KNOWLEDGE, PRACTICES AND PERCEPTION RELATED TO ABORTION UNDERGRADUATE STUDENTS OF THE UNIVERSITY OF IBADAN, IBADAN, NIGERIA

BY

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DEDICATION

I'm dedicating this project to Almighty God for is abundant grace and infinite mercy for the completion of the uphill task. I also dedicate this work to the best people in my life who brought me to this world, my parents Mr. and Mrs. S.A.B. Adeyemo.

ABSTRACT

Abortion-related complications among young persons in tertiary institutions constitute a public health problem in many developing countries including Nigeria. Previous studies on the antecedent factors relating to abortion among young persons focused more on secondary school students and out-of-school youth, thus leaving the phenomenon among Nigerian university undergraduates relatively under-studied. The study was therefore designed to determine the knowledge, practices and perception related to abortion among undergraduates in the University of Ibadan, Nigeria.

A cross-sectional study design was adopted and a three-stage random sampling technique was used to select 587 consenting respondents from halls of residence, blocks and rooms. A semi-structured self-administered questionnaire which included questions on socio-demographic characteristics, 24- point knowledge of abortion, 10-point perception scales and abortion related-practices was used for data collection. Knowledge scores of ≤8, >8-16, >16 were categorised as poor, fair and good respectively. Perception scores of <5 and ≥5 were categorised as pro-choice (in favour of abortion) and pro-life (against abortion) respectively. Data were analysed using descriptive statistics, t-test and Chi-square with level of significance set at 0.05.

Age was 21.1±3.2 years and 59.1% were males. Nearly half of the respondents (47.0%) had heard about the Nigerian abortion-related laws and only 13.0% could correctly state the laws as the "penal code" and "criminal abortion-related laws". Respondents' knowledge scores was 10.9±4.2. Respondents with poor, fair and good knowledge relating to abortion were 27.9%, 64.7% and 7.4% respectively. The mass-media (38.1%) topped the list of their sources of information. Significantly more males (43.7%) than females (33.5%) had ever had sexual intercourse. A significantly higher proportion of respondents aged 21-25 years (57.3%) compared with those aged 16-20 (28.0%) and 26-31 years (14.7%) had ever had sex. Ages at sexual debut for males and females were 18.2±2.7 and 19.3±2.4 years respectively with a significant difference. The number of current Sexual Partners (SP) among respondents was 1.3±0.8. Prevalence of un-intended

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pregnancy was 35(43.8%) among female who have had sexual intercourse and among this cohort all had experienced abortion at least once. Over a quarter male respondents (27.6%) had ever impregnated a female and among this sub-group most 43(88.4%) had ever encouraged their SP to procure abortion. Private clinics (31.9%) topped the list of the places where respondents procured abortion. Many (58.0%) of respondents had pro-life perception while (42.0%) had pro-choice perception. The perception of 65.5% males and 56.5% females was that abortion is unacceptable in all circumstances. There was a significant difference between the knowledge scores of abortion for male (10.3±4.3) and female (11.6±3.7).

Knowledge of abortion among majority of the respondents was fair and abortion was perceived by most of them as unacceptable. In spite of their position to abortion, majority of the respondents were sexually active and still resorted to abortion whenever they were faced with un-intended pregnancies. Reproductive health education and counselling are therefore recommended.

Keywords: Undergraduates students, Pro-choice, Un-intended pregnancy, Abortion, Pro-life

Word count: 467

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CERTIFICATION

I certify that this study was conducted by Bolanle Adeyinka ADEYEMO in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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Operational Definition of Terms

Indigenous Churches: They are native church which shares the life of the country in which it is planted and it is self governed and reproduces itself. It is a belief that Christianity should better be expressed in the African perception.

Non-Indigenous Churches: These are evangelical churches from Europe called "missionaries" that moved across borders and boundaries for the purpose of converting people to Christianity and also provides humanitarian service to the less privileged.

Criminal Law on Abortion: In the southern part of the country, the criminal code of 1916 is in effect. The criminal code is modeled on English offences against the person Act of 1861 "Permits an abortion to be legally performed only save the life of the woman".

Penal Code on Abortion: In the northern part of the country, penal code, law No.18 of 1959 is in effect. This is related to the criminal law in Pakistan and India; an abortion may be legally performed only to save the life of the woman.

CHAPTER ONE

INTRODUCTION

1.1 Background

All over the world young adolescents and women experience unwanted pregnancy due to unprotected sex and some of them seek to terminate the pregnancy by any possible means. The termination of such pregnancies most generally known as "abortion" is a universal phenomenon that occurs among women especially the adolescents (Ndifon, 2006). Abortion is the separation or expulsion, by medical or surgical means, the product of conception before the 24th week of pregnancy (Louis-Kennedy, 2007). It can also be the removal or expulsion of an embryo or foetus from the uterus, resulting in or causing its death. This can occur spontaneously as miscarriage or artificially induced by chemical, surgical or other means (Olaitan, 2011; Wahab, 2009).

Abortion is a controversial issue worldwide and in many countries it is either outlawed and treated like the murder of a human person, or remains a legal choice available to all women because it is intricately linked up with morbidity and mortality among the teenagers and adult women in the society. According to World Health Organization, nearly all abortion cases (92 per cent) are safe in developed countries, whereas in developing countries, more than half (55 per cent) are unsafe. The burden of unsafe abortion is thus more common in developing countries (World Health Organization (WHO), 2003; Akinleye, 2011; Aiere, 2012).

In Nigeria, abortion remains restricted and in most cases unsafe. Globally abortion is a major cause of maternal deaths accounting for a global average of 13% of pregnancy related fatalities (WHO, 2004). About 760,000 abortions occur annually in Nigeria despite the country's restrictive abortion law (Gilda Sedgh, Akinrinola Bankole, Boniface Oye-Adeniran, Isaac F. Adewole, Susheela Singh and Rubina Hussain 2006, Guttmacher Institute, 2011). Experts say "unsafe abortion is one of the world's highest maternal mortality ratio of 1,000 death per 100,000 live births" (Otolde Valentine, Frank Oronsaye, Friday, Okonofua Friday (2001). It has been documented that young adults are

more likely to delay seeking abortion, employ the use of unqualified and unskilled providers and also use dangerous methods to induce abortion (WHO. 2003). Annually, an estimated 2-4.4 million adolescents resort to abortion worldwide (UNFPA. 2003). It has been estimated that unsafe abortion in the African region among the youth aged between 15-24 years account for more than 50% of all abortion related mortality (WHO 2004; Cadmus, 2011).

The Centre for Human Development, Ile-Ife in conjunction with UNICEF reported that over 50% of women in Nigeria have experienced unwanted pregnancy by the age of 20 and in some communities it is as high as 80% (Wahab. 2009). Out of this number, 21-28% have given birth between the ages of 15 and 17 years while 40% are likely to be mothers by the age of 18 years. A large number of the adolescents who experienced unintended pregnancy resort to abortion to save them from stigmatization. Abortion or termination of unwanted babies among adolescents is due to so many reasons ranging from poverty, illiteracy to incompetence on the part of the abortion service provider (Wahab, 2009; Guttmacher, 2011).

In Nigeria nearly one-third (28%) of women of reproductive age have had an unwanted pregnancy at some point in their lives. Among Nigerian women of reproductive age, one in seven (14%) have tried to have an abortion, and one in 10 (10%) have actually ended an unwanted pregnancy (Guttmacher, 2011). The reasons women give for terminating a pregnancy suggest that two broad groups of women have abortions: young, unmarried, childless women, and married women with children who want to postpone or stop another birth (Bankole, Oye-Adeniran, Singh, Adewole, Wulf, Sedgh and Hussain, 2006).

Over 21.6 million unsafe abortions occurred globally in 2008. The highest prevalence of 36 per 1,000 women were in Eastern and Middle Africa (Guttmacher, 2011). A study in Nigeria shows that more young women who have not yet started their families tend to be the group of people who seek abortion (WHO, 2004; Wahab, 2009). The majority of women who have ended a pregnancy were younger than 25 years. However, the practice

of induced abortion is not limited to women with these characteristics. Forty-five percent of women who ended their pregnancy were aged 25 years or older at the time, 37% were or had ever been married and 40% had at least one living child (Bankole et al; 2006). In another study to determine the prevalence of abortion, majority of abortion seekers were found to be young, single girls, with over 90% having first sexual experience before the age of 20 years (Ujah, 2000).

In Nigeria, performing or seeking abortion is a criminal or an illegal act except the pregnancy threatens the health or life of the mother. Despite the strict abortion related law in the country abortion is still secretly practiced by medical practitioners and it is mostly common among adolescents (Otoide, 2001). Abortion in Nigeria is governed by two different laws. In the predominantly Muslim states of the far Northern Nigeria, the Penal Code, Law No. 18 of 1959, is in effect while the criminal code of 1916 is in effect in the southern part of the country. Although, both Codes generally prohibit the performance of abortion, differences in the wording of the Codes as well as in their interpretation, have resulted in two slightly different treatments of abortion offences (Wahab, 2009; Louis-Kennedy, 2007).

Unsafe abortion could have a significant negative impact on the well-being of Nigerian women and their families. The practice mostly result in complications which include incomplete removal of the foetus, cervical or vaginal lacerations, haemorrhage, bowel or uterine perforation, sepsis, and secondary reproductive tract infections; these complications sometimes result in long-term adverse health related consequences including chronic pelvic inflammatory disease and secondary infertility (Ndifon, 2006; Ujah, 2000). Infertility can also result from a hysterectomy (removal of the uterus) performed to manage the complications of unsafe abortion. If not treated in time, these complications could lead to one form of impairment or the other or even death (Tautz, 2004; WHO, 2004).

Young adults represent a significant proportion in Nigerian institutions of higher learning; they also represent a large proportion of women who choose abortion. A study

by Guttmacher showed that a greater proportion of females who sought for abortion were among secondary school (66%) or university (71%) levels women than among uneducated women (39%) (Bankole,et al (2006). WHO estimates that at least 33% of all women seeking hospital care for complications related to abortion are less than 20 years of age (WHO, 2004). The Society of Gynaecologists and Obstetricians of Nigeria estimates that about 50% of Nigerian women who die from unsafe abortion each year are adolescents, and abortion complications are responsible for 72% of all deaths among teenagers below the age of 19 years (Raufu, 2002). The commonest reasons for not wanting these pregnancies are bad timing, desire to continue schooling and the high cost of education; the commonest method of resolving unwanted pregnancy among them is by abortion (Ndifon, 2006).

Most females have premarital sex without use of contraceptives and study have also shown that more than 60% of Nigerian women with unplanned pregnancies utilize low levels of contraceptive (Mitsunagu; et al, 2005). This study focused on knowledge, perception and practices of abortion among undergraduates who do not want a pregnancy, the role of the males or partners responsible for the pregnancy in decision making before going for abortion services and the factors that influence the seeking for abortion.

1.2 Statement of Problem

Abortion is of public health significance because it can endanger young female's reproductive health and lead to serious or life-threatening complications which may result in maternal morbidity and mortality (Cadmus, 2011). Abortion may be undertaken by females themselves or they may seek the service of a non-medical person or consult a health worker in unhygienic conditions (Bankole, 2004). This kind of abortion seeking behaviour is most profoundly demonstrated among adolescents. Hospital based study has shown that in Nigeria up to 80% of patients with abortion-related complications are adolescents (Okunufua, 1996). Similarly, a community based study of abortion prevalence has shown that one-third of women who obtained an abortion were adolescents most especially female undergraduates (Oloide, 2001).

Undergraduate university students mostly reside on their own for the first time after their secondary school career; this gives them freedom and opportunity for unplanned and unprotected sexual experimentation. This could lead to unwanted pregnancy and consequently many may seek for abortion. Abortion is illegal in Nigeria except to save the life of a woman. Despite this stringent law against the practice thousands of undergraduates in Nigeria still seek for abortion (Wahab, 2009). Few or no studies have focused on male and female undergraduates' level of knowledge relating to abortion and factors influencing undergraduates in seeking abortion. This study was therefore designed to determine the level of knowledge of undergraduates on abortion related issues. It also focused on the post abortion experiences and feelings of any form after they and/or their partner had sought for abortion.

1.3 Justification of the study

The findings of this study are potentially useful as baseline programme for the designing of educational intervention aimed at preventing and/or controlling unwanted pregnancies and practice of unsafe abortion among the study population. In addition, the finding could be used to effect the review of the content of reproductive health already infused into the general studies programme of the University of Ibadan.

Furthermore, findings of the study could be used to design educational programs aimed at upgrading undergraduates' knowledge about related issues on abortion and Nigeria related laws through collaborative efforts from University authority, Student Union Government, Non-Government Organization, College of Medicine and other relevant government agencies including Ministry of Health and Youth and Sports development.

1.4 Research questions

1. What is the level of awareness and knowledge relating to abortion among undergraduates of University of Ibadan?
2. What are the perceptions of undergraduates relating to abortion?

3. What is the prevalence of abortion and sexual experiences among undergraduates of the University of Ibadan?
4. What are the factors influencing the adoption of abortion among undergraduate students of the University of Ibadan?
5. Where do University of Ibadan undergraduates seek for abortion services?

1.5 Objectives

1.5.1 Broad Objective

To investigate the knowledge, perceptions, experiences and abortion related practices among male and female undergraduates of the University of Ibadan.

1.5.2 The Specific Objectives

The specific objectives of the study were to:

1. Assess the level of knowledge relating to abortion among undergraduates of University of Ibadan.
2. Assess the perceptions of University of Ibadan undergraduates relating to abortion.
3. Determine the prevalence of abortion and sexual experiences among undergraduates of University of Ibadan.
4. Identify the factors which influence the adoption of abortion among University of Ibadan undergraduates.
5. Identify the places where University of Ibadan undergraduates seek for abortion services

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction and Conceptual Clarification

Women experience unwanted pregnancy all over the world (Cadmus, 2011); some of them however seek to terminate the pregnancy by safe medical means or any available means (Otoide, 2001). Abortion currently poses one of the greatest challenges to women's reproductive health in sub-Saharan Africa. In Nigeria, the law on abortion is highly restrictive and does not permit termination of pregnancy except when it is needed to save the life of a woman (Okonufua et al, 2009). The termination of pregnancies most generally known as "abortion" is a universal phenomenon occurring throughout all levels of societal organization and recorded history (Wahab, 2009). Unsafe abortion can endanger women's reproductive health and often leads to serious life-threatening complications. Furthermore, unsafe abortion imposes a heavy burden on women and society, a burden arising from the serious health consequences that are often associated with it (World Health Organization (WHO), 2008; Cadmus, 2011).

Unsafe abortions that take place each year are more than 20 million, mostly in countries where abortion is illegal (David et al, 2006). Studies have shown that abortion is safe in countries where it is legal, but dangerous in countries where it is outlawed and performed clandestinely (WHO, 2008; Guttmacher, 2011). According to WHO, nearly all abortions (92%) are safe in developed countries, whereas in developing countries, more than half (55%) are unsafe.

The word abortion comes from the Latin word "*abortion*", which means "to abort", "miscarry" or "deliver prematurely". The Latin word *abortus* means "miscarriage, premature, untimely birth" and in medicine abortion means ending a pregnancy prematurely. An abortion can occur spontaneously as a result of complications during a pregnancy, or it can be induced. An induced abortion carried out to preserve the health of the mother (gravida) is a therapeutic abortion (Bernabé-Ortiz, 2009, Nancy Brown, 2012).

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Abortion therefore means ending a pregnancy before the fetus (unborn child) can live independently outside the mother. If abortion happens spontaneously before 24 weeks of pregnancy, it is called a miscarriage. An induced (or "therapeutic") abortion is caused deliberately in order to end the pregnancy (Nancy Brown, 2012). Pregnancy is ended so that it does not result in the birth of a child. Sometimes this is called 'termination of pregnancy'. The pregnancy is removed from the womb, either by taking pills (medical abortion) which involves taking medicines to cause a miscarriage or by surgery (surgical abortion) where the pregnancy is removed from the womb. Most abortions can be provided on a day care basis which means you do not need to stay at a clinic overnight (WHO, 2004)

Induce abortion could be classified into safe and unsafe abortion. Safe abortion is an induced abortion that is performed before 12 weeks gestation by a trained health professional under hygienic conditions (WHO, 2004). The WHO recognises unsafe abortion as a silent pandemic and believes safe and legal abortion is a fundamental right of women, irrespective of where they live (Gilda Sedgh, Akinrinola Bankole, Friday Okonofua, Collins Imarhiagbe, Rubina Hussain, Deirdre Wulf, 2009).

Unsafe abortion is of public health concern because of its dire reproductive health consequences and impact on maternal morbidity and mortality (Cadmus, 2011 and Wahab, 2009). The prevention and control of unsafe abortion will go a long way in contributing to the achievement of one of the Millennium Developmental Goals, which aims to reduce overall maternal mortality by two thirds by the year 2015(Cadmus, 2011).

Unsafe abortion is defined as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO, 2004). Unsafe abortion may also be self induced using hazardous techniques or medical methods without the involvement of a skill provider (Babarinsa, 2008)

Abortion is a controversial human right related issue (Gilda et al, 2007; Louis-Kennedy, 2007). There are several advocates for the support and against the practice of abortion in the world. The need for a scientific and objective information on the issue is therefore imperative. However, because of the sensitive nature of the topic and restrictive legal enactments relating to the practice, data sources are limited and accurate information on the occurrence of induced abortion is difficult to obtain (Gilda et al. 2007). The distinction between safe and unsafe abortion is crucial because each has different public health implications. Safe abortion has few health consequences, whereas unsafe abortion is a threat to women's health and survival (WHO Editor, 2000).

The incidence and trends in induced abortion worldwide from 1995 to 2008 shows that while there is a decline in the practice of unsafe abortion in Western countries, the rate is rising in South America and Africa (Guttmacher Institute, 2011; Iqbal, 2009). Between 1995 and 2003, a drop down is reported within the global abortion rate from 35 to 29 per 1000 women (Grimes, et al; 2006). The study conducted by the Guttmacher Institute, showed that since 2003 the global rates stayed stable till 2008 at 28 per 1000 women. Although the numbers of cases of abortions remained stable, the numbers which are preformed in dangerous conditions, rose from 44% in 1995 to 49% in 2008 (Iqbal, 2009; WHO, 2008). About 78% of all abortions in 1995 took place in the developing world and increased to 86% in 2008 (Iqbal, 2009; Bankole Akinrinola, Isaac F. Adewole, Rubina Hussain, Olutosio Awolude 2013).

2.2 Types of Abortion Procedures or techniques

There are broadly two types of abortion which are medical abortion and surgical abortion. Medical abortion involves taking medicines (Pills) to end a pregnancy (Akinleye, 2011). Surgical abortion on the other hand involves a minor operation carried out when a patient is either awake or asleep (Stacey, 2011). Both medical and surgical abortion methods are available based on the stage of the pregnancy. Typically, once a pregnancy is past 7 weeks, only surgical abortion methods can be used. Second-trimester abortions tend to carry higher risks than first-trimester ones (Akinleye et al 2011; Echendu et al 2012).

Safe abortion is mostly done in the first trimester (before the 12th week of pregnancy). Pregnancy weeks are counted from the first day of the woman's most recent menstrual period (WHO, 2012). The type of abortion performed depends on how far the pregnancy has progressed. Approximately 88% of abortions are performed within the first trimester of a pregnancy (WHO, 2003). Roughly 59% of abortion cases take place within the first eight weeks of pregnancy, 19% in weeks 9 to 10, and 10% in weeks 11 to 12. About 10% of abortions occur during the second trimester (6% in weeks 13-15 and 4% by week 20). After 24 weeks or pregnancy, abortions are only provided due to serious health reasons [and account for less than 1% of total abortions] (Stacey, 2011; Akinleye, 2011). Earlier cases of abortions are easier, safer, and tend to be less expensive than abortion which takes place later in a pregnancy (Stacey, 2011).

Medical abortion involves taking pills orally within 24-48 hours or 6-8 hours apart (the correct time gap depends on the individual's circumstances). The first pill commonly taken is mifepristone. As the pregnancy progresses, the body will start to prepare for the changes and one of the very early processes is when hormones in the body start to adjust to make the lining of the womb ready for the egg that has been fertilized. Mifepristone stops this from taking place (WHO, 2012). The second drug could be prostaglandin and it is taken two days later. This works within four to six hours to break down the lining of the womb. As the lining is broken down, the embryo is also removed (Stacey, 2011). The result of these drugs is akin to a really heavy period. There can also be some side effects associated with this medicine such as nausea, sickness and diarrhea (Akinleye, 2011; Stacey, 2011; UK Health Centre, 2012).

After the 16th week of pregnancy, abortion seekers resort to prostaglandin. Prostaglandin is a chemical hormone which induces violent labor and premature birth when injected into the amniotic sac (WHO, 2012). Since prostaglandin results in an unusually high percentage of live births, salt, urea or another toxin is often injected first. The risk of the live birth from a prostaglandin abortion is so great that its use is recommended only in hospitals with neonatal intensive care unit (Louis-Kennedy, 2007).

In Surgical abortion, the doctor removes the lining of the womb, either by Manual Vacuum Aspiration (MVA) or Dilatation suction (curettage) [D&C]. With MVA method a handheld tool is used, while D&C is carried out with a suction machine and tools (WHO, 2012). MVA can only be carried out during the first ten weeks of pregnancy, while D&C can only be done between week 4 and the end of week 13 (Grossman Daniel, Naomi Lince, Jane Harries, Debbie Constant, Marijke Alblas, Kelly Blanchard, 2009). For both MVA and D&C the doctor injects the cervix with a numbing agent, the cervix is then stretched open with a dilator and a tube is inserted (Akinleye, 2011; WHO, 2012). The uterus is emptied through this tube and it is common for bleeding to occur intermittently for a few weeks after the pregnancy is terminated. (American College Obstetrician and Gynecologists [AGOG] 2011).

The suction method is usually carried out under local anaesthetic but sometimes one can choose to have no anaesthetic at all. The neck of the womb, called the cervix, is opened or dilated. A tablet may be placed in the vagina so that the cervix becomes softer and opens more easily. This allows a tube to be inserted through the vagina to gently suck the foetus from the womb. Some of the surrounding tissue is also removed to ensure nothing is missed, as this could cause serious problems (WHO, 2012). Vacuum Aspiration is a very quick procedure, taking 5 -10 minutes to complete. Most women go home within an hour or so. It causes experiences of some vaginal bleeding, a bit like a heavy period for a couple of weeks after the treatment (WHO, 2012; Delphine, 2010).

A surgical procedure called Surgical Dilation and Evacuation (D&E) is carried out under general anaesthetic. Prior to the section, the person may require having an empty stomach or fasting for a certain period beforehand. The cervix is opened so the foetus can be removed using a surgical tool such as forceps, and a suction tube. The contents of the womb are carefully checked to make sure the abortion has been completed fully. This procedure usually takes around 20-30 minutes and if it goes smoothly and there are no complications and the patients would be able to go home the same day (WHO, 2012, Akinleye, 2011). The patient who benefitted from this procedure can however experience

vaginal bleeding for a couple of weeks after this procedure. (Bankole, 2004; Delphine, 2010)

Abortion carried out 20-24 weeks is often called late abortion (Delphine, 2010). There are two ways by which an abortion can be carried out at this stage. These are surgical and medically induced abortion. In surgical abortion pregnant individual will be given a general anaesthetic. This procedure carries the risks associated with the use of general anaesthetic and any other surgical procedure. The first stage is carried out by softening and dilating the cervix then stopping the heart of the foetus, from beating. Stage two is when the foetus is removed with forceps and a suction tube, as in the surgical and dilation method. As this is a two-stage procedure it usually means patients will have to stay in hospital overnight. (Stacey, 2011)

Medically Induced Abortion results in symptoms similar to a late natural miscarriage (Grossman et al, 2009; Stacey, 2011). The victim is awake throughout the first part of this treatment and will receive a general anaesthetic for the second part. The medicine used for an early abortion, prostaglandin is injected direct into the womb causing strong contractions as if the person is in labour. These contractions can last between six and 12 hours during which time patient could be offered painkillers. Again the foetus is removed with forceps and a suction tube as in the Surgical and Dilation method. (WHO, 2012; Delphine, 2010)

2.3 Crude and traditional methods

Abortion can involve the use of herbs or traditional methods to induce pregnancy termination or the insertion of nonsurgical objects such as knitting needles and clothes hangers into the uterus. The use of sharpened implements and the application of abdominal pressure have been reported and these are crude methods of procuring abortion (Akinleye, 2011).

The knowledge of traditional means of procuring abortion which involves variety of methods passed down from generation to generation. Sometimes abortion may be guided

by a medical or informal provider or by friends or by the woman's immediate circle (Bankole et al, 2006).

In Africa some plants are renowned for their contraceptive and abortive properties (Akinleye, 2011). These methods are sometimes described in the literature as methods to "bring on a period" rather than to abort a pregnancy. They can be purchased in markets or prescribed by traditional practitioners (Dehne, 1999; Akinleye, 2011). They are often taken in the form of drinkable solutions, enemas or vegetal pessaries. These tmditional abortificient can cause infections, haemorrhages, comas, fever and even the death of a woman (Akinleye, 2011). It has been reported that in northern Burkina Faso, women drink an herbal tea that provokes uterine contractions and abortion; however it is characterized by side effects, severe haemorrhage is particularly serious (Dehne, 1999).

A study carried out in Lagos and Edo states revealed some of the traditional methods used as abortificients and they include lime, potash, ogogoro (a local alcoholic gin or other spirits), salt and vinegar, harp beer, brown codeine and fresh kolanut leaves. In Edo State some rural women above 50 years old reported the use of kolanut leaves from a plant whose root crosses a road. These are boiled and the broth given to the woman to drink in a calabash while sitting by the door. Another method mentioned was the use of *oziza* herbs prepared with native gin (Dehne, 1999; Akinleye, 2011).

Another study revealed the use of inserted harmful objects methods into the vagina and the ingestion of special concoctions. Others reported taking very high doses of quinine, forcefully massaging the abdomen and washing out the vagina with harsh chemicals such as bleach. All these procedures can endanger women's reproductive health and cause serious life threatening complications such as perfomtion of the uterus, fainting and death (Ciganda, 2003, Akinleye, 2011).

The following non-clinical abortion related practices have been reported: drinking poisonous or harmful substances (herbs, bleach, hair dye), taking dangerous doses of over-the-counter medicine, douching with poisonous and caustic substances (bleach) inflicting physical abuse (falling down stairs, blow to the abdomen, jumping from

heights) (Ciganda, 2003; Dehne, 1999). In Africa, 13% of maternal deaths are due to non-clinical abortions; in the proportions of such cases in Asia, Latin America and Europe are 12%, 21% and 17% respectively (Alan Guttmacher institute AGI, 1999). Ninety-five percent of all non-clinical abortions take place in developing countries; Nigeria is one of such countries. The overall death rate in America from abortion (regardless of safety), is 119 per 100,000 abortions (Alan Guttmacher institute AGI, 1999).

There are some pharmaceutical products that are also renowned for their abortive properties. These are essentially drugs that are not recommended for pregnant women and are taken in overdose to induce abortion: examples of such pharmaceutical include anti-malaria (Nivaquine and quinine), hormones (Crinex and Syncrgon), aspirin, Paracetamol and antibiotics. Sometimes several of these products are combined for greater "efficiency". Quinine, when used in very high doses, has grave consequences on women's health, even when it does not produce the abortion anticipated (Smit J. A, McFadyen, M. L., 1998).

2.4 Risky sexual behavior among young persons, reasons for opting for abortion and prevalence of abortion among them

Globally, research studies on adolescents' sexual behavior have shown that most young people are pressured to become involve in sexual activities due to earlier physical maturation with accompanying sexual desires, peer pressure, permissive societal attitude, access to birth control methods, abortion and misleading mass media messages (Rasheed, 2009). There is a high prevalence of risky sexual behaviours among students in both secondary schools and institutions of higher learning in Nigeria. This may be due to the erosion of custom, values and observances which protect the people from indulgence in pre-marital sexual practices. Other factors which can cumulatively promote the insolent of young people in risky sexual practices are unstable family background, peer pressure and harsh economic situations (Bonke, 2006).

The consequences of risky sexual behavior among adolescents include sexually transmitted Infections (STIs) and unwanted pregnancies. Unwanted pregnancy leads some of them to adopt unsafe abortions (Ndifon, 2006). Induced abortion in hazardous circumstance roses threat to the health of young people (Okonkwo *et al*, 2005). Studies have shown that young people of both sexes are poorly informed about methods of protection against sexual risk behavior i.e. unwanted pregnancy (Mahesh, 2002). There is need therefore for quick actions to be taken to control risky sexual behavior among the youth; they should be made to understand and have access to reproductive and sexual health information and services (Ndifon, 2006).

Majority of university students are unmarried youths. On entry into universities, young people acquire independence from parents. This increase in autonomy manifests in very permissive attitudes and increased risky sexual experimentation (Ejembi, 2004).

According to Okonkwo *et al* (2005) high risky sexual behaviours are common among students in tertiary institutions in Nigeria. According to them, Nigerian youths indulge in risky behaviours such as, unprotected sex, multiple sexual partners which results in unwanted pregnancy and illegal abortions.

According to Bankole et al, (2006) high rates of unwanted or unintended pregnancy amoog adolescents are a major public health concerns. Unsafe abortion has been documented as one of the leading causes of maternal mortality especially in developing countries to which Nigeria belongs. Surveys in developing countries show that up to 60 percent of pregnancies to women below age 20 are mistimed or unwanted which often end in abortion. Pregnant students in many developing countries often seek abortions to avoid being expelled from school (Ndifon, 2006). According to a study among in-school adolescents in north central Nigeria established that 100% females and 87.5% males had influenced or sought for induced abortion in the past (Aderibigbe, 2011). This finding is similar to the findings from a study conducted by Abiodun et al in Ilorin where 63.5% of female students aged 15- 24 years in tertiary institutions have had induced abortion (Abiodun M.O; Olayinka .R.B 2009). It is noteworthy that all the abortions were said to have been done by unqualified people. This is a serious setback for adolescent reproductive health and indeed for the campaign to reduce maternal mortality.

It is the prevalence of unwanted pregnancy among young people that influence the prevalence of abortion among them. Official statistics on the prevalence of abortion in Nigeria do not exist because abortion is illegal. The practice is severely regulated and restricted to saving the lives of women. Unofficially, one in 10 Nigerian women of childbearing age say that they have had an abortion. Among women who had had an abortion, four in 10 have had at least two (Gilda et al, 2006). A 1996 study based on a nationally representative sample of 672 health facilities that were considered potential providers of abortions or post-abortion care estimated that 610,000 abortions occurred each year in Nigeria (Bankole, et al, 2013). With the country's growing population, the annual number of abortions is estimated to have increased to 760,000 abortions by 2006 (Sudbinaraset 2008; Gilda et al, 2006).

In another survey it is estimated that about 600,000 cases of abortions occur annually and about 25 out of 1,000 women of childbearing age had an abortion in a year. Unfortunately, most of these cases of abortions occur under unsafe conditions, which thus constitute a major source of maternal morbidity and mortality. About 44% of women having abortion in Nigeria are believed to experience complications. Induced abortion is a cause of chronic pelvic inflammatory disease, ectopic pregnancy and secondary infertility among Nigerian women. Unsafe abortion is a major cause of maternal mortality as it accounts for as many as 40% of maternal deaths in Nigeria (Bankole et al, 2004, Gilda et al, 2006).

A considerable population of adolescents, aged 15-19 years are sexually-active. This has become more worrisome in light of their involvement in unprotected sexual activities. This is inspite of their poor knowledge of reproductive health and sexuality education (Bankole et al, 2004). A survey shows that young adults are more likely to delay seeking termination, employ the use of unqualified and unskilled providers and also use dangerous methods to induce abortion (Cadmus, 2011). Hospital-based studies conducted in the 1990s in Nigeria showed that adolescents make up a disproportionately high proportion of women treated for abortion complications between 61–75% (Adetori, 1999; AGI, 2004).

Annually, an estimated 2-4.4 million adolescents resort to abortion worldwide (WHO, 2008). A WHO estimate of unsafe abortion revealed that in the African region, youth aged between 15-24 years account for more than 50% of all abortion related mortality (WHO, 2008; Cadmus, 2011). According to hospital based studies in Ethiopia, Kenya, Tanzania and Nigeria, women seeking care for abortion complication tend to be single women with no children, less than 20 years old and they are most in-school students or unemployed (Rasch Vibeke, Hamed Muhammed, Ernest Urassa, Stalfnn Bergstrom, 2001).

An average of eight percent of all pregnancies in Nigeria are unintended and majority occur among the unmarried (Bankole et al, 2013). The commonest reasons for not wanting these pregnancies are bad timing, desire to continue schooling and the high cost of education; the commonest method of resolving unwanted pregnancy is by abortion (Ndifon, 2006; Abiodun et al, 2009; Cadmus, 2011). The incidence of induced abortion in Nigeria is put at 25 per 1000 women of reproductive age per year (Bankole et al, 2006). There are approximately 610, 000 abortions performed in Nigeria annually, 60% of which are unsafe, resulting in an abortion mortality rate of 120 deaths per 100,000 live births (Ndifon, 2006)

Unsafe abortion is a neglected women's health issue in Nigeria and in many developing nations even though maternal mortality and morbidity due to unsafe abortions can easily be prevented when women have access to safe abortion services (Iqbal, 2009). Worldwide, 46 million pregnancies each year end in abortion, with 19 million of these abortions taking place under unsafe conditions; nearly all unsafe abortions (95%) occur in developing countries (WHO, 2004, Sushanta, 2008). The WHO has explained that almost all abortion-related deaths are preventable when performed by a qualified provider using correct techniques under sanitary conditions (WHO, 2003). The WHO (2008) reported that 68,000 women die due to lack of access to safe abortion services and treatment for abortion related complications.

All over the world, women experience unwanted pregnancy; some of these women seek to terminate the pregnancy by safe medical ntcans, if possible but often by whatever means available. The termination of pregnancies most generally known as "abortion" is a universal phenomenon occurring throughout all levels of societal organization and recorded history (Wahab, 2009; Sushanta 2008). Techniques used are highly varied, as are circumstances under which it is practiced. It has existed before history recorded and it still persists in all cultures or societies (Wahab, 2009).

Induced abortions outside the legal framework are frequently performed by unqualified and unskilled providers or are self-induced; such cases of abortions often take place in unhygienic conditions and involve dangerous methods or incorrect administration of medications (Guttmacher. 2004; Sushanta, 2008). Even when performed by a medical practitioner outside the conditions of the law it may generally carry additional risk because it is likely done under poor condition. Hence, there is tendency for complications to arise and the woman may not receive appropriate post abortion care which might lead to mortality or severe complications (Iqbal, 2009).

In most developing countries, induced abortion is legal only if the pregnancy threatens the health or life of the mother. Many women, therefore, seek clandestine abortion, services which are too often unsafe and thus place the woman at risk of complications and death (AGI, 2004). Forty percent of women live in countries where abortion is legally restricted (Bankole et al, 2006). In 2003, an estimated 55% of induced abortions in developing countries were unsafe, and 97% of all unsafe abortions were in developing countries (Sushanta, 2008). Women who have complications from clandestine abortions may not seek medical help for fear of being reported to legal authorities by health care workers (Valentine, 2001; Bankole et al 2006). Induced abortion currently accounts for 20,000 of the estimated 50,000 maternal deaths that occur in Nigeria each year (Valentine 2001).

There is a public health need to determine more accurately the burden of, and risk factors for, clandestine induced abortion in different countries. The lack of official records and

underreporting by those involved make this task difficult. Rates of clandestine induced abortion are estimated with the use of either direct methods, such as population-based surveys and surveys of providers of illegal abortions, or indirect methods, such as the application of multipliers to recorded rates of hospital admission or death attributed to induced abortions (Antonio 2009).

2.5 Consequences of unsafe abortion

Pregnancy is one of the most important periods in the life of a woman. Waiting for and delivering a baby is beautiful and exciting, but, at the same time, bringing a new person to this world is always accompanied with big changes, big efforts, with other significant upheavals. It is therefore absolutely essential for a woman to be well-prepared before getting pregnant (AGI, 2004; Sushanta, 2008). Unfortunately, not every pregnancy is a result of planned decisions due to lack of information or negligence relating to the use of contraception (Bankole et al, 2013).

The mortality and morbidity risks associated with unsafe induced abortion depend on the facilities and the skill of the abortion provider, the intervention method used the general health of the woman and the stage of her pregnancy (Singh, 2005). Illegal abortion attempts may involve: insertion of a solid object (root, twig or catheter) into the uterus; a dilatation and curettage procedure performed improperly by unskilled providers; ingestion of harmful substances; and exertion of external force. In many settings, traditional practitioners vigorously pummel the woman's lower abdomen to disrupt the pregnancy which can cause the uterus to rupture, killing the woman in the process (WHO, 2008; Cadmus, 2011; Singh, 2005).

Because of lack of knowledge and skill in using contraception, adolescents are more likely than adults to experience unintended pregnancies (Sudhinaraset, 2008). Adolescents are more likely than adults to delay an abortion, resort to unskilled persons to perform it, to use dangerous methods and to delay seeking care when complications arise (Sudhinaraset, 2008; WHO, 2008). Adolescents are also more likely to experience complications, such as hemorrhage, septicemia, internal organ damage, tetanus, sterility,

and even death (Cadmus, 2011). Adolescents make up a large proportion of patients hospitalized for complications of unsafe abortions. For example, in Malawi, Uganda and Zambia, adolescent women represent one fourth to one-third of patients suffering from complications from unsafe abortion, and in Kenya and Nigeria, more than half of women with the most severe complications are adolescents. (WHO. 2008).

Unsafe abortion affects every aspects of Nigerian society. It compromises the health and well-being of women, which in turn compromise the well-being of their families and communities. It also imposes a tremendous burden on Nigeria's health care system, as post-abortion care diminishes the system's capacity to provide other services (Sudhinaraset 2008).

Each day 192 women die as a result of complications arising from unsafe abortion: that is one woman every eight minutes, nearly all of them being in developing countries (WHO. 2008; Iqbal, 2009). These women are likely to have had little or no money to procure safe services; many of them are young, perhaps in their teenage years, living in rural areas and having little social support to deal with their unplanned pregnancy (Iqbal, 2009). Some women had been raped, while some could have experienced an accidental pregnancy due to the failure of the contraceptive method they were using or the incorrect or inconsistent way they used it (Akinleye et al 2011; Echendu et al 2012). Some of them lacked knowledge of methods for preventing unintended pregnancy or did not have the means to obtain them. Some may have found contraceptive services hard to reach, while others may have been turned away by judgmental or insensitive providers (Aiken, A.A. Ayodele, J.O. Omololu, O. (2012); Singh, 2005). A large proportion of pregnant women may have first attempted to self-induce abortion on failing they then turned to an unskilled, but relatively inexpensive providers (Valentine 2001).

The most frequent complications are incomplete abortion; one of the commonest complications of unsafe abortion is when parts of the products of conception stay in the uterus. This is called incomplete abortion, also we have other complications like, sepsis, haemorrhage and intra-abdominal injury, such as puncturing or tearing of the uterus

These can be fatal if they are not treated promptly (WHO, 2008). W.H.O recommends the use of vacuum aspiration for managing incomplete abortion. Long-term health problems caused by unsafe abortion include: chronic pelvic pain, tubal blockage, secondary infertility, ectopic pregnancy and increased risk of spontaneous abortion or premature delivery in subsequent pregnancies (WHO, 2000; Singh, 2006; Bankole et al, 2006).

Unsafe abortion may be undertaken by women themselves or they may seek the service of a non-medical person or that of a health worker in an unhygienic condition (Bankole, 2004; Cadmus, 2011, Singh, 2006). Abortions done under such conditions may involve any of the following: insertion of a solid object into the uterus, an improperly performed dilation and curettage procedure, ingestion of harmful substances, or exertion of external force (Bankole, 2004).

Induced abortions outside the legal framework are frequently performed by unqualified and unskilled providers or are self-induced; such abortions often take place in unhygienic conditions and involve dangerous methods or incorrect administration of medications (Iqbal, 2009; AGI, 2004). Even when performed by a medical practitioners, legal framework and appropriate environment for abortion could still be risky this is so because medical back-up may not immediately be available in an emergency or the woman may not receive appropriate post-abortion attention and care. In addition, if complications occur, the woman may hesitate to seek medical care (AGI , 2004, Iqbal 2009). Nigerian women experience a variety of complications from unsafe procedures. These include retained pregnancy tissue, infection, hemorrhage, septic shock, anemia, intra-abdominal injury (including perforation of the uterus and damage to the cervix or bowel) and reactions to chemicals or drugs used to induce abortion (Sudhinaraset 2008)

Generally the adverse consequences of abortion can be differentiated into three:-Physical, Psychological and emotional consequences

The Physical adverse consequences

One in four women obtaining abortions experience serious complications in Nigeria (Bankole et al, 2006; Bankole. et al; 2008). According to Bankole (2006) twenty-five

percent of all women having abortions report serious complications (defined here as severe bleeding, severe pain, moderate or high fever, or any injury). The proportion experiencing serious complications is larger among women who have the procedure after 12 weeks of gestation than among their counterparts who obtain it earlier in the pregnancy. Severe pain is the most commonly cited serious complication, followed by injury and fever; heavy bleeding is reported much less often (Bankole, et al, 2006).

When an abortion is performed on a woman, she becomes subject to many physical complications. Blood loss during the procedure could cause diversion of blood flow to various organs thus resulting in shock. When the canal of the cervix is dilated, the insides of the uterus, fallopian tubes, and the abdominal cavity are exposed to invasion by bacteria. Abdominal infection can cause peritonitis and abscess formation. Severe hemorrhage often follows an abortion. Instruments can perforate the uterus causing injury, infection, and bleeding to internal organs (Singh, 2006; Bankole, et al, 2006; Iqbal, 2009; Cadmus, 2011).

Women who have abortions increase their risk of breast cancer; abortion of a first pregnancy interrupts the natural growth process of the breast, leaving millions of cells at a high risk. It has been found that future pregnancy failure is increased by forty-five percent with just one previous abortion. Other complications are greater risk of premature births, tubal pregnancy, sterility, and damage to the cervix. As a result of abortion, women suffer many physical injuries (Central Illinois Right To Life [CIRTL], 2012).

Furthermore, women with a history of foetal loss, either miscarriage or abortion, appear more likely to experience an unexplained foetal death in later pregnancies. Also, abortion may confer a risk for low birth weight in later pregnancies, although this association may be weak (Henriet et al, 2001). Abortion may influence later fecundity While it appears that women who have had abortions have an above average fecundity, there may be a "genuine reduction in the formerly high fecundity of those who undergo 'termination of pregnancy' (Henriet et al, 2001, Hassan et al, 2005).

A study carried out in Nigeria revealed the common physical hazard (complications) women face after abortion: Complication may arise in the case where cervical methods of abortion is used to perform the abortion, where dilation of the uterus is required, series of instruments for increasing size are inserted into the cervix, the forceful stretching by the abortionist to open the cervix which of course takes over a period of many hours can result in permanent physical injury to the mother (Ibrahim et al, 2011; David et al, 2006).

In suction abortion, where smaller tubes requiring little dilation of the cervix are used and where the fatal remains are not removed completely, infection often results, which require a full dilation of the cervix and scraping out of the womb (David et al, 2006; Wahab,2011).

Another consequence can be seen in the case of hysterectomy or caesarean which section is adopted mainly in the last three months of pregnancy (7 months). The womb is entered by surgery through the wall of the abdomen. The technique is similar to a caesarean delivery, except that the umbilical cord is usually cut while the baby is still in the womb. The possible resultant effect of this section is death, as some women do not survive it, and some who survive are often faced up with other complications such as damaged wombs and perennial cervix pain (Wahab,2011).

Pyschological or Emotional consequences

Some health problems to consider are the psychological health of a woman who has just undergone an abortion. After abortions women may have mixture of feelings, although they had the abortion for a reason, many may feel very depressed and traumatized by the procedure (Dyke et al, 2011). A woman's feelings may be affected by adjustment in hormonal levels, the attitude her community reflects toward abortion, or possibly lack of support by family and friends (Akinleye et al, 2011). Feelings of depression are manageable and are usually overcome with feelings of happiness in many women (Pregnancy Advisory Centre (PAC), 2012; Dyke et al 2011). Most physicians recommend that women see a counselor and have family or friends they can talk to during this negative psychological state of mind. This is another way in which clinical

abortions, which are safe, help in monitoring the patient and their progress, by having counselors and support group meetings available (Pregnancy advisory centre {PAC}, 2012).

Numerous studies have identified psychological and emotional distress immediately after abortion and in the months following the procedures (Fergusson et al 2006; Dyke et al, 2011). Women experience a range of emotions after abortion, including sadness, loneliness, shame, guilt, grief, doubt and regret (Fergusson et al. 2006). However, some studies also identify positive reactions like relief, happiness and satisfaction (Fergusson, 2006). In the longer term, some women exhibited cognitive dissonance, describing their abortions of 10 years or more ago in terms of negative emotions yet believing the correct choice was made. In several instances of this specific strategies of avoidance were used to cope (Dyke et al, 2011)

Some women experience feelings of guilt, remorse, shame, anger, and sadness following an abortion (Dyke et al, 2011). Having these feelings does not necessarily mean that they have made the "wrong" choice. Rather, these feelings probably indicate that they are experiencing normal grief and distress about all of the things they have been through. They may find that feelings of sadness come after months or years following an abortion (Fergusson, 2009). Some women do not experience negative emotions, but do report relief, happiness, and resolution. These feelings may be coupled with the realization that abortion was the right choice for them and the most frequent post abortion emotion however, is a combination of relief and sadness (Nothando, 2008).

There is a wide variety of symptoms of abortion's aftermath, ranging from mild grief to profound reactions which may include Post-Traumatic Stress Disorder. It is the people working in the field of bereavement who have written about the need to resolve abortion losses and recognize that this disenfranchised loss surfaces during subsequent losses The society, churches, and families do not recognize abortion as a legitimate loss. In fact, the societal message says that this experience solves a problem and that it is a non-

experience. With other surgical procedures, there is an acknowledgement of the need to recover and to process the experience (CIRTL, 2012).

Priscilla (2010) state some emotional factors that individual pass through post abortion. Many of the symptoms discussed are symptoms common to complicated mourning and to trauma reactions. The manifestations of abortion's aftermath are: Low self-esteem, grief, depression, guilt, a sense of alienation from self, friends and others, shame, pain during sex, isolation, self-imposed actions to avoid sharing the abortion experience with others, anger, depression and anger are flip sides of the same experience.

Post abortion effects on Men

Many factors influence how a man will respond to an abortion; these includes his background, values and beliefs, the part he has played in the decision and the actual process, current situation and ambitions (Coyle, 1999). The few published studies concerning men suggest that, like women, men may experience grief, anxiety, guilt, helplessness, and anger (Coyle, 1999). The fact that men tend to repress their emotions may also make it more difficult for them to resolve their grief. Even men who support their partners' abortion may experience ambivalent feelings such as relief along with anxiety, anguish, grief, and guilt (Kero et al, 2004).

Men can be affected by abortion in similar ways as women and many have reported post-abortion psycho-social consequences such as: feelings of grief and helplessness, guilt and shame, depression, sexual dysfunction, substance abuse, self-hatred, self-esteem and confidence problems, fear of relationships, increased risk taking and suicidal behavior, greater tendencies to becoming angry or violent and a sense of lost manhood (Post Abortion Trauma Healing Service [P.A.T.H], 2002). As with women, some men whose partners abort may demonstrate self-destructive behavior such as indulging in psycho-active substances and sex. Men often push women to have an abortion, and in these cases, their initial reaction is relief. In later therapy, however, some of these men demonstrate symptoms of distress, guilt, and grief. It is well documented that a large percentage of

unmarried relationships dissolve after an abortion (Lauzon, Roger-Achim, Achim, Boyer, 2000).

Grief and regret may be profound among men as abortion often involves multiple losses including loss of the child, of the relationship and of hopes for the future. Abortion is a death experience and once adopted, cannot be undone (Kero et al, 2004). Men may often suffer from the following; anxiety, persistent thoughts about the lost child, difficulty concentrating, sleep disturbances, and other somatic complaints such as headaches or palpitations and pervasive feelings of helplessness. The trauma of abortion may be severe enough to cause symptoms of Post Traumatic Stress Disorder (Coyle, 1999; Kero et al, 2004).

Men who had experienced abortion felt distressed. Other men who were already fathers did experience a connection to the fetus. For them, the decision to abort was more difficult. Talking about abortion is an even greater taboo for men than for women (Fergusson, 2006). In some cases there are greater impacts on the males than the females. Men find it difficult to express their emotion openly or share their depression with a third party due to their natural masculinity (i.e. if a man wants to shed a tear, he had better do it privately due to manly beliefs). If he feels that the abortion had denied him his child, he had better work it through himself((Coyle, 1999; Kero et al, 2004).

Typical male grief includes remaining silent and grieving alone. In the silence a man can harbour guilt and doubts about his ability to protect himself and those he loves, some become depressed and or anxious, others controlling, demanding and directing. Still others become enraged and failure in any relationship can trigger hostility from their disenfranchised grief. A guilt-ridden tormented man does not easily love or accept love (Lauzon, 2000).

A study on male involvement in abortion that was carried out in south west of Nigeria revealed that significant number of the participants experienced fear of the outcome of abortion process i.e. fear that the partner may experience complication and even deaths

Being afraid of the outcome and consequences of abortion process was positively associated with marital status. The results showed that many of the respondents (38.7 percent) were afraid of the outcome and likely consequences of their action (47.5 percent among married and 28.6 percent among unmarried). Those that were nervous and confused formed about 17.3 percent; the same proportion claimed to be naïve and shy about it. Responses to their feelings after the abortion process show that majority of the respondents felt relieved (58.8 percent); this comprised of 42.2 percent and 80 percent of married and unmarried men respectively (Ogunjuyigbe and Adedini ,2009).

2.6 Ethics and controversies relating to Abortion

Ethics refers to a code of conduct that guides human action generally. It has to do with personal behaviour and moral duty. It is concerned with what is right and wrong. In life situation, it is concerned with principles and practices of moral and good conducts in life (Ogundele, 2010, Demirel, 2011).

Usually debates about abortion focus on politics and the law: should abortion be outlawed and treated like the murder of a human person, or remain a legal choice available to all women? (Aramesh, 2007). Behind the debates are more fundamental ethical questions which are not always given the specific attention they deserve. Some believe that the law should not legislate morality, but all good law is based upon moral values (Demirel, 2011). The issue of abortion, which means to kill a foetus using surgical or medical ways, could be viewed from two main approaches; these are "religious" and "secular" perspectives (Aramesh, 2007).

Some people and groups argue vigorously and passionately for providing abortion services to all women who want it for whatever reason. These are the pro abortion advocates for legalization of abortion. Pro-abortionists usually prefer the term "pro-choice," meaning that they believe women should have the choice to abort their babies (Aramesh, 2007). "Pro-life" advocate or groups on the other hand support the right to life of the unborn child and argue against making abortion easily available to anyone who wants it. The pro-choice advocates that the woman should have the right to choose

whether or not to end her pregnancy. This position really only has one basic argument, that the unborn baby is not a person, and so has no right to life. (Aramesh, 2007, Oduwole, 2010).

The pro-life advocates, consist of those who oppose abortion on religious grounds and those who do share secular school of thought but oppose abortion. All the same both groups of pro-life advocates have different reasons. Religious and the secular groups that oppose abortion are in agreement that the right of the foetus to live should be protected (Demirel,2011).

Abortion is clearly one of the most controversial and divisive contemporary moral problems. Abortion has been controversial ever since the ability to terminate a pregnancy was feasible. The ethical problems which involved in the abortion debate range from the right of the foetus, women and their obligations towards the foetus, the society and its obligations to the foetus, and medical professionals obligations to the foetus. While some people feel abortion should be the choice of the mother (and sometimes the father should be involved), others believe abortions are wrong regardless of the situation (Louis-Kennedy, 2007).

A fundamental ethical feature of abortion is the perceived morality, bothering on whether it is morality right or wrong ending the life of an unborn human being. The process of deductive reasoning clarifies the most common anti-abortion argument. One premise argues that the fetus is an innocent human being while the other argues that it is morally wrong to kill an innocent human being; It is morally wrong to kill a fetus. A similar deductive reasoning is used by some pro-choice advocates to justify desirability of abortion. Among the pro-choice advocates, the first premise is that the fetus has no moral status. The related premise is that it is not morally wrong to destroy something that has no moral status, it is not morally wrong to destroy a fetus (Jones et al, 2007)

Most people agree that deliberate killing of innocent people is wrong, and that the fetus is a human being. On the one hand, pro-abortionist may want to argue that the fetus is not

actually a human being or person. Therefore the personhood of the fetus is in question: if the fetus is not a human being then killing it according to them is not wrong (Oduwole, 2011, Louis-Kennedy, 2007). Pro-abortionists insist that abortion is not the deliberate killing of an innocent person because the fetus is not a person. The term 'human being' in the argument refers either to a genetically human being or to a person, that is, a human being in the moral sense. On the other hand, anti-abortionist claims that there is no stage of fetal development at which a fetus resembles a person enough to have a significant right to life. A fetus's potential for being a person does not provide a basis for the claim that it has a significant right to life. Even if a potential person has some right to life, that right could not outweigh the right of a woman to obtain an abortion, since "the rights of any actual person invariably outweigh those of any potential person" (Aramesh, 2007, Oduwole, 2010).

There are common arguments for determining the ontological status of a fetus. By ontology we mean the kind of being the fetus is (Louis-Kennedy, 2007). Waren, 1973 who is pro-abortionist have argued whether the fetus is an individual organism; The other questions relating to the being of the foetus relates to whether the feotus is a biologically human being; a psychologically human being or a person? Some argue that only a human being has a right to life and the question is, is the fetus a person with rights? If the fetus is a person then abortion is murder and should be illegal according to pro-life (Oduwole, 2011, Louis-Kennedy, 2007).

The pro-life advocates use the process of conception to argue that the feotus is a human being. According to them, in normal conception, a sex cell of the father, a sperm, unites with a sex cell of the mother, an ovum. They note that within chromosomes of these sex cells are the DNA molecules which constitute the information that guides the development of the new individual brought into being when the sperm and ovum fuse (Aramesh, 2007). When fertilization occurs, the 23 chromosomes of the sperm unite with the 23 chromosomes of the ovum. At the end of this process there is produced an entirely new and distinct organism. This organism, the human embryo, begins to grow by the normal process of cell division – it divides into 2 cells, then 4, 8, 16, and so on (the

divisions are not simultaneous, so there is a 3-cell stage, and so on). This embryo gradually develops all of the organs and organ systems necessary for the full functioning of a mature human being (Oduwole, 2011, Louis-Kennedy, 2007).

The pro-lifers also explain that what makes one to belong to the human race is that he has the genetic characteristics of the human race. These genetic characteristics are obtained from his or her father and mother, both of whom belong to the human race (George, 2001)

Nardone, (1973) corroborates this view by saying:

"A living being's designation to a species is not by the stage of development, but by the sum total of its biological characteristics.... if we say that [the foetus] is not human i.e a member of Homo sapiens, we must say that it is a member of another species but this cannot be"

The arguments of George, (2001) and Lee, (2011) attest to the human nature and being of the foetus. According to them, the foetus is a human being can be justified on three grounds. First, from the start it is distinct from any cell of the mother or of the father. This is clear because it is growing in its own distinct direction. Its growth is internally directed to its own survival and maturation. The second justification is that the embryo is human, it has the genetic make up characteristic of human beings. The third, and most importantly, the embryo is a complete or whole organism, inspite of the immaturity. The human embryo, from conception onward, is fully programmed actively to develop himself or herself to the mature stage of a human being, unless the process of miscarriage (George, 2001, Lee, 2011).

It has been argued by some pro-choice advocates that permitting abortion diminishes the respect society has for other vulnerable humans, a situation which can possibly lead to their involuntary euthanasia, Those who consider that an embryo, from the moment of conception, is a human being with full moral status, see abortion as killing in the same sense as the murder of any other person. Those who take this view cannot accept that

women should be allowed to obtain abortion without legal repercussions, irrespective of the situation such woman and their families may find themselves (British Medical Association [BMA], 2007).

The pro-choice advocates on the other hand, often distinguish a "human being" from a "person" they claim that the embryonic human beings are not (yet) *persons*. They hold that while it is wrong to kill persons, it is not always wrong to kill human beings who are not persons. Their position based on the reasoning that human beings in the embryonic stage are not persons and that embryonic human beings do not exercise higher mental capacities or functions. The pro-abortionists claim that the human person has a consciousness which is inbuilt with self-identify group and it's a physical organism. The argument here is that the "human organism" comes to be at conception, but claims nevertheless that the human person, comes to be only much later when ones self-awareness develops (Lee, 2011)

These types of argument by the pro-choice advocates are based on the premise that the embryo starts off without rights, although having a special status from conception in view of its potential for development, and that it acquires rights and status throughout its development. The notion of developing fetal rights and practical factors, such as the possible distress to the pregnant woman, nurses, doctors or other children in the family, gives rise to the view that early abortion is more acceptable than late abortion (BMA, 2007).

The pro-choice has frequently argued in favour of abortion and support the view that a woman should have the right to choose to have an abortion if she wishes. This comes from the belief that it is her body and therefore her choice. However, a person's right over her own body is not an absolute right. Also the Pro-choice (pro-abortion) supporters have also vehemently argued that without access to abortion women will suffer more economic hardship. They will be limited to a life of poverty that will also be unfair to the children they bring into the world. It is true that many women left to care for big families are facing great hardship (George, 2001, Louis-Kennedy, 2007)

2.7 Legal issues relating to abortion.

Abortion has been controversial ever since. Some societies see termination of unwanted pregnancy as feasible, while some societies place highly restrictive laws on the intent or attempt at inducing abortion (IPAS, 2010).

About 21.6 million unsafe abortions take place each year, mostly in countries where abortion is illegal (WHO, 2008). According WHO (2008), Guttmacher Institute, (2004) abortion is safe in countries where it is legal, but dangerous in countries where it is outlawed and performed clandestinely. According to WHO (2008), nearly all abortions (92 percent) are safe in developed countries, whereas in developing countries, more than half (55 per cent) are unsafe. Nigeria is among the countries with the most restrictive abortion laws in the world; in Nigeria abortion is permitted only to save the life of a woman, and persons who violate the laws are subject to lengthy jail terms—up to seven years for a woman obtaining an abortion for other reasons and 14 years for any provider convicted of performing an illegal procedure (Okonofua, 2009).

The practice of abortion in Nigeria is also governed by the criminal Code, which applies to the southern states of Nigeria, while it is governed by the penal code which is applicable to the northern states. Relevant provisions of the criminal Code are based substantially upon Section 58 of the offences against the person Act 1861 (of England). The penal code that regulates abortion is based upon Scottish Common law. The main difference between the two is that whereas the former applies to anyone acting with the intent of procuring the miscarriage of a woman "whether or not she is with child" the latter applies to those cases where a woman is in fact "with child" (IPAS, 2010)

The Criminal Code Act, Cap.38, chapter 25, Laws of the Federation of Nigeria (revised ed.2004), prohibits abortions and prescribes penalties for any person that procures a miscarriage of a woman or supplies anything intended to be used for the procurement of a miscarriages of a woman or any woman who procures her own miscarriage. The act makes exceptions in section 297 making operation on an unborn child excusable if it is performed to save the life of the woman. The implication is that it is an offence when the

surgical operation is not carried out to save or preserve life. The penal code which is applicable in the north also prohibits abortion unless it is for the purpose of saving the life of the woman.

The relevant provisions of the criminal code Act Cap 38 Chapter 25 Laws of the Federation of Nigeria (revised. 2004) which relates to abortion are as follow:

Any person who, with intent to procure miscarriage of a woman whether she is or is not with child, unlawfully administer to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable to imprisonment for fourteen years(section 228).

Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years (Section 229).

Any person who unlawfully supplies to or procuresfor any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony, and is liable to imprisonment for three years (Section 230).

A person is not criminally responsible for performing in good faith and with reasonable skill a surgical operation ....upon unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having regard to the patient 's state at the time and to all the circumstances of the cases (Section 297).

Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a felony, and is liable to imprisonment for life (Section 328).

However the penal code laws of Northern Nigeria (revised ed.2004) stipulates in sections 232 that;

Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment for a term which may extend to 14 years or with fine or with both

Abortion mortality and morbidity tend to be highest in countries where abortion laws are most hindering or restrictive (IPAS, 2010). Many such laws are colonial in origin and are no longer operative in the countries that wrote them. Restrictive laws allow abortion only when a woman can be seen as a victim of circumstances, i.e. in cases of medical emergency, fetal abnormality, rape or incest (Smyth, 1998).

The legal status of abortion in Africa ranges from highly restrictive (Permitted only to save a woman's life) to freely available upon request (See figure 1 for details). Abortion is permitted by law to save the life of the woman in all African countries. Some countries will also allow abortion to protect the woman's physical health or in cases of rape or incest. Six countries (Botswana, Gambia, Ghana, Liberia, Namibia and Sierra Leone) allow abortion on the broader grounds of protecting mental health. In Zambia, abortion is also allowed on socio-economic grounds. Cape verde, South Africa and Tunisia permit first trimester abortion upon request and without restrictions (Onwuka Nzeshi, 2008, Okonofua, 2009) Table 1- highlights African countries and their salient abortion related legal provisions.

Table 2.1: Salient legal provisions related to abortion in Africa

Abortion related legal provisions	Countries
Prohibited altogether, or no explicit legal exception to save the life of a woman.	Angola, Central African Republic. Congo (Brazzaville), Democratic Republic of the Congo, Egypt, Gabon, Guinea-Bissau Madagascar, Mauritania, Mauritius, São Tomé and Principe, Senegal, Somalia Lesotho.
To save the life of a woman	Côte d'Ivoire, Libya (e), Malawi (f), Mali (a,b), Nigeria, Sudan (a), Tanzania, Uganda
To preserve physical health (and to save a woman's life)*	Benin (a,b,c), Burkina Faso (a,b,c), Burundi, Cameroon (a), Chad (c), Comoros, Djibouti, Equatorial Guinea (c,f), Eritrea (a,b). Ethiopia (a,b,c,d), Guinea (a,b,c), Kenya, Morocco (f), Mozambique. Niger (c), Rwanda, Togo (a,b,c), Zimbabwe (a,b,c)
To preserve mental health (and all of the above reasons)	Algeria, Botswana (a,b,c), Gambia, Ghana (a,b,c), Liberia (a,b,c), Namibia (a,b,c), Seychelles (a,b,c), Sierra Leone, Swaziland (a,b,c)
Socioeconomic grounds (and all of the above reasons)	Zambia (c)
Without restriction as to reason	Cape Verde, South Africa, Tunisia

Source: Guttmacher Institute, 2011

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. *Notes:* Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal impairment or (d) other grounds. Some laws restrict abortion by requiring parental or spousal authorization (see (e) or (f) in table 2.1). Countries that allow abortion on socioeconomic grounds or without restriction as to reason have gestational age limits (generally the first trimester); abortions may be permissible after the specified gestational age, but only on prescribed grounds.

Legal situation of abortion in Africa in 1999

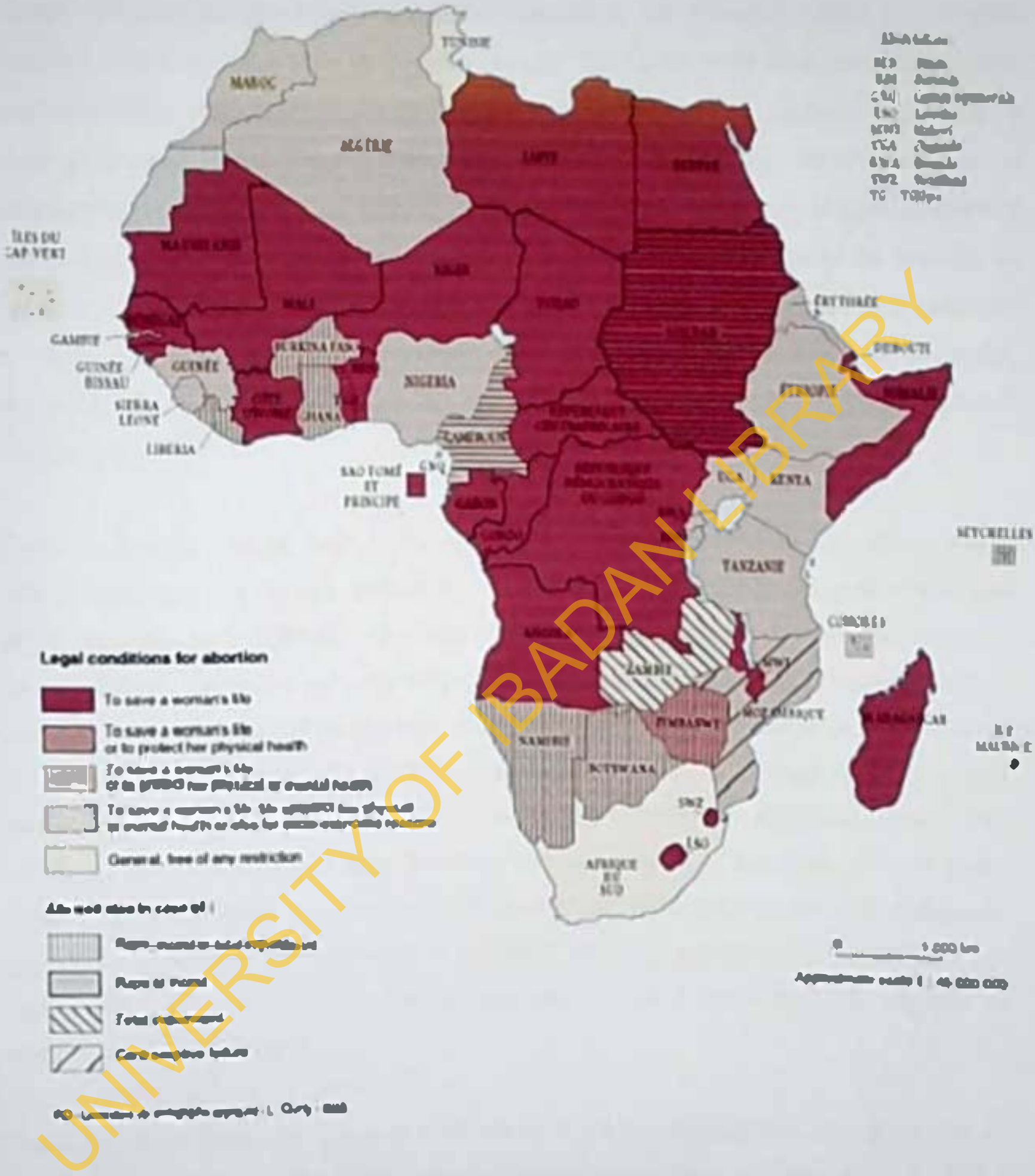

Figure 1 (c) (Cepied Centre Population et Development 1999; Louis-Kennedy, 2007

2.8 Determinants of unwanted pregnancies among undergraduates.

Induced abortion is increasing and is considered to be a major cause of maternal mortality, which is quite high in Nigeria (Singh, 2005). Reports from several surveys, principally from university teaching hospitals, indicate that the highest risk group is young girls aged 15-19 years (Sudhinaraset, 2008; United Nation, 2000). The fear of interruptions in education, the risk of unemployment and the social stigma associated with raising a child born out of wedlock are among the principal reasons for seeking an abortion. A significant number of incomplete abortions are regularly treated in hospitals in Nigeria, indicating a high incidence of illegal and poorly performed abortions. Moreover, abortion is reported to be widely available in the private sector (United Nation, 2000).

There have been several studies on factors that are responsible or influences young female aduh into sexual risk behaviours that could lead to unwanted pregnancy. The global change have affected the lifestyle of the adolescents by globalization of communication i.e. social network through internet, mobile phone etc. Glamorization of sex and immoral materials on the media and our dear traditional norms decadence have led to declining age at sexual debut, increased sexual activity through multiple sexual partners and unstable relationship (Ejembi et al, 2004; Ndifon et al, 2006). Most young adults get involved in sexual risky behavior due to low level of knowledge on the likely consequences and those who are well informed about the consequences still negligently ignore the immediate effects in other to satisfy their sexual pleasure. Therefore, they hardly take precaution through having protected sex to avoid unwanted pregnancies (Ejembi et al, 2004; Wahab, 2011).

Majority of the female students in institutions of higher learning are unmarried and on the point of entry to school they acquire independence from parental and secondary school restrictions. This increases their autonomy and they manifest their newly gained independence in awkward ways and this encourages most females to initiate sexual experimentation, replete with risky sexual practices (Ejembi et al 2004). Some scholars have outlined some factors that could lead females to engage in sexual activity in the

school environment. One of such is factors is coercion from older students and the liberal atmosphere of the University, which encourages experimentation with sex (Ndifon et al, 2006). Coupled with their lack of, or poor knowledge of contraception, quite a few usually end up with unwanted pregnancies (Cadmus, 2011).

It has been stated that the factors that have strongly influenced the pattern of pregnancy among young adults include the declining age at menarche and the increase in the number of years spent in school (Wahab, 2011). This situation influences the sexual behavior of young adults; some females get expose to sex during this long spell of education and which can lead to unwanted pregnancy. Adolescents who have finished at least 7 years of schooling (in developing countries) are more likely to delay marriage until after the age of 18 years (Salako et al, 2006).

The major reasons given for why adolescents seek termination of pregnancy were the need not to interfere with schooling (Ejembi et al,2004); not being old enough to get married (Gilda et al 2006; Cadmus, 2011); fear of family members knowing (Salako et al, 2006); not planning to marry the sexual partner (Sudhinaraset, 2008); being jilted by a fiancé (Singh, 2005); following rape or incest (Iqbal, 2009; Ejembi et al, 2004); and not knowing the actual father (Wahab, 2011). Less-common reasons were the need to test fertility (Bankole et al, 2006) and, in some cases, as a means of making financial demands on male partners. This last reason was often mentioned by the less-educated persons, although it was also given by more-educated person as well (Otoide et al, 2001)

Some broad factors that pave the way for teenage pregnancy to occur which are in most cases unwanted include rapid urbanization, low socioeconomic status, low educational and career aspiration, residence in a single parent home and poor family relationship (Adegbenga et al 2003). In 1999, Nigeria's adolescent fertility rate was 111 births per 1,000 women aged 15 to 19 years (Bankole et al, 2006, Aderibigbe, 2011). Abortion could be due to socio-economic reasons most especially in Nigeria (Wahab, 2011) and these includes the following specific factors; unmarried mother who feels religiously or socially that having a child would be unacceptable (Ndofon et al, 2006), a mother

abandoned by her partner who feels she cannot raise a child by herself (Akinrinola et al, 2004), and adolescents who are not mature enough to raise a child (Olaitan, 2010; Abiodun et nl 2009). Also, parents who are financially unable to support a child, some families with too many children already and women in abusive situations or environments unsuitable for rearing a child often take to abortion (Alan Guttmacher Institute AGI, 1999).

Most parents in Nigeria scarcely disseminate sexuality education to their children; they rather obligate it to the school, where reproductive health and sexuality education have not been properly implemented, in spite of several recommendations (Olaitan, 2010; Abiodun et al 2009). Consequently, adolescents seek reproductive information and care from a variety of non-formal sources that include peers, pornography and magazines (Ejembi et al 2004). The unguided youths usually experiment with the information received and often become exposed to unintended pregnancy and sexually transmitted infections (STIs), among others (Wahab, 2011).

The reasons adduced for taking to abortion vary among women of all ages and circumstance surrounding the pregnancy in Nigeria. The major causes identified will be explained in greater details starting with; lack of financial assistance or poverty, due to the poor economic situation of the country and the fear of financial difficulty to raise a child undergraduate tend to seek for the abortion of an unintended pregnancy. Financial instability and lack of support from the sexual partner and the psychological fear of scaling through the nine months is one of the major factors or causes of the practice of abortion among most adolescents (Cadmus, 2011; Wahab, 2011). In respect to adolescents who in their young age might lack finance to raise a child especially when their partners do not own to the responsibility of the pregnancy they might be left with no option than to seek for abortion (Wahab, 2011). Economic reason was also cited by some women for waiting to seek for abortion (Bankole Akinrinola , Susheela Singh and Taylor Haas, 1998).

The second reason is the fear of what parents would say or what would be their reaction.

Most adolescents stand in awe of their parents and as such nurse the fear of what would or might be the parents' response should they be aware that they are pregnant (Wahab, 2011). The fear and discomfort of carrying pregnancy for nine months especially those who are inexperienced take to abortion (Ohaitan, 2010).

The third adduced factor is Rape (Wahab, 2011). Rape is a horrible abuse with traumatic effect for many of its victims (Ogunwale et al, 2012). For a teenage girl who is a victim of rape that results in unintended pregnancy mostly seek for abortion as a way to ease the attendant trauma and stigmatization (Ohaitan, 2010; Abiodun et al 2009; Wahab, 2011). In the U.S, a woman is raped every 45 seconds and that is considering that only one out of every ten rapes is reported. So, rape happens more often and most women who became pregnant as a result to seeking of abortion (Cunningham, 1998).

Male factors related determinants of abortion seeking abortion

The male play a vital role in women's reproductive health. The relationship that the man has with the woman, i.e. whether the woman is his wife, mistress or girlfriend, most likely influences his involvement as well as his desires regarding how to manage her reproductive health (Coyle, 2009). Whereas expectations about childbearing within marriage may lead a man to support his wife to carry a pregnancy to term, a man might encourage a girlfriend to abort since social sanctions might be brought to bear on them for having a child out of wedlock (Ann, 2011)

Some men actively encourage their partners to abort (AGI, 2003). Some abandon their partners or threaten to do so and therefore indirectly encourage abortion. There are men who are not aware of a partner's abortion until after it occurs. Still other men offer support of some kind which may or may not include a commitment to a long-term relationship. Some men oppose abortion and make their views clear but, ultimately, they are at the mercy of their partners' decisions. Finally, many men concede to the often promoted view that abortion decisions belong solely to women and so defer those decisions to their female partners (Coyle, 2009).

Few studies directly address men's roles in women's abortion decisions and experiences. Some indirect evidence is however available in developing countries, where abortion is largely banned or restricted and many terminations are performed in unsafe circumstances, many women end unwanted pregnancies because of unstable relationships with the men in their lives (AGI, 2003).

Many women seeking abortions say their primary reason is that they do not want to be single mothers. Many abortion seekers had pregnancies which resulted from pre-marital relationships or relationships between unmarried people (Coyle, 2009); another factor is the threat by the men that he would abandon the woman if she had the baby (Rausch et al, 2005). In many countries, being in a troubled or fragile relationship ranks high among the reasons women give for seeking abortions (Ogunjuyigbe,P, Akinlo, A., Ebigbola J.A. 2005).

2.9 Conceptual Framework

PRECEDE Model

This model was developed by Green, Kreuter, and associates. This provides a road map for designing health promotion and education programs. It guides planners through a process that starts with desired outcomes and works backwards to identify a mix of strategies for achieving objectives. The model views health behavior as influenced by both individual and environmental forces, it has two distinct parts: an "educational diagnosis" (PRECEDE) and an "ecological diagnosis" (PROCEED). The PRECEDE acronym stands for Predisposing, Reinforcing, Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. For the scope of the research focus on Educational and Ecological Assessment, the practitioner identifies antecedent and reinforcing factors that must be in place to initiate and sustain change. According to the framework, any behaviour is caused by some behavioural antecedents. These anteeedents could be differentiated into three typologies-pre-disposing, enabling and reinforcing factor (Green and Kreuter, 1991).

The Predisposing factors refer to any condition that enhances the specific cause of a behaviour. There are some factors that motivate or provide a reason for a behavior or action; they include knowledge, attitudes, cultural beliefs, and readiness to change. Within the context of this study, the level of knowledge about the risk that is associated with abortion, the perception and belief towards abortion seeking behavior and the influence of their partner and environment of making decision to seek for abortion.

The model explains how the level of knowledge of undergraduate students will affect the outcome of seeking abortion. The level of knowledge is a strong factor that will determine if a student will seek for abortion because if they are aware of the risk and its effects the chance of going for abortion should be low. Also, the model explores the influence of perception and belief on undergraduate towards abortion seeking behavior. The model explains if students perceive abortion as risky behaviour or normal way to get rid of unwanted abortion. The perception and belief of undergraduate students will determine if they will seek abortion i.e. if they have a positive belief that abortion does

not carry any risk and is the best option to get rid of unwanted abortion then their high chance of them going for it. The model also explains if the partner who is responsible for the pregnancy has strong influence on the decision of seeking abortion. The role of partner and the influence of friends could also be strong determinant for an undergraduate who experience unwanted pregnancy to seek for abortion or to keep the baby (presented in Figure 2).

The enabling factor enable persons to act on their predispositions. These factors include available resources, supportive policies, assistance, services, facilities, hospital and clinics, money and access to abortion induced drugs in the environment that could affect the undergraduates in seeking abortion. The presence or absence of any of these variables has potential for influencing the behaviours of undergraduates relating to seeking abortion (Presented in Figure 2).

The third typology is reinforcing factors, which come into play after behaviour has been initiated; they encourage repetition or persistence of behaviors by providing continuing rewards or incentives. Parent reaction, boyfriend, society, school environment, shame, Social support, praise, reassurance, and symptom relief might all be considered reinforcing factors. This help to understand if students who have gone for abortion in the past will still seek for abortion in the future or encourage their partner to go for another abortion in case of another unwanted pregnancy. This helps to know if the undergraduates are exposed to any information on abortion which could be positive or negative reinforcement through the media and internet that could encourage their action.

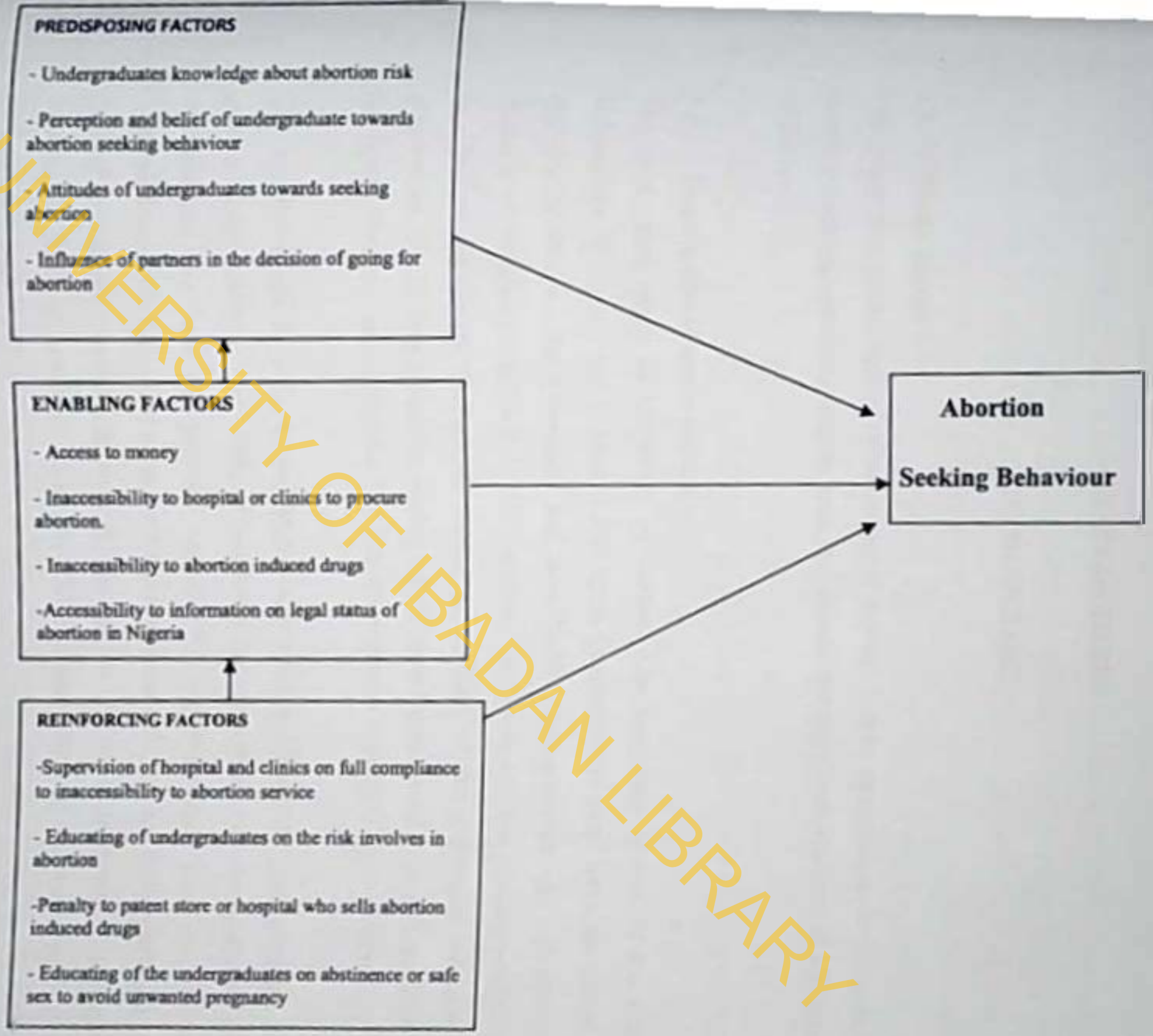

Figure 2.2: PRECEDE Framework applied to Abortion seeking behaviour

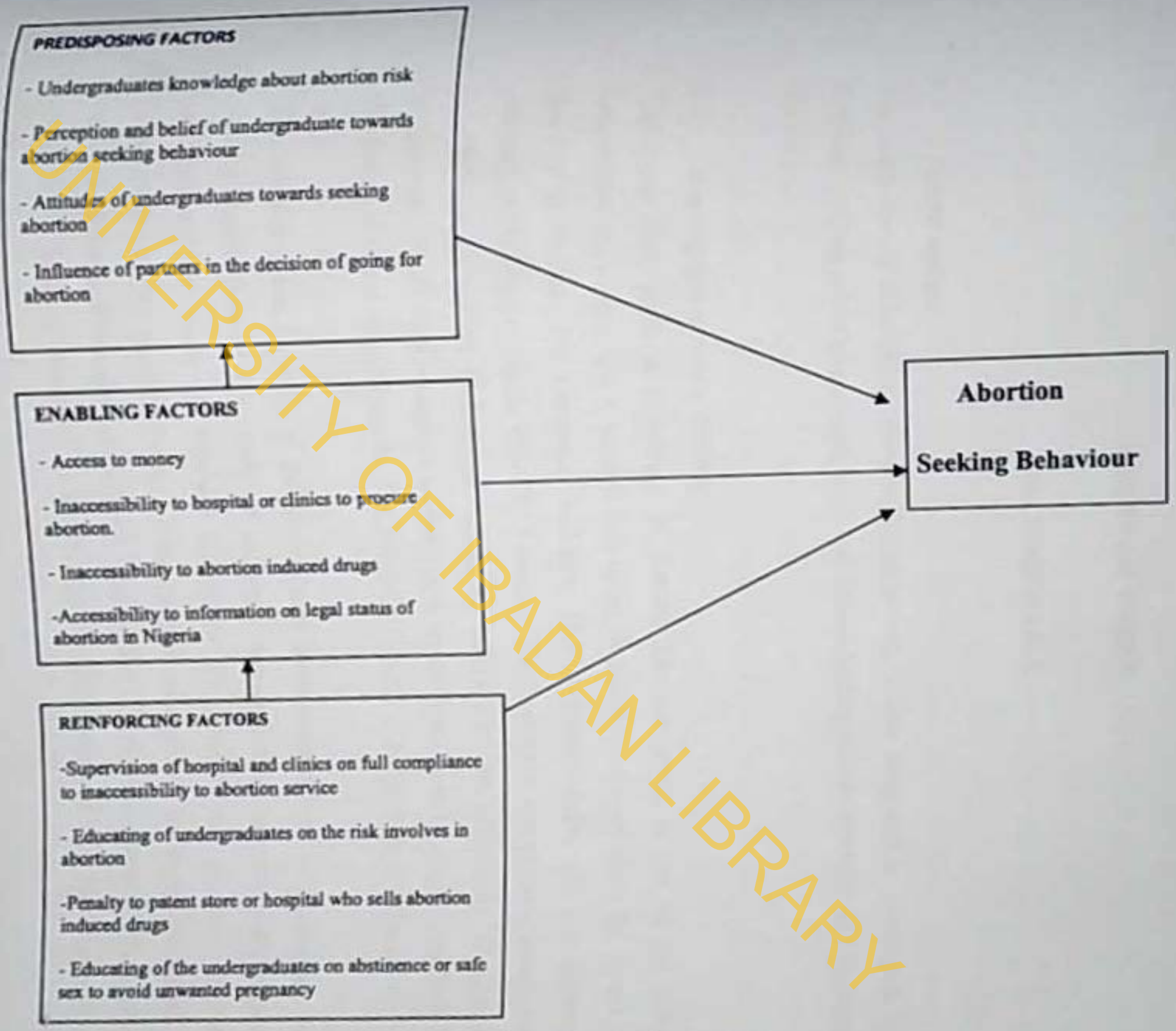

Figure 2.2: PRECEDE Framework applied to Abortion seeking behaviour

CHAPTER THREE

METHODOLOGY

3.1 Study design

The study was a descriptive cross-sectional survey. It was designed to investigate the abortion seeking behaviour among male and female undergraduate students of University of Ibadan.

3.2 Description of study setting

The study took place at University of Ibadan. The institution is one of the oldest universities in Nigeria and is located five miles (8 kilometres) away from the centre of the city of Ibadan. The University had over 12,000 undergraduate and post-graduate students of different sexes for 2011/2012 session. The University was initially established in 1948 as University College of Ibadan an affiliate of the University of London (Ogunwale, 2012). It is located in Ibadan North Local Government Area of Oyo State in the South-Western part of Nigeria. The Institution covers over 2550 acres of land.

The institution has 12 halls of residence which accommodate both undergraduate and post graduate students. Ten halls of residence accommodate only the undergraduate students and two halls are reserved exclusively for post-graduate students. The ten undergraduate halls consist of three for female students only, six for males only and one for both males and females (see Table 3.1 for the list of halls of residence). The records kept in the halls of residence as at 2012/2013 session showed that there were 7923 undergraduate students.

The university is a liberal higher institution that allows students to express their social life without restriction except for some illicit behaviour that could lead to violence in the school such as smoking within the school premises and taking of alcohol in public which are highly prohibited. There are different social activities in the school that the students

engage in such as Student Union Government (SUG) Week, Faculty Week, Departmental Week, Hall Week, dancing competition, drama shows, inter- departmental competition within the Faculty and inter faculty competition within the University. Also, there are some relaxation spots within the school where students recreate during their leisure time and spots where they take alcohol, party and hang out with friends. Outside the school premises, there are different relaxation spots that students in the school patronize such as night clubs, hotels and beers parlour etc.

3.3 Study population

The undergraduate students of University of Ibadan constituted the study population. These were male and female students who were officially accommodated in the halls of residence of the University.

3.4 Inclusion criteria

The main criterion that was used in selecting participants in the study was that the male and female undergraduate students of University of Ibadan were officially accommodated in the halls of residence in the institution.

3.5 Exclusion criteria

Undergraduate students who live off campus and those who are "squatting" or not officially accommodated on campus were excluded from the study.

3.6 Sample size determination and Sample size

The following formula for sample size determinant according to Leslie Kish, (1963) was used:

$$n = \frac{Z\alpha^2 p(1-p)}{(p)\, d^2}$$

Where,

N= sample size

Zα is standard normal deviation at 5% (Standard value of 1.96)

P is the assumed prevalence of abortion among undergraduates

The prevalence (P) was obtained from a study conducted at University of Benin which showed that 34% of female undergraduates interviewed had ever terminated a pregnancy (Aziken, 2003).

d is relative precision at 0.04

$$n = \frac{1.96^2 \times 0.34(1-0.34)}{(0.34)\ 0.04^2}$$

$$= 540$$

In order to make up for no response or attrition 10% of 540 i.e. (54) was added to increase the sample size to 600.

A Multi-stage sampling technique involving four stages was used to select participants in the study

Step 1: Probability proportionate to size technique was used to calculate and determine the number of respondents that were interviewed from each of the halls of residence for undergraduate students. The proportionate sampling was calculated using the following formula:

$$\text{Proportion of respondents from each hall} = \frac{\text{Total number of students in each hall}}{\text{Total number of undergraduate student residing in all the halls}} \times \text{sample size}$$

Based on this formula, the proportion of respondents that were selected from each hall of residence was calculated. Using Queen Elizabeth II Hall as an example:

$$\text{Proportion of respondents in the hall} = \frac{1039 \times 600}{7923} = 79$$

(See Table 3.1 for details in respect of proportionate samples for all the halls)

Step 2: Probability proportionate to size was used to determine the number of students that were interviewed from each block within the halls of residence. This was done because each hall of residence has different number of blocks and the number of rooms in each block varies. Some blocks are bigger than each other and they can take or accommodate more rooms than the others. Therefore, probability proportionate to size was used to determine the numbers of participants that were interviewed in each due to the fact that the number of rooms in each block varies in size and in order to ensure equal representation of all the blocks.

The probability proportionate to size was calculated using the following formula:

Proportion of respondents from each block =

$$\frac{\text{Total no of students in each block}}{\text{Total no of undergraduate student residing in each hall}} \times \text{sample size allotted for each hall}$$

Based on this formula, the proportion of respondents that were selected from each hall of residence was calculated. Using block A of Queen's hall as an example.

Proportion of respondents from the hall = $\frac{52 \times 79}{1039} = 4$

(See the Table 3.1 for details in respect of proportionate samples for each block from all the halls.)

Table 3.1: Distribution of undergraduate's students in halls of residence in University of Ibadan (2011/2012 Academic section).

S/N	Halls	Number of student in each hall	Number of undergraduate students in each block		Proportion of respondents that was be selected from each hall of residence	Proportion of respondents to selected from each block in various halls
1	Queen Elizabeth II Hall	1039	Block A Block B- Block C- Block D Block E- E ext Block F- BlockG- Block H- Block I- Block GR-	52 73 80 101 60 36 42 163 155 254 23	$\frac{1039\times600}{7923}$ = 79	4 5 6 8 5 3 3 12 12 19 2
2	Queen Idia Hall	1200	Block A- Block B- Block C- Flat-	432 488 208 72	$\frac{1200\times600}{7923}$ = 91	33 37 16 5
3	Obafemi Awolowo Hall	979	Block E Block F Block G Block H Block I Box room-	193 215 140 254 72 105	$\frac{979\times600}{7923}$ =74	15 16 11 19 5 8
4	Alexander Brown hall(female)	230	Block A Block B Block C Block F	98 56 56 20	$\frac{230\times600}{7923}$ = 17	7 4 4 2
5	Bello Hall	540	Block A Block B Block C Block D Block E	228 84 60 114 54	$\frac{540\times600}{7923}$ =40	17 6 5 8 4

S/N	Halls	Number of student in each hall	Number of undergraduate students in each block	Proportion of respondents that was be selected from each hall of residence	Proportion of respondents to selected from each block in various halls
6	Tedder Hall	552	Block A 225 Block B 126 Block C 135 Block D 66	$\frac{552\times600}{7923}$ =42	17 10 10 5
7	Mellamby Hall	552	Block A 281 Block B 36 Block C 153 Block D 82	$\frac{552\times600}{7923}$ =42.	21 3 12 6
8	Independent Hall	969	Block A 300 Block B 300 Block C 300 Block D 56 Box room 13	$\frac{969\times600}{7923}$ =73	22 22 22 5 2
9	Nnamdi Azikwe Hall	971	Block A 300 Block B 300 Block C 300 Block D 56 Box room 15	$\frac{971\times600}{7923}$ =74	23 23 23 4 1
10	Obafemi Awolowo Hall(male)	20	Block C 20	$\frac{20\times600}{7923}$ =2	2
11	Kuti Hall	555	Block A 78 Block B 225 Block C 126 Block D 72 Block E 54	$\frac{555\times600}{7923}$ =42	6 17 10 5 4
12	Alexander Brown Hall(male)	316	Block D 98 Block E 98 Block O 120	$\frac{316\times600}{7923}$ = 24	7 7 10
13	New post-graduate hall	NS	NS	NS	NS
14	Tafawa Balewa	NS	NS	NS	NS
	TOTAL	7923		600	

*Source - *Records kept by Hall wardens and Hall supervisor of each hall of resident in University of Ibadan*

Note: NS= Not Studied (because they are exclusively for post-graduate students)

Step 3: A systematic random sampling technique was employed at this study. A sampling frame consisting of the number of rooms occupied by undergraduates resident in the halls was constructed (see Table 3.2). Then rooms of the participant were selected in each block using table of random numbers. The sampling interval for each block was calculated to reduce selection bias and to allow for equal chance of the participants to be selected.

The systematic random sampling (sampling interval) was calculated using the following formula:

$$= \frac{\text{Total no of rooms in each block}}{\text{Sample size allotted for the block}}$$

After the calculation using the above formula, the sampling fraction obtained was used as a constant difference or interval between the rooms of respondent that were selected from each block.

Table 3.2: Sampling frame for selecting each room.

Number of rooms per each block in each hall of residence		Sampling interval for selecting each room where each participant was selected
Queen Elizabeth hall(blocks)	No of rooms	
Block A	22	6
Block B	35	7
Block C	30	5
Block D	50	6
Block E	20	4
E Ext	16	5
Block F	7	2
Block G	27	2
Block H	27	2
Block I	53	3
Block G	3	2
Queen Idia Hall		
Block A	108	3
Block B	122	3
Block C	52	3
Flats	16	3
Obafemi Awolowo Hall(female)		
Block E	54	4
Block F	62	4
Block G	64	6
Block H	66	3
Block I	24	5
Box Room	37	5
Alexander Brown Hall(female)		
Block A	60	6
Block B	40	10
Block C	40	10
Block F	10	5
Alexander Brown Hall(male)		

Block D	60	6
Block E	60	9
Block G	80	8
Bello Hall (Blocks)		
Block A	57	3
Block B	28	5
Block C	30	6
Block D	38	5
Block E	18	5
Tedder Hall (Blocks)		
Block A	75	4
Block B	42	4
Block C	45	6
Block D	33	7
Mellamby Hall (blocks)		
Block A	97	5
Block B	18	6
Block C	51	4
Block D	41	7
Kuti Hall (Blocks)		
Block A	26	4
Block B	75	4
Block C	42	4
Block D	36	7
Block E	27	7
ZIK Hall(Blocks)		
Block A	75	3
Block B	75	3
Block C	75	3
Block D	28	7
Box room	5	5
Independence Hall (Blocks)		
Block A	75	3
Block B	75	3
Block C	75	3
Block D	28	7
Box room	5	5

Step 4: All students that stayed in the selected rooms had equal chance of selection and one participant from each selected rooms were interviewed provided they gave their consent. Where it was noticed that a student occupies a room alone or where only one student was in the room as at the time of administering the questionnaire, he/she was purposively selected for interview. On the other hand where two or more roommates were present in a room balloting was used to select one of the participant for the study.

Five hundred and eighty seven out of 600 respondents participated in the study and returned the questionnaires while 13 respondents did not return the instrument. Some of the participants declined to participate because they felt it was a very sensitive issue and they would not be able to divulge such information. A few of them also claimed not to have ever engaged in sexual intercourse, so it would not be necessary for them to participate in the study but after some explanation on confidentiality of their responses, they agreed to participate. It was also noted in the process of data collection that some of the respondents that were selected in some of the rooms where they were more than 2 in numbers were not sincere in their responses or felt reluctant to answer the questionnaire. Hence, the researcher decided to make use of the hall common room and reading rooms to allow for privacy for the respondents to answer the questionnaire without fear or interference from roommates.

3.7 Methods and Instruments for data collection

The quantitative method was solely used to facilitate the data collection.

Semi-structured questionnaire

The instrument was developed after reviewing related literatures and extracting the pertinent variables on abortion related issues. Series of consultations were also held with experts in the fields of Obstetrics and Gynecology, Reproductive Health and Health Promotion and Education. The content of the instrument was divided into six sections labeled A to F: Section A contained questions used to assess the socio-demographic characteristics of the target population while section B consisted questions for assessing the level of knowledge of undergraduates on the abortion law related issues in Nigeria

and adverse health effects of the practice. Section C focused on undergraduate students' perception relating to abortion, there were sub-sectioned on ethical perception, legal perception, social and cultural perception and perceptions relating to psychological consequences. Section D was sub-divided into two subsections which contained separate questions for male and female undergraduate students (Section D1 and D2 respectively); these were questions on the prevalence of abortion and sexual experiences among undergraduates. Sections E contained questions on the factors influencing undergraduate students in adopting abortion while service outlet where undergraduates seek for abortion services were documented with the aid of questions in section F (See Appendix I).

3.8 Validity and Reliability

Some measures were taken into consideration to ensure the validity and reliability of the instrument for data collection.

Validity of instrument

In order to ensure construct validity of the instrument for data collection, the questionnaire was written in simple English language for easy comprehension and understanding of abortion related issues by the respondents. The content validity of the questionnaire was strengthened through the review of abortion related literature. In-house pre-testing of the instrument was done among experts in Health Promotion Department, Obstetrics and Gynecology, Centre for Reproductive Health and Family planning unit at University College Hospital (UCH), Ibadan.

Reliability of the instrument

Sixty copies of the questionnaire were pre-tested in a population that has similar characteristics with the actual study population. The pre-testing was done among undergraduate students' resident on campus at Obafemi Awolowo University, Ile- Ife, Osun State. After the pre-test, the questionnaire was revised and ambiguous questions were rephrased. This activity helped to screen for potential problems in the questionnaire to detect errors and take appropriate measures to rectify them before collecting the data using the instrument. The instrument also went through measures of internal consistency with the use of Cronbach's Alpha model technique of the SPSS to determine its

reliability. This is a model of internal coefficient based on the average inter-item correlation. A result showing a correlation coefficient greater than 0.50 using the technique is said to be reliable; in this study the result was 0.750, which is greater than 0.50, thereby confirming its high degree of reliability.

In addition to reliability and validity processes, Field Assistants (FA) were recruited and trained to ensure that they had adequate understanding and knowledge of the instruments prior to the commencement of data collection. The training focused on the objectives of the study, sampling processes, administration of the questionnaire, ethical consideration, basic interviewing skills and on how to review the instrument to ensure that it is properly completed.

Training of Field Assistants

Three field assistants were recruited and trained to participate in the data collection. They were trained to have adequate understanding of the instrument and the methods to be use in collecting the data prior to the commencement of data collection. The field assistants were also involved in pre-testing of the questionnaire at the Obafemi Awolowo University, Ile-Ife, in other to facilitate a better understanding of the study and likely constraints that may be encountered in the course of actual data collection

3.9 Data Collection process

This was carried out within the period of three weeks; visits were paid to all the halls of residence for undergraduates with prior approval by hall warden. Three field assistants, a male and two females were employed for the data collection.

The data collection process involved the following steps.

1. Identification and visits to the selected halls of residence.
2. Identification of each hall warden or supervisor for formal introduction and to seek for permission to conduct the study.
3. Identification and establishment of rapport with the eligible participant in each of the selected rooms, including a disclosure of the nature of the study, its objectives and any inconveniences that maybe involved.
4. Obtaining consent from the participants

5. Administration of the questionnaires to the participants
6. Collection and review of the completeness of the questionnaires.

3.10 Data management and analysis

The investigator ensured the daily review of the questionnaire and clenning of data collected in the field. The copies of the questionnaires were also checked for completeness. A coding guide was developed to facilitate coding and data entry. The data were subjected to descriptive (i.e. percentage, mean, median and mode) and inferential (i.e. T-Test and Chisquare) statistical analyses. Data entry and analysis was done using SPSS statistical package (SPSS version 16).The knowledge level on effects of abortion was assessed using 24-point knowledge scale. The scores of 0 and 8 was graded as poor, while scores of 9-16 were graded as fair. Knowledge scores which were equal to and greater than 7 were graded as good. The results were summarized and presented in tables and charts (See Chapter 4). Finally, copies of the questionnaire were kept in a place where they can't be accessed by unauthorized persons.

3.11 Ethical Consideration

Ethical approval for the study was sought from the joint University of Ibadan and University College Hospital (UI/UCH) Ethical Review Committee. Approval to each hall of residence was sought from Hall wardens or secretaries in all the selected halls of residence before the commencement of the study. Informed consent was obtained from the study participants (see Appendix 3 for the informed consent form). All research participants were informed that the survey was voluntary, and that they did not have to participate; they were told that they could withdraw at any point if they so wished. Each participant had autonomy to accept or decline to participate in the research. Participants were assured confidentiality of responses would be maintained during and after data collection. Serials numbers were assigned to each questionnaire and no name was required on the instruments. Serial numbers were used to facilitate data entry, analysis and no one was able to link the identity of the participants with the numbers.

3.12 Limitation

Abortion is a sensitive issue in the society; the probability of falsifying information was high. Some respondents declined to participate in the study because of the nature of the study. It was necessary to ameliorate these challenges to ensure valid information from the respondents. The participants were briefed about the purpose of the study and they were also assured over and over again that confidentiality of responses would be maintained. The interview was conducted in an atmosphere that ensured confidentiality.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic characteristics of the respondents.

The socio-demographic characteristics of the respondents are presented in Table 4.1. Nearly half (49.1%) of the respondents were aged 16-20 years while those within 21-25 years age bracket were (42.1%). The overall mean age of the respondents was 21.1±3.2; with an age range of 16-31 years. The proportion of respondents who were aged ≤ 19 years (adolescents) was 49.1%; those aged 15-24 years (youth) constituted 91.2% while young persons aged ≤ 24 years accounted for 91.2%. Over half (59.1%) of the respondents were males, majority (86.2%) were Christian and nearly half (48.7%) of the Christians belonged to the indigenous Christian religious denomination.

About one-third (27.9%) were from Faculty of Arts; the details of the faculty affiliation of the respondents are shown in the Table 4.1. Students in the first (100 level), second (200 level), third (300 level), fourth (400 level) and fifth (500 level) year of study were interviewed; over one-quarter of the respondents were in the 100 and 400 levels. Majority (71.6%) of the respondents were of the Yoruba ethnic group followed by the Ibos (18.1%). Most of the respondents (97.3) were single, few (2.3%) were married.

Table 4.1: Respondents' socio-demographic characteristics

N=587

Characteristics	Response	
	Number	Percentage
Age* :		
16-20	287	49.0
21-25	247	42.0
26-31	53	9.0
Sex:		
Male	347	59.1
Female	240	40.9
Religion:		
Christianity	506	86.2
Islam	81	13.8
Denomination(n=506)		
Indigenous church	286	48.7
Non indigenous church	220	37.5
Faculty Affiliation		
Arts	164	27.9
Education	83	14.1
Social Science	80	13.6
Science	74	12.6
College of Medicine	57	9.7
Technology	47	8.0
Agriculture and Forestry Science	25	7.0
Law	41	4.3
Pharmacy	7	1.2
Veterinary Medicine	9	1.5
Level of study		
100 level	168	28.6
200 level	131	22.3
300 level	83	14.1
400 level	168	28.6
500 level	37	6.3
Ethnicity		
Yoruba	420	71.6
Igbo	106	18.1
Edo	18	3.1
Middle belt ethnic Minorities	14	2.4
Core Niger Delta ethnic minorities	11	1.9
Hausa	9	1.5
Delta state ethnic groups	9	1.5
Marital Status		
Single	571	97.3
Married	16	2.7

*Overall mean age was=21.1±3.2; age range =16-31 year

Awareness and knowledge of abortion related issues among the respondents.

This section contains findings on respondents' awareness of abortion related laws, sources of the information of the law, respondents' knowledge of abortion and conditions under which abortion is legally acceptable in Nigeria.

Slightly over half (53.0%) of the respondents had not heard of the Nigerian abortion related laws. Among respondents that have heard about such laws, few (13.0%) were able to mention the two abortion related laws in Nigeria, which are the Northern Nigeria penal code and the criminal law which applies mainly in the south. The television topped (24.7%) the list of the mentioned sources of information followed by peer group (17.2%), school (17.2%) and Journal (15.8%). Table 4.2. Presents the other details.

Table 4.3 highlights respondents' knowledge on abortion and conditions under which abortion is legally acceptable in Nigeria. Majority (88.2%) of the respondents were knowledgeable about the correct concept of abortion as the termination of pregnancy or taking life of the foetus. Only one of the respondents (0.3%) knew that the correct condition under which abortion is legal is when the life of a woman is at risk. Almost one third (30.8%) of the respondents stated that abortion is legal in case of incest. Seventy five percent of the undergraduates correctly dissented that abortion is legal irrespective of the state of health of woman or girl provided it is her wish. Similarly, a majority (74.6%) described as false the notion that abortion is legal provided it is done by a qualified doctor for any reason. Slightly over half (51.1%) wrongly described as true the view that abortion is legally allowed in Nigeria if a pregnancy is as a result of rape or incest. (See the Table 4.3 for other details).

Table 4.5 shows respondents' knowledge of health related complications. Questions relating to knowledge of complications or effects were divided into three subsections, as follow: immediate effects; Long term effects; and other effects; Many (42.1%) respondents wrongly listed damage to the bladder as a possible immediate effect of abortion. Damage to the cervix was correctly listed by 64.9%. Womb damage or uterine perforation was correctly mentioned by most (91.1%) respondents. The other possible

immediate effects of abortion which were correctly mentioned included Vesico vagina fistula (62.0%) and septic shock (65.2%). The correctly mentioned long term effects of abortion were chronic pelvic pains or pelvic inflammatory disease (63.4%) and infertility (80.9%). The other possible complication of abortion correctly mentioned by the respondents was death (85.0%).

The methods listed by respondents for inducing abortion are presented in Table 4. The use of drugs or medications (48.5%) topped the list followed distantly by surgical approach (25.1%). Use of herbal or traditional means were mentioned by 11.2%. (See table 4.4 for details). Table 4.6 presents the comparison of respondents' mean knowledge by sex. The mean knowledge scores for male and females were 10.3±4.3 and 11.6±3.7 respectively with a significant difference ($P<0.05$).

Table 4.2: Awareness of abortion related laws among the respondents

Awareness of abortion related laws	Number	Percentage
Ever heard about abortion related laws in Nigeria(N=587)		
Yes	276	47.0
No	311	53.0
Types of abortion related laws in Nigeria (N=276)		
Penal code	19	6.9
Criminal law/code	111	40.2
Penal code and criminal law*	36	13.0
Abortion decree	72	26.1
None	38	13.8
Sources of information about abortion related laws (N=276)		
Radio	68	13.4
TV	125	24.7
Journal	80	15.8
Peer group	87	17.2
School	87	17.2
Internet	59	11.7

*Correct response

Table 4.3: Respondents' knowledge of abortion and conditions under which abortion is legally acceptable in Nigeria

Knowledge/conditions	Number	Percentage
*Concept/Definition of abortion**(N=587)*		
Abortion is the termination of unwanted pregnancy/taking life of a foetus.	518	88.2
I don't know	69	11.8
Condition(s) under which abortion is acceptable as legal in Nigeria(N=276)		
It is illegal to abort in all circumstances	13	4.7
Rape	46	16.7
When life of the woman is at risk*	1	0.3
If the woman cannot care for the child	3	1.1
Incest	85	30.8
None	41	14.9
No response	87	31.5
In Nigeria, abortion is legal irrespective of the state of the health of a woman or girl provided it is her wish(N=276)		
True	69	25.0
False *	207	75.0
Abortion is legal provided it is done by a qualified doctor for any reason(N=276)		
True	70	25.4
False*	206	74.6
Abortion is allowed in Nigeria if a pregnancy is as a result of rape or incest(N=276)	141	51.1
True	135	48.9
False*		

*Correct response

**There were no responses

Table 4.4: Methods of inducing abortion listed by respondents

Methods**	Number	Percentage
Drugs or Medication+	600	48.5
Operation/surgery (D & C)+	310	25.1
Herbal/traditional means	138	11.2
use of sharp object e.g. hanger or stick	40	3.2
Other questionable means*	149	12.0

*Other questionable means are as follow with figures in parenthesis being in percentages: lime 22(1.8), Lime and alabukun 22(1.8), Lime and alum 6(0.5), Stress 25(2.0), Assaulting 7(0.6), Alcohol 14(1.1), Concoction 13(1.0), Abortion belt 9(0.7), Native doctor (spiritual means) 4(0.3), Chemical intake e.g. poison and bleach 10(0.8), Hot water with salt 2(0.2), Potash 3(0.2), unripe fruit 3(0.2), Lemon, alcohol and potash 9(0.7).

**There were multiple responses

+ The only orthodox methods listed

Table 4.5: Respondents' knowledge of health related complications of abortion

Health related complications	True (%)	False (%)	No idea (%)
(A) Immediate effects (N=587)			
Damage to the bladder	247(42.1)	99(16.9)	241(41.1)
Diabetes	67(11.4)	269(45.8)	251(42.8)
Damage to the cervix*	381(64.9)	54(9.2)	152(25.9)
Womb Damage (uterine /perforation)*	535(91.1)	6(1.0)	46(7.8)
Vesico vagina fistula *	364(62.0)	25(4.3)	198(33.7)
Septic shock*	383(65.2)	37(6.3)	167(28.4)
Fibroids	196(33.4)	112(19.1)	279(47.5)
(B) Long term effects(N=587)			
Chronic pelvic pain or pelvic inflammatory disease.*	372(63.4)	25(4.3)	190(32.4)
Cervical cancer	288(49.1)	71(12.1)	228(38.8)
Damage to the lungs	72(12.3)	226(38.5)	289(49.2)
Kidney failure	89(15.2)	187(31.9)	311(53.0)
Infertility or inability to bear children later*	475(80.9)	34(5.8)	78(13.3)
(C) Others: Death*(+)	499(85.0)	30(5.1)	58(9.9)

*Possible complications

+ Death can result from abortion either in short or long term

Table 4.6: Comparison of respondents' mean knowledge scores by sex

N=587

Sex	Number	Mean	Sd	T-test	P-value
Male	348	10.32	4.3	4.473	0.04*
Female	239	11.63	3.7		

*Significant (P≤0.05)

Perceptions relating to abortion amoog uodergraduates

Table 4.7 highlights details of respondents' ethical perceptions relating to abortion. A majority (65.1%) of the male undergraduates and 56.5% of their female counterparts were of the perception that abortion should not be acceptable irrespective of the circumstances with no significant difference (P≤05). Majority (86.8%) of the male and 82.4% of the females were of the perception that abortion is like killing human being with no significant difference (P≤05). The notion often championed by pro-choice advocates that at certain age the foetus is not yet a human being, is not common among respondents in this study as 64.4% males and 61.5% females kicked against it. However 45.6% females and 42.5% males were of the view that abortion should be allowed when foetus (baby in the womb) is found to have genetic disorder or deformities that can affect its quality of life as a human being; no significant difference was observed by sex.

Many males (46.3%) and over half (55.2%) of the female respondents did not share the view that abortion should not be allowed even if the pregnancy will affect the health and interest of a girl/woman. Significant difference was noticed regarding the perception among the respondents by sex (P≤05).

Significantly more females (77.8%) than their male counterparts (64.5%) were of the perception that a lady and her sexual partner/husband have equal rights in decision relating to whether to an abortion or not. The abortion-related ethical orientation or stance of the respondents is highlighted in Figure 3. Clearly a majority (58.0%) of them were pro-life advocates.

Table 4.7: Respondents' perceptions relating to the ethics of abortion by gender

N=587

Ethical perceptions	Agree** (%)	Disagree** (%)	No opinion (%)	X^2	P-Value
Abortion is unacceptable irrespective of the prevailing circumstances				4.6	0.31
Male **	228(65.5)	94(27.0)	26(7.5)		
Female **	135(56.5)	83(34.7)	21(8.8)		
Overall	**363(61.8)**	**177(30.2)**	**47(8.0)**		
Abortion is like killing someone				3.9	0.52
Male **	302(86.8)	29(8.3)	17(4.9)		
Female**	197(82.4)	32(13.4)	10(4.2)		
Overall	**499(85.0)**	**61(10.4)**	**27(4.6)**		
A foetus (baby in the womb) of whatever age is an unborn human being with rights to life as other human beings. So it should not be aborted on grounds that it is not yet a person.				1.8	0.17
Male **	276(79.3)	40(11.5)	32(9.2)		
Female **	188(78.7)	38(15.9)	13(5.4)		
Overall	**464(79.0)**	**78(13.3)**	**45(7.7)**		
At a certain age the foetus (baby in the womb) is not yet a human being or person so it could be aborted in the interest of the mother				0.8	0.38
Male **	90(25.9)	224(64.4)	34(9.8)		
Female**	70(29.3)	147(61.5)	22(9.2)		
Overall	**160(27.3)**	**371(63.2)**	**56(9.5)**		
Abortion should be allowed when the foetus(baby in the womb) is found to have serious genetic disorder or deformities that can affect its future quality of life as a human being.				0.03	0.86
Male**	148(42.5)	129(37.1)	71(20.4)		
Female**	109(45.6)	92(38.5)	38(15.9)		
Overall	**257(43.8)**	**221(37.6)**	**109(18.6)**		

Ethical perceptions	Agree** (%)	Disagree** (%)	No opinion (%)	X^2	P-Value
Abortion should not be allowed even if the pregnancy carried will affect the health and interest of a girl/woman.				5.5	0.02*
Male **	128(36.8)	161(46.3)	59(17.0)		
Female**	67(28.0)	132(55.2)	40(16.7)		
Overall	**195(33.2)**	**293(49.9)**	**99(16.9)**		
Only a lady's interest/ wish should be relied upon to induce an abortion; the opinion of the husband/boyfriend should not be taken into consideration.				0.72	0.39
Male **	75(21.6)	230(66.1)	43(12.4)		
Female**	60(25.1)	155(64.9)	24(10.0)		
Overall	**135(23.0)**	**385(65.6)**	**67(11.4)**		
A Man or boy should be the ultimate decision maker regarding decision to abort a pregnancy or not				0.99	0.31
Male**	49(14.1)	258(74.1)	41(11.8)		
Female **	43(18.0)	180(75.3)	16(6.7)		
Overall	**92(15.7)**	**438(74.6)**	**57(9.7)**		
Foetus(baby in the womb) has right to life which is sacred; so its life should be protected and nurtured				1.11	0.29
Male **	287(82.5)	32(9.2)	29(8.3)		
Female **	212(88.7)	17(7.1)	10(4.2)		
Overall	**499(85.0)**	**49(8.3)**	**39(6.6)**		
A pregnant lady and her sexual partner/husband have equal rights in decision relating to whether to have an abortion or not; all of them must agree				7.58	0.01*
Male **	225(64.5)	68(19.5)	55(15.8)		
Female **	186(77.8)	29(12.1)	24(10.0)		
Overall	**411(70.0)**	**97(16.5)**	**79(13.5)**		

*Significance at 0.05, degree of freedom=1
** Cross-tab variables

18(b)

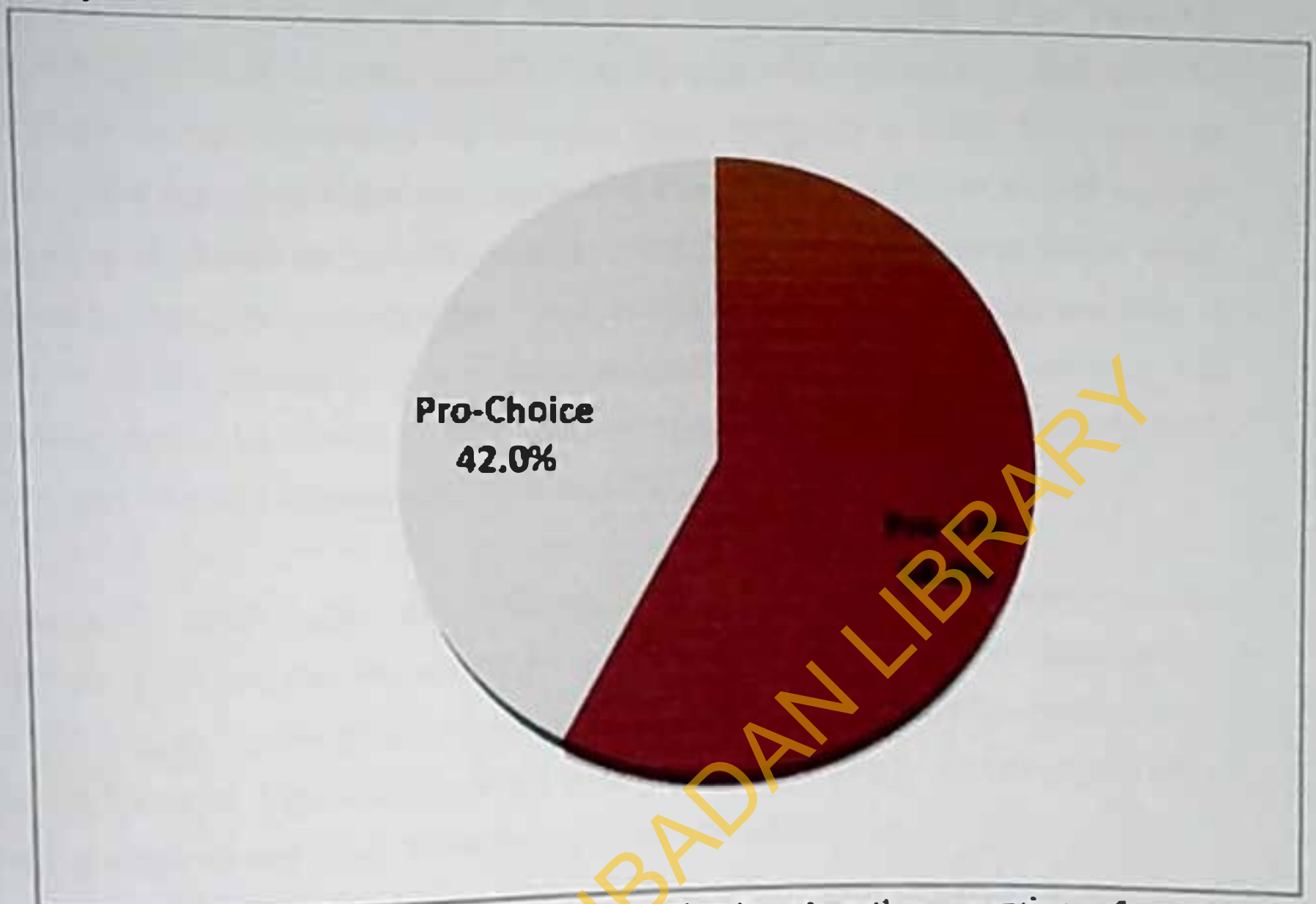

Figure 4.3: Abortion related ethical orientation based on the perceptions of respondents

The respondents' legal perceptions relating to abortion are contained in Table 4.8. Majority (62·6%) of the males and 62.3% of females with no significant difference did not share the legal perception that abortion should be legally available to anyone who wants under any circumstances. About half(50.3%) of the males did not support the view that abortion should be legalized so as to avoid illegal abortion that can cause health related problems for women/ladies. About half (47.7%) of female respondents were in support of the perception. Fewer male respondents (37.4%) were of the view that abortion should be limited to only cases of pregnancy resulting from rape or incest compared with their female counterparts (43.5%).

Fewer males (64.5%) than females (68.9%) were of the perception that every foetus has the right to life and therefore abortion is a criminal act that should be punishable by law. Similarly more females (75.3%) than males (67.2%) had the view that abortion is a crime against humanity. Figures 4 shows that based on the perceptions of the respondents using legal principles as standard, 54.0% were pro-life advocates.

Table 4.8: Respondents' legal perceptions of relating to abortion by gender

Legal perception	Agree** (%)	Disagree** (%)	No opinion (%)	X^2	P-Value
Abortion should be legally available to anyone who wants it under any circumstances				0.277	0.59
Male **	94(27.0)	218(62.6)	36(10.3)		
Female**	71(29.7)	149(62.3)	19(7.9)		
Overall	**165(28.1)**	**367(62.5)**	**55(9.4)**		
Abortion should be legalized sons to avoid illegal abortion that can cause health related problems for women/ladies				6.1	0.01*
Male **	132(37.9)	175(50.3)	41(11.7)		
Female**	114(47.7)	97(40.6)	28(11.7)		
Overall	**246(41.6)**	**272(46.3)**	**69(11.8)**		
Abortion should be limited to only cases of pregnancy resulting from rape or incest(sex with relatives)				2.82	0.09
Male **	130(37.4)	165(47.4)	53(15.2)		
Female **	104(43.5)	97(40.6)	38(15.9)		
Overall	**234(39.9)**	**262(44.6)**	**91(15.5)**		
The life of the foetus(baby in the womb) is inferior to the life of its mother; so abortion should not be criminalized but allowed in the interest of the affected lady				0.14	0.70
Male **	110(31.6)	192(55.2)	46(13.2)		
Female**	72(30.1)	135(56.5)	32(13.4)		
Overall	**182(31.0)**	**327(55.7)**	**78(13.3)**		
Free access to abortion without legal restriction is part of a woman's reproductive health right				0.22	0.67
Male **	74(21.3)	217(62.4)	57(16.4)		
Female **	51(21.3)	165(69.0)	23(9.6)		
Overall	**125(21.3)**	**382(65.1)**	**80(13.6)**		

Legal perception	Agree** (%)	Disagree** (%)	No opinion (%)	X^2	P-Value
The Nigeria abortion related laws are primitive; they should be liberalized in the country to make abortion a matter of choice				0.34	0.55
Male **	114(32.8)	148(42.5)	86(24.7)		
Female**	77(32.2)	112(46.9)	50(20.9)		
Overall	**191(32.5)**	**260(44.3)**	**136(23.2)**		
Abortion for whatever reason should be legalized but should put in the hand of the lady and her doctor to prevent the practice of abortion by unqualified persons				0.09	0.75
Male **	114(32.8)	185(53.2)	49(14.1)		
Female**	81(33.9)	124(51.9)	34(14.2)		
Overall	**195(33.2)**	**309(52.6)**	**83(14.1)**		
Every foetus (baby in the womb) has a right to life; therefore abortion is a criminal act that should be punishable by law.				0.61	0.43
Male **	226(64.5)	78(22.4)	44(12.6)		
Female **	164(68.9)	48(20.1)	27(11.3)		
Overall	**390(66.4)**	**126(21.5)**	**1(12.1)**		
Abortion is a crime against humanity				3.04	0.08
Male**	234(67.2)	58(16.7)	56(16.1)		
Female**	180(75.3)	29(12.1)	30(12.6)		
Overall	**414(70.5)**	**87(14.8)**	**86(14.7)**		

*Significance at 0.05, degree of freedom=1

** Cross-tab variables

19(b)

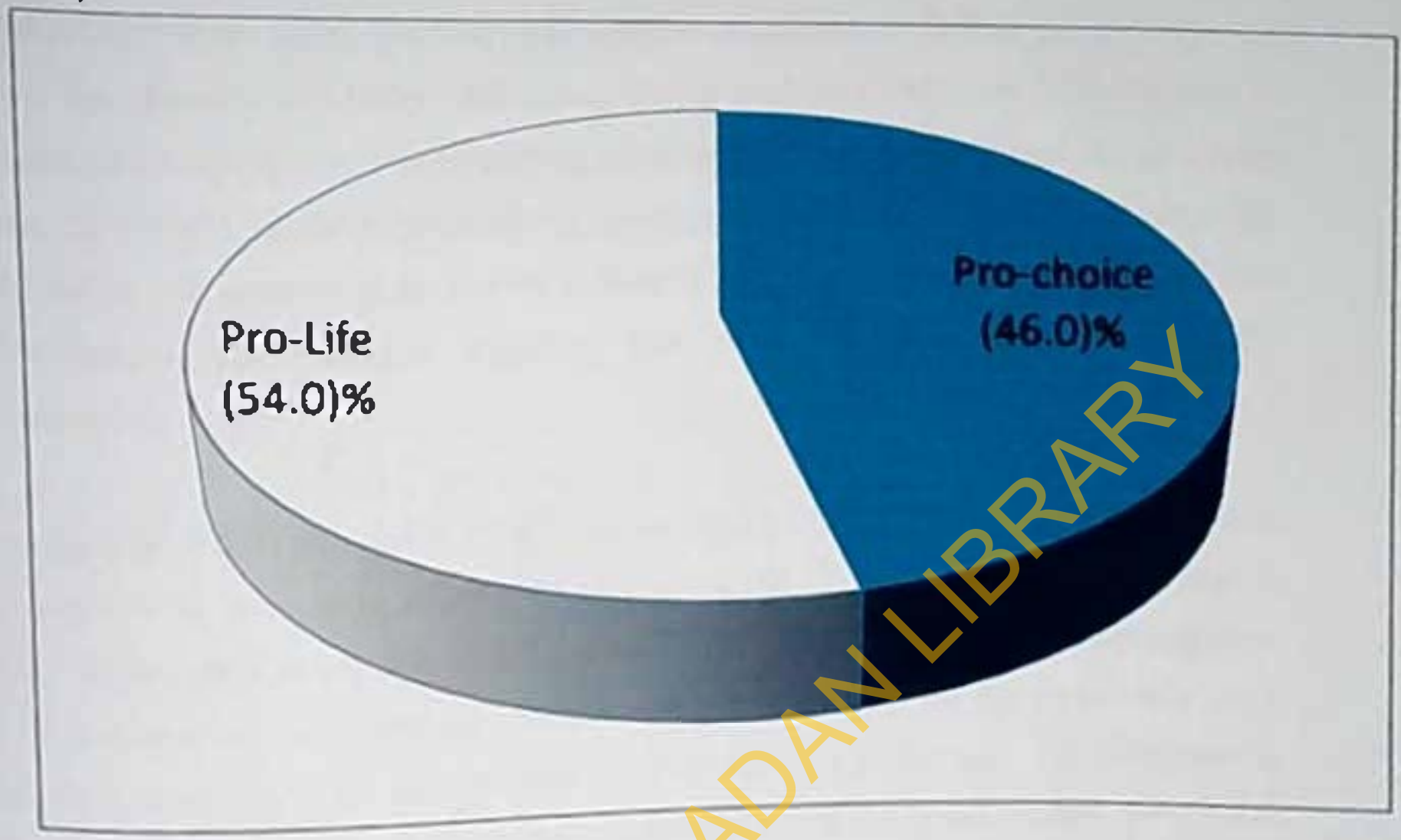

Figure 4.4: Abortion related orientation based on respondents' legal perceptions
* Derived based on question 19b (see appendix I for the question).

Table 4.9 shows the social and cultural perceptions relating to abortion among the respondents. More males (60.0%) than females' counterparts (59.0%) did not share the view that abortion is a better choice than giving birth to a child one does not want or cannot care for properly. The proportion of males and females who shared the perception were 28.7% and 32.6% respectively. A mostly (68.7%) of the respondents were of the perception that abortion is against the culture of people also should not be allowed. The male/female differentiations regarding this perception were 67.0% and 71.1% respectively.

A majority of the respondents (61.0%) were of the perception that abortion is a sin and should not be allowed in Nigeria. More females (58.3%) than their male counterparts (64.9%) had this perception. The perception of a majority (60.6%) of the respondents was that abortion can reduce the marriage chances of a lady if people get to know about it. More males (63.8%) than females (56.1%) had this perception. The difference in perception was found to be statistically significant using social and cultural perceptions relating to abortion, the respondents were categorized with 57.0% pro-life advocates and 43.0% pro-choice advocates (see figure 5)

Table 4.9: Social and cultural perceptions relating to abortion among the respondents by gender

N=587

Social and cultural perception	Agree (%) **	Disagree (%) **	No opinion (%)	X^2	P-Value
Abortion is a better choice than giving birth to a child one does not want or cannot care for properly				0.69	0.41
Male **	100(28.7)	211(60.6)	37(10.6)		
Female **	78(32.6)	141(59.0)	20(8.4)		
Overall	**178(30.3)**	**352(60.0)**	**57(9.7)**		
It is better to have an abortion rather than allow an unwanted pregnancy to ruin ones educational career				0.05	0.82
Male**	68(19.5)	243(69.8)	37(10.6)		
Female**	47(19.7)	176(73.6)	16(6.7)		
Overall	**115(19.6)**	**419(71.4)**	**53(9.0)**		
Abortion is against the culture of our people and so should not be allowed				0.28	0.59
Male **	233(67.0)	78(22.4)	37(10.6)		
Female**	170(71.1)	51(21.3)	18(7.5)		
Overall	**403(68.7)**	**129(22.0)**	**55(9.4)**		
It is better to have an abortion than having a child whose father is not known or is in doubt				3.23	0.07
Male**	69(19.8)	237(68.1)	42(12.1)		

Female **	36(15.1)	186(77.8)	17(7.1)		
Overall	**105(17.9)**	**423(72.1)**	**59(10.1)**		
Social and cultural perception	**Agree (%) ****	**Disagree (%) ****	**No opinion (%)**	**X^1**	**P-Value**
Abortion is a sin and should not be allowed in Nigeria				1.67	0.19
Male **	203(58.3)	98(28.2)	47(13.5)		
Female**	155(64.9)	58(24.3)	26(10.9)		
Overall	**358(61.0)**	**156(26.6)**	**73(12.4)**		
Only a woman/girl and her doctor should determine when abortion is necessary or not; other considerations e.g. religious, legal, moral should not be entertained				2.36	0.12
Male **	74(21.3)	224(64.4)	50(14.4)		
Female**	66(27.6)	147(61.5)	26(10.9)		
Overall	**140(23.9)**	**371(63.2)**	**76(12.9)**		
Abortion reduces the marriage chances of a lady if people get to know about it				8.05	0.01*
Male **	222(63.8)	79(22.7)	47(13.5)		
Female**	134(56.1)	82(34.3)	23(9.6)		
Overall	**356(60.6)**	**161(27.4)**	**70(11.9)**		

*Significance at 0.05, degree of freedom=1

** Cross-tab variables

20(b)

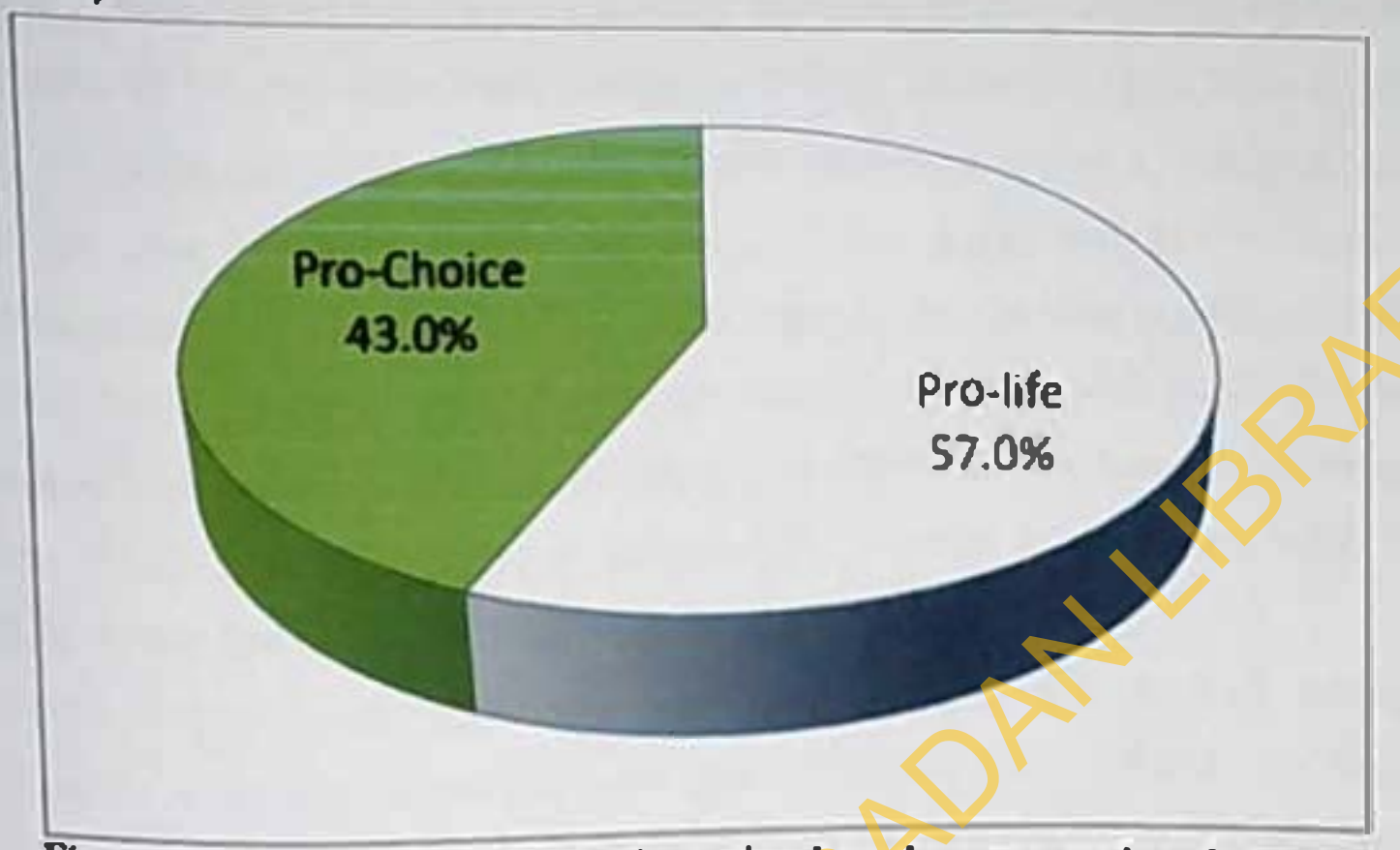

Figure 4.5: Abortion related orientation based on respondents' social and cultural perceptions

* Pie Chart constructed by data generated from question 20b (see appendix 1)

Respondents' perceptions related to the psychological consequences of abortion are shown in Table 4.10. Overall, a majority (83.8%) of the respondents were of the perception that abortion leaves one with guilt feelings concerning the killing of unborn child. There was no significant difference between the proportions of males (80.7%) and females 88.3% who shared this perception P>0.05. About half (50.2%) of the females and 47.1% of the males did not share the view of abortion produces a feeling of relief in a boy or girl after it has been done. A total of 33.9% males and 31.4% females had this perception. To a majority (73.8%) of the respondents, abortion is a sad experience which takes time to be forgotten. This view was shared by 72.7% males and 75.3% females. The respondents' perception of the psychological effects of abortion can be categorized into two effects which hurt one psychological (51.3%) and those that do not (48.7%). This information has been graphically presented in Figure 6.

Table 4.11 presents the respondents' perceptions of the physical consequences of abortion. Over half (55.5%) of male respondents and 59.4% of female respondents were of the perception that the physical adverse effects of abortion are usually mild. Over half (54.6%) of the male respondents and 59.0% were of the view that abortion is a major cause of death among girls or women in Nigeria.

Table 4.10: Respondents' perceptions of the psychological consequences of abortion by gender

N=587

Perception of psychological consequences	Agree** (%)	Disagree** (%)	No opinion (%)	X^2	P-Value
Involvement in abortion leaves one with guilt feelings concerning the killing of an unborn child				2.43	0.12
Male **	281(80.7)	33(9.5)	34(9.8)		
Female **	211(88.3)	15(6.3)	13(5.4)		
Overall	**492(83.8)**	**48(8.2)**	**47(8.0)**		
The abortion of an unwanted pregnancy leads to low self-esteem in a girl or woman				2.33	0.13
Male **	230(66.1)	66(19.0)	52(14.9)		
Female**	147(61.5)	58(24.3)	34(14.2)		
Overall	**377(64.2)**	**124(21.1)**	**86(14.7)**		
Abortion produces a feeling of relief in a girl or boy after it has been done				0.54	0.46
Male **	118(33.9)	164(47.1)	66(19.0)		
Female **	75(31.4)	120(50.2)	44(18.4)		
Overall	**193(32.9)**	**284(48.4)**	**110(18.7)**		
Abortion is a sad experience which takes time to be forgotten				0.27	0.60
Male**	253(72.7)	45(12.9)	50(14.4)		
Female**	180(75.3)	28(11.7)	31(13.0)		
Overall	**433(73.8)**	**73(12.4)**	**81(13.8)**		
The unpleasant experiences resulting from abortion are more than the relief which one experiences				3.26	0.07
Male **	220(63.2)	58(16.7)	70(20.1)		
Female**	167(69.9)	28(11.7)	44(18.4)		
Overall	**387(65.9)**	**86(14.7)**	**114(19.4)**		

Significance at 0.05, degree of freedom=1

** Cross-tab variables

21(b)

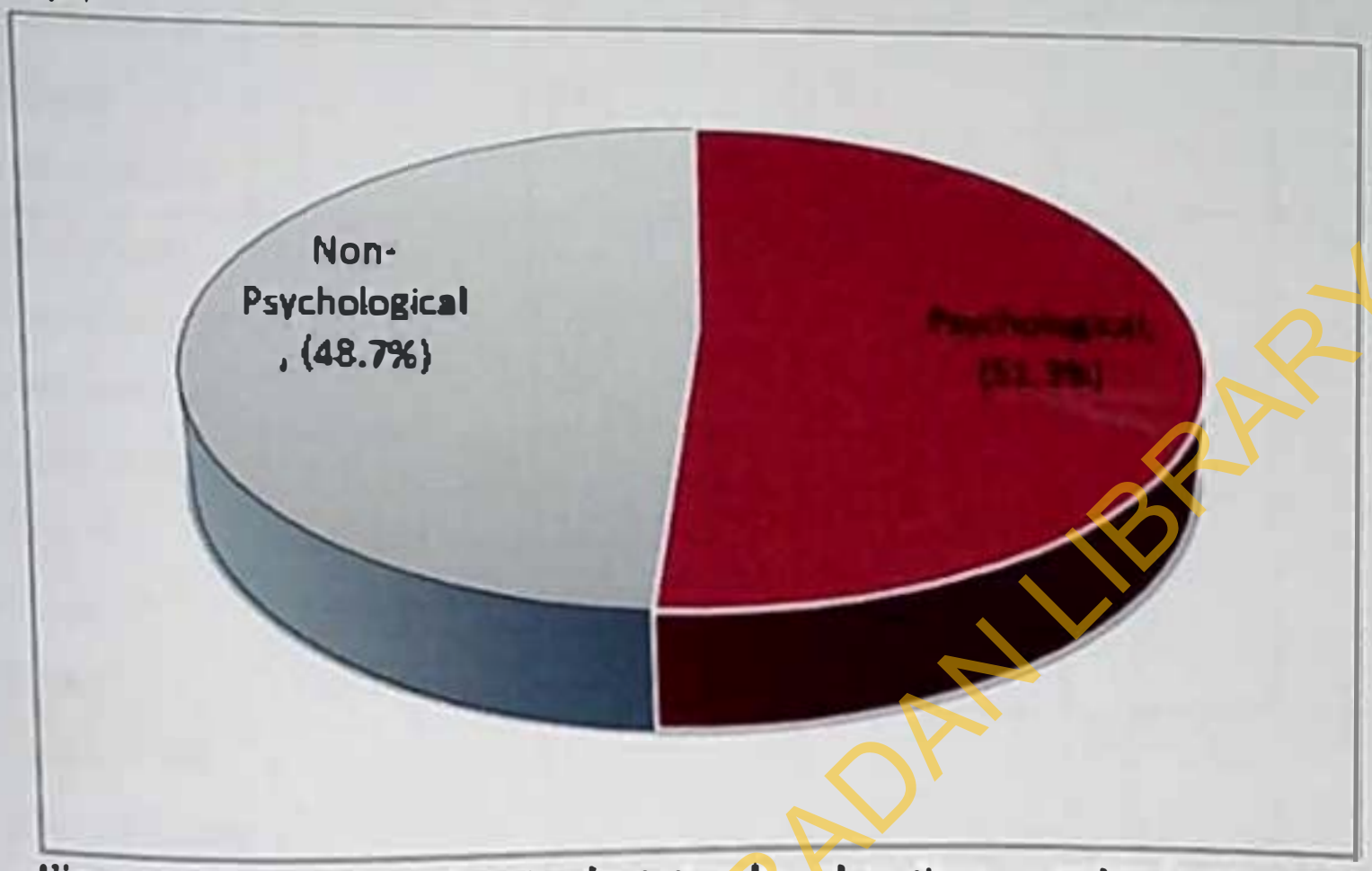

Figure 4.6: Abortion related orientation based on the respondent's psychological perception

*Pie Chart constructed by data generated from question 21b (see appendix I)

Table 4.11: Respondents' perceptions of the physical consequences of abortion by gender

N=587

Perception of physical consequences	Agree (%)**	Disagree** (%)	No opinion (%)	X^2	P-Value
The physical adverse effects of abortion are usually mild				0.41	0.84
Male **	71(20.4)	193(55.5)	84(24.1)		
Female **	50(20.9)	142(59.4)	47(19.7)		
Overall	**121(20.6)**	**335(57.1)**	**131(22.3)**		
Abortion has no any adverse side effects				3.51	0.06
Male **	43(12.4)	265(76.1)	40(11.5)		
Female **	19(7.9)	201(84.1)	19(7.9)		
Overall	**62(10.6)**	**466(79.4)**	**59(10.1)**		
Abortion is a major cause of death among girls or women				0.04	0.83
Male **	190(54.6)	88(25.3)	70(20.1)		
Female **	141(59.0)	68(28.5)	30(12.6)		
Overall	**331(56.4)**	**156(26.6)**	**100(17.0)**		

*Significance at 0.05, degree of freedom=1

** Cross-tab variables

Sexual experiences and prevalence of abortion among respondents

The sexuol experience and age at sexual debut are presented in Table 4.12. Many (43.7%) of the male respondents and about one third (33.5%) female respondents were sexually active as at when the study was carried out. Significant difference was noticed regarding sexual experience among sexes (P≤0.05) see details in Table 4.13. However, among male respondents base on the age at first sexual intercourse: nearly half (48.7%) of the respondents age 18-22 years topped the list followed closely by those within 13-17 years (42.8%) and few (8.5%) were within the age 23-27 years when first had sexual intercourse. Similarly, among female respondents overwhelming majority (72.5%) of those within the age of 18-22 years topped the list followed by few (18.8%) of those within age 13-17 years. Overall, over half (56.9%) among respondents had their first sexual intercourse within age 18-22 years. There was significant difference observed regarding sexual experience and age category (P≤0.05) see details in table 4.13.

Table 4.14 presents respondents' pattern of contraceptive use during their first sexual intercourse. Majority (59.9%) of the male respondents that were sexual active as at when the study was carried out reported that they did not use contraceptive during their first sexual debut similarly many (43.8%) of the female respondents accepted not to have used contraceptive too. Among those who used contraceptive, overwhelming majority males (91.8%) and 77.8% of the females respondents agreed to have used condom during their sexual debut followed by the use of contraceptive pills by 17.8% of the male and 11.4% of female respondents.

Contraceptive methods adopted by respondents who were sexual active are contained in Table 4.15. About half (47.4%) of the male respondents said they used condom during sexual intercourse followed by the use of drugs/pill by 28.9% of the male. Similarly, many (40.0%) of female respondents agreed to have regularly used condom during sexual intercourse followed by 24.6% who claimed to have taken emergency contraceptive after sexual intercourse and few (13.4%) of the female conceded to have used withdrawal method.

Table 4.17 highlights the number of sexual partners by respondents' who were sexually active as at the time of the study. Significantly more females (80.0%) than their male counterparts (61.5%) agreed to have only one sexual partner while few (17.1%) of the male respondents claimed to have two sexual partners compare to 8.8% of the female counterparts. Only (7.2%) of the male and 2.5% of the female respondents have three (3) sexual partners as at the time of the study. There were no significant relationship between the number of sexual partners and level of knowledge of abortion ($P \leq 0.05$).

Table 4.19 shows the respondents' pattern of use of contraceptive methods whenever experience or about to experience sexual intercourse. Over one quarter (36.2%) of the male and many (43.8%) of the female respondents claimed to not regularly use contraceptive whenever experiencing sexual intercourse with their sexual partner while 34.2% of the male and 21.3% of the female always use contraceptive whenever having sexual intercourse. Few (15.1%) of the male and about one third (26.3%) of the female respondents rarely use contraceptive when experiencing sexual intercourse.

Table 4.12: Respondents sexual experience and age at sexual debut

Sexual experience	Yes (%)	No (%)
Ever had sex(N=587)		
Male	152(43.7)	196(56.3)
Female	80(33.5)	159(66.5)
Age at first sexual intercourse	**Number**	**Percentage (%)**
Males(n=152)		
13-17**	65	42.8
18-22	74	48.7
23-27	13	8.5
Females (n=80)		
13-17++	15	18.8
18-22	58	72.5
23-27	7	8.6
Overall (n=232)		
13-17	80	34.5
18-22	132	56.9
23-27	20	8.6

*Males and Females combined
**42.8% male respondents had their first sexual intercourse from age 13 -17 years
++18.8% female respondents had their first sexual intercourse from age 13 -17 years
Male mean age 18.21±2.7
Female mean age 19.34±2.4

Table 4.13: Comparison of sexual experience among respondents by sex, level of study and age

N=587

Sex	Ever had sex		Df	X^2	P-Value
	Yes	No			
Male	151	196	1	6.163	0.01*
Female	80	160			
Level of study					
100	41	127	5	27.557	0.00*
200	53	78			
300	35	48			
400	86	82			
500	15	21			
Age					
16-20	65	222	2	68.841	0.00*
21-25	133	114			
26-31	34	18			

*Significant (P≤0.05)

Table 4.14: Respondents' pattern of contraceptive use during first sexual intercourse

Pattern of use of contraceptives	Yes (%)	No (%)
Use of contraceptive during first sexual intercourse (n=232)		
Male	61(40.1)	91(59.9)
Female	45(56.3)	35(43.8)
Contraceptives used during first sexual intercourse	**Number**	**Percentage (%)**
Male(n=61)		
Condom	56	91.8
Contraceptive pills	4	6.6
Withdrawal method	1	1.6
Female(n=45)		
Condom	35	77.8
Contraceptive pills	8	17.8
Withdrawal method	2	4.4
Overall(n=106)		
Condom	91	85.8
Contraceptive pills	12	11.4
Withdrawal method	3	2.8

*Males and Females combined

Table 4.15: Contraceptive methods adopted by respondents by gender

Contraceptive method adopted	Number	Percentage (%)
Males (n=152)		
Condom	72	47.4
Drug/pills	44	28.9
Withdrawal	8	5.3
Safe period	11	7.2
No protection	8	5.3
Don't know	0	0
No response	9	5.9
Female n=80		
Condom	32	40
Drug/pills	13	16.3
Withdrawal	23	28.8
Safe period	6	7.5
No protection	3	3.6
Don't know	1	1.3
No response	2	2.5
*Overall n=232		
Condom	104	44.8
Drug/pills	57	24.6
Withdrawal	31	13.4
Safe period	17	7.3
No protection	11	4.7
Don't know	1	0.4
No response	11	4.7

*Males and Females combined

Table 4.16: Respondents' who had friend of opposite sex at the time of the study by gender

232

Practice of having friend of opposite sex	Yes (%)	No (%)	X^2	Df	P-Value
Male(152)	118(50.9)	34(14.7)	13.5	5	0.18
Female(80)	71(30.6)	9(3.8)			

Table 4.17: Number of sexual partners by respondents' who had sex as at the time of the study by gender

N=232

Sex	Number of sexual partners				
	Zero (%)	One (%)	Two (%)	Three (%)	Four (%)
Males (n=152)	8(5.3)	94(61.8)	26(17.1)	11(7.2)	4(2.6)
Females (n=80)	1(1.3)	64(80.0)	7(8.8)	2(2.5)	2(2.5)
Overall	9(3.8)	158(68.1)	33(14.2)	13(5.6)	6(2.6)

Overall mean =1.3±0.8

Table 4.18: Comparison of knowledge by number of sexual partners
N=232

Number of sexual partners	Level of knowledge			Df	X^2	P-Value
	Poor	Fair	Good			
Zero/none	4(44.4)	5(55.6)	0	4	2.519	0.641
One	43(26.7)	104(64.6)	14(8.7)			
Two and above	13(25.0)	36(69.2	3(5.8)			

Table 4.19: Respondents' pattern of use of contraceptive methods whenever experience or about to experience sexual intercourse by gender

Sex	Pattern of use of contraceptive				
	Always (%)	*Sometimes (%)*	*Rarely (%)*	*Never (%)*	*Total*
Male	52(34.2)	55(36.2)	23(15.1)	22(14.5)	152
Female	17(21.3)	35(43.8)	21(26.3)	7(8.8)	80
Overall	69(29.7)	90(38.8)	44(19.0)	29(12.5)	232

The history of unintended pregnancy among respondents are presented in Figure 7. Many (44.0%) of the female respondents who were sexually active had experience unintended pregnancy. Majority (80%) of the sexually active female respondents were in tertiary institution when they experienced unintended pregnancy. See Figure 8 for details.

Table 4.20 highlights respondents' age when first had unintended pregnancy. The proportion of respondents who were between 20-23 years of age constituted 65.7% of those who had experience unintended pregnancy followed by few (25.7%) of those within aged 15-19 years.

Respondents' feelings when first experienced unintended pregnancy are contained in Table 4.21. Many (26.7%) of the female respondents felt "bad" when they experienced unintended pregnancy while only (17.7%) claimed to have felt sad and few (13.4%) of the female respondents were scared. (See table 22 for other details).

The number of times that the female respondents ever had unintended pregnancy are presented graphically in figure 9. Majority (82.9%) of the female respondents claimed to have had unintended pregnancy once while few (11.4%) said that they experienced unintended pregnancy twice.

Table 4.22 shows comparison of pregnancy experience among female respondents by level of study and age category. There is no significant difference between female who had experienced unintended pregnancy and their level of study ($P \leq 0.05$). However, there is significant difference between age category and female respondents that have experienced unintended pregnancy ($P \leq 0.05$).

The outcome of unintended pregnancy and places where the abortion took place are highlighted in Table 4.23. Among respondents who had unintended pregnancy majority (97.1%) aborted their pregnancy while only (2.9%) delivered the baby and most (88.2%) of the respondents who had aborted their unintended pregnancy sought for it in hospital/clinic. However, among the female respondents who sought for abortion few 2(5.7%) were married while the remaining 33(94.3%) were single. Similarly, among those who had experienced pregnancy twice, all of them aborted the pregnancy and they all sought for abortion at the hospital. Also, for those that had unwanted pregnancy three times, all of them aborted their pregnancy and sought for abortion at hospital.

Table 4.24 contains reason adduced by respondents for aborting their unintended abortion. Many (38.2%) of the female respondents claimed that they were not ready to care of a child while few (23.5%) reported that it was due to financial constraint that led them to seek for abortion among those who aborted once. While among female respondents who sought for abortion twice, 50% of them claimed it was due to unwanted pregnancy followed by few (16.7%) that claimed to be ashamed. experienced ectopic pregnancy and not ready to take care of a child respectively. (See Table 4.24 for other details). For the respondent who delivered her pregnancy adduced the reason for delivery of the child to being married. There was no significant difference between abortion experienced and level of knowledge of the female respondents ($P \leq 0.05$). (See Table 4.25 for details).

Figure 10 depicts the number of times the female respondents ever had abortion. Majority (86.0%) of the respondents claimed to have aborted their unintended pregnancy once, few (8.0%) of the females sought for abortion twice and 6.0% had abortion three times. However, majority (77.0%) felt relieved initially but later regretted their action while only (23.0%) felt relieved and still feel so as at when the study was carried out among those who had sought for abortion in the past. Respondents' feelings after procuring is graphically highlighted in figure 11.

Abortion related complications ever experienced among those who had sought for abortion are shown in Table 4.26. Over half (51.1%) reported to have not experienced any form post-abortion complication while many (42.9%) claimed to have had experienced complication after procuring abortion. Among those who had experienced complications after procuring abortion, majority (73.3%) had excessive bleeding while few (20.0%) experienced stomach ache. Significantly (89.0%) of the respondents reported that they would not seek for abortion in case of a future unwanted pregnancy. (See figure 12 for details). However, over a quarter (32.4%) female respondents who claimed to be prolife (abortion shouldn't be acceptable on any condition) sought for abortion when they experienced unintended pregnancy.

N=35**

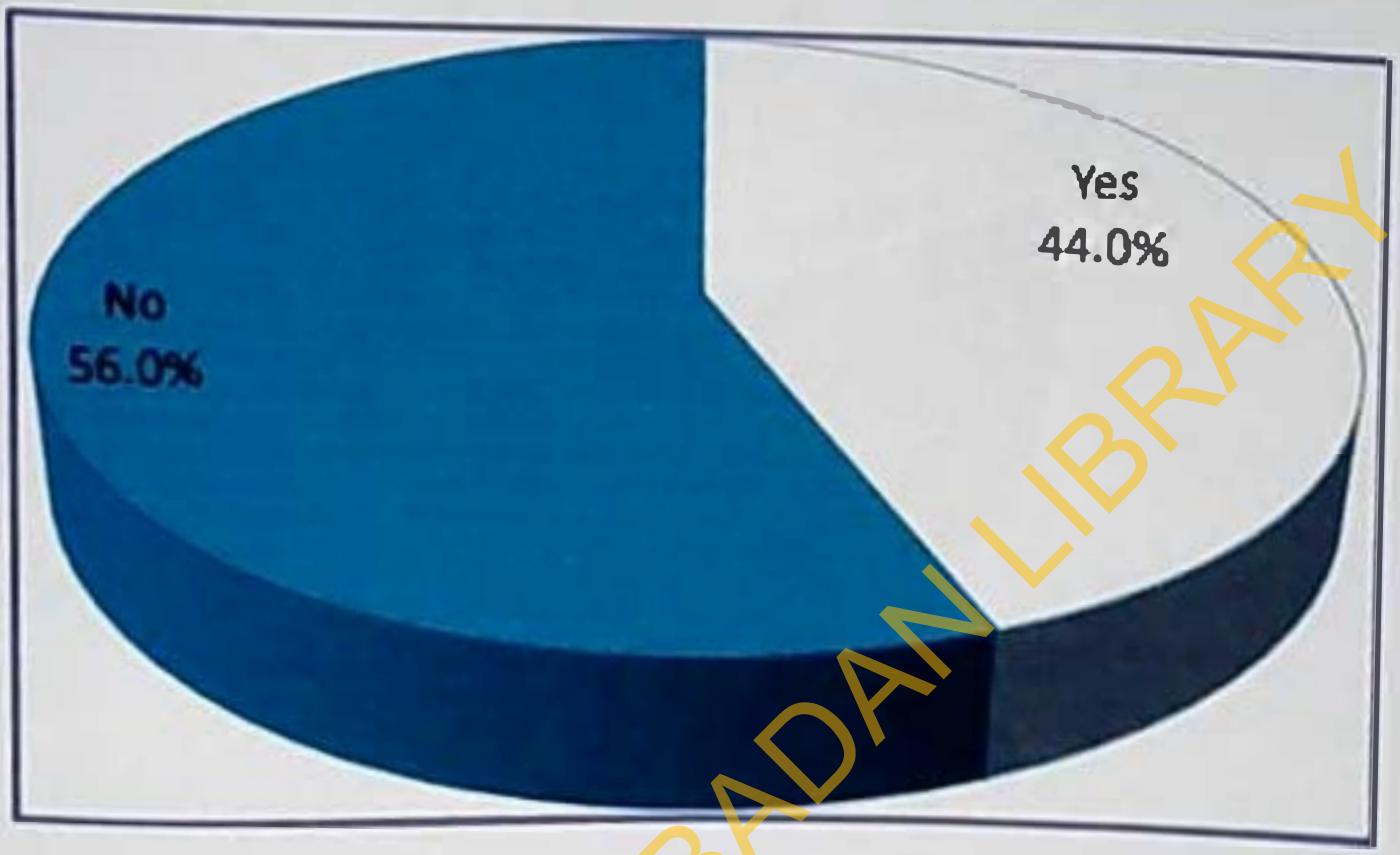

Figure 4.7: History of unintended pregnancy among female respondents

* Pie Chart constructed by data generated from question 29.a (see appendix I)

** These 35 were the female respondents that had ever had unwanted pregnancy

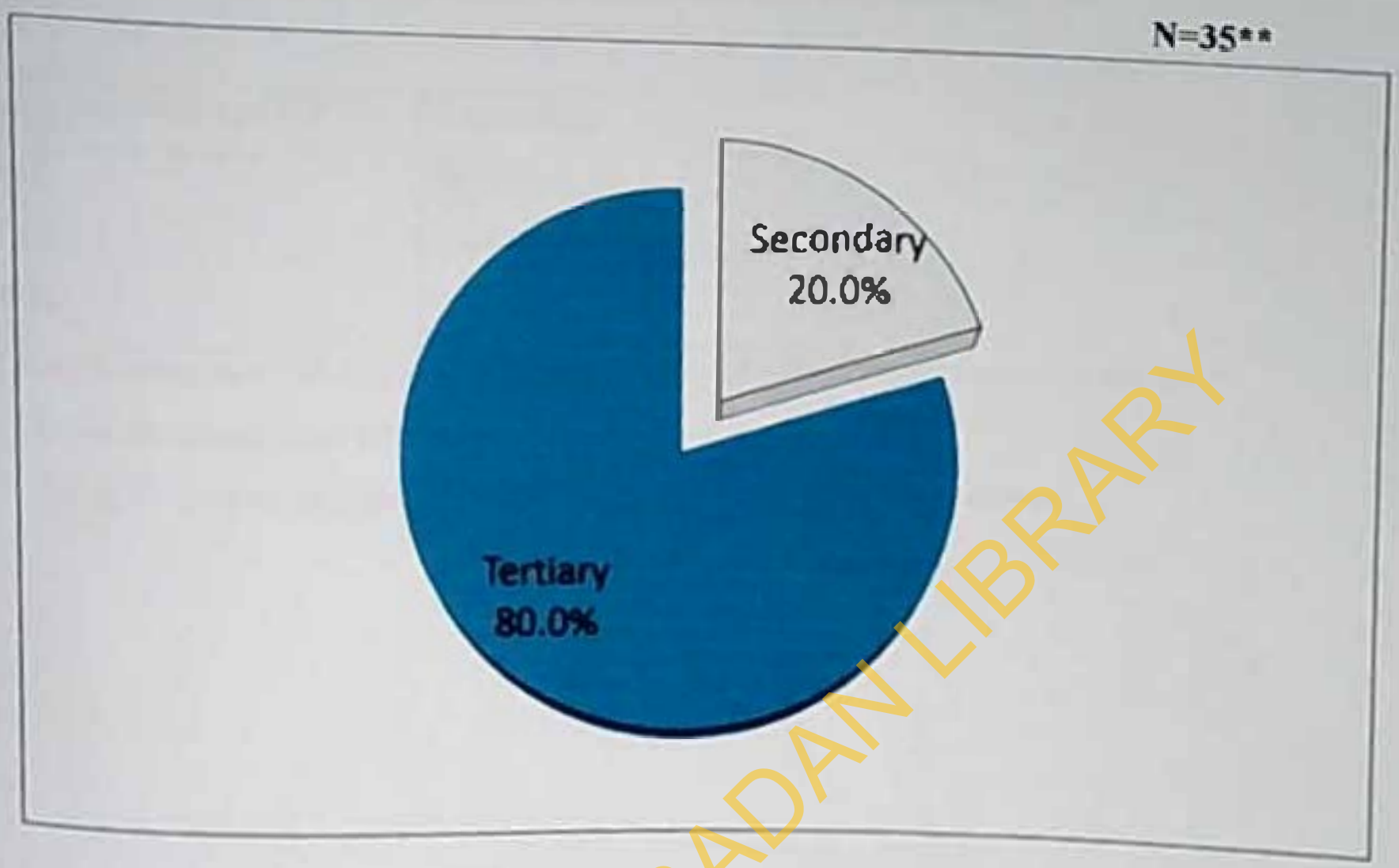

Figure 4.8: Sexually active female respondents' level of education when first had Un-intended Pregnancy (UP)

* Pie Chart constructed by data generated from question 29.b (see appendix 1)

** These 35 were the female respondents that had ever had unwanted pregnancy

Table 4.20: Respondents' age when first had unwanted pregnancy

N=35**

Age when first had UP	Percentage
15-19	9(25.7)
20-23	23(65.7)
24-28	3(8.6)

*Overall mean age =20.4±2.4 with those aged 15-24 years (young person) making up 25.7% of the overall age population

** These 35 were the female respondents that had ever had unwanted pregnancy

Table 4.21: Respondents' feelings when first experienced UP

N=35

Feelings*	Percentage (%)
Guilty	6(13.3)
Rejected	6(13.3)
Sad	8(17.7)
Shocked	4(8.9)
Bad	12(26.7)
Scared	6(13.4)
So disappointed and empty	3(6.7)

*There were multiple responses

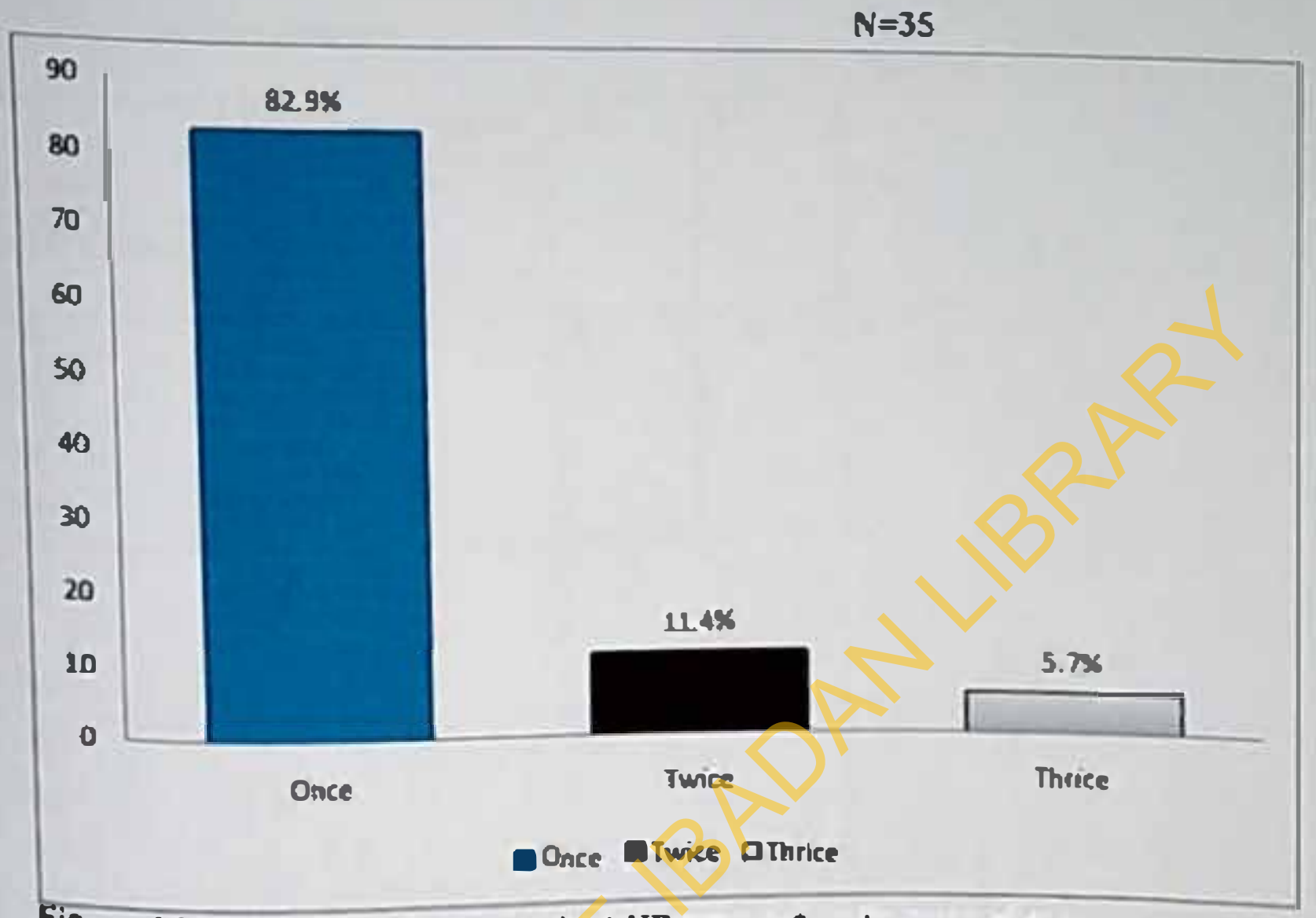

Figure 4.9: Number of times ever had UP among female respondents

Table 4.22: Comparison of pregnancy experience among female respondents by level of study

and age category

N=81**

Variable	Ever been pregnant		Df	X^2	P-Value
	Yes	No			
Level of study					
100	4	14	6	8.404	0.21
200	5	9			
300	6	9			
400	14	13			
Age					
16-20	3	20	2	12.371	0.00*
21-25	28	22			
26-31	4	3			

*Significant ($p \leq 0.05$)

** 81 respondents were exclusively the female respondent that were sexually active as at the period of conducting of the study

Table 4.23: Outcome of UP and Places where abortion took place by pregnancy order

Pregnancy order	Outcome of pregnancy		If aborted place where it took place.		
	Delivered the baby	Aborted pregnancy	Hospital/Clinic (%)	Used unacceptable methods* (%)	No response (%)
1st pregnancy	1(2.9)	34(97.1)	30(88.2)	2 (8.8)	1(2.9)
2nd pregnancy	0	6(100)	7(100)	0	0
3rd pregnancy	0	2(100)	2(100)	0	0

*Unacceptable means unorthodox methods of inducing abortion

Table 4.24: Reasons adduced by respondents for aborting their UP by pregnancy order

Pregnancy order	Reasons adduced for taking to abortion										
	Unwanted pregnancy	Financial constraint	Fear	Scared it was going to affect my studies	The guy responsible did not accept it	Ashame	Not married	Peer Influence	Stigma	Ectopic pregnancy	Not ready to care of a child
1st preg(n=34)	3(8.8)	8(23.5)	5(14.7)	1(2.9)	1(2.9)	1(2.9)	1(2.9)	1(2.9)	0	0	13(38.2
2nd preg(n=6)	3(50)	0	0	0	0	1(16.7)	0	0	0	1(16.7)	1(16.7)
3rd preg(n=2)	1(50)	0	0	0	0	1(50)	0	0	0	0	0

Table 4.25: Comparison of respondents' levels of knowledge and number of abortion experienced among female respondents

N=35

Frequency of abortion experience	Levels of knowledge			Df	X^2	P-Value
	Poor	Fair	Good			
Once	2(6.7)	25(83.3)	3(10.0)	6	11.355	0.078
Twice	0	2(66.7)	1(33.3)			
Thrice	1(50)	1(50)				

(31)

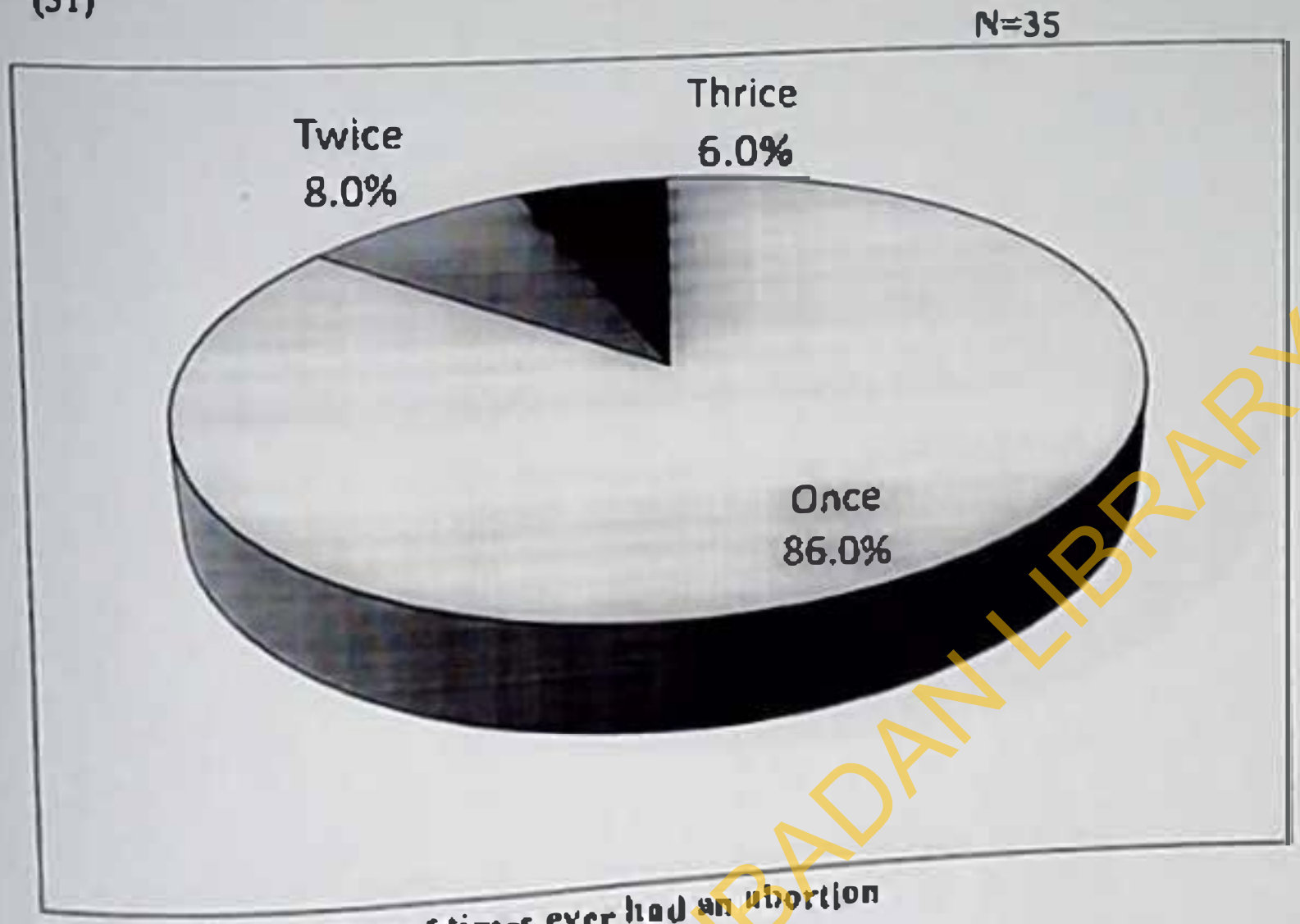

Figure 4.10: Number of times ever had an abortion

(32)

N=35

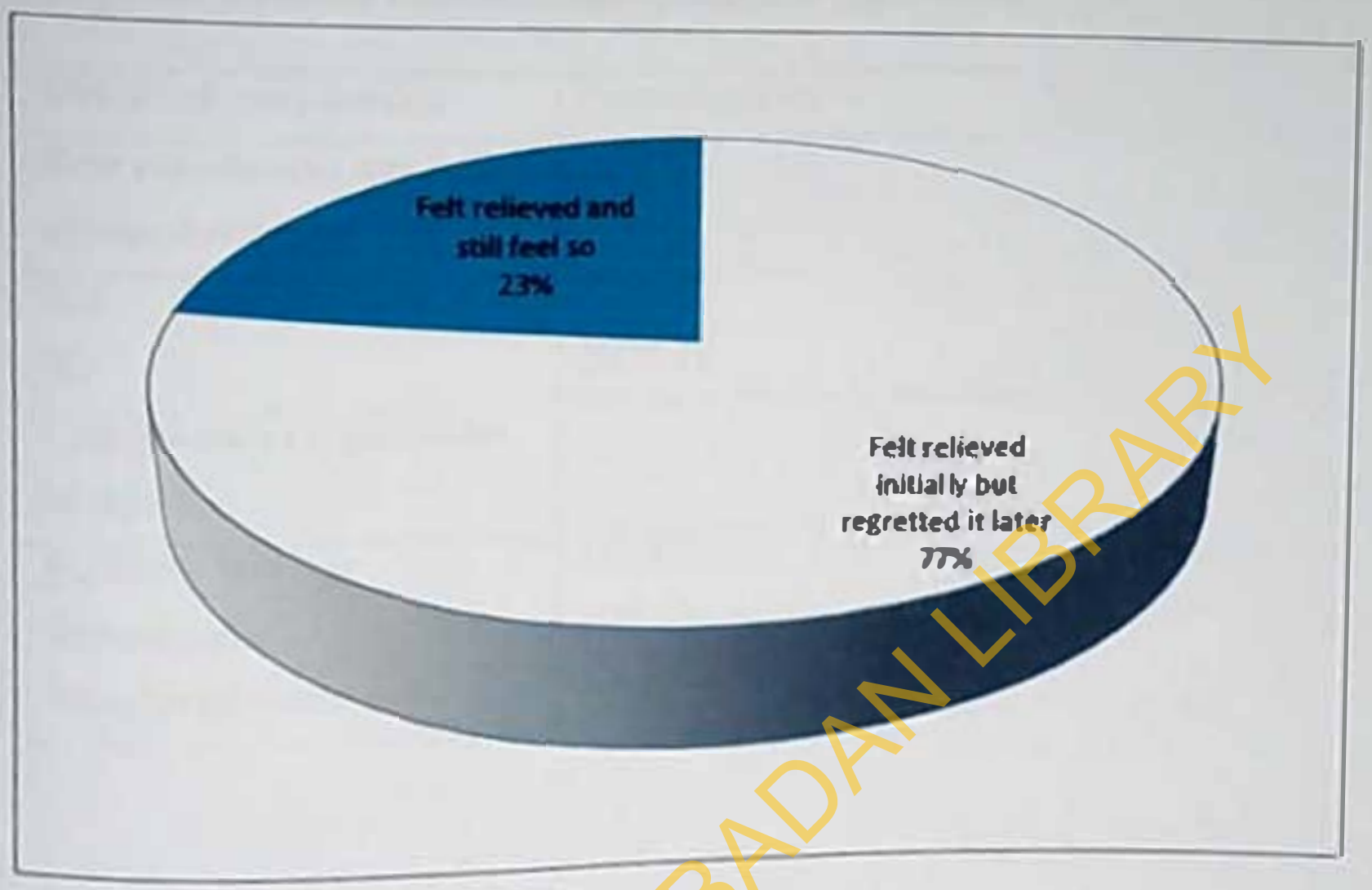

Figure 4.11: Respondents' feelings after procuring abortion
* Data used for generating pie chart were derived from question 32 (appendix I)

Table 4.26: Abortion related complications ever experienced

History of complication	Percentage(%)
Ever experienced any form of complication (n=35)	
Yes	15(42.9)
No	20(51.1)
Complications experienced (n=15)	
Excessive bleeding	11(73.3)
Stomach ache	3(20)
Irregular menstrual cycle	1(6.7)

(34)

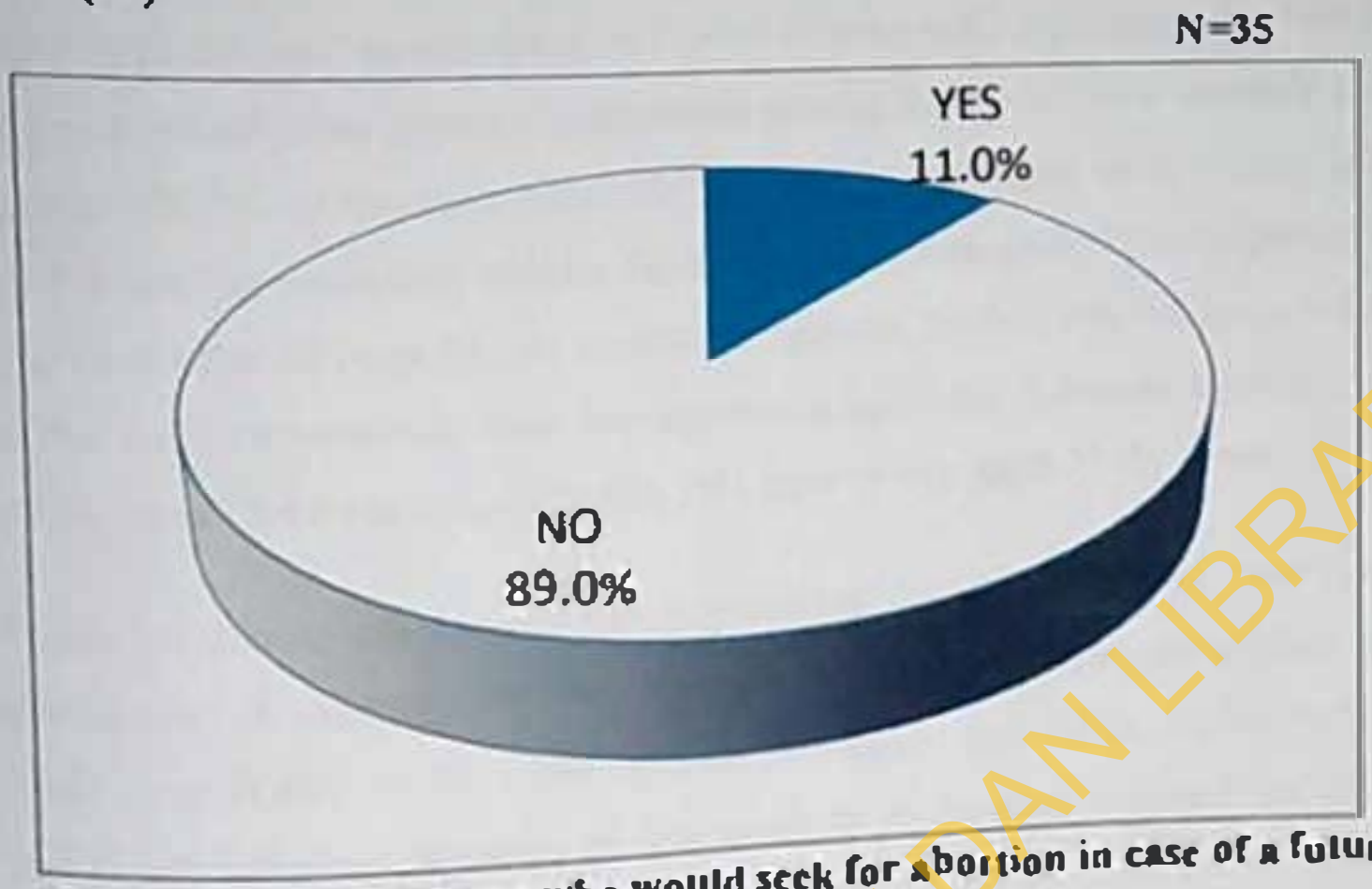

Figure 4.12: Respondents who would seek for abortion in case of a future unwanted pregnancy

* Data used for generating pie chart were derived from question 34 (appendix 1)

Table 4.27 shows the prevalence of impregnating girls among male respondents. Majority (72.4%) of the male respondents had never impregnated a girl/partner while few (27.6%) reported to had impregnated a girl/partner among those who were sexually active. A third quarter (76.2%) of the male respondents' level of education were tertiary institution and 23.8% were in secondary among those who had impregnated a lady/partner in the past. The proportion of respondents who were between 20-24 years of age constituted 50.0% of the male respondents who impregnated a girl/lady followed by few (33.3%) those within aged 15-19 years and few (16.7%) were within aged 25-29 years.

Figure 14 shows graphically the respondents' number of times ever impregnated a girl/partner. A majority (83.0%) of male respondents impregnated their partner once while only (7.0%) of the male impregnated twice and thrice respectively. There is a significant difference between the age category of the male respondents and their sexual practice that led to impregnating a lady/partner ($P \leq 0.05$). (See Table 4.28 for details). Respondents' feelings first time impregnating a lady. Many (30.9%) of the respondents reported to have been scared while 20.0% claimed to have been uncomfortable and few (18.2%) said they were shocked when they first mistakenly impregnated a lady/partner. (See others details in Table 4.29).

Prevalence of influencing girl/partner impregnated to procure abortion presented graphically in figure 15. Majority (88.0%) of the male respondents reported to have influenced their sexual partner in seeking abortion. Table 4.30 shows the outcome of unintended pregnancy and places where abortion took place. Significantly (88.4%) of the male who had mistakenly impregnated a lady reported to have influenced their sexual partner in procuring abortion while 11.6% of the respondents delivered the baby. Among those who influenced their partner to seek abortion, most (76.3%) sought for abortion at the clinic while 23.7% used unacceptable methods. For those who impregnated a lady more than once, majority (87.5%) of the respondents aborted the pregnancy while few (12.5%) delivered the baby. Over half (57.1%) of those respondents that aborted the pregnancy sought for abortion at the clinic and many (42.9%) used unacceptable methods. (See Table 4.30 for other details).

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Reason adduced by male respondents for allowing sexual partners to deliver their babies highlighted in Table 4.31. Many (40%) of the respondents reported that their parent influenced them while some claimed it was their first baby. Table 33 contains reasons adduced by male respondents for aborting their sexual partner pregnancies. Over half (55.3%) of the respondents reported that they were not ready to be a father while few (18.4%) claimed to be scared which influenced their decision of seeking abortion for their sexual partner. Among respondents who aborted twice, majority (71.4%) claimed that they were not ready to be a father while 28.6% reported that it was due to their parental influenced. (See other details in Table 33).

Comparison of encouraging sexual partner to seek abortion in the past by age category and marital status presented in table 34. There is significant difference between age category and ever encouraged sexual partner to seek abortion ($P \leq 0.05$). There is significant difference between respondents' marital status and abortion seeking practice among the respondents ($P \leq 0.05$). Table 35 summarizes the abortion related complications sexual partners of male respondents' ever experienced. Majority (60.5%) of the male respondents reported that their sexual partner did not experience any form of complication while 39.5% claim that their sexual partner experienced complication after seeking for abortion. Among those male respondents that their sexual partner experienced complications, many (75%) of the sexual partner experienced excessive bleeding while 12.5% experienced stomach ache.

Figure 16 highlights the male respondents' feelings after terminating a pregnancy. Majority (79.0%) of the male respondents felt relieved initially but later regretted their action while 21% felt happy that they did it and even up till the moment of the study. Respondents' likelihood of seeking for abortion in case of another unwanted pregnancy is presented graphically in figure 15. Significantly (80.0%) of the male respondents would not seek for abortion in case of another of unwanted pregnancy. However, Majority (65.7%) male respondents who claimed to be prolife (abortion shouldn't be acceptable on any condition) influenced their partners in seeking for abortion when she experienced unintended pregnancy.

Table 4.27: Prevalence of impregnating girls among male respondents

Prevalence	Number (%)
Ever impregnated a girl/lady n=152	
Yes	42(27.6)
No	110(72.4)
Level of education when first impregnated a lady	
Primary	0
Secondary	10(23.8)
Tertiary	32(76.2)
Age when first impregnated a girl/lady(n=42)	
15-19	14(33.3)
20-24	21(50.0)
25-29	7(16.7)

(36)

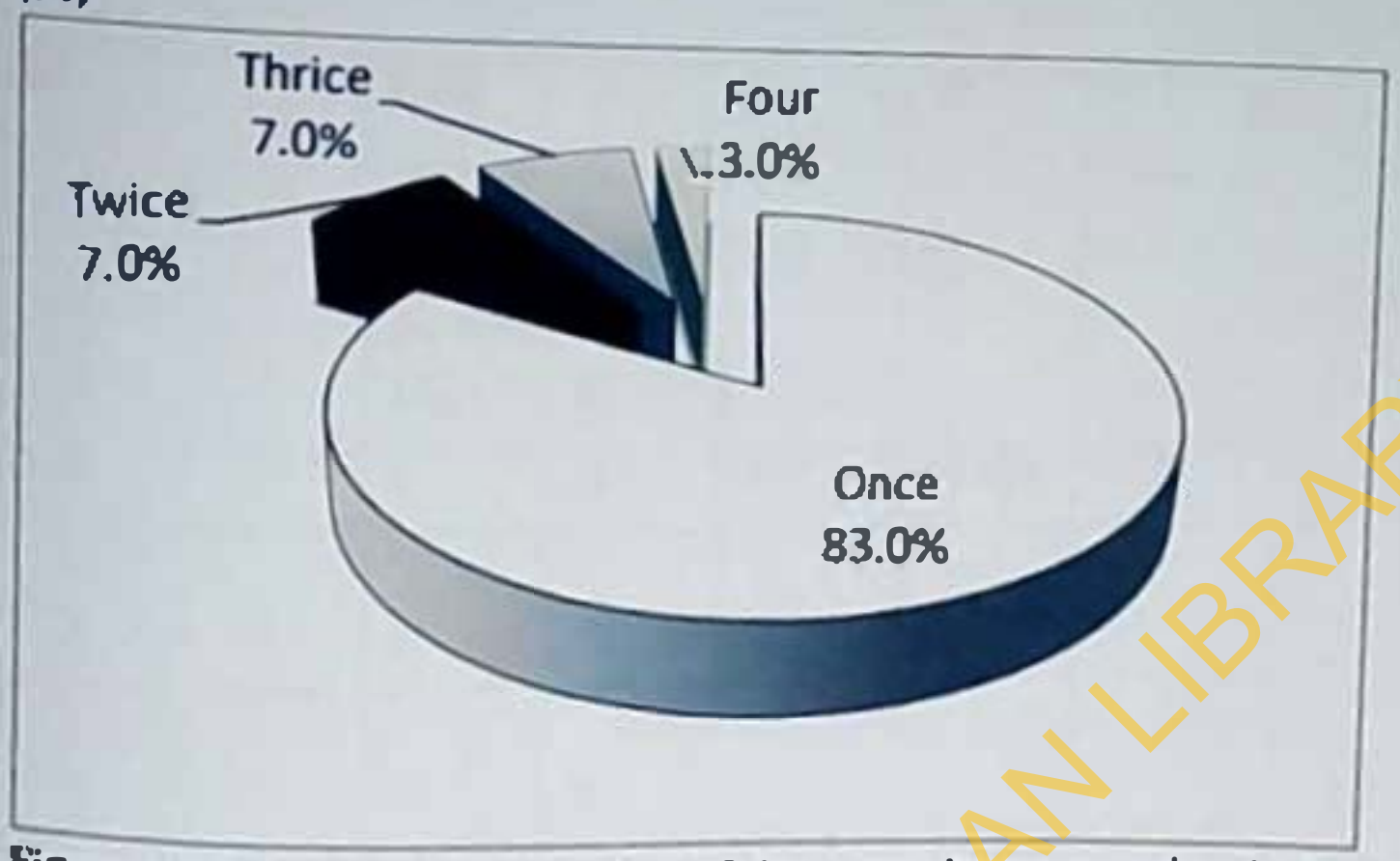

Figure 4.13: Respondents' number of times ever impregnated a girl/lady (n=42)
* Data used for generating pie chart were derived from question 36 (appendix 1)

Table 4.28: Prevalence of ever impregnating a female sexual partner by age

N=152**

Age	Ever impregnated a female sexual partner		Df	X^2	P-Value
	Yes	No			
16-20	8	34	4	49.383	0.00*
21-25	23	60			
26-31	11	16			

*Significant (P≤0.05)

**152 respondents were the male respondent who were sexually active as at the time of study was carried out

(37) Table 4.29: Male respondents' feelings first time impregnated a lady

N=35

Feelings*	Number (%)
Scared	17 (30.9)
Happy	5 (9.1)
Uncomfortable	11(20.0)
Sad	9(16.4)
Regrets	1(1.8)
Shocked	10(18.2)
Dejected	1(1.8)
I was not prepared to get married	1(1.8)

*There were multiple responses

(38)

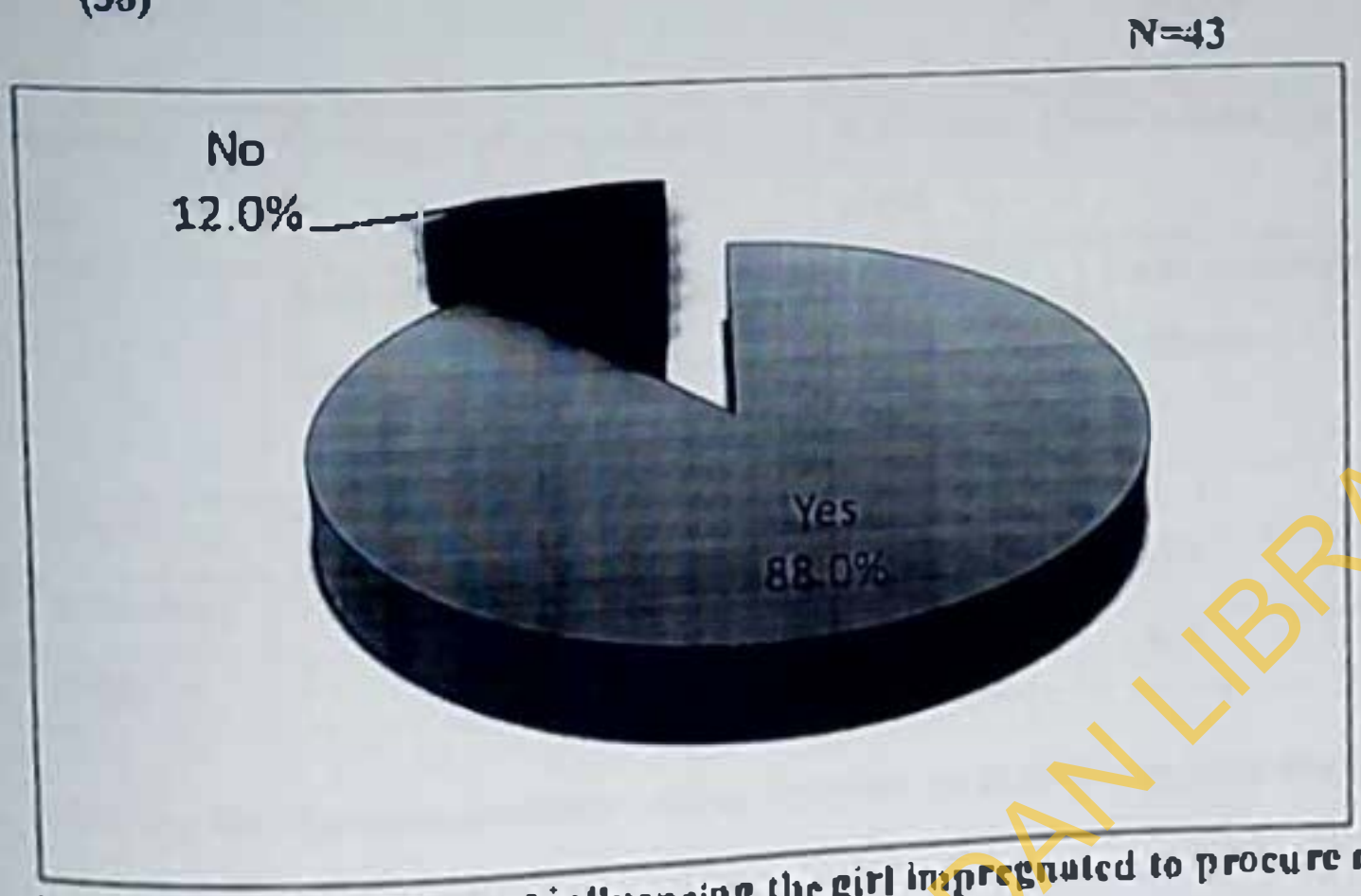

Figure 4.14: Prevalence of influencing the girl impregnated to procure abortion

(39) Table 4.30: Outcome of unintended/unwanted pregnancy and places where abortion took place.

N=43

Pregnancy order	Outcome of pregnancy		If aborted, place where it took place.	
	Delivered the baby (%)	Aborted pregnancy (%)	Clinic (%)	Used unacceptable methods (%)
1st pregnancy	5(11.6)	38(88.4)	29(76.3)	9(23.7)
2nd pregnancy	1(12.5)	7(87.5)	4(57.1)	3(42.9)
3rd pregnancy	0	4(100)	2(50)	2(50)

* Among the male respondents who influenced their partners in seeking abortion

Table 4.31: Reasons adduced by male respondents for allowing sexual partners to deliver their babies by pregnancy order

N=6

Pregnancy order	Adduced reasons (%)		
	Parent influence	First baby	Married
1st pregnancy (n=5)	2(40)	2(40)	1(20)
2nd pregnancy (n=1)	1(100)	0	0

Table 4.32: Reasons adduced by male respondents for aborting their sexual partner pregnancies N=45

Pregnancy order	Reasons adduced						
	Unwanted pregnancy	Not ready to be a father	Scared	Parental Influence	Ashamed	Peer influence	Ectopic pregnancy
1st pregnancy (n=35)	1(2.6)	21(55.3)	7(18.4)	4(10.5)	2(5.3)	1(2.6)	2(5.3)
2nd pregnancy (n=3)	0	5(71.4)	0	2(28.6)	0	0	
3rd pregnancy (n=4)	0	3(75)	0	1(25)	0	0	

Table 4.33: Comparison of ever encouraging sexual partner to seek abortion by age and marital status among male respondents

N=42

Age category	Ever encouraged partner to seek abortion		Df	X^2	P-Value
	Yes	No			
16-20	7	1	4	26.220	0.00*
21-25	21	2			
26-31	9	2			
Marital status					
Single	34	1	2	16.864	0.00*
Married	3	4			

*Significant at P<0.05

Table 4.34: Abortion related complications sexual partners of male respondents' ever experienced

History of complications	Number (%)
Girlfriend ever experienced abortion-related complications (n=38)	
Yes	15(39.5)
No	23(60.5)
Complications experienced (n=15)	
Bleeding	12(75.0)
Stomach ache	2(12.5)
Pain along the private part	1(6.3)
Pelvic pain	1(6.3)

(43)

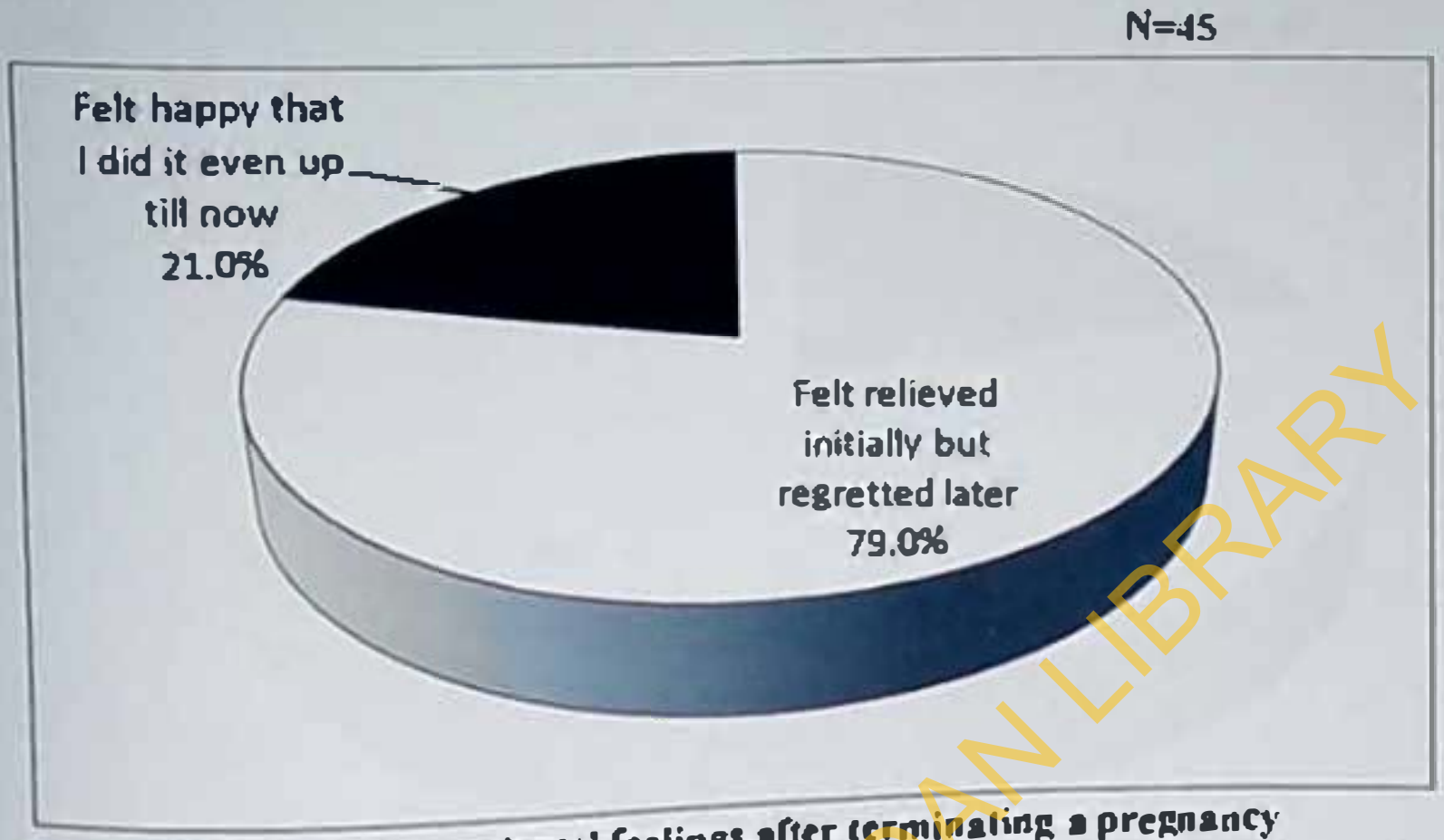

Figure 4.15: Male respondents' feelings after terminating a pregnancy

* Data for constructing the pie chart was generated from question 43 (see appendix 1)

(44) N=45

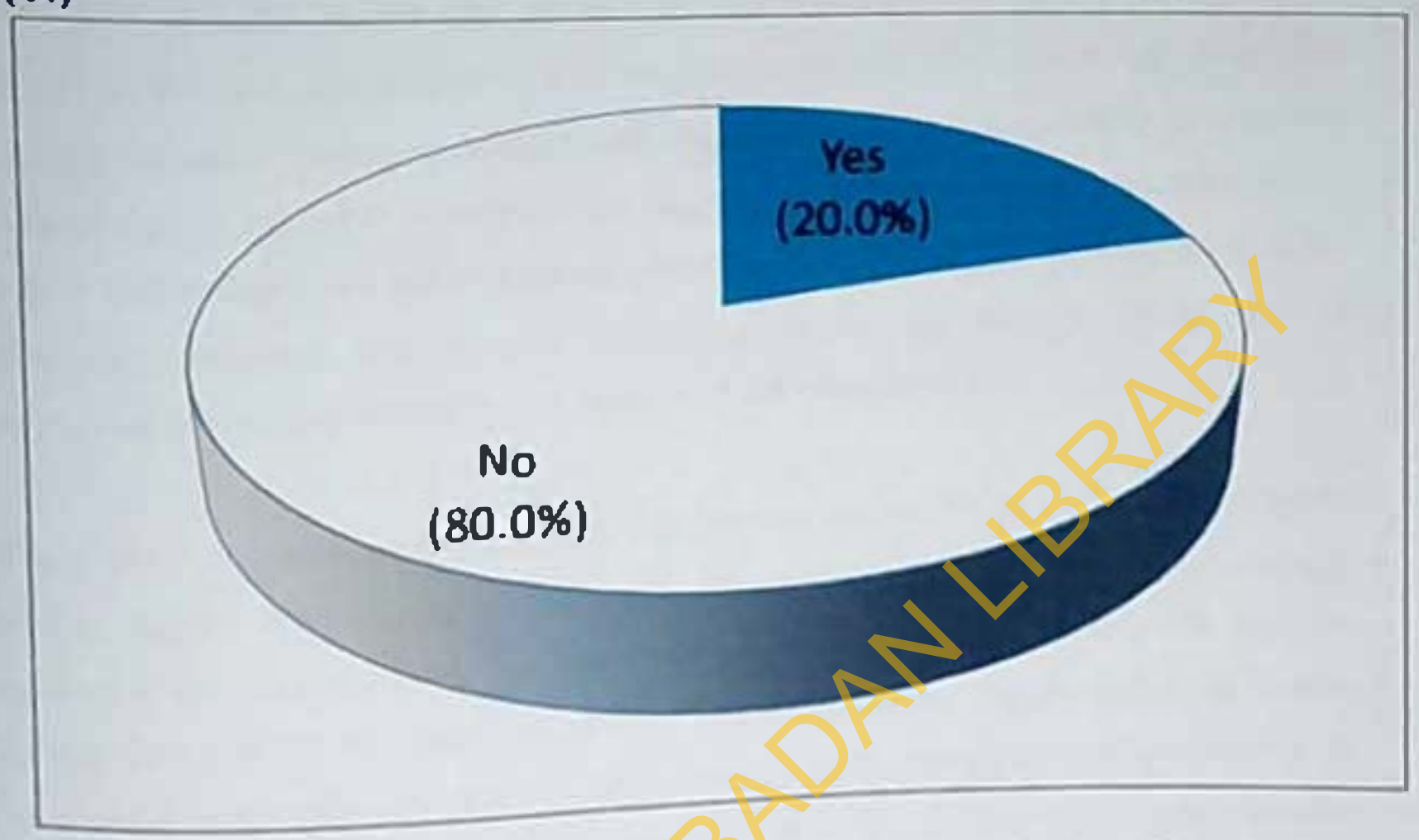

Figure 4.16: Respondents' likelihood of seeking for abortion in case of another unwanted pregnancy.

* Data for constructing the pie chart was generated from question 44 (see appendix I)

Table 4.35 presents factors that influences undergraduates to seek abortion. Many (18.4%) of the respondents believe that educatiooal career/future is a strong factor that normally influence undergmdautes to seek abortion in case of unintended of pregancy followed by 17.3% who perceived fear as another factor that could be responsible. Few(14.2%) believes that public embarassment/tarnish of image/shame and 12.1% of the respondents believed that fioancial constraint could also play a strong role in undergradaotes seeking abortion.(See Table 4.35 for other details).

Places where undergraduates often seek for abortion are shown in Table 4.36. Majority (92.8%) agreed that undergradaotes seek for abortion at private clinics similarly, significant (83.5%) accepted that undergradaotes visit chemist (PMV) for abortion service. Over half(55.9%) approved that some undergradaotes consult traditional healers for abortion while majority (80.2%) disagreed that undergradaotes seek for abortion at government hospital. Overwhelming majority (85.7%) agreed that undergradaotes conduct self induced abortion

Figure 17 shows graphical representation of the prevalence of having at least a friend who had ever aborted pregnancy in the past. Most (67.0%) claimed not to have a friend that has aborted in the past compared to few (33.0%) who had at least a friend that has aborted. Table 4.37 shows the prevalence of ever influenced a friend to take to abortion. Significantly (85.7%) reported not to have counseled or advised a friend on seeking abortion while few (14.3%) claimed to have advised a friend in the past to take to abortion. The number of time ever counseled a friend among those who had advised a friend in the past to seek abortion, majority (71.4%) of the respondents advised a friend once to seek abortion while 11.9% advised friends twice, many (15.5%) advised at least friend to seek for abortion thrice. See table 4.37 for other details.

Table 4.35: factors which generally influence undergraduates to take to abortion

N=587

Percieved factors*	Number (%)
Educational career/future	463(18.4)
Fear	434(17.3)
Public embarrassment/tarnish of image /shame	357(14.2)
Financial constraint	305(12.1)
Not ready for marriage	303(12.0)
Peer pressure	276(10.9)
If man responsible for pregnancy reject it/paternity problem	108(4.3)
Rape or incest	87(3.5)
If lady does not know who is responsible for the pregnancy	70(2.8)
Difference in religious belief	53(2.1)
Shock	31(1.2)
When health of the woman is at risk	17(0.7)
If the foetus is deformed	9(0.4)
Birth control	6(0.2)

*Multiple responses present

Table 4.36: Places where undergraduates often seek for abortion

N=587

Percieved places where undergradautes often seek for abortion	Yes (%)	No (%)
Private clinics	545(92.8)*	42.(7.2)
Chemist((PMV)	490(83.5)	97(16.5)
Traditional healers	328(55.9)	259(44.1)
Government hospital	116(19.8)*	471(80.2)
Maternity hospital	231(39.4)*	356(60.6)
Self induced abortion	503(85.7)	84(14.3)

* Places where likelihood of having unsafe abortion is high

(47)

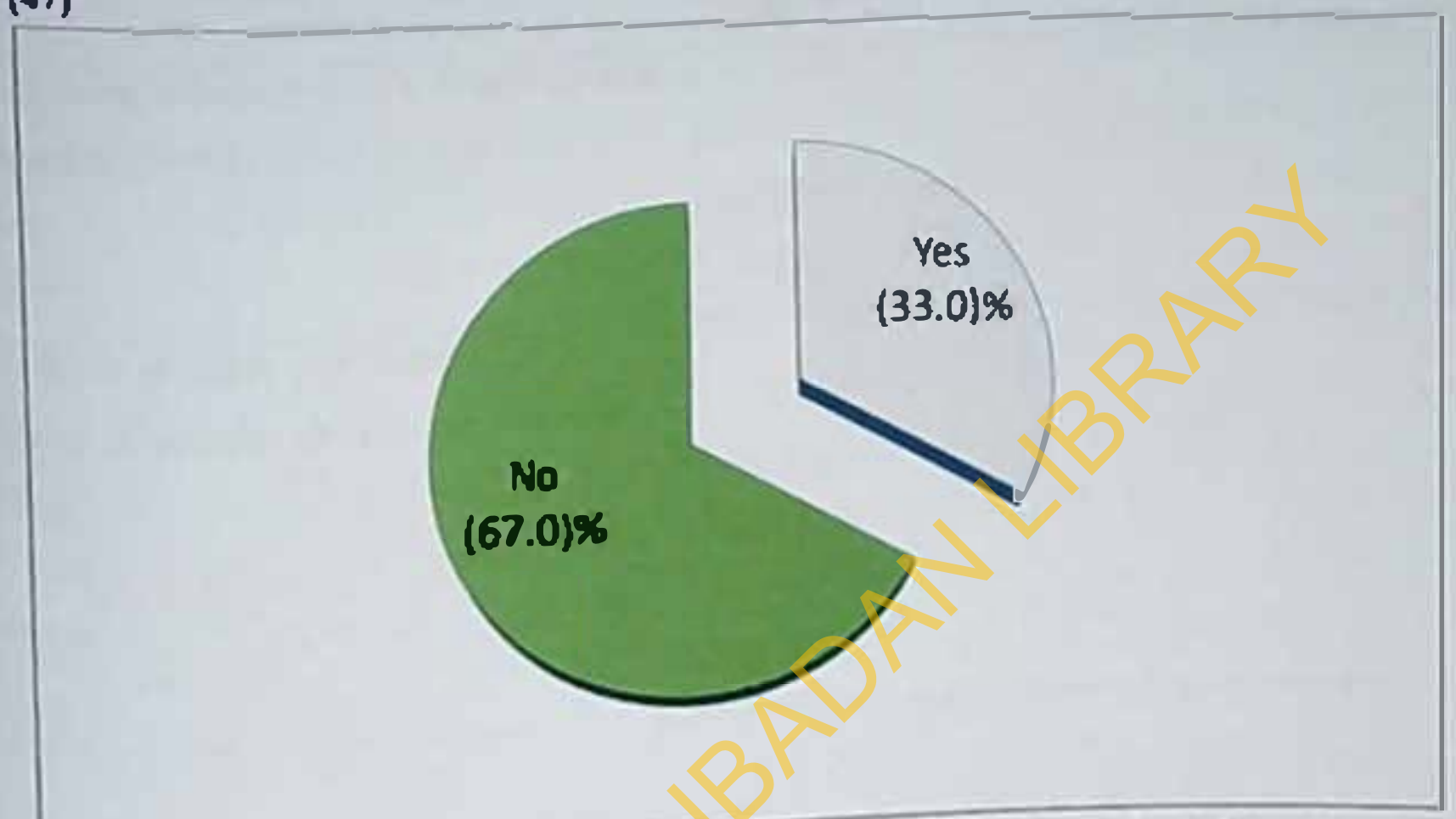

Figure 4.17: Prevalence of having at least a friend who had ever aborted pregnancy among the respondents

Table 4.37: Prevalence of ever influencing a friend to take to abortion.

	Number (%)
Ever counselled/advised a friend to take abortion (N=587)	
Yes	84(14.3)
No	503(85.7)
Number of times ever counselled a friend to seek for abortion (n=84)	
Once	60(71.4)
Twice	10(11.9)
Thrice	13(15.5)
Five	1(1.2)

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This chapter is organized into the following sections: socio-demographic characteristics; awareness and knowledge of abortion related issues; perceptions relating to abortion; sexual experiences among undergraduates; factors that influence undergraduates to seek for abortion and places where undergraduates seek for abortion. The chapter ends with discussion, conclusion and recommendations.

5.1 Socio demographic characteristics of the respondents.

The age of respondents ranged from 16-31years with a mean age 21.1 years. This implies that the target population comprises young persons aged less than 25 years and adult aged ≥25 years. Previous studies on undergraduates yielded a similar age profiles. For instance a study conducted among undergraduates of University of Ibadan revealed a mean age of 21.0 years (Ogunwale et al; 2012). Another study earlier conducted in the University revealed a mean age of 22.7 years among undergraduates (Iwuagwu, Ajuwon and Olasoha, 2000). The age range of respondents in the current study suggests that some of the respondents may have completed their secondary school education before the statutory or official age of 18 years as contained in the National Policy of Education and subsequently gained admission into the institution before the mean age and the age recorded.

Many of the respondents who participated in the study were males. The variation maybe as a result of the fact that the study was restricted to undergraduates that reside in the University's hall of residence and the institution has more hall of residence for males than for females. Therefore, this could have accounted for the higher male participation in the study.

Majority of the respondents were of the Yoruba ethnic group. This maybe as a result of the fact that the University is situated in south west region of Nigeria which is mainly inhabited by the Yoruba. Hence, there is a higher probability for people of Yoruba

decent that reside in south west region to attend the institution than other ethnic groups because of proximity of the school.

5.2 Awareness and knowledge of abortion related issues among the respondents.

Findings from this study revealed that awareness of legal provisions guiding abortion in Nigeria was low, as only a few were aware of the criminal and penal code law on abortion. A study earlier conducted by Babatinsa (2008) however revealed that doctors and nurses in Kaduna state were aware of Nigeria legal provision on abortion although only few of them could mention the two legal provisions guiding abortion in southern and northern part of Nigeria. This finding could be attributed to the fact that majority of the students do not see it as being mandatory to read these laws in order to get acquainted. Also, many of the respondents believe it is the responsibility of the lawyers to read and understand the legal provision guiding abortion. Other authors or authorities (Guttmacher Institute. 1999; Berer. 2002; Billings et al., 2002; Cook et al., 2003; World Health Organization (WHO), 2004; Warriner. 2006) have likewise reported poor awareness and understanding of the legal provision relating to abortion among persons studied.

There was lack of sufficient knowledge among respondents on the condition under which abortion can be conducted in Nigeria. Majority of them were not able to correctly state the condition. Only a few who were aware of abortion related law in the country knew that abortion is permissible only "when the life of the woman is at risk/threatened". Many respondents erroneously believed that abortion is only acceptable in Nigeria in the case of incest or rape, a finding which clearly shows a knowledge deficit on abortion related issues among the respondents in this study. The findings also shows that the legality or otherwise of abortion is not usually taken into consideration in the process of seeking for abortion services.

Respondents were able to list different drugs or medications and surgical procedures that undergraduates use for the termination of abortion. The result is comparable to the findings of Omo-Aghoja et al.(2009), who revealed that many of their respondents were able to list various methods that women use for inducing abortion which included

different forms of local and orthodox medications. Similarly, Mundigo (2006) revealed that respondents were able to mention different methods that include metrigen injection, a drug that is used to restore the menstrual cycle in women who lack estrogen or progesterone; quinine and herbal drugs etc for inducing abortion. Quinine, for instance is not designed for terminating abortion; it is for the treatment of malaria, its use therefore a case of irrational drug use.

This study showed that majority of the respondents knew different complications that can result from unsafe abortion. A similar study that was conducted at university of Ibadan by Cadmus (2011) revealed that majority of the respondents (83.3%) had good knowledge about the complications of abortion. Findings from Cadmus's study showed that 90.4% respondents knew that the complication of abortion included infertility, death and with severe bleeding. However, almost all the respondents who had ever been pregnant terminated the pregnancy despite the knowledge of the possible complications

5.3 Perceptions relating to abortion among Undergraduates.

The perception of the students varied on ethical perception of abortion. Majority of the undergraduates were of the perception that abortion should not be acceptable irrespective of the circumstances. They believed it is morally and ethically wrong to procure abortion, this is a pro-life argument or philosophy. A previous study conducted by Okonofua et al, (2009) similarly revealed that more than one-third of their respondents opined that abortion should not be acceptable under any circumstance. Religious and moral concerns were the most common reasons for opposing the liberalization of abortion laws by respondents in their study.

Questions were asked from the respondents on their position on the controversial issues on humanity and status of the life of the foetus. The "Pro-life" advocates are the group that support the right to life of the unborn child and argued against making abortion easily available to anyone who wants it (Geary Cynthia Waszak, Hailemichael Gebreselassie, Pascal Awah, Erin Pearson, 2012). The pro-choice advocates on the other hand are the group that supports a woman having the right to choose whether or not to

end her pregnancy (Louis-Kennedy, 2007). The pro-life group also argues that the foetus at conception has the absolute right to life while the "pro-choice" group argues that the woman has the right to make decisions about her body, including the foetus, inside her body (Louis-Kennedy, 2007). Most of the participants were of the perception that abortion is tantamount to killing a human being and majority of the them also kicked against the notion often championed by pro-choice advocates that at a certain age the foetus is not yet a human being. Consistent with these findings, previous studies by Geary et al (2012) and Appiah-Sekyere (2012) noted that their respondents had a negative attitudinal disposition towards abortion because they were of the perception that abortion is like killing and it is therefore immoral.

This study has revealed that majority of the undergraduates were of the perception that abortion should not be legalized irrespective of the circumstances. A previous study conducted by Wahab (2009) among undergraduates similarly revealed that majority of the students rejected the legalization of abortion. Baharinsa (2008) who conducted a similar study among doctors and nurses in Kaduna also noted that majority of their respondents were of the opinion that abortion should not be liberalized or legalized.

Respondents differed (by sex) in their opinion on whether abortion should be legalized in the case of life threatening health related conditions for the mother. Most of the male respondents opposed the view that abortion should be allowed for women when it affects the life of the mother while majority of the female respondents had contrasting view on the issue. Although abortion laws in Nigeria is one of the most restrictive in the world, the procedure is often performed to save the life of a woman (Okonofua, 2009). In support of this finding Geary et al (2012) noted that women were more likely than men to support a woman's right to decide whether to continue a pregnancy.

Respondents were of the opinion that every foetus has the right to life and that abortion is a criminal act that should be punishable by law. This is in consonance with previous studies (Paluku et al, 2010; Appiah-Sekyere, 2012) which supported the argument that

end her pregnancy (Louis-Kennedy, 2007). The pro-life group also argues that the foetus at conception has the absolute right to life while the "pro-choice" group argues that the woman has the right to make decisions about her body, including the foetus, inside her body (Louis-Kennedy, 2007). Most of the participants were of the perception that abortion is tantamount to killing a human being and majority of the them also kicked against the notion often championed by pro-choice advocates that at a certain age the foetus is not yet a human being. Consistent with these findings, previous studies by Geary et al (2012) and Appiah-Sekyere (2012) noted that their respondents had a negative attitudinal disposition towards abortion because they were of the perception that abortion is like killing and it is therefore immoral.

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Respondents were of the opinion that every foetus has the right to life and that abortion is a criminal act that should be punishable by law. This is in consonance with previous studies (Paluku et al, 2010; Afrifah-Sekyere, 2012) which supported the argument that

abortion should be prohibited because the foetus is a human being and deserves the right to life.

With regards to respondents' social and cultural perception of abortion, most of the participants did not perceive abortion as a better choice than giving birth to a child one does not want or cannot care for properly. Most of them were also of the opinion that abortion is against the culture of the people. Previous study by Omo- Aghoja et al (2009) revealed that many respondents were similarly of the belief that their religious affiliations regard abortion as a bad act, and that the tenets of their faith abhor it. This perception cuts across respondents' who practised African traditional religion and those in other religious groups. The results of this study are consistent with that of the participants also reported that culturally abortion is seriously frowned at and prior to westernization it was considered a great taboo. Also, Respondents are of the opinion that abortion reduces the marriage chance of a lady if people get to know about it. Most of the respondents believe that abortion may likely reduce the marriage chance of a lady if people in the community or in her environment are aware of it.

Perceptions relating to psychological consequences of abortion were probed into in the study. It was noted that most of the respondents were of the view that abortion leaves one with guilt feelings for the killing of an unborn child; they were also of the belief that abortion brings about sad experiences which takes a long time to be forgotten. Studies conducted by Akinleye et al, (2011), Sobie et al (2001) and Mitsunaga et al (2005) similarly noted that people are likely to experience severe pain during abortion and that abortion is perceived to be stressful and associated with feelings of guilt, depression and a sense of isolation.

5.4 Sexual experiences among respondents.

In this study, many (43.7%) of the male respondents and 33.5% of the female respondents were sexually active. This is not surprising because the study population consisted of young people who are usually known to be sexually active. Infact, a study conducted by Cadmus (2011) revealed that 29% of undergraduate respondents at the

University of Ibadan were sexually active. The proportion of sexually active undergraduates in this study is closer to that documented by Fabanwo et al, (2012) at the University of Lagos which was 37.2%. The variation in the proportion of sexually active undergraduates in this study compared to Cadmus study suggests that more undergraduates are increasingly becoming sexually active.

This study revealed that fifty-seven percent of the respondents had their sexual debut when they were within the 18-22years age range. The proportion of males and females who had their sexual debut within this age range were 48.7% and 72.5% respectively. This is contrary to Cadmus's study which revealed that majority of University of Ibadan students had their sexual debut when they were within the age range of 11-25 years. Many undergraduates aged 19 years or less (adolescents) indulged in unprotected sex. this leads to unwanted pregnancy and recurs to abortion.

Findings from this study revealed the pattern of contraceptive use among respondents during their first sexual intercourse.; majority of the male respondents that were sexually active reported that they did not use contraceptive and many (43.8%) of the female respondents did not also use contraceptive. This makes them i.e. female students to be vulnerable to unwanted pregnancy. (Bello, A.O., Wasiu, O.A. Olugbenga, L.A, 2009) earlier conducted a study among young persons and they noted that their respondents did not use contraceptive during their last sexual episode. This study has shown that contraceptive prevalence among respondents was low; less than half of males and females used condom. This finding is in confonnity with results from previous studies by Fabanwo et al. (2012) and Bello, et al, (2009) who noted that less than half of the sexually active respondents were using modern contraceptive.

Male respondents were more sexually active than their female counterpart though they share similar age of sexual debut exaggeration of sexual exploits by young males may have resorted to this. Previous studies have shown that males are more likely to over report or exaggerate their sexual activities while females tend to under-report their sexual experiences.

5.5 Prevalence of pregnancy and abortion among the undergraduates

The result revealed that among female respondents who were sexually active many (44.0%) had experienced unintended pregnancy while among male respondents who were also sexually active fewer (27.6%) reported to have impregnated a girl/sexual partner. The prevalence of pregnancy in studies conducted by Bankole et al. (2004) and Cadmus. (2011) were 28% and 24.5% respectively. In this study majority of the sexually active female respondents' experienced unintended pregnancy as an undergraduates and most of the male respondents' were already undergraduates when they impregnated a girl/female sexual partner. This implies that both male and female students in institutions of higher learning could tremendously benefit from to reproductive health education including family life health education that can help to prevent pregnancy and ultimately abortion.

Most of the respondents experienced unwanted pregnancy when they were within 20-24 years age range. This finding underscores the need for reproductive health education among the respondents in other to ensure that they practice safer sex. All female respondents that experienced unwanted pregnancy sought for abortion. Similarly 88% of male respondents who had ever impregnated a lady influenced their sexual partner to seek for abortion. This finding implies that overall, the prevalence of indulgence in abortion among respondents was very high. This finding is quite interesting because respondents take abortion as an option even though majority of them were of the opinion that it should not be legalised and also felt that it is a criminal act that should be punishable by law. Cadmus (2011) also reported a similar finding among undergraduates in University of Ibadan, 93.3% had experienced unwanted pregnancy and sought for abortion. Other investigators (Aderibigbe et al, 2011 and Abiodun et al: 2009) have also lend credence to high prevalence of abortion among students in tertiary institutions.

All cases of abortions were said to have been performed by unqualified person. This practice can predispose abortion seekers to various adverse health consequences. Unsafe abortion has been documented as one of the leading causes of maternal mortality especially in developing countries including Nigeria. The reasons adduced for seeking abortion was that they were not prepared to take care of a child and financial constraints

constitutes another factor. The problem of undergoing unsafe abortion by unqualified personnel maybe further compounded by the fact that abortion is illegal in Nigeria. Atere et al (2012) revealed that pregnant adolescent girls have a multiplicity of reasons for taking to abortion and these includes financial hardship, stigma associated with being accidental mothers. The reasons given by the respondents in the study conducted by Cadmus (2011) for ever indulging in abortion was the fact that they were not yet ready to bear the responsibility of having and raising a child. Inherent in this reason also is the issue relating to financial constraint. Reasons given by respondents in this and other studies are useful for designing educational intervention aimed at promoting safe reproductive health practices among in-school adolescents including university undergraduates.

The highest number of times an individual had an induced abortion in this study was eight times. Reproductive health programme targeted at undergraduates should stress the possible complications associated with incessant indulgence in abortion. Abortion related complications ever experienced by females who sought for abortion included excessive bleeding, damage to the cervix, vesico vagina fistula, chronic pelvic pains or (pelvic inflammatory disease), infertility. According to Gutunatcher institute, (2008) and Cadmus et al, (2011) majority of women who had had induced abortions reportedly experience complications ranging from manageable pain and bleeding to serious infections and death.

5.6 Factors that influences undergraduates to seek abortion

The results of this study have shown that undergraduates seek for abortion due to many underlying factors. These included, fear of adverse effects on educational career and the desire to continue schooling for enhanced socio-economic status. Many of the respondents disclosed that the fear that their parent may not be happy with their action was another reason why students resort to abortion. Wahab, (2009) has similarly noted this in their studies. There is need to design an appropriate preventive and control measures to curb the prevalence of abortion among undergraduates in higher learning institution.

However, some respondents believe that public embarrassment/ tarnishing of ones image and shame may cause undergraduates to seek abortion. The society also brand girls with unwanted pregnancy as "tramps" or "slut" and the family look at them with disdain (Omo-Aghoja, et al 2009). Financial constraint is major determinant of abortion. Fasubaa, et al (2003) noted other adduced reasons why adolescent seek for abortion and these include ignorance of adolescents relating to unwanted pregnancy, lack of awareness of the fertility period in the menstrual cycle and lack of sex-education. In addition, Atere et al (2012), Omo- Aghoja, (2009) and Fasubaa et al (2003) have revealed other cases which are, cultural restriction which makes it difficult for them to have access to contraceptives, low level of education, poor financial standing and poor knowledge of reproductive health of women and increasing rate of moral decadence.

Majority of the undergraduates claimed that victims of unintended pregnancy seek for abortion in private clinics; some even visit chemist for abortion service which is a risky practice. Cadmus et al, (2011) reported a similar finding in their study. According to WHO, (2000) adolescents usually resort to unskilled providers and/or use hazardous techniques and unsatisfactory facilities to procure abortion. Women who resort to clandestine facilities and /or unqualified providers put their health and life at risk. Omo-Aghoja, (2009) has noted that restrictive laws on abortion have not prevented abortion or reduce the incidence rather it only succeeds in driving it underground with unqualified professionals taking the center stage with significant havoc inflicted on the women folk.

In the same vein Echendu et al, (2012) have noted that restrictive Nigerian abortion laws drive women to seek abortion services from unqualified persons, such as patented medicine dealers, pharmacists, nurses, and native doctors/herbalists. Many of the respondents in this study disclosed that some undergraduates even consult traditional healers for abortion services. This previous study have thus revealed that there are several methods to the adoption of abortion services among respondents

5.7 Implications for Health promotion and education

Health Education focuses on the modification of peoples' behavior and behavioural antecedent factors (Green and Kreuter, 1991). Findings from the study have health Promotion and education implications and suggest the need for multiple interventions directed at tackling abortion related problems noted among the students.

Results of the study shows that there is low level of awareness on Nigerian abortion related laws i.e. the criminal code for southern Nigeria and Nigeria Penal Code for the northern part of Nigeria. In addition majority were not knowledgeable about the condition under which abortion is legally acceptable in Nigeria. This situation can create opportunities for undergraduates to seek for abortion in clandestine places. Efforts need to be made to increase the knowledge of undergraduates about the existing abo related laws in

The training of undergraduates on the laws related to abortion and the right condition under which abortion can take place can be included in the sexual and reproductive health education courses organized as part of the General Study (GST) programme of the university for fresh students. The course should include content element such as unwanted pregnancy, abortion related issues and abortion related laws in Nigeria and conditions under which abortion can take place in Nigeria. However it will be necessary to re-appraise the curriculum of sexual and reproductive health education course offered at the University of Ibadan with a view to increasing curricula contents relating to the physical, psychological, social and economic burden of unwanted pregnancy and abortion.

Many of the undergraduates are sexually active yet many of them do not use contraceptives, a situation that leads to unintended pregnancy and abortion. There is need to make school based sexual health education mandatory for all undergraduates, since most students in university are young adults who are no longer under the control of their parents and so need factual information relating to unwanted pregnancy and abortion.

School-based sexual health education can play an important role in the primary prevention of reproductive health problems.

The impact of sexual health education on the sexual behaviour of young person has been extensively examined in a large number of evaluation research studies. A meta-narrative of 174 studies examining the impact of different types of sexual health education and promotion interventions found that these programs help in decreasing the frequency of sexual behaviour or number of sexual partners (Smoak et al, 2006; Public Health Agency of Canada (PHAC), 2008). More specifically, from a review of 83 studies aimed at measuring the impact of curriculum-based sexual health education programs, concluded that evidence is strong that programs do not hasten or increase indulgence in sexual behaviour but instead some programs delay or decrease resort to sexual behaviours or increase contraceptive use among sexually active people (Kirby et al. 2007; PHAC, 2008). Such programs in Nigeria University system should include 'Abstinence only', sex negotiation skills, life building skills, communication skills and contraceptive use among those who are sexually active.

Public enlightenment programmes are essentially mass communication programme that are useful in helping to create awareness, influence knowledge to some extent, attitudes and perception related to health issues (Maduakonam, 2001). Campus-based mass media outlets can be used effectively to upgrade undergraduates' knowledge relating to reproductive health matters including abortion. The media should convey key messages concerning the complication and implication of seeking for abortion from clandestine and unsafe places or environments. This can work proactively to promote sexual health and responsibility. Other strategies can be combined such as advocacy and peer education to effectively reduce the prevalence of abortion among University students. Posters, leaflets, billboards, documentaries and jingles on Diamond FM (campus radio) can be used as part of the public enlightenment interventions.

Research has shown that the possession of life skills could be critical to young people's ability to positively adapt to and deal with the demands and challenges of life (UNICEF, 2000). A review by UNICEF found that approaches relying on life skills have been

effective in educating the youth about health-related issues such as indulgence in tobacco, other drugs as well as risky sexual behaviour. The life skills approach is an interactive, educational methodology that not only focuses on transmitting knowledge but also aims at shaping attitudes and developing interpersonal skills. The main goal of this approach is the enhancement of young people's ability to take responsibility for making healthier choices, resisting negative pressures and avoiding risky behaviours. Teaching methods should involve youth friendly, interactive and participatory session. other teaching methods for behavioural change can include working in groups, brainstorming, role-playing, story-telling, debating and participating in discussions.

Community mobilization approach can be good programme in reduction of abortion among youths. Community involvement in the design and implementation of adolescent reproductive health programs has proven to be successful in other countries. Community mobilization engages all sectors of the population in a community-wide effort to address sexual health behaviour issues. It brings together policy makers, opinion leaders, religious leaders, stakeholders and individual community members (Centre For Disease Control and Prevention CDC, 2003). An evidence was a project that was carried out in Peru; the project gathered information on youth related problems from young people, key adults including parents, civic authorities, teachers, health workers and clergy. Adults and youth formed "adolescent health committees" to identify and prioritize adolescent sexual and reproductive health needs and to propose concrete actions. The strategy could be used to change knowledge, attitude, socio-cultural norms and practices that may encourage sexual behavior and abortion among the youths. Places where community mobilization approach has proved successful include Bangladesh, Burkina-Faso, Egypt and Kenya (Hammer et al. 1999).

Combined use of two or more of the above mentioned health promotion and education strategies would give a better preventive measure in controlling risky sexual behaviour that could lead to unintended pregnancy and abortion among undergraduates' students. The use of a combination of strategies ensures that weaknesses of one are counter-balanced by the strengths of the others (PHAC, 2008).

5.8 Conclusion

The research explored the awareness and knowledge relating to abortion issues as well as perception on abortion among undergraduates, thier sexual experiences and abortion related practices. Factors that influence undergraduates to seek abortion and places where they often seek for abortion were also examined. Awareness level among respondents about laws relating to abortion in Nigeria was low. Majority of the respondents were unable to state the correct condition under which abortion can be conducted in Nigeria. Most respondents have good knowledge of abortion related complications or effects. Undergraduates were of the perception that abortion should not be acceptable irrespective of the prevailing circumstances and many ofthe respondents did not support the view that abortion should be legalized. Majority of the respondents were therefore pro-life advocates.

Undergraduates' students of University of Ibadan were sexually active yet contraceptive use among them was poor. Most of the females who were sexually active had experienced unintended pregnancy. Similarly many males who were sexually active had impregnated their sexual partners. All the females who had experienced unintended pregnancy claimed to have sought for abortion; likewise most males who had impregnated their sexual partners claimed to have influenced them to seeking for abortion. Most of the respondents sought for abortion in private clinics and some used unreliable methods to procure abortion. Despite their level of knowledge on complications of abortion many of them still visited clandestine places to seek for abortion. The reasons adduced by respondents for seeking for abortions included career/future, fear of parents, embarrassment and financial constraints.

5.9 Recommendations

1) Family life education should be incorporated into the curriculum of the undergraduates in order to increase their knowledge on abortion and other risky sexual and reproductive health issues. These could be integrated into the core courses taken by students of the University of Ibadan.

2) There are indications of lack of accessibility to abortion related issues and overwhelming majority do not have in depth knowledge of abortion policy in Nigeria. There is need for University authority, Student Union Government. Non-Government Organization, College of Medicine and other relevant government agencies including Ministry of Health and Youth and Sport development to design educational programs aimed at upgrading undergraduates' knowledge about abortion related issues and Nigeria related laws.

3) Students should be empowered with Life building skills to help develop sex negotiation skills. This could be done through organizing awareness programme, symposia and social activities in which sex negotiation skills, sexual assertiveness and communication skills can be incorporated into the programme. This will help in developing sexual decision making skills among the students.

4) Campus-based mass media outlets should be mobilized to be involved in enlightening undergraduates' knowledge relating to reproductive health matters including abortion. The media should convey key messages concerning the complication and implications of seeking for abortion from clandestine and unsafe places. This can work proactively to promote sexual health and responsibility among undergraduates.

5) The government should review the abortion related law in the country so as to allow abortion for victim of rape and incest.

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APPENDIX I

QUESTIONNAIRE

KNOWLED GEPRACTICES AND PERCEPTION RELATED TO ABORTION UN ER GR UATE STUD EN TSTHE UN I VE RSITOF IBADAN IBADAN , N I GE RIA

Dear respondents.

I am post graduate student of the University of Ibadan, Ibadan. This study is designed to investigate abortion seeking behavior among male and female undergraduate students, University of Ibadan, Nigeria. Your consent to participate and to give full, honest and correct information will be appreciated.
Please be informed that this exercise is not an examination or a test. I would like to inform you that your identity, responses and opinions will be kept confidential. This means that your information name is not required on this questionnaire. You are to ask questions about the study at any time during cause of interview.

Thank you Ma/Sir for your cooperation.

For office use Only
Date of interview.....
Cluster area.....
Serial Number.....
Interview.....

Section A

Sec|a. Demographic information

Please answer the following questions by ticking the boxes (√) provided or by completing the blank spaces provided

1) What is your age as at last birthday?.....

2) Sex 1) Male ☐ 2) Female ☐

3a) Which religion do you practice? 1) Christianity ☐ 2) Islam ☐

3) Traditional ☐ 4. Other (specify).....

3b) If Christian what is the denomination?.....

4) What is your course of study?.....

5) What level of study are you? 100 level ☐ 200 level ☐ 300 level ☐

400 level ☐ 500 level ☐ 600 level ☐ any other specify.....

6) Ethnicity (1) Igbo ☐ (2) Yoruba ☐ (3) Hausa ☐ (4) Others .....

7) Marital status 1) Single ☐ 2) Married ☐ 3) Married but separated ☐

4) Cohabiting ☐

Section B

Awareness and Knowledge relating to abortion

Please answer the following questions by ticking the boxes (√) provided or completing the blank spaces provided

8) What does abortion mean?.....

.....

.

9) Have you ever heard about abortion related laws in Nigeria? 1) Yes ☐ 2) No ☐

10) What are your sources of information about abortion related law? (Tick one or more that apply to you)

1) Radio ☐ 2) TV ☐ 3) Journal ☐ 4) Peer group ☐ 5) School ☐

6) Internet ☐

7) Others .....

11) If yes to question 8, under which condition is abortion acceptable as being legal in Nigeria.....

.....

.....

.....

12) In Nigeria, abortion is legal irrespective of the state of the health of a woman or girl provided it is her wish?

Yes ☐ No ☐

13) Abortion is legal provided it is done by a qualified doctor for any reason

1) Yes ☐ 2) No ☐

14) Abortion is allowed in Nigeria if a woman/girl's pregnancy experience is as a result of rape or incest?

1) Yes ☐ 2) No ☐

15) Mention 4 methods that can bring about induced abortion?

.....

.....

.....

.....

16) Table 1 contains a list of health related conditions or problems. *For each options tick (√) "True" if it can result from abortion and "False" if it cannot result from abortion.*

Table 1

S/N	Health related condition	True	False
	Immediate effects		
16.1	Damage to the bladder		
16.2	Severe blood lose		
16.3	Cervical damage		
16.4	Womb damage(uterine perforation)		
16.5	Intestinal/bowel damage		
16.6	Septic shock		
16.7	Infection		
	Long effects		
16.8	Chronic pelvic pain or pelvic inflammatory disease		
16.9	Genital tract infection		
16.10	Septicemia		
16.11	Renal failure		
16.12	Infertility or inability to bear children		
16.13	Excessive blood lose leading to death		

17) What are the other possible negative health effects of abortion not listed in the above table? Please list in the spaces provided

1)....

2)....

3)....

4)....

Section C

Perception relating to abortion

QUESTIONS FOR BOTH MALE AND FEMALE

Please answer the following questions by ticking (√) the boxes provided or by completing the blank spaces provided.

Table 2

S/N	Ethical Perceptions	Agree	Disagree	No opinion
18.1	Abortion is unacceptable irrespective of the prevailing circumstances			
18.2	Abortion is a bad thing because it is like killing someone			
18.3	A fetus of whatever age is an unborn human being with rights to life as other human beings. So it should not be aborted on grounds of the fact that it is not yet a person.			
18.4	At a certain age the fetus is not yet a human being or person so it could be aborted			
18.5	Abortion should be allowed when the fetus is found to have serious genetic disorder or deformities that can affect its future quality of life as a human being.			
18.6	Abortion should not be allowed even if it's put the life of the mother carrying the pregnancy at risk.			
18.7	Only a lady's interest/ wish should be relied upon to induce an abortion; the opinion of the husband/boyfriend should not be taken into consideration.			
18.8	Man or boy should be the ultimate decision maker regarding decision to abort a pregnancy or not			
18.9	Fetus has right to life which is sacred, so its life should be protected and nurtured			

QUESTIONS FOR BOTH MALE AND FEMALE

Please answer the following questions by ticking (√) the boxes provided or by completing the blank spaces provided.

Table 3

S/N	Legal Perception	Agree	Disagree	No opinion
19.1	Abortion should be legally available to anyone who wants it under any circumstances			
19.2	Abortion should be legalized so as to avoid illegal abortion that can cause health related problems for women/ladies			
19.3	Abortion should be legal in Nigeria only in cases of rape or incest			
19.4	The life of the fetus is inferior to the life of its mother; so abortion should not be criminalized but allowed			
19.5	Access to abortion without legal restriction is part of a woman's reproductive health right			
19.6	The Nigeria abortion related laws are primitive; they should be liberalized in the country			
19.7	Legalization of abortion should be considered to prevent the practice of abortion by unqualified persons			
19.8	Every fetus has a right to life, therefore abortion is a criminal act that should be punishable by law.			

QUESTIONS FOR BOTH MALE AND FEMALE

Please answer the following questions by ticking (√) the boxes provided or by completing the blank spaces provided.

Table 4

S/N	Socio cultural perception	Agree	Disagree	No opinion
20.1	Abortion is a better choice than giving birth to a child one does not want or cannot care for properly			
20.2	It is better to have an abortion rather than allow an unwanted pregnancy to ruin ones educational career			
20.3	Abortion is against the culture of our people and so should not be allowed			
20.4	It is better to have an abortion than having child whose father is not known or is in doubt			
20.5	Abortion is a sin and should not be allowed in Nigeria			
20.6	Only a woman/girl and her doctor should determine when abortion is necessary or not; other considerations e.g. religious, legal, moral should not be entertained			

QUESTIONS FOR BOTH MALE AND FEMALE

Please answer the following questions by ticking (√) the boxes provided or by completing the blank spaces provided.

Table 5

	Perceptions relating to psychological consequences	Agree	Disagree	No opinion
21.1	Involvement in abortion leaves one with guilt feelings concerning the killing of an unborn child			
21.2	The abortion of an unwanted pregnancy gives sign of relief and happiness.			
21.3	The abortion of an unwanted pregnancy leads to low self- esteem in a girl or woman			
21.3	Abortion produces a feeling of relief in a girl or boy after it has been done			
21.4	Abortion is a sad experience which takes time to be forgotten			
21.5	The physical complications of abortion in the long run are more than the relief which one experiences			

21.6	The physical adverse effiects of abortion are usually mild			
21.7	Abortion has no any adverse side effiects			
21.8	Abortion is a major cause of death among girls or women			

Section D

Prevalence of abortion and sexual experiences among undergraduates

(QUESTIONS FOR BOTH MALE AND FEMALE) *Please answer the following questions by ticking (√) the boxes provided or completing the blank spaces provided.*

22) At what age did you have sexual intercourse for the first time?.....

23) Did you or your sexual partner use anything to prevent pregnancy when you had your first sexual intercourse?

1. Yes ☐ 2. No ☐

24) Do you have a boy/girlfriend who is your sexual partner? 1) Yes ☐ 2) No ☐

25) What methods do you or your partner use to prevent pregnancy?.....

26) How many sexual partners do you have now? .....

27) How frequently do you use anything to prevent pregnancy whenever you experience sexual intercourse? 1) No ☐ 2) Alway ☐ 3) Sometin ☐ 4) on rare occasions ☐ 5) Never ☐

Questions for females only (55-64)

28a) Have you ever become pregnant at a time when you were not expecting to become pregnant? 1) Yes ☐ 2) No ☐

28b) What was your level of education at the time of your first unintended pregnancy?

1) Primary ☐ 2) Secondary ☐ 3) Tertiary ☐

28c) If tertiary please (specify).....

28d) How old were you when you first experienced an unwanted pregnancy? .....

28e) How did you feel the first time you ever become pregnant? .....

.....

28f) How many times have you ever had an unintended pregnancy?

.....

29) If you have ever had unwanted pregnancy or unintended pregnancy, what was the outcome of the pregnancies? Use the table 6 to answer the questions by ticking (√) the boxes provided or by completing the blank spaces provided

Table 6

S/N	Pregnancy order	Outcome of the pregnancy		Reason why the baby was delivered	Reason why the pregnancy was aborted	If aborted place where the abortion was procured
		Delivered the baby	Aborted the pregnancy			
29.1	1st Pregnancy					
29.2	2nd Pregnancy					
29.3	3rd Pregnancy					
29.4	4th Pregnancy					
29.5	5th Pregnancy					

30a) What was your level of education at the time of your first abortion experience?

1) Primary ☐ 2) Secondary ☐ 3 Tertiary ☐

30b) If tertiary please (specify).....

31) How many times have you ever had abortion? .....

32) How do you feel after terminating a pregnancy?.....

.....

.....

.....

33) Have you ever experienced any form of complications or problems resulting from any of the experiences of abortion you had in the past? 1☐ ☐0

34) What kind of complications or problems have you ever experienced?

QUESTIONS FOR MALE ONLY (65-74)

35a) Have you ever impregnated a girl when you were not expecting to father a child?

1) Yes ☐ 2. No ☐

35b) What was your level of education at the time you got your partner pregnant?

1) Primary ☐ 2) Secondary ☐ 3) Tertiary ☐

35c) If tertiary please (specify).....

35d) How old were you when you first made a lady pregnant?.....

35e) How many times have you gotten a lady pregnant?.....

36) How did you feel the first time a lady became pregnant for you describe in detail?

.....

.....

.....

37) Have you ever encouraged your sexual partner (girlfriend) to seek for abortion?

Yes ☐ No ☐

38) If your partner ever had an unwanted or unintended pregnancy. what was the outcome of the pregnancy or pregnancies? Use the table 7 to answer the questions by ticking (√) the boxes provided or by completing the blank spaces provided

Table 7

S/N	Pregnancy order	Outcome of the pregnancy		Reason why the baby was delivered	Reasons why the pregnancy was aborted	If aborted place where the abortion was procured
		Delivered the baby	Aborted the pregnancy			
38.1	1st Pregnancy					
38.2	2nd Pregnancy					
38.3	3rd Pregnancy					
38.4	4th Pregnancy					
38.5	5th Pregnancy					

39) Has any of your partners (girlfriends/wife) experienced any form of complications after receiving an abortion service 1) ☐ 2) ☐

40) What kind of complications has any of your sexual partners (girlfriends) experienced in the past?

.....

.....

.....

.....

.....

41) Did you feel relieved after terminating any of the pregnancy of your partner?

1) Yes ☐ 2) No ☐

Question for both males and females

42) Would you seek for abortion in case of another instance of unwanted pregnancy?

1) Yes ☐ 2) No ☐

Section E

Factors influencing undergraduate students in adopting abortion. *Please answer the following questions by ticking (√) the boxes provided or by completing the blank spaces provided.*

43) Generally, there are many reasons why undergraduate students might want to abort an unwanted pregnancy. Please what are these reasons? (List as many as possible)

1).....

2).....

3).....

4).....

5).....

6).....

7).....

8).....

9).....

10).....

Section F

Where undergraduates seek for abortion services(both male and female) *Please answer the following questions by ticking (√) the boxes provided or completing the blank spaces provided.*

44) Where do you think undergraduates often seek for abortion? (Tick the appropriate options and complete the blank spaces)

Table 9

S/N	Places	Yes	No
44.1	Privates clinics		
44.2	Chemist(Patent medicine vendor)		
44.3	Traditional healers		
44.4	Government hospitals		
44.5	Maternity hospital/clinics		
44.6	Self induced abortion		
44.7	Other 1)..... 2)..... 3)..... 4).....		

45) Do you know any undergraduate who has undergone an abortion in the past?

1) Yes ☐ 2) No ☐

46) Have you ever counselled or advised a friend or partner to seek for abortion?

1) Yes ☐ 2) No ☐

47) How many times have you ever advised or counseled a friend to take abortion?.....

Appendix 2

Consent form for survey participants

Title of the research: KNOWLEDGE, PRACTICES AND PERCEPTION RELATED TO ABORTION UNDERGRADUATE STUDENTS OF THE UNIVERSITY OF IBADAN, IBADAN, NIGERIA.

Names and affiliation of researcher: This study is being conducted by Adeyemo Bolanle Adeyinka of the Department of Health Promotion and Education, Faculty of Public Health College of Medicine, University of Ibadan, Oyo State, Nigeria.

Purpose of research: The purpose of this research is to investigate the perceptions, knowledge, experiences and behavioural related issues on abortion among male and female undergraduates of university of Ibadan.

Procedure of the research: A total number of 600 male and female undergraduate students residing officially in all the hall of residence for undergraduate will be recruited for this study. A self administered semi-structured questionnaire will be given to each recruited respondents and will be collected back afterwards. Three research assistants will be recruited and trained to participate in the quantitative data collection. There after an in-depth interview will be conducted among students who disclosed to have experienced abortion in the past and who consented during the semi structured in build to be subjected to in-depth interview (IDI). The interview will be conducted in a private place.

Expected duration of research and of participant's involvement: Each respondent will spend about 15 minutes to 20 minutes in filling the questionnaire and for the interview.

Risks: There are no physical risks associated with participation in this study. However, if you feel uncomfortable with some of the questions being asked, one may decide not to answer any questions one feels uncomfortable about.

Costs to the participants: Your participation in this research will not cost you anything.

Benefits: There will be no direct benefit to you but the information obtained from the study will help to provide suggestions that will enable the researcher design or

recommend to appropriate quarters to provide the right intervention on the policy making and management of Infertility.

Confidentiality: All information collected in this study will be given code numbers and no names will be recorded. Your responses will not be linked to you in anyway and your name will not be used in any publication or report. However, as part of my responsibility in the conduct of this research, only the researcher, members of the researcher's staff and representatives from the Universities of Ibadan and/or UCH Ethical Committees may have access to study records. They are required to keep your identity confidential. Results of this study may be used for research publications or presentations at scientific meetings, but your personal results will never be discussed as an individual. No identifying information will be kept on the actual survey form.

Voluntariness: You do not have to take part in this research if you do not wish to do so. You may stop participating in the interview at any time that you wish, and there will be no negative consequences for you in any way.

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

Statement of person giving consent:

The study has been well explained to me and I fully understand the content of the study process. I hereby agree to be part of the study.

DATE: _____ SIGNATURE: _____

NAME: _____

Detailed contact information:

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at Biode Building, Room T10, 2nd Floor, Institute for Advanced Medical Research and Training, College of Medicine. University of Ibadan, Telephone: 08032397993, E-mail: uiuchirc@yahoo.com. In addition, if you have nny question about your participation in this research, you can contact the principal investigator,

Mr. Adeyemo, Boinnle Adeyinka

Address: Department of Henlth Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan.

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Or

Dr. F. O Oshiname

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INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)

COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN, NIGERIA.

Director: Prof. A. Ogunniyi, [illegible]

Tel: 08023038583, 08038094173

E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: NHREC/05/01/2008a

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Abortion Seeking Behavior among Male and Female Undergraduate Students, University of Ibadan, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/12/[illegible]

Name of Principal Investigator: Bolanle [illegible] Adegemo

Address of Principal Investigator: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan

Date of receipt of valid application: 08/10/2012

Date of meeting when final determination on ethical approval was made: 21/02/2013

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the UI/UCH Ethics Committee.

This approval dates from 21/02/2013 to [illegible]. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the UI/UCH EC assigned number and duration of UI/UCH EC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. No changes are permitted in the research without prior approval by the UI/UCH EC except in circumstances outlined in the Code. The UI/UCH EC reserves the right to conduct compliance visit to your research site without previous notification.

UI/UCH EC
21 FEB 2013
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: [illegible]

• Drug and Cancer Research Unit • Environmental Sciences & Toxicology • Genetics & Cancer Research • Molecular Entomology • Malaria Research • Pharmaceutical Research • Environmental Health • Bioethics • Epidemiological Research Services • Palliative Care • HIV/AIDS [illegible]