ATTITUDE AND PRACTICE OF INDUCED ABORTION AMONG FEMALE UNDERGRADUATE STUDENTS IN EKITI STATE, NIGERIA

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CERTIFICATION

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ABSTRACT

Abortion is being committed on a daily basis in Nigeria despite the restrictive abortion law placed by the government. Abortion constitutes severe danger to a woman's health and it is safe for the woman only if it is performed by a specialist. From previous studies, it has been revealed that several factors has been responsible for the practice of abortion by women in Nigeria such as education, fear of having a child outside wedlock and also the fear of been labeled by the society as loosed. This study seeks to examine the Attitude, and practice of induced abortion among female undergraduate students in Ekiti state. Three levels of analysis (univariate, bivariate, and multivariate analysis) were employed to test for the relationship between social demographic characteristics of respondents and their Attitude and practice of induced Abortion. Findings from this study revealed that the socio-demographic characteristics of respondents such as Religion, Ethnicity, Education etc, plays a significant role or has an influence on the Attitude and practice of induced abortion, this study therefore recommends that the usage of contraceptives should be encouraged by the government in order to prevent unwanted pregnancy hence reducing the rate of abortion.

CHAPTER ONE

1.0 BACKGROUND TO THE STUDY

Abortion is the termination of a pregnancy associated with the death and expulsion of a fetus from a uterus before it reaches the stage of viability. An abortion may occur spontaneously, in normal parlance it is called a miscarriage, or it may be brought on purposefully in which case it is often called an induced abortion (www.britannica.com). The issue of abortion has attracted substantial attention in recent times in Nigeria and everywhere in the world; abortion has therefore become a global issue (Alimson, 2001). The major concern in most of the discussions on abortion and related situation draws heavily from the fact that abortion constitutes severe danger to a woman's health, but at the same time when performed by medical specialist (i.e abortion specialists) abortions are safe for the woman, and relatively simple. Religious institutions are against the abortion process as they believe abortion is a process of committing murder and murderer are seen as sinners (Knight, 2003). Abortion is therefore forbidden in many societies especially the traditional ones. The technique chosen to terminate pregnancy depends on the stage of pregnancy and the policies of the institution and patient needs. It is rare for a fetus to survive if it weighs less than 500 g, or if the pregnancy is terminated before 20 weeks of gestation. These factors are, however, difficult to determine with a high degree of accuracy while the fetus is still *in utero;* survival of the fetus delivered near the end of the second trimester often depends to a great extent on the availability of personnel and equipment capable of supporting life until the infant develops sufficiently.

STATEMENT OF PROBLEM

Unintended or unplanned pregnancy poses a major economical, psychological, social, and/or religious challenge in women of reproductive age, especially in developing countries. It has been estimated that, of the 210 million pregnancies that occur annually worldwide, about 80 million (38%) are unplanned and 46 million (22%) end in abortion. Since abortion is illegal in Nigeria (unless medically recommended to save a mother's life), many abortions are carried out clandestinely, and often in an unsafe environment. Induced abortion is not only widespread in Nigeria but is also provided and practiced in a number of different settings, from traditional medical practitioners, herbalists, and private practicing clinicians to modern pharmacists. The consequences of these clandestine abortions are grave and can be life-threatening, often leading to maternal death. Abortions account for 20%–40% of maternal deaths in Nigeria.

Within Nigeria, rates of abortion vary: In 2012, there were 27 abortions per 1,000 women aged 15–49 in the South West and North Central zones; 31 per 1,000 in the North West and South East zones; and 41 and 44 per 1,000 in the North East and South South zones, respectively.The proportion of pregnancies ending in induced abortion was lowest in the South West (11%), and highest in the North East (16%) and South South (17%). The higher rates of abortion in the North East and South South zones can be explained by two of the main underlying factors that increase women's need for abortion: the desire for smaller families and the non use of contraception. Women in the North East have the country's lowest rate of contraceptive use (only 3% are using a method), and women in the South-South have the lowest desired number of children (3.9 on average). in 2013, an estimated 16.10% of women in Nigeria have an unmet need for contraception according to Nigeria Demographic and Health Survey (2013). Unmet

need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception (World Bank 2008). Several factors are mentioned in the literature as being responsible for this. Some women do not use contraceptives because of its limited availability, and this may end up in unwanted pregnancy and high rates of abortion.

Apart from contraceptives, several causes have been identified as inducing abortion rather than medical. However, abortion in most countries is legal under limited conditions For example, in Nigeria the abortion Act of 1967 as amended in 1982 states the following:

1. If the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy was terminated, then the pregnancy should be terminated.
2. If the termination is necessary to prevent grave permanent impurity to the physical or mental health of the pregnant woman, it should be terminated.
3. If the pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve greater risk than if the pregnancy were terminated or injury to the physical or mental health of the existing children of the family of the pregnant woman, it should be terminated.
4. If there is substantial risk that if the child is born it would suffer from much physical or mental abnormality as to be serious by handicapped, the pregnancy should be terminated (George, 2004)

Mindful of the social stigma of having unwanted pregnancies, many young ladies who become pregnant seek abortion as the only way to end unwanted pregnancies. Therefore this study seeks to examine the extent to which the socio-demographic factors influences induced abortion among married and unmarried women.

RESEARCH QUESTIONS

This study will seek answers to questions such as:

1. What is the extent of induced abortion practiced among undergraduate females studying in Ekiti state, Nigeria?

2. To what extent does socio-demographic status of female students influence their attitude towards induced abortion in Ekiti state, Nigeria?

3. To what extent do other factor (such as peer influence), influence the practice of induced abortion among undergraduate females studying in Ekiti State?

OBJECTIVE OF THE STUDY

GENERAL OBJECTIVE;

To determine the attitude and practice of induced abortion among female undergraduate students in Ekiti state

SPECIFIC OBJECTIVE

1. To examine the extent to which induced abortion is practiced among undergraduate females studying in Ekiti state, Nigeria

2. To assess the influence of respondents socio-demographic status on their attitude towards induced abortion in Ekiti state, Nigeria

3. To examine the extent to which other factor (such as peer influence) influences the practice of induced abortion among undergraduate females studying in Ekiti State?

SIGNIFICANCE OF THE STUDY

The study is therefore significant because it will be beneficial to all categories of women, female students and the society at large. This is because the understanding of the reasons for induced abortion will enable society, university authorities and policy makers look for means to address and reduce the menace. It will help individuals identify the negative effect or disadvantage associated with the involvement of abortion and how it affects the society at large. Finally, this study is relevant to explain the incidence of induced abortion among youths in the society.

RESEARCH HYPOTHESES

1. H_0: There is no significant relationship between knowledge and practice of induced abortion among undergraduate females studying in Ekiti state, Nigeria

2. H_0 : There is no significant relationship between respondents socio-demographic status and their attitude towards induced abortion in Ekiti state, Nigeria

3. H_0 : There is no significant relationship between peer influence and the practice of induced abortion among undergraduate females studying in Ekiti State

CHAPTER TWO

LITERATURE REVIEW

2.1 History of Abortion

The history of abortion dates back to the 1800's when laws forbade the act after 16 weeks of conception. By the early 1900's, the act was completely prohibited but even at that, women were still having abortions. Formerly, the procedure was very precarious. Despite the risks involved, many still resorted to it to terminate unwanted pregnancies. Abortion became legal in 1973 through a well-known Supreme Court case. This ruling took superiority over state laws that banned abortion. However, there were restrictions in the legislation for later stage abortions. The difference today is that medical knowledge has increased so that the process is probably safer for women than it used to be.

Today abortion is much safer for the mother, but just as deadly to the child (Esther Archibong 2013). There were evidence to show that historically, pregnancies were terminated through a number of methods, including the administration of abortificient herbs, the use of sharpened implements, the application of abdominal pressure, and other techniques.

2.2 Forms and Nature of Abortion

Abortion is not just a simple medical procedure. For many women, it is a life changing event having a significant physical, emotional, and spiritual consequence on the individual involved because it involves the termination of pregnancy through the expulsion of a fetus from the womb prior to the age of viability. The age of viability usually varies from one country to another. Abortion can be spontaneous or induced (Henshaw, Singh and Haas, 1999).

According to the program of the action of the 1994 conference on population and development held in Cairo government and other relevant organizations were urged "to deal with

the health impact of unsafe abortions as a major public health concern and to reduce the option of abortion through extended and enhanced family planning services" (U.N Conference on population and Development, 1994). However, in spite of the recommendation of the conference, the forms and nature of abortion still show a level of variation across cultures and countries all over the world. Abortion can be performed or done through different ways, and each method are usually undergone under different circumstances and after different developments of the embryo or fetus. No method of abortion can be said to be 100% successful.

2.3 Methods and Risk of Abortion

Right from the time abortion first started, different methods and ways of aborting or terminating pregnancy has been discovered both local and medical methods. These methods include the following:

2.3.1 Dilation and Curettage

This method is commonly known as "D & C", this is a surgical procedure generally used within the first 12 weeks of a pregnancy. Unless there are unusual problems, this procedure may be done in a doctor's office or a clinic. When this method is carried out the cervix is slowly opened and the fetus, placenta and membranes are scraped from inside the uterus with a sharp instrument. This method is done surgically and usually involves some risks or complications and this possible complications involves; infection of the uterus, torn cervix, infection of fallopian tubes, Punctured uterus, blood clots in the uterus, excessive bleeding etc.

2.3.2 Methotrexate/Misoprostol:

This is a type of medical abortion with the first medication (methotrexate) being given by injection into the muscle followed by placement of misoprostol into the vaginal. When this is done, the fetus, the placenta and membranes are generally expelled the next day, if this does not

happen then the dosage of misoprostol is repeated. This process also involves certain risks and complications which involves; incomplete abortion which may necessitate a surgical abortion, prolonged bleeding, nausea and vomiting, diarrhea, abdominal pain and cramping etc.

2.3.3 Mifepriston/Misoprostol (RU-486)

This medication can be taken up to 5 weeks after conception or approximately 7 weeks after the first day of the woman's last normal menstrual period. After administering the medication, the woman is given mifepristone taken by mouth and then spends a period of time in the doctor's office before going home. 36-48 hours after the dose, the woman is asked to return to the doctor's office in order to receive the proper amount of misoprostol.

After this procedure has been carried out the woman is watched closely by doctors and nurses for a few hours this is because the fetus, the placenta and membranes are usually expelled during this time. On the 14th day after taking the medication the woman is required to return to the doctor's office in order to check up and make sure that there are no problems and complications and ensure that the fetus, placenta and membranes have been fully expelled. There are usually some certain risk and complication associated with this method these include: incomplete abortion which may necessitate a surgical abortion, prolonged bleeding, nausea and vomiting, diarrhea, abdominal pain and cramping.

2.3.4 Dilation and Evacuation:

This method is usually performed under local anesthetic between 13 and 20 weeks of pregnancy and usually involves the gradual opening of the cervix and removing the fetus, placenta, and membrane by alternating suction and sharp curettage. Risks and complications involved in this method include blood clots in the uterus, incise or frayed cervix, pelvic infection, incomplete abortion, infertility and reaction to anesthesia.

2.4 Factors Contributing to Abortion

George (2001), Fagbemi (2001), Lucas (1985) and Norton and Walls (1983) have recognized numerous factors that induce abortion. These factors include;

1. Medical factors.
2. Economic factors.
3. Educational factors.
4. Social/cultural factors.
5. Family size.

George (2004) noted that individual females resolve to pregnancy abortion mostly because of medical and economic factors. The non-use of contraceptives by teenagers and young people causes high level of pregnancies and abortions (Ejidah, 1999).

2.5 Society, Socio-Cultural Factors and Abortion

In the lives of people today, culture plays a very significant role. It performs a major regulatory behavior in which actions and reactions of individuals are set or ordained. There are different societies with their varying cultures all over the world and they all seem to frown down on abortion especially from the cultural and religious point of view (Bankole and Adebayo, 1999). In some countries like Nigeria for instance, Christian, Islamic and traditional religious practices are against abortion and have equally prevented their members from engaging in it. These religious groups see abortion as nothing but "murdering of unborn babies" (Bankole and Adebayo 1999).

2.6 Review of Related Theories

1. Theory of Reasoned Action

This theory was propounded by Fishbein and Ajzen (1980) and it was designed not just to explain health behaviour but also to explain all volitional behaviors. This theory is based on the assumption that most behaviors that are of social relevance are under volitional (willful) control. In addition, a person's intention to perform (or not to perform) the behaviour is the immediate determinant of that behaviour. The goal is not to predict human behaviour but also to understand it.

According to this theory, a person's intention to perform a specific behavior or act like having an abortion is a function of two factors; attitude (positive or negative) towards abortion and the influence of the social environment (general subjective norms) on abortion. The attitude towards abortion is determined by a person's belief that a given outcome will occur if he/she has no abortion and by the evaluation of the outcome. The social or subjective norm is usually determined by a person's normative belief about what is important or what others thinks she would do and by the motivation of the individual to comply with those other people's wishes or desires.

In this theory, attitude towards abortion are usually functions of beliefs, that is if a person believes that having an abortion is a positive action, she would have a favourable attitude towards having an abortion. On the other hand, a person who has the belief that having an abortion will lead to negative outcomes (like health problems and its likes) will definitely have an unfavourable attitude against abortion.

2. The Health Belief Model

This model was propounded by Irwin M. Rosenstock in 1966. This model maintains that the decision whether or not to engage in health related behavior involves a form of cost/benefit analysis. The key elements involved in the decision process are the health gain that would be as a result of the outcome of a particular behavior and benefit (social, psychological, physical physiological etc) of engaging in such a particular behavior. Some of these elements include;

i. The belief of susceptibility to illness.

ii. The possible severances of the illness.

iii. The health benefit of engaging in that behavior.

iv. Solutions to the actions of the belief which brings about the decision to engage in such behaviour.

In the first place perceived susceptibility with respect to unwanted pregnancy opines that each individual has his/her own perception of livelihood in experiencing a condition that would adversely affect ones Health. The perceptions to ascertain the degree of health discomfort that may likely to arise from certain pregnancy vary from one individual to another. This situation at often times influences their decision in a particular way leading to the decision to terminate such pregnancy (Okonfua, 1993, Fagbemi, 2001). Also perceived seriousness is about the belief a person holds concerning the effect that a given condition would have on one state of affairs. Those at the extreme situation (e.g. educational institutions, adolescents etc) who get pregnant without due preparation for it may seek possible option of terminating it.

Perceived benefit/gain may resolve to particular decisions relating to the direction of Acton that a person chooses and this would be influenced by the belief regarding the actions. Barriers to taking the action may be ignored as a result of the possible benefits of taking such

actions, which seems to be essential. Barriers relate to the characteristics of a treatment (that is; aborting unwanted pregnancy), which may be inconvenient, unpleasant or expensive, painful or upsetting (Okonfua, 1993).

3. **The Social Cognitive Theory**

This is another theory used in explaining an individual's productive health behavior. This is termed social-hearing theory or Bandura's social cognitive theory (Bandura 1986) it is a wing of skinners operant conditioning paradigm with its root in psychology. This theory assumes that individuals want to maximize their gains from the environment and the outcome is achieved by cognitive process. This theory is of the position that individuals are motivated to gain the maximum reinforcement and minimum punishment for their environment. Behaviors are usually motivated by long term and short term gains. In addition, individuals are capable of learning behavioral possibilities from the observation of others and behave within a moral framework.

Under this perspective, choice of behavior is premised on two sets of expectancies. The first expectancy relates to the extent to which an individual behaves that an action would lead to a particular outcome and this outcome will then be considered in terms of its value to the individual. The other set of expectancy is the self-efficacy explanation, which usually reflects the degree to which an individual believes she is of the behavior being considered.

This theory is therefore fundamental to the premise that an individual is most likely to consider a behavior if they believe in a desired outcome and that she is capable of successfully managing the outcome. In essence, both outcome and self-efficacy beliefs have been shown to

be an important prediction of a number of health related behaviors including the determination to abort unwanted pregnancies.

This theory has helped in providing explanations for the reason why individuals tend to take certain actions and reactions in relation to their actions and reactions in relation to their sex act or practices.

4. The Protection Motivation Theory

This theory is based on the work of Roser (1983), it combines elements of health belief model and social cognitive theory in explaining how fear arising from reproductive health communication are reprocessed and acted upon. The theory is based on two broad categories of reaction:

i. The threat appraisal.

ii. The coping appraisal

The possible outcome of the assessment processes is an intension to behave in either adaptive or maladaptive manner, the strength of which reflects the degree of motivation to avoid getting unwanted pregnancy, the perceived susceptibility to reproduce health inconveniences and its severity (Edijah, 1999).

The protection motivation theory builds a relationship between knowledge about a particular outcome from an intended act and individual behavioral pattern towards that act. This theory is therefore significant in explaining the attitude and practice of induced abortion among female undergraduate students in Ekiti state (Nigeria).

2.7 Theoretical Framework

Out of the four theories cited in this work, just two will make up the theoretical framework. These are the theory of reasoned action and the protection motivation theory.

The theory of reasoned action is based on the assumption that before a particular action is carried out, the person who is to carry out such action thinks of it and that most of the actions taken are done willingly. Under this theory, a person's intention to perform a specific behaviour like having an abortion is based on two factors: the attitude towards abortion and the influence of the environment on abortion. Under this theory attitude towards abortion is usually based on beliefs and these beliefs are usually the basis of a person's attitude towards abortion and can be referred to as behavioral beliefs.

The protection motivation theory merges the basics of health belief model and social cognitive theory and this is based on two broad categories; the risk appraisal and the coping appraisal. The possible outcome of the appraisal processes is a plan to behave in either adaptive or maladaptive manner. The protection motivation theory helps to differentiate knowledge of a particular outcome from an intended act. Therefore, this theory is important in explaining the occurrence of induced abortion among women in Nigeria.

2.8 Hypothesis

The following hypothesis were formulated in order to guide the study

Hi: Socio-demographic characteristics have significant relationship with induced abortion

Hi;peer pressure has significant influence on attitude and practice of induced abortion

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The objective of this research study is to access the Attitude and Practice of Induced Abortion among Female Undergraduate students in Ekiti State, Nigeria. This section briefly explains the method of collecting data for the study, and the method used in analyzing the data obtained from the fieldwork. It covers aspects such as the research population, sampling frame, sampling size, data collection instrument, procedure for data collection and method of data analysis. Nigeria is situated on the west coast of Africa, sharing borders with the Republics of Benin in the west, Cameroon in the east, Niger and Chad in the north. Although it is spatially the fourth largest country on the African continent, with a total land area of 923,768 square kilometers, its population of 144 million (NPC, 2006) is the largest on the continent, hosting a quarter of the continent's population and constitutes the world's tenth most populous nation.

The population in the country is diverse, with over 350 ethnic groups, each with distinct historical, social and cultural identities; the larger ones include the Hausa/Fulani in the north, Yoruba and Ibo in the south. Its vegetation ranges from the swampy rain forest along its southern Atlantic coastline, through the savannah grasslands of the middle-belt, to the almost desert topography of its northernmost areas. Almost the entire country share a common two-phase climatic pattern: a rainy season in the months of April to September and dry, dusty harmattan season particularly in the northern part of the country in October to March.

These diverse vegetations and climate are strong determinants of the occupations and lifestyles of the people in the respective parts of the country. Peasant farming and petty trading

remain the dominant occupations of Nigerians in spite of the relegation of agriculture by crude oil as the country's leading foreign exchange earner since the 1980s. This scenario coupled with rife mismanagement of resources to account for a high prevalence of poverty among its predominantly rural population, as an estimated 70% of its people are reported by the World Bank to still live 'below the poverty line'[1].

Nigeria has an annual Crude birth rate of 43 per 1000, a Crude death rate of 15 per 1000, with a resultant annual population growth of 2.8%. Therefore, Nigeria has a Population doubling time of 24 years. Although the country's Total Fertility Rate (TFR) remains high by international standards, there has been a slow but steady decline in recent years: 6.3 in 1982, 6.0 in 1990 and 5.7 in 2003. Although there has been a decline in the family size desired by Nigerians within the past four decades, the 2003 NDHS revealed that large families were still preferred, the ideal numbers expressed by men and women being 6.7 and 8.6 respectively. This scenario partly explains the huge gulf between knowledge of contraceptive methods in the country and actual utilization: whereas 78.5% of women and 90.2 % of men have knowledge, only 8.9% of all women currently use modern contraceptives. The Infant Mortality Rate and Maternal Mortality ratio are high, being 100 per 1000 live births and 800 per 100,000 live births respectively.

Ekiti is a state in western Nigeria, it was declared a state on 1 October 1996 alongside five others by the military under the dictatorship of General Sani Abacha. The state comprises the following towns and villages: Oye Ekiti, Ilupeju Ekiti, Ayegbaju Ekiti, Ire Ekiti, Itapa Ekiti, Osin Ekiti, Ayede Ekiti, Itaji Ekiti, Imojo Ekiti, Ilafon Ekiti, Isan Ekiti, Ilemeso Ekiti, Omu Ekiti, Ijelu Ekiti, Oloje Ekiti and a host of others. Local Government Areas Ekiti State is one of the thirty-six states (Federal Capital Territory (Nigeria) that constitute Nigeria. Ekiti State is reputed to have produced the highest number of professors in Nigeria. Oye Local Government is

bounded by Ilejemeje Local Government to the North, Irepodun/Ifelodun to the South, Ikole local Government to the East and Ido/Osi Local Government to the West.

Federal University Oye Ekiti is a government-owned and -operated Nigerian university. The university is in the ancient city of Oye-Ekiti, Ekiti State, Nigeria. The university was founded in 2011 as the Federal University Oye Ekiti by the federal government of Nigeria, led by President Goodluck Jonathan. Federal University Oye-Ekiti (FUOYE) was one of the nine Federal Universities established by the Federal Government of Nigeria, pursuant to an executive order made by the former President of the Federal Republic of Nigeria, His Excellency, Dr. Goodluck Ebele Jonathan, GCFR. The Motto of the University is Innovation and Character for National Transformation. Federal University Oye-Ekiti, whose pioneer Vice Chancellor, was Professor Chinedu Ostadinma Nebo, OON, and the present Vice Chancellor Professor Kayode Soremekun who was recently appointed by the current President, has two campuses at Oye-Ekiti and Ikole-Ekiti and 5 Faculties and 30 Departments, namely:

• The Faculty of Agriculture (Agricultural Economics and Extension, Fisheries and Aquaculture, Soil Science, Animal Science, Crop Production and Horticulture, Food Science Technology, Water Resources and Agrometerology)

• The Faculty of Engineering (Agricultural and Bio-Resources Engineering, Civil Engineering, Computer Engineering, Electrical and Electronics Engineering, Mechanical and Mechatronics Engineering, Material and Metallurgical Engineering)

• The Faculty of Social Sciences (Demography and Social Statistics, Economics and Development Studies, Psychology, Sociology)

• The Faculty of Arts/Humanities (English and Literary Studies, Theatre and Media Arts)

• The Faculty of Science (Animal and Environmental Biology, Biochemistry, Geology, Computer Science, Geophysics, Industrial Chemistry, Mathematics, Microbiology, Physics, Plant Science and Biotechnology). The Motto of the University is Innovation and Character for National Transformation. The strategic vision of the University is to become an academic giant, the pace—setter among universities in the Third World, in the quality of its scientific research, the level of its innovative teaching, and the robustness of its community service.

3.2 RESEARCH DESIGN

Research design can be described as an outline, arrangement of conditions, or a blueprint for collection, measurement and analysis of data, in a manner that combines relevance to the purpose of the research with economy in procedure (Kothari, 2004). The purpose of this research was to access the Attitude and Practice of Induced abortion among Female Undergraduate Students in Ekiti State Nigeria through a survey study. Primary source of data collection was through questionnaires under the study area. The Attitude and Practice of Induced Abortion was tabulated in a questionnaire form for easy ranking.

3.3 STUDY POPULATION

Okoko (2001) defines population as a collection of elements being studied and about which conclusions are to be drawn. Due to the limited time schedule, financial constraints, familiarity with the area and ease of collecting data, this research focused on Ekiti State. The target Population is Female Undergraduates from Federal University Oye Ekiti and Ekiti State University.

3.4 SAMPLING FRAME

Sampling frame consists of a list of items from which the sample is to be drawn, this frame is either constructed by a researcher for the purpose of his study or may consist of some existing list of the population (Okoko 2001). The Sampling frame for this research consisted of 200 Female Undergraduates from Federal University Oye Ekiti and Ekiti State University.

3.5 SAMPLING SIZE

The sample size for the study was randomly selected consisting of 206 female Undergraduates from Federal University Oye Ekiti and Ekiti State University, Nigeria.

3.6 SAMPLING TECHNIQUE

Due to unavailability of some of the respondents, coupled with time and financial constraint on the part of the researcher in meeting all the respondents, simple random sampling technique was employed to collect data from the respondents.

3.7 DATA COLLECTION INSTRUMENT

The instrument used for collecting data from the respondent was through a well-structured questionnaire that was administered by the researcher. The questionnaire designed for this research was such that the first section dwelt on the Demographic Characteristics of the respondents while other sections focused on matters relating to the research study. Its application implies that most part of the data analysis were based on a scoring system. The schedule contained simple and straight forward questions in chronological order that was designed in such

a way that response to it did not take more than 20 minutes considering the busy schedules of the respondents.

3.8 METHOD OF DATA ANALYSIS

For this research, frequency and percentage tables were employed for data presentation.

CHAPTER FOUR

4.0 DATA PRESENTATION AND ANALYSIS OF RESEARCH FINDINGS

This chapter focuses on the presentation and data analysis of research work on attitude and practice of induced abortion among female undergraduate students in Ekiti state, Nigeria. This study examined selected socio-demographic characteristics of the female - age, religion, place of residence, marital status, level of education, parents level of education, parents occupation ,parents average monthly income , average monthly allowance from parents ,ever been pregnant, ever had induced abortion and their attitude towards induced abortion . The weighted sampled population for this study 206 undergraduate females whose response was used to answer the research questions raised for this study. All the research questions were analyzed using simple percentage for the univariate and bivariate. The hypotheses were tested at 5% level of significance using the Pearson Chi-square and logistic regression statistical techniques.

Table 1: **SOCIO-DEMOGRAPHIC CHARACTERISTIC OF RESPONDENTS**

UNIVARIATE-ANALYSIS

VARIABLES	FREQUENCY	PERCENTAGE
AGE		
15-24	12.2	62.1
25-34	78	37.9
TOTAL	206	100.0
RESIDENCE		
URBAN	120	58.3
RURAL	86	41.7

TOTAL	206	100.0
ETHNICITY		
IGBO		
YORUBA		
HAUSA		
OTHERS		
RELIGION		
CHRISTAIN	175	85
OTHERS	31	15.1
EVER BEEN PREGNANT		
YES		
NO		
TOTAL		
INVOLVE IN ABORTION PROCUREMENT		
YES	57	27.2
NO	149	72.8
TOTAL	206	100.0
LEVEL OF RESPONDENT		
100	17	8.3
200	53	25.7
300	76	36.9
400	42	20.4
EXTRA STUDENT	18	8.7

MARITAL STATUS		
SINGLE		
ENGAGED		
MARRIED		
COHABITING		
TOTAL		
FAMILY STRUCTURE		
MONOGAMY	102	49.5
POLYGAMY	104	50.5
TOTAL	206	100.0
AVERAGE ALLOWANCE FROM HOME		
< 10,000		
BETWEEN 10,000-20,000		
>20,000		

The table shows that 62.1% of the respondents fall between the ages of 15-24, while 37.9% are between the ages of 25-34, the percentage distribution of incidence of abortion among female undergraduate as shown in table 1 disclose that approximately 72.8% of the respondents had never terminated pregnancy while 27.2% of the respondents currently had terminated pregnancy before. 85.0% of the respondents are Christians and 18.1% are from other religion. it is observed that most of the respondents dwell in urban centers with 58.3%, while 41.7% of the respondents reside in rural areas. The marital status of the respondent disclosed that Most of the respondents

were single with 62.1%, 2.9% are married, 20.4% engaged and 14.6% cohabiting. The table also disclosed that 50.5% are from polygamous home while 49.5% of the respondents are from monogamous family. The table also shows that 13.1% of the respondents receive a monthly allowance of

TABLE 2: BIVARIATE ANALYSIS ON BACKGROUND CHARACTERISTIS BY INDUCED ABORTION

INDEPENDENT VARIABLES	**EVER BEEN INVOLVE IN ABORTION PROCUREMENT**		
	NO (%)	**YES (%)**	**TOTAL (%)**
FAMILY STRUCTURE			
MONOGAMY	**78**	**24**	**102**
POLYGAMOUS	**71**	**33**	**104**
TOTAL	**149**	**57**	**206**
Pearson chi2(2)=			

ETHNICITY			
YORUBA	85	21	106

HAUSA	5	10	15
IGBO	39	20	59
OTHERS	20	6	26
TOTAL	149	57	206

PEARSON CHI2 (2)= 16.086 Pr=0.001

RESIDENCE			
RURAL	61	25	86
URBAN	88	32	120
TOTAL	149	57	206

PEARSON CHI2 (2) = 0.145 Pr = 0.753

RELIGION			
CHRISTAIN	137	38	175
ISLAM	10	19	29
TRADITIONAL	2	0	2

PEARSON CHI2 (2) = 24.622 Pr = 0.000

LEVEL OF			

RESPONDENT			
100	9	8	17
200	37	16	53
300	63	13	76
400	31	11	42
EXTRA STUDENT	9	9	18
TOTAL	57	149	206

PEARSON CHI2 (2) = 12.130 Pr = 0.016

MARITAL STATUS			
MARRIED	4	2	6
SINGLE	99	29	128
ENGAGED	30	12	42
COHABITATION	16	14	30
TOTAL	149	57	206

PEARSON CHI2 (2) = 7.130 Pr = 0.068

TABLE 3.0

MULTIVERIATE ANALYSIS

dep	Odds Ratio	P>z	[95% Conf. Interval]	
AGE				
15-24	RC(1.00)			
25-34	.9567225	0.915	.425092	2.153223
RESIDENCE				
Rural	RC (1.00)			
Urban	.7442656	0.519	.3032259	1.826794
MARITAL STATUS				
Married	Rc (1.00)			
Single	1.234548	0.849	.1415559	10.76683
Cohabiting	2.352819	0.483	.2154822	25.69008
ETHNICITY				

Yoruba	Rc(1.00)			
Hausa	2.056519	0.416	.3624153	11.66968
Igbo	2.013722	0.112	.8497429	4.772123
Others	.5024702	0.373	.1106672	2.281402
FAMILY STRUCTURE				
Monogamy	Rc (1.00)			
Polygamy	2.094273	0.085	.9019887	4.862564
RELIGION				
Christian	Rc (1.00)			
OTHERS	10.87906	0.000	2.885036	41.02341
LEVEL OF RESPONDENT				
100	Rc (1.00)			
200	.3229459	0.113	.0799011	1.30529
300	.097008	0.003	.0209267	.4496902
400	.2846225	0.117	.0591455	1.369674
Extra student	.8572621	0.851	.1709525	4.298846

The logistic regression in the table revealed that some of the level of socio-demographic characteristics of the respondent has significant relationship to induced abortion among Nigerian women. The likelihood odds ratio of respondents in ages 25-34years indicated that they are more likely to practice induced abortion than their counterpart in ages 15-24 years (OR=0.195, p<0.001), . The likelihood odds ratio of respondents in religion indicated that other religion are more likely to practice induced abortion than Christians although (OR=10.897, p>0.000>)

The likelihood odds ratio of respondents by their level of education showed that those in 300 level are less likely to practice induced abortion compared to those in 100 and 200 level with a significant likelihood (OR=1.353, p<0.003), also those who had secondary education are more likely to practice induced abortion than those with no education with a significant likelihood (OR=1.422, p<0.001) and those who had higher education are more likely to practice induced abortion than those with no education with a significant likelihood (OR=1.470, p<0.001).

The likelihood odds ratio of respondents by their marital status showed that those who married are more likely to practice induced abortion than those who are single with a significant likelihood ratio (OR=7.595, p<0.001), also who are divorced, widowed or separated from their spouse are more likely to practice induced abortion compared to those that are single (OR=6.823, p<0.001). The likelihood odds ratio of respondents by children ever born exposed that those who had 5 or more children are less likely to practice induced abortion than those with 0-4 children with a significant likelihood ratio (OR=0.725, p<0.001). The likelihood odds ratio of respondents by their ethnicity showed that Igbo people are less likely to practice induced abortion compared to Hausa although not significant (OR=0.948, p>0.05) while Yoruba people are less likely to practice induced abortion compared to Hausa with a significant likely ratio (OR=0.586, p<0.01)

In conclusion, this result has confirmed that the socio-demographic characteristics of respondent really give a likelihood ratio to practice of induced abortion.

CHAPTER FIVE

5.1 Introduction

5.2 Conclusion

In conclusion, this study has confirmed that the socio-demographic characteristics of respondent contribute a likelihood ratio to practice of induced abortion. This is in agreement with George (2004) who observed that females resort to abortion mainly as a result of medical and economic factors.

The work also identified the place of contraceptives in preventing unwanted pregnancy and sexual transmitted disease. However, inadequate use of contraceptive could lead to unwanted pregnancy and thereby cause induced abortion.

5.3. Recommendations

In view of the social stigma attached to unwanted pregnancies, many women who become pregnant seek abortion to terminate unwanted pregnancies. In examining the extent to which the socioeconomic/socio-demographic factors influences induced abortion among married and unmarried women, the study proffers the following recommendations:

- Practice of contraception among married women should be upheld instead of going for abortion which may be associated with some maternal risk.
- Government should ensure availability of contraceptive and subsidize the cost.

It is the belief that if the recommendations given in this study are implemented there should be a drastic reduction in the level of induced abortion among women and individual household and Nigeria at large.

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QUESTIONNAIRE SURVEY

FEDERAL UNIVERSITY OYE-EKITI, EKITI STATE

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS

Dear Respondent,

I am a final year student of the Department Demography and Social Statistics in the above mentioned University. I am conducting a research on the topic, "***Attitude and practice of induced abortion among undergraduate female students in Ekiti State, Nigeria".*** I therefore appeal to you to spare some of your valuable time to answer the attached questions to enable the successful completion of the research project. I assure you that all information supplied will be confidentially treated and used solely for academic purpose.

Yours faithfully,

Igbinosa O. Blessing

SECTION A: SOCIO- DEMOGRAPHIC CHARACTERISTICS

Instruction: please fill in the appropriate and tick the correct option, where it is necessary.

1. How old are you? (a) 18-24 (b) 25-29 (c) 30-34 (d)35+
2. Place of residence (a) Rural (b) Urban
3. Sex of Respondent (a) Male (b) Female
4. Marital Status (a) Married (b) single (c) Engaged
5. Ethnicity (a) Yoruba (b) Hausa (c) Igbo
6. Family Structure (a) Monogamous (b) Polygamous
7. Religion (a) Christianity (b) Islam (c) Traditional
8. Level of respondent (a) 100 level (b) 200 level (c) 300 level (d) 400 level

SECTION B: GENERAL KNOWLEDGE OF ABORTION

1. Do you understand the term abortion? (a) Yes (b) No
2. Generally would you encourage induced abortion? (a) Yes (b) No
   a. If yes, which of the following would be your reason? (a) on medical ground (b) on economic ground (c) on educational ground (d) other specify please
   b. If no, which of the following would be your reason? (a) on religion ground (b) on cultural ground (c) other specify please
3. Do you believe that stigma is associated with carrying unwanted pregnancy?
   (a) Yes (b) No
4. Do you believe that fear of becoming a mother at a tender age can influence individual's desire to terminate an unwanted pregnancy? (a) Yes (b) No
5. Will you recommend abortion to other student or anyone in general? (a) Yes(b) No
6. Give reason(s) for your answer ________________________________

SECTION C: ATTITUDE ON INDUCED ABORTION

S/N	QUESTION	YES	NO
7.	Stigma associated with carrying unwanted pregnancy		
8.	Becoming a mother at a tender age can influence individual's desire to terminate an unwanted pregnancy?		
9.	Abortion causes psychological trauma on people		
10.	Would recommend legislation of abortion?		
11.	If pregnant now, would you consider abortion?		
12.	Abortion should be banned		
13.	Abortion is equivalent to murder		
14.	Abortion is a social problem in the society		
15.	There should be serious enlightment on abortion		

SECTION D: PRACTICE OF ABORTION

16. Have you been directly or indirectly involved in an abortion procurement?
(a) Yes (b) No

17. If yes who conducted the abortion? (a) Quack/Chemist (b) Pharmacist (c) Trained Doctor (d) Trained Nurse/Midwife (e) other

18. Where was the abortion carried out? (a) In a chemist/patent drug store (b) In a clinic/maternity home (c) In a hospital (d) other

19. Do you support abortion among students? (a) Yes (b) No