in Nigeria (more than three-quarters) than in some Asian countries where abortion is legally restricted (about half in the Philippines, Myanmar, Laos and Cambodia). However, the proportion of nonpoor urban women who go to physicians is somewhat higher in Latin America (eight in 10) than in Nigeria (two-thirds).

Medically trained practitioners, including private doctors, have probably played an increasing role in abortion provision in Nigeria over the past 20–30 years. Despite the legal restrictions, trained medical practitioners perform the procedure because the demand for it is increasing, awareness of the risks of unsafe abortion is growing, and the practice is clandestine and is rarely prosecuted.25 The fact that medical personnel may be underemployed or underpaid increases the likelihood of their providing abortions. The 1994–1995 study in Jos and Ife found that about 80% of women who reported ever having had an abortion said they had gone to a private doctor; most of the remainder said they had attempted to induce the abortion themselves.26

By comparison, the health professionals in our survey believe that on average in Nigeria, only a little more than half of women seeking abortions go to medically trained providers, and the rest go to traditional providers or chemists, or induce the abortion themselves. While health professionals may exaggerate the extent of unsafe provision of abortion, women who report their abortions in a face-to-face interview may be better educated, and therefore more likely to have gone to a medical doctor, than women who do not report their abortions. The actual profile of abortion provision in Nigeria may lie between the pictures presented by these two studies.

Information from the 1990 NDHS suggests that low levels of knowledge of modern contraceptives and method sources, as well as poor access to sources and supplies, contribute to women’s need to seek abortion. According to the survey, only about 44% of all women aged 15–49 knew of at least one modern contraceptive method, and only 33% knew of a source (Table 4); the proportions were lower still (35% and 29%, respectively) among women aged 15–19.27

Only 9% of all women aged 15–49 and 4% of teenagers had ever used a modern method; about 4% of all women and 2% of adolescents were using one at the time of the survey. It is encouraging, however, that 31% of sexually active unmarried adolescent women were using a method, even though only 26% of users were relying on an effective modern method.28 Levels of knowledge and use are substantially higher in the South than in the North, but even in the South, only 12% of married women were using a modern method at the time of the survey.

The total fertility rate in Nigeria remains high—six births per woman nationally, although it is substantially lower in the South than in the North. Relatively few births are characterized as unplanned. Overall, 12% of NDHS respondents reported that their most recent birth had been unwanted or mistimed. By comparison, in the 1994–1995 study of Ife and Jos, 20% of women of reproductive age reported having had at least one unwanted pregnancy.29 However, very high proportions of married NDHS respondents aged 15–49 either wanted no more children or wanted to delay the next birth by two or more years (15% and 49%, respectively). Combined with low levels of contraceptive use, these high levels of desire to postpone or prevent childbirth mean that 28% of all women 15–49 have an unmet need for effective contraception.

With new attention being given to reproductive health, social concern about unsafe abortion has been expressed in many ways. Professional medical organizations have focused on this issue, and the Nigerian Medical Association established the Campaign Against Unwanted Pregnancy about 20 years ago. Nigerian physicians have spearheaded initiatives to modify the existing legislation concerning the conditions under which abortion is allowed, though without success so far.30 Other groups that focus on improving health, researchers in large medical teaching hospitals and universities, public health activists and women’s organizations are trying in varied ways to bring public attention to unsafe and clandestine abortion. Areas in which these groups are active include improving medical services for the treatment of women with abortion complications, providing contraceptive counseling and services for women who have had an abortion, expanding contraceptive service provision and, possibly, broadening the conditions under which abortion is permitted.

This survey has made available more detailed information on induced abortion practices at the national level than has been available so far. The findings may be useful in guiding policy formulation and the development of programs that will decrease the adverse consequences of clandestine, unsafe abortions for women and society in Nigeria and that will improve women’s ability to prevent unplanned pregnancies. There is great need for more research on abortion, especially at the national level, but also in-depth studies covering smaller areas. As social and economic conditions, as well as the provision of abortion services, in Nigeria change, the need for research that is representative of a broad cross-section of women in the country becomes even greater.