articulate the often complex and sensitive processes that lead to such decision. Be that as it may, this study was able to navigate the tough rigorous terrain to explore the interface between the incidence of abortion and family size among women in the study area. It is quite in tandem with existing literature and theoretical disposition that there is significant association between the number of children already had and incidence of induced abortion in the study area. Similarly, the incidence of son preference was implicated in the decision for induced abortion among the respondents. The study also revealed that there is significant relationship between sex of children already had an incidence of induced abortion among married women in the study area which is a corollary to the result on son preference.

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