

An Explorative study of abortion among the Tarok in Central Nigeria

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Abstract

This paper, part of a larger study, was conceived in response to the high maternal morbidity and mortality rates attributable to unsafe abortion in Nigeria. The study was predicated upon the assumption that socio-cultural practices influence the reproductive health outcome of most women in Nigeria and therefore explored these practices in relation to abortion among the Tarok ethnic group in central Nigeria. It utilized qualitative method that provided for a detailed and descriptive analysis of data from female and male respondents of various socio-demographic groups through thirty in-depth interviews and focus group discussion sessions conducted between April and May, 2008. The study found a high level of Tarok women's exposure to unintended pregnancy, which is largely rooted in unequal gender relations, traditional gender roles and social taboos. It concludes that intervention strategies aimed at improving maternal health must go beyond the provision of, and access to contraceptives and legalisation of abortion to addressing socio-cultural practices that have overwhelming influence on the life and death of women in Nigeria.

Keywords: *Abortion, gender, unintended pregnancy, socio-cultural practices, maternal health, the Tarok.*

Introduction

In African societies, there is a huge value placed on pregnancy and childbirth; yet, the loss of pregnancies either through spontaneous or induced abortion is not uncommon. In Nigeria, the focus of this paper, unsafe abortion performed by unskilled persons or under insanitary conditions or both, has been found to contribute 40 percent of maternal deaths in Nigeria (Sai 2004). In Medical science, there are two categorises of maternal deaths: direct and indirect obstetric deaths. The former derives from complications during pregnancy, delivery or postpartum period while the latter, is a factor of medical conditions that are aggravated by pregnancy or delivery (UNFPA 2001).

Medical conditions are nonetheless, grossly inadequate in explaining health particularly, women's reproductive health (RH) (which includes maternal health), because the major determinants of health are external to biology and medicine. Health, 'a state of complete physical, mental and social well-being and not merely the absence of

disease or infirmity' (World Health Organisation 2012:), is determined by cultural, social, economic, political, psychological, and religious factors among others. This is particularly true of heterogeneous societies and underdeveloped countries. Therefore solution to African women's RH challenges should not be limited to medicine and biology but should also be sought within the social and cultural contexts under which pregnancies occur. Prominent among the socio-cultural factors that influence pregnancies and their outcome in Nigeria are: gender relations, gender roles, social taboos, and traditional beliefs surrounding sexual practices.

World Health Organisation (WHO) estimates that one in five of the 210 million women who become pregnant each year worldwide resort to abortion (UNFPA 2007). Out of the estimated 46 million abortions carried out globally every year, 19 to 20 million are unsafe. Five million and three hundred thousand women (5.3million) are also estimated to suffer disabilities as a result of unsafe abortion globally while 13 percent or one in every eight of all maternal deaths that occur every year is related to unsafe abortion (UNFPA 2007). Nigeria accounts for 20 percent of the global estimates of abortion-related deaths (Health Reform Foundation of Nigeria [HERFON] 2006). Furthermore, unsafe abortion has been found to increase the risk of ectopic pregnancy, preterm delivery and miscarriage. The overwhelming burden of death and disabilities due to unsafe abortions carried out in developing countries fall especially on poor women (UNFPA 2007). Up until almost a decade and half ago, approximately 610,000 abortions, a rate of 25 abortions per 1,000 women aged 15-44 was carried out in Nigeria annually (Henshaw et al. 1998). While current figure is not immediately available, the Society of Gynaecologists and Obstetricians of Nigeria (SOGON) estimates that about 20,000 Nigerian women die from unsafe abortions each year and that adolescents constitute about half of this figure. This death rate from unsafe abortion is one of the highest in Africa (Raufu 2002). Rather than being spontaneous, much of this is induced and the illegality that characterises induced abortion in Nigeria renders the practice clandestine and perilous for many women.

Lack of existing laws that support or approve a woman's choice to procure abortion has often been blamed for the high rate of unsafe abortion in Nigeria (see Henshaw et al. 1998; Raufu 2002). Thus, intervention strategies designed to reduce unsafe abortion in Nigeria pay very little attention to the non-medical or socio-cultural factors that expose women to carrying unwanted/unplanned pregnancies that may eventually bring about the quest for induced abortion whether safe or unsafe. Moreover, literature on non-medical conditions that influence induced abortion are also health facility related as they often point to factors like universal access to RH education and family planning (FP) services; availability of and access to modern health facilities; women's health seeking behaviour; etc. Not much attention is given to understanding and documenting the critical role of social and cultural factors in unintended pregnancy and abortion.

The principal aim of this paper therefore was to investigate and document the social

and cultural practices that underlie the poor attainment of maternal health in Nigeria with reference to abortions. It specifically explored how these factors influence pregnancy and the loss of pregnancy among Tarok women in Plateau State, Nigeria.

Survey of Related Literature

Chapter eight, paragraph nine of the 1994 ICPD Programme of Action urged governments and other relevant organizations 'to reduce the recourse to abortion through expanded and improved family-planning services' and 'to deal with the health impact of unsafe abortion as a major public health concern' (ICPD 2012). To implement this recommendation, policymakers are urged to seek information on the availability and quality of family planning services, the extent of harm to women's health caused by unsafe abortion, and the incidence of abortion. Implicit in the recommendation above is the reduction of unsafe abortion to a single factor namely, inadequate family planning services. Henshaw et al. (1998) investigated the incidence of induced abortion in Nigeria and argued for policies that would enhance access to contraceptives and in turn reduce unwanted pregnancy and unsafe abortion. -

According to Sai (2004), causes of high maternal mortality in Africa include malnourishment of many girl children, overwork of young mothers, low level of education, early and forced marriage, early child-bearing, poverty which 'forces women to work through the final stages of pregnancy'. The factors also include impunity associated with sexual and domestic violence even during pregnancy, women's poor access to decision-making, and female genital cutting/mutilation which can cause obstetric and other physical damage. Sai (2004) challenged African leaders to demonstrate the much needed political will for prioritising reproductive health and promoting a favourable environment for it to thrive. Similarly, Wall (1998) studied the social context of maternal morbidity and mortality among the Hausa of Northern Nigeria and revealed numerous health challenges to maternal health. They include poor antenatal care, lack of formal education and maternal age. The paper concluded that the 'solution to these medical problems will come only when appropriate changes in the social system takes place' (1998: 355). Key among the social change recommended by the study is 'upgrading the social status of women' and 'education of Hausa men regarding women's reproductive health' (1998:355). Ten years later, Okonofua (2007) examined the status of maternal and child health in Nigeria and underscored the role of 'adverse socio-economic and cultural circumstances' in increased maternal and child mortality in Nigeria. Izugbara and Ezeh (2010) explored the perceptions of women in north-western Nigeria on high fertility in the region and showed that many women reportedly give birth to many children to prevent divorce and/or plural marriage by their male spouses. This they related to the inheritance structure of Islam, the dominant religion in northern. The paper therefore underscored the importance of social meanings in high fertility.

Of the socio-cultural determinants of RH discussed by Dixon-Mueller (1996), gender power relation was shown to have the most extensive implication for women's sexual and reproductive health. Similarly, Doyal (1995) argued that unlike their male counterparts, many women in poor countries cannot determine the nature of their reproductive lives which implies that they cannot maximize their health. Furthermore, Alubo (2000) identified peer and economic pressure as the most important factors that influence sexual behaviour of youth in tertiary institutions in Nigeria. Other factors found by the study were gender and responsibility in RH matters, and social taboo associated with public discussion of sex.

In their investigation of abortion proportions among young women of 17 years and below in Britain, Lee et al. (2004) linked the following indices to decisions for or against motherhood: social deprivation, interpersonal variables, and access to abortion services. On the influence of interpersonal relationships (of partners, friends, family and community), on abortion decisions, findings revealed among other things that 'parents' likely reaction' is a significant source of fear among the two different study groups: those who chose to continue with pregnancy; and those who chose to terminate it. Although the conditions that characterise termination of pregnancy and motherhood in Britain are quite different from those of Nigeria, Lee et al. (2004) and other studies discussed above, all point to the important role of non-medical factors in maternal health including pregnancy, abortion and maternity.

Study Setting

The research was conducted in Nigeria a country in the West African sub-continent. The 2006 population census gave Nigeria a population figure of 140,003,542 (Federal Republic of Nigeria 2006) and approximately two-third of these live in rural areas.

Nigeria is occupied by sundry ethnic groups with distinct traditions, customs languages. The Hausa/Fulani, Igbo and Yoruba are the largest and politically dominant ethnic groups while the North central zone of the country (where the Tarok ethnic group is located), is characterized by a massive concentration of small ethnic groups of autonomous political systems (Ekanade 1986). The country is divided into thirty-six States and a Federal Capital Territory that make up the Federal Republic of Nigeria. These States are further sub-divided into 774 Local Government Areas.

The Tarok constitutes the predominant ethnic group in Langtang North and Langtang South Local Government Areas (LGAs) located in the lowland Southern Senatorial District of Plateau State. Tarok men and women are traditionally agriculturalists who cultivate several kinds of cereal: guinea corn (*Sorghum Bicolour*), millet (*Pennisetum Americanum*) and sesame. They also keep livestock like goats and sheep while horses and some dwarf cows are reserved for the well-

off. Men, women and grown up children all take active part in farming while cattle herding is exclusively by boys or young men. Some of the men combine farming with hunting (especially in the dry season) and others engage in artisanal trades like blacksmithing, woodcarving, and weaving. Certain aspects of masonry such as plastering and flooring of houses, pot making, fetching firewood and water, cooking and brewing of nce/burukutu (local beer made from guinea corn or millet) are done exclusively by women.

The dominant religions in Tarok land are traditional religion and Christianity. The traditional religion of the Tarok is characterised by the belief in a supreme being and the worship of the spirits of deceased ancestors through orim which is the highest institution of social control and is exclusive to men who often use it as a ready instrument to control and subdue women. The activities of orim cult are strictly kept secret from women and uninitiated men, and any betrayal of this attracts extreme penalties including death. Traditional religious celebrations, rituals, and markets are incomplete without locally brewed beer.

In the early 20th century, early Christian missionaries of the Sudan United Mission (SUM) an international and interdenominational Mission which comprised various protestant missionaries from Britain, United States of America, Netherlands, South Africa, Australia and New Zealand arrived Tarok land (Yarnap 1985; Shagaya 2005). The missionaries brought Western education and medical services. The Tarok people embraced Western education and many on completion sought paid employment in the large urban centres. They have taken to several careers but made the most impact in the Nigerian Armed forces. Military career seems to fit the traditional values of bravery and valour among Tarok men and women.

The Tarok are organised around patriarchal system. Juridical rights over children however, rest in their maternal uncle or grand uncle (ukyan). They practice strict lineage exogamy and traditionally, marriage is mostly polygynous with patrilocal mode of residence with each uterine family having a separate hut. This patrilocal residential pattern often implies that authority, control and inheritance lie with the male head of the family. Prevailing gender-based social and cultural beliefs and practices that are traits of resilient patriarchal structures influence virtually every aspect of life of the Tarok, including the definition of the nature of gender relations; nature of sexual relations and partnerships for men and women; nature and types of marriage. These gender-based differences often translate to gender inequality and provide the context for the various types of marriage in Tarok land: (1) marriage by elopement (ivang kebar); (2) marriage by abduction (Fazing 1991; Shagaya 2005); (3) giving a woman out in marriage to compensate for damages caused by her family (Fazing 1991; Galam 1999); (4) an arranged marriage either between the groom and the girl's grand/maternal uncle or between the groom and latter's maternal grand

father often without the girl's consent or the usual marriage rites (ivang nzok/nzok ucar); and (5) widow inheritance (Ntem akup).

Methods

A qualitative research method was utilized in conducting the study in four Tarok communities in Langtang North Local Government Area of Plateau State namely, Langtang, Gazum, Reak and Pilgani. In-depth interviews and focus group discussion were the two major techniques used for data collection. The interview and group discussion guides which were very similar contained topics on a whole range of social, cultural, RH, and RR issues including those related to loss of pregnancy. In-depth interview (IDI) respondents included female and male community, religious, and opinion leaders as well as senior modern health service providers while focus group discussions (FGD) consisted of female and male community members with a good knowledge of the mores, social norms, workings, and practices of the community in relation to issues of interest. A purposive, non-probability sampling procedure which allowed for reflection of the differences in the study population and a selection of strategic informants capable of providing desired comprehensive and articulate information relevant to the study was used. Four IDIs and six FGDs were conducted in each community, three each for men and women. To ensure homogeneity, the FGDs were constituted based on age, educational and marital status among other socio-demographic factors. Youth groups of different socio-demographic background were also part of the study sample. The opinions of this class of respondents some of who were sexually active varied from those of the older respondents and thus, enriched the data. The respondents were females and males aged 15 years and above married and unmarried. They were mostly Christians with very few male animists. Virtually all of them were involved in one form of farming activity or another, while a few combine this with paid employment and petty trading. Less than half of the respondents reported having completed secondary education and far less than that, tertiary education.

Three experienced research assistants including a retired professional Hausa/English teacher all Tarok, who were fluent in Tarok, Hausa and English languages were recruited and given adequate training on the study objectives and field work procedures and expectations. Researchers were not required to obtain ethical approval but they took time to explain the research purpose to would-be-respondents and sought their individual consent before each IDI and FGD session. Interviews and discussions were conducted in Tarok, Hausa and English languages and auto-recorded. The principal researcher and all three research assistants were involved in data gathering, transcription and translation of data into English language as well as in the examination and coding of key variables in relation to the issues and themes covered by the research instruments. Thereafter,

results were written from translated texts, coded master sheets, and researchers' memos to ensure that reported responses were contextual. Some of the findings with contextual connotations were reported verbatim, most were summarized and others that were not so relevant to the study objective were left out. Reported findings were then compared with those of previous studies on similar issues and discussed.

The study has some limitations. First, because of the common belief that humans have no control over spontaneous abortion even if it was the result of their carelessness, respondents were more willing to discuss induced than spontaneous abortion. Second, only abortion procured by choice was perceived as induced. All other forms of abortion even those that result from physical violence were regarded as miscarriage or spontaneous abortion by most respondents. Third, most of the respondents (apart from the youth) were married and so opinions on the experiences of unmarried women were mainly drawn from the responses of those who were married. Fourth, adult respondents generally discussed issues concerning sexual intercourse largely within the context of marriage. This may not be unconnected with the popular belief that marriage is obligatory and that it is what confers the right to sexual activities on individuals. Most youth respondents however, did not tie sex to marriage. Nonetheless, since induced abortion was recognised as being on the increase, and since majority of Tarok women and men are married, results of this study can adequately be used to explain how socio-cultural practices influence unintended pregnancy and abortion among the Tarok.

Major Findings

The importance of social and cultural factors in unintended pregnancy and abortion is indicated by findings. These findings have been classified into three subheadings: the first and second present data on socio-cultural practices related to unintended pregnancy and abortion respectively; and the third discloses the procedures used by Tarok women for induced abortion.

1. Social and cultural practices related to unintended pregnancy

Majority of respondents attributed unintended pregnancy to prevailing sexual practices. Interestingly, reasons proffered by respondents for unintended pregnancy varied across age and gender. The opinions of most older female respondents of 55 years and above (ranging from majority to minority view) are summarised thus, lack of sexual discipline among young men and women (married or single); lack of a separate residence for husband and wife; fear of repercussion in terms of men's withdrawal of essential support; threat from male spouse, in-laws and the male dominated institution of social control (orim); female poverty; polygyny and competition among co-wives; and refusal of modern young women to move to their mothers' homes during lactation. Some of these points were explained:

In those days a man's hut was separate from his wife's but now they live always together ... in those days men were patient even up to three years ... breast-feeding mothers would move temporarily to their mothers' home ... but now you talk about abstaining for only days... that is what is disturbing us with this generation (FGD, 70+, Female, Uneducated, Urban).

Orim is sometimes used to force a woman to sleep with her husband even against her wish and this sometimes leads to unwanted pregnancy (IDI, 72, Female Uneducated, Urban).

... If your husband has many wives, you may want to sleep with him anytime he asks you ... as a sign of your love for him ... even if it results in unwanted pregnancy (FGD, 65+, Female, Primary, Rural).

Majority of male respondents (25years and above) attributed unintended pregnancy to love affairs between sexual partners; monogamy; female promiscuity; and the prevalent modern youth sex culture. In contrast, most young women mention poor access to contraceptives; men's refusal to use condom with their wives; husbands' disapproval of child spacing activities out of fear of unrestrained female sexual activities; forced sex and marriage; and women's fear of losing their husbands to other women as illustrated in the following statement:

Many men do not like condom and they would not allow you use contraceptives out of fear that you will be unfaithful ... (FGD, 50-55, Female, Educated, Rural).

... If you do not allow him he will go to those girls out there and you will have yourself to blame... you just have to take the risk sometimes even when you know you may become pregnant ... You cannot even discuss use of condom with him if you don't want trouble (FGD, 35-44, Female, Educated, Urban).

Male youth mentioned: provocative dressing and sexual promiscuity of some girls; drunkenness; schooling; and delayed marriage:

Some of these girls go about parading themselves and inviting men for fun ... why won't they get pregnant (FGD, 18-24, Male, Educated, Urban).

... They do all kinds of things in school when they are out of their parents' home and they get pregnant sometimes without even knowing the father of the child (FGD, 16-24, Male, Educated, Rural).

Young female respondents below 25years on the other hand attributed unintended pregnancy to: male violence and forced sex; men's general dislike for condom; social pressure from friends and peers; and economic pressure to acquire fashionable items. A respondent described unwanted pregnancy due to forced sex or marriage by abduction:

... after they capture you against your wish, they will lock you up with him and he will sleep with you and make sure you become pregnant before you can come out of that house whether you like it or not (FGD, 15-24, Female, Educated, Urban).

Male sexual violence within the context of forced marriage is relatively common in Tarok land especially on market days in very remote and rural areas where men arrange to have their bride-to-be abducted against her wish (see Orisaremi & Alubo 2012).

2. Social and cultural practices related to abortion:

In providing responses to the causes of abortion respondents often made a distinction between spontaneous and induced abortion. Their responses are thus, grouped into two to reflect this distinction.

2.1 Spontaneous abortion:

Respondents referred to this as 'miscarriage' and a natural occurrence. It was described by an elderly IDI respondent as an 'involuntary loss of pregnancy over which no one but God alone has control.' Reasons adduced by respondent health workers for spontaneous abortion are: women's overwork especially during farming season; poor nutrition during farm work; ill-health; male violence; exposure to mosquito bites and infections. Some of these opinions are illustrated below:

Cases of spontaneous abortion are more common among the middle aged married women... I want to associate it with over-activity especially during farming season when the woman goes and works on the farm under very hot sun without eating any good food all day... (IDI, 45, Female, Educated, Urban)

Cases of miscarriage [spontaneous abortion] are more common during rainy season because they are exposed to mosquitoes, strenuous activities as they stay on the farm from morning till 5-6pm and they don't even feed well (IDI, 51, Male, Educated, Urban).

There are cases of fight between husbands and pregnant wives here seriously.

We admit some of them here... sometimes when the pregnancy is two to three months, the husband may beat her and she will start bleeding non-stop so all we do is to terminate the pregnancy (IDI, 33, Male, Educated, Rural).

Respondent female community members attributed spontaneous abortion to ill-health and male perpetrated sexual/domestic violence including the use of orim:

Sometimes even when you are in the process of delivery, a husband can kick you, his wife and it won't bother him (FGD, 45-50, Female, Primary, Rural).

Men beat their pregnant wives her sosai! [very well] in the past they would beat them on their legs but now they beat them anywhere even if it will cause injury to the baby and the mother oho! ... Also, there are some women that have womb that cannot hold pregnancy. Once they are pregnant they become very sick until the baby comes out of their body (FGD, 30-35, Female, Educated, Urban).
... They [orim] will bring the pregnant woman out of her room at night and b-e-a-t her. They can beat her and endanger her life (FGD, 35-44, Female, Primary, Urban).

Majority of adult male respondents in contrast, mentioned female stubbornness, disobedience, and refusal to have sex with their male spouse which often provoke men and sometimes lead to male violence:

A man can beat his wife to the extent that she can even loose the baby because of matrimonial fighting ... sometimes, if you need her [have sex with her] she will refuse [general laughter] that can provoke you to get the hell out of her (FGD, 25-34, Male, Primary, Rural).

... Some women are very stubborn and disrespectful especially when they are pregnant ... the only medicine that some of them need is beating and our young men these days lack patience... they beat their wives anyhow even if it leads to abortion they do not care (IDL, 68, Educated, Rural).

2.2 Induced abortion

This is choosing to terminate a foetus before it reaches the age of maturity without any medical justification. There was a general consensus among all categories of respondents that induced abortion characterised by choice, is on the increase and widespread:

Induced abortion is only common these days. In the past, there where only cases of spontaneous abortion but now induced abortion is everywhere (FGD, 70+, Female, Uneducated, Rural).

They explained that virtually all categories of young women, namely, teenage girls, married, and unmarried women alike engage in the practice. Reasons given by respondents for induced abortion have been categorised into three: for adolescent girls; unmarried young women; and for married women.

Induced abortion among adolescents was most commonly attributed to: forced marriage; rape; availability of abortifacient; men's denial of sexual relationships and rejection of the outcome (pregnancy); unpreparedness and poverty on the part of young men; fear of parents; poor parenting; fear of the stigma attached to pregnancy outside marriage; and school related factors. Below is a range of some of the opinions summarised above:

Forcing a girl to marry a man she doesn't love can lead her to commit abortion. She would not want to keep his child and will be ready to run out of the man's house any moment (FGD, 30-39, Male, Educated, Urban).

... Even at eight months she will take medicine to force the baby out and if the baby comes out alive, she will keep the baby somewhere if she doesn't want it and she will run away (FGD, 15-24, Female, Educated, Urban).

Sometimes poverty can force the boy either to reject the girl and the pregnancy, or to give her medicine for abortion whether native or modern so that people will not see her pregnant (FGD, 25-34, Male, Primary, Rural).

... Some do that because they are students and they want to complete their education (IDI, 45, Female, Educated, Urban).

The reasons given for the procurement of induced abortion by unmarried young women are: stigma associated with pregnancy outside marriage; female prostitution; male denial/rejection of the woman and her pregnancy; availability of modern drugs for abortion; "hit and go" relationships (casual sex with strangers); unstable relationships; and fear of losing the prospect of a future husband.

... Sometimes if the women were impregnated in their fathers' homes as single women, or if the men involved denied it. Then they may go get rid of it so that they will protect the name of their family and find husbands in the future (FGD, 45-50, Female, Primary, Urban).

Induced abortion among married women on the other hand, was traced to: provocation or a woman's feeling of bitterness and anger against her male partner; infidelity on the part of husbands; male violence; men's inability to care for their wives and children; and the general economic hardship. Other reasons offered were: "stubbornness", anger and infidelity on the part of the wife; stigma and shame associated with becoming pregnant too soon after delivery; belief that pregnancy is dangerous to the health of a breastfeeding child; and availability of abortifacient. Provocation from a male spouse and economic hardship were the most commonly mentioned reason for induced abortion procured exclusively by married women without recourse to their spouses. A female respondent described an incident of provocation:

If one's husband provokes her... It happened in our compound that a married woman with two children took drugs and attempted to abort twins. She died and left her two kids. In fact it was one of my father's daughters whose husband had provoked her... He couldn't take good care of her and her two children yet he was dating other women outside... when she confronted him, he beat her up.... She got angry and tried to commit abortion. She died in the process along side the twins she had aborted. She was buried with the twins in the same coffin, in the same grave (FGD, 30-34, Female, Primary, Urban).

Asked if men were often part of the decision to have induced abortion? Overall, respondents perceived women as being responsible for the decision for induced abortion except when it has to do with: (1) illicit/extramarital affair (in which case the man responsible may initiate the process or be supportive of the decision if made by the woman); (2) stigma associated with breastfeeding among married couples (whereby the couple can take a joint decision to terminate the pregnancy). Otherwise, women were said to initiate the process of induced abortion often without the knowledge of their male partners.

While the general reaction to spontaneous abortion was that of sympathy, anger characterized the reaction of most male and older respondents to induced abortion. For younger female respondents, it was more of: (1) 'teaching the men a hard lesson'; and (2) the only solution they have to unwanted/unplanned pregnancy.

3. Procedures used by women for induced abortion

Respondents gave descriptions of some of the various processes used by Tarok women to induce abortion. These include intake of locally prepared herbal mix, water from boiled coins, or lime; insertion of certain locally prepared mixture through the vagina; while others reportedly procure the services of chemists at patent medicine stores and some charlatans in private clinics. Very few according to them, patronize public health facilities for induced abortion except in cases of complications arising from attempts by unskilled persons or post abortion care as reported by a health service provider:

After they have carried out the induced abortion themselves, if they develop complications, they prefer to manage it with chemists and people like that except if it is much then you see them coming here to the clinic. Most of them hardly come here for D&C. Very few come here with complications and if we are able to manage them well with antibiotics fine, if not, we refer them... (IDI, 45, Female, Educated, Urban).

There were indications that women 'victims' of breastfeeding and pregnancy who seek medical assistance from qualified health service providers get correct health information on adequate feeding and care. However, while some of them put the information into practice, others who find it extremely difficult to cope with the stigma attached to pregnancy during lactation, look for alternative and mostly unsafe means to terminate their pregnancies in spite of their knowledge of the risks involved.

Discussion

Induced abortion was generally traced by respondents to unwanted or unplanned pregnancy. However responses on reasons for unwanted pregnancy varied along gender and age lines. Older respondents tended to give reasons that are rooted in traditional beliefs and practices about how to avoid unwanted pregnancy like a new mother moving to live with her own mother while younger ones made reference to gender issues surrounding forced sexual intercourse, contraceptives and birth spacing and the youth added school related problems as well as social and economic pressure which could be an indication of more openness to change from traditional to more modern values. Forced sex was commonly mentioned by all categories of young women as a major cause of unwanted pregnancy. This is clearly related to the cultural practice of marriage by abduction earlier documented by Orisaremi and Alubo (2012). It is worthy of note that forced sex in this context goes beyond the conventional rape to include premeditated and arranged forced sexual intercourse that involves other accomplices (not as in gang rape) but those who help to 'capture' the soon-to-be-victim of rape.

Interestingly, reasons given by men point more to the need for sex based on the assumption that it is a basic physiological need in both men and women. This undermines to a certain extent, the social, economic, cultural and political context under which sexual relationships and pregnancy take place (Doyal 1995; Dixon-Mueller 1996; Wall 1998; Alubo 2000; Lee et al. 2004; Okonofua 2007; Izugbara & Ezeh 2010). This was indicated in some of the reasons given by women both young and old which clearly reveal that subsisting social structure renders many women vulnerable not only to unintended pregnancy but also the consequences associated with finding solution to the problem. Also, the pervasiveness of patriarchy in societies across Nigeria and indeed, Africa makes the relationship between men and women unequal. Patriarchy generally strips women of access to control over scarce resources and decision making while subjecting them to male authority and power in virtually all spheres of life including sexuality and reproductive matters (Doyal 1995; Ravindran & Balasubramanian 2004). This further undermines their dignity as human beings. Gender inequality plays a very significant role in society's definition of men and women's sexuality and places on women, the bulk of the burden of sexual and reproductive ill-health (Dixon-Mueller 1996) while limiting their ability to make informed decisions and choices in relation to practices that directly affect their sexual and reproductive well-being.

Respondents recognised a clear difference between spontaneous and induced abortion. The sense of sympathy that generally characterised the reaction of respondents is related to the perception that spontaneous abortion as a phenomenon is natural and beyond human control. Yet, virtually all the causes of spontaneous abortion identified by respondents are human induced and preventable. Induced abortion on

the other hand, was largely regarded as immoral hence anger and intolerance typified the reaction of most respondents except the younger women who perceived it as the only solution to their problem of unwanted pregnancy. The immorality attached to induced abortion contributes in no small measure to the stealth that characterises the process. Moreover, consistent with Lee et al, (2004) findings reveal that unlike the popular belief that only adolescents and single women procure induced abortion, married women also engage in the practice for various socio-cultural, interpersonal and economic reasons. Most married Tarok women work very hard and contribute substantially to the upkeep and education of their children in the face of the current economic hardship. Hence they actively though secretly, look for means to prevent frequent pregnancies and child birth irrespective of the risks involved. Also, induced abortion by married women attributed to provocation by spouse may be traceable to the subordinate and disadvantaged position of the former which denies them other avenues of giving vent to their anger, displeasure or frustration.

Furthermore, even when women work hard to contribute to the well-being of their families, they remain financially, materially or socially dependent on men and have limited power to exercise control or negotiate sex in relationships for fear that the men may deny them access to certain basic needs. Women are generally not expected to negotiate sex with their spouse because these rights are culturally subsumed under the perceived obligation to provide sexual satisfaction to their male spouse which is directly linked to the latter's obligation to the payment of bride wealth. Hence a few married women, who either attempt to exercise their right to negotiate sex with their male spouses or to terminate unwanted pregnancy for plausible reasons, are labelled 'stubborn' and they risk facing the wrath of their in-laws and the much dreaded male dominated institution of social control (orim).

Results corroborate Dixon-Mueller (1996) and show that gender norms in Tarok society tend to make men macho and women passive and more vulnerable in different ways to unwanted pregnancy. For example, men may associate masculinity with sexual exploits and may be reluctant or not bother to find out the result of their casual penetrative sexual encounters with their female sex partners thereby, leaving the girls/women to bear the psychological and emotional pains resultant upon such casual or unstable relationships with little or no help from these male sex partners. In general, men are shown to be supportive of the decision for abortion primarily when it has to do with protecting their self-image, avoiding stigma and shame; and protecting the health of their breastfeeding infants rather than in the interest of the pregnant women.

Data on methods used to induce abortion indicate that women generally do not have the audacity or the wherewithal to procure abortion in the few health facilities that are willing to risk carrying out manual vacuum aspiration (MVA) or dilation and curettage (D&C) on women. Instead they place their lives at risk by trying out all sorts of unhealthy and inexpensive methods that guarantee secrecy since induced abortion is

considered immoral and illegal. They are compelled to seek clandestine abortion often provided by charlatans, popular traditional methods or other unsafe methods to save cost in the midst of poverty (Adetoro et al. 1991). Even those who conduct D&C in health centres are far from being specialists.

Conclusion

The descriptive results of major findings presented above indicate that patriarchy and the subordinate position of women in society are major factors in unintended pregnancy and abortion. The study therefore underscores the importance of understanding the relationship between unintended pregnancy/loss of pregnancy and the socio-cultural milieu that forms and regulates the lives of women and men especially in societies that are not only heterogeneous but largely traditional. The overwhelming implications of social and cultural practices for the life and death of women in Nigeria implies that addressing them is crucial in attaining maternal health and saving women's lives.

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