DETERMINANTS AND PERCEIVED CONSEQUENCES OF UNWANTED PREGNANCY AMONG WOMEN IN OYE LOCAL GOVERNMENT AREA, NIGERIA.

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CERTIFICATION

This is to certify that OLAOLUWA ADEDAYO OLUWAROTIMI, of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic "Determinants and Perceived Consequences of Unwanted Pregnancy among Women In Oye Local Government Area, Nigeria" in partial fulfilment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision

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DATE

DEDICATION

The project is dedicated to the Almighty God and my Late Father Rev. Oluwarotimi Dele.

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All glory and honor be to God who has kept me all through my course of study in Federal University Oye-Ekiti. I am a sum total of what God has helped me to do during this time.

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ABSTRACT

Unwanted pregnancy is one of the major causes of unsafe abortion, high fertility and low standard of living. This study examined the relationship between determinants and perceived consequences of unwanted pregnancy among women in Oye local government Area, Ekiti State Nigeria. The data for this work was generated from questionnaire survey administered to 300 women of the reproductive age of 15-49 years. These women were sampled from 6 villages in the local government areas. Statistical techniques such as descriptive statistics, Chi-square (X^2), and multinomial logistic regression analysis were used for analysis. The data was analyzed with STATA 2013.

The results of the descriptive statistics revealed that there is low level of unwanted pregnancy 13.80% in the local government area. The result of Chi-square showed determinants that were significant relationship between marital status, religion, ethnic group, employment status, occupation, partner's religion, partner's ethnic group, place of residence, wealth status, failure to use contraceptive and use contraceptive and fertility behaviour.

The multinomial logistic regression results identified major indicators of unwanted pregnancy in the study areas, they are; other marital status such as engaged and cohabiting. Based on these findings, addressing the issue of unemployment and early marriage among women, provide information, education; communication programs and improvements in counseling and family planning availability were recommended.

Keywords: unwanted pregnancy, contraceptive, unsafe abortion, education.

CHAPTER ONE
INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Worldwide, unwanted pregnancy causes as a major social and public health concern. An unwanted pregnancy can also occur at a time a woman did not want to be pregnant. (Egesa, 2014). It is the pregnancy that is either unwanted (the pregnancy occurs when no more child is desired) or mistimed (the pregnancy occurs earlier than desired), unprotected intercourse is the primary cause of unwanted pregnancy in Nigeria and many women with unintended pregnancies decide to end them by abortion. (Palamuleni, 2014).

Unwanted pregnancy is a core concept that is used to understand the fertility of populations and the unmet need for birth control and family planning, sometimes, unintended pregnancy is due to incorrect or inconsistent use of effective contraceptive methods. The incidences of unintended pregnancies are Common worldwide. Over 100 million acts of sexual intercourse take place each day resulting in around one million conceptions, about 50% of which are unplanned and about 25% are definitely unwanted (UNFPA, 1997).

Unwanted pregnancy is an important public health issue in both high income and also in low and middle income countries because of its negative association with the social and health outcomes for both mothers and children. It is one of the factors contributing to high level of maternal and child morbidity and mortality. According to World Health Organization (WHO), at least one woman dies from complication related to pregnancy or childbirth in every minute which account for nearly 529,000 women in a year and also for every woman who dies in childbirth, around 20 or more suffer infection, injury or diseases which account for nearly10 million morbidity each

year. Unsafe abortion is one of the leading causes of maternal mortality and it accounts for nearly 13percent of death (WHO, 2013).

Multiple determinants of unintended pregnancy have been cited in different studies across the world, but these determinants were not studied collectively, particularly in developing countries. Thus, studying determinants of unintended pregnancy is of great importance, which would help to design useful strategies and cost-effective interventions to reduce the burden of unintended pregnancy. (Sumera A, 2016)

Low rates of contraceptive usage might be associated with the increase in the number of unwanted pregnancies across the world (Burke AE). Family planning and the burden of unintended pregnancies. Almost 210 million women become pregnant annually worldwide, out of whom, 75-80 million (35.7-38%) women experience unintended pregnancy, and approximately 42-46 (>50%) millions of these unintended pregnancies are terminated. It affects the social, economic and health outcomes for mothers and their children.

According to Santelli et al, 2003 women who have an unintended pregnancy are more likely to delay antenatal care or have fewer visits, maternal morbidity and mortality as well as have fewer educational and development opportunities. Unintended children are more likely to have low birth weight, premature birth, infant morbidity and mortality, poor mental wellbeing, poor utilization of antenatal and postnatal care, less breastfeeding, acute respiratory infection and diarrhea, less likely to receive vaccinations, lower nutritional status, and limited education and economic prospects (Muthee, November 2015).

Unintended pregnancy is a potential hazard for every sexually active woman; it is a worldwide problem that affects women, their families and the society (Palamuleni, 2014) .A complex set of

social and physiological factors put women at risk of unintended pregnancy Abortion, infertility; child abandonment and maternal death are negative consequences of unintended pregnancy (Nwokocha,2006). Family planning is one of the most effective strategies in reducing maternal death due to the unwanted pregnancy and risk of unsafe abortion. It can also prevent closely spaced and ill- timed pregnancies and births which contribute to high infant mortality rate in developing world.

1.2 STATEMENT OF RESEARCH PROBLEMS

Unwanted pregnancy has been a rampant phenomenon worldwide especially in developing country. Many researchers are not really dealing with the influence of socio-demographic determinants of unwanted pregnancy across geographical locations.

There are different factors predicting unwanted pregnancy and studies have reported different determinants for this issue. These factors are divided into socio demographic, socio economic, fertility related, and access related factors (Sumera A, 2016)

. The socio demographic and socioeconomic factors included age, education, occupational status, location and autonomy of the mother, and residential area e.t.c. The fertility related factors included mother's age family planning methods included knowledge about contraceptive methods, the use of contraceptives, and awareness about family planning personnel

In Nigeria, an increase in the incidence of unwanted pregnancy is likely to result in a rise the incidence of unsafe abortions. This in turn is likely to raise the proportion of women with abortion-related morbidity and mortality.

Unwanted pregnancy among women can result from contraceptive failure, non-use of contraceptive services and rape. (Nwokocha, 2006; Kost, et. al. 2012; Ikamari et. Al 2013) Abortion is a frequent consequence of unintended pregnancy and in the developing world; it can

result in serious long-term negative health effects including infertility and maternal death. In many developing countries, poverty, malnutrition, and lack of sanitation and education contribute to serious health consequences for women that are experiencing an unintended pregnancy

Furthermore, many married women are at increased risk for unplanned pregnancy, and the highest rate of unwanted pregnancy has been reported to be among individuals between the ages Nof 14–19 years. Further, it can create serious health consequences for women age 15-49, children and family (Nwokocha, 2006; Kost, et. al. 2012; Ikamari et. al2013). Unintended pregnancy poses a major and continuing social and health challenges in Africa, accounting for more than a quarter of 40 million pregnancies that occur annually in the region. It is a key risk factor for adverse pregnancy and maternal outcomes, including mortality and morbidity associated with unsafe and induced abortion.

Worldwide, approximately 85 million pregnancies (40% of all pregnancies) were unwanted in 2012. In the developing world, 74 million unintended pregnancies occur annually, of which a sizable share, 30% are due to contraceptive failure among women using some type of contraceptive method (whether traditional or modern). One of the negative consequences of unintended pregnancy in developing countries is abortion that can result to serious negative health effect including infertility, maternal death and other complications. Unintended pregnancy is the most common cause of maternal mortality in developing countries. In order to probe into the determinants of unwanted pregnancy to complement the existing studies on the issue, therefore, this research will examine the determinants of unwanted among women in Oye local Government Area, Nigeria.

1.3 RESEARCH QUESTION

1. What is the level of unwanted pregnancy among the women in Oye Local Government Area, Nigeria?
2. What are the socio-demographic factors (age, marital status, education and location etc.) associated with unwanted pregnancy among women in Oye Local Government Area, Nigeria?
3. .What is the perceive consequences of unwanted pregnancy among the women in Oye local Government Area, Nigeria?

1.4. OBJECTIVES

1.4.1 OBJECTIVE OF THE STUDY

The main objective of this research is to examine the determinants of unwanted pregnancy among women in Oye Local Government Area, Nigeria.

1.4.2 THE SPECIFIC OBJECTIVES ARE:

1. To examine the level of unwanted pregnancy among women in Oye Local Government Area, Nigeria.
2. To examine the socio-demographic factors (age, marital status, education and location etc.) associated with unwanted pregnancy among women in Oye Local Government Area, Nigeria.
3. To know the perceived consequence of unwanted pregnancy among women in Oye Local Government Area, Nigeria.

1.5 Justification of the study

The study will increase the understanding about the determinants of unwanted pregnancies. Research show that nearly one-third (28%) of women of reproductive age (15-49) have had an unwanted pregnancy at some point in their lives. In addition to low levels of contraceptive use, the desire for smaller families is fundamental. Growing urbanization, the increasing participation of women in the paid labor force and the diminishing ability of families to support many children (partly because of the costs of educating them (Akinrinola, 2006), all contribute to the desire to limit family size. Strong efforts to reduce unwanted pregnancies through family planning programs and other measures are needed, because in their absence, unwanted pregnancies and abortion rates are likely to rise to higher levels. (Chimaraoke Izugbara, 2014). Unwanted intercourse is the primary cause of unwanted pregnancies in the world, and many women with unwanted pregnancies from unintended intercourse decide to end them by abortion or suicide (Lamina, 2015).Quite a number of studies have also focused extensively on the determinants of unwanted pregnancy throughout the globe, while little attention has been given to unintended pregnancy among the woman in less privileged areas, particularly Oye local government areas. Hence, this research work therefore seeks to address the determinants of unwanted pregnancy among the women in Oye Local Government Area, Nigeria.

Finally, this study focuses on the determinants of unwanted pregnancy among women which has not been look and carried out in this study area. Also, there is dearth in literature on unwanted pregnancy in Oye Local Government and determinants are difference.

1.6 Definition of terms

Unwanted pregnancy: This can be seen as unwanted or mistimed pregnancy.

Pregnancy: also known as gestation, this refers to period from conception to birth. The nine months or so for which a woman carries a developing embryo and fetus in her womb (World Health Organisation)

Abortion: abortion can be define as pregnancy termination prior to 20 weeks' gestation or a foetus born weighing less than 500 g. the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO).

Contraception: it is the deliberate action taken by persons in union to control birth, space birth and control their family size.

Fecundity: The physiological capacity of a woman to produce a child.

Fertility: Fertility is the actual reproductive performance of a couple

Maternal Mortality Ratio (MMR): The number of women who die as a result of pregnancy and childbirth complication per 100,000 live births in a given year

Family planning: The conscious efforts of couples or people in union to regulate the number and spacing of births through artificial and natural methods of contraception. Family planning connotes contraception control to avoid pregnancy and abortion.

Induced abortion: This is the deliberate interruption of pregnancy before 28 weeks of gestation.

Socio-demographic characteristics: ***Socio-demographic*** variables included: gender, age, level of education, employment status, profession, and marital status, total number of persons living in the house and living arrangements. The last three variables were used as potential measures of social support.

Rape is a type of sexual assault usually involving sexual intercourse or other forms of sexual penetration carried out against a person without that person's consent. The act may be carried out by physical force, coercion, abuse of authority, or against a person who is incapable of giving valid consent, such as one who is unconscious, incapacitated, has an intellectual disability

CHAPTER TWO
LITERATURE REVIEW

2.0. INTRODUCTION

This chapter presents the literature review and discusses the theoretical framework which the study is hinged and makes a case for their appropriateness. This chapter also presents the conceptual and the operational frameworks to be used in the analysis of data.

2.1. UNWANTED PREGNANCY AS AN ISSUE

Unwanted pregnancy is defined as the situation when a pregnancy comes sooner than desired or when woman do not have any intention of having a baby (Johnson et al., 2004). According to Santalli (2003), unintended pregnancies are "pregnancies that are reported to have been either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired)". Unintended pregnancy can result directly from the contraceptive failure, less or inconsistent use of contraceptives, lack of knowledge of contraceptives and sometimes even rape (David, 2006).

Furthermore, it can create serious health consequences for women, children and family (Ikamari et. al 2013). There is very little published literature that focuses on the determinants of unintended pregnancy in developing countries and particularly in Malawi. However, some research studies conducted outside of Malawi have shown the relation between unintended pregnancy and socioeconomic and demographic characteristics (Kost, et. al. 2012; Ikamari et. al 2013). Moreover, there is very little known about unintended pregnancy in cultural contexts. (Palamuleni, 2014)

The incidences of unintended pregnancies are is common worldwide. Over 100 million acts of sexual intercourse take place each day resulting in around one million conceptions, about 50% of

which are unplanned and about 25% are definitely unwanted (UNFPA, 1997). Data suggest that approximately 49% of all pregnancies in the United States (Finer and Zolna, 2006) are unintended. Almost all occurred due to nonuse of family planning method or contraceptive failure. About 50% of all unintended pregnancies in the United States are due to contraceptive failure (Finer and Zolna, 2006, 2011; Finer and Henshaw, 2006). In Chile, women aged less than 25 and of low socioeconomic status were more likely, than their peers living in households of better socioeconomic status, to have unplanned pregnancies (World population review 2015) . In Harare, a significant association was found between unintended pregnancy and age, with women aged 19 years and below or 35 years and above having a higher risk of unintended pregnancy. Similar results have been reported in several other studies. Young women have higher likelihood of inconsistent or non use of effective family planning methods than older women and have greater risk to have mistimed than intended pregnancy (carolyne, 2014).

Therefore, unintended pregnancy is an issue that cannot be ignored for it increases health and economic risks for children, women, men and families (UN2013). Research indicates that unintentional pregnancy is a key risk factor for adverse pregnancy and maternal outcomes, including mortality and morbidity associated with unsafe induced abortions. (Chimaraoke,2014)

2.2. UNWANTED PREGNANCIES RELATED TO AFRICA

In most countries of Africa, specifically sub-Sahara Africa, unintended pregnancy is high. In Adetunji's study of eight sub-Saharan African countries, Kenya recorded the highest proportion of unintended childbearing. In the 2003, the Kenya Demographic and Health Survey (KDHS) showed that nearly 50% of unmarried women aged 15–19 and 45% of the married women reported their current pregnancies as mistimed or unwanted (Adetunji's, 1998).

The 2008–09 KDHS showed that 43% (26% mistimed and 17% unwanted) of married women in Kenya reported their current pregnancies as unintended. Unintended pregnancy is one of the most critical factors contributing to schoolgirl drop out in Kenya. In addition, unsafe pregnancy termination contributes immensely to maternal mortality which currently estimated at 488 deaths per 100 000 live births.

Sub-Saharan Africa continues to have the highest rates of unintended pregnancies, as a region, sub-Saharan Africa has the lowest level of contraception prevalence with an estimated 25 % unmet need for family planning among women aged 15 and 49 (UN2015). In sub-Saharan Africa, unintended pregnancy accounts for more than a quarter of the 40 million pregnancies that occur annually. Unintended pregnancy has also been linked to low use of appropriate maternal health care and also a major cause of unsafe abortion (Erena & Kerbo, 2015)

Studies conducted in various developed and developing Countries revealed that unintended pregnancies can have serious health, social, and economic consequences. The negative consequences of unwanted pregnancies are increased risk of low birth weight and of being born prematurely; as a result, infants have a high risk of mortality.

In Ethiopia a national survey in 2013 stated that the prevalence of unintended pregnancy was 24%, while in Southern Ethiopia it was found to be about 43%. Specifically in Hosanna town it was 34%. High prevalence of unintended pregnancy occurs due to the high unmet need for family planning. According to report of the Ethiopian Demographic and Health Survey 2011, 25% of married women had an unmet need for family planning. On the other hand 9% of births were not wanted and 16% of births were mistimed.

According to Ministry of Health (2006) approximately half a million pregnancies annually end in induced abortion among 3.7 million pregnancies, which is a reflection of the high rate of

unintended pregnancy. Issues related to unintended pregnancy has been studied by few researchers in Ethiopia and little has been discussed about its cause especially in the rural parts of the county (Akalework, 2008).

In Nepal, the prevalence of unintended pregnancy in the five years preceding the survey is high (35%). Among these, more than one in five births (21%) is unwanted and one in seven (14%) is mistimed (Ministry of Health (Nepal), New ERA, and ORC Macro, 2002). Family planning method failure rate is high. A study found that 20% in rural and 16% in urban married women aged 15-49 reported method failure as the reason for their unintended pregnancy (Tamang, et al., 2002). Similarly, one research study estimated that during the first year of vasectomy, 1.7% women would become pregnant (Nazerali, et al., 2003), which leads to the higher unintended pregnancies and abortion. A study conducted at 5 major hospitals showed that abortion related admissions account for 20% to 48% of the total obstetric and gynaecological patients (Crehpa, 1999). Despite the legalization of abortion laws (After March 2002) in the country, lack of awareness about the law and facility centres, many women still seek abortion clandestinely and most often they consult unskilled or unqualified health workers, resulting in high rates of abortion related morbidity and mortality (Crehpa ,2002).

2.3. UNINTENDED PREGNANCY RELATED TO NIGERIA.

Studies have consistently indicated that large numbers of Nigerian women experience unwanted or mistimed pregnancies and births. According to a 1997 survey of women in south western Nigeria, at least 27% of women had unintended pregnancy. Similarly, in a survey conducted in south western and northern Nigeria in the mid-1990s, 20% of women reported ever having experienced an unwanted pregnancy (Gilda Sedgh, 2006). The 2003 Nigeria Demographic and Health Survey (DHS) found that of live births to women in the previous three years, 15% were

reported to be unplanned. It has been estimated that about 12% of all pregnancies in Nigeria (not including those that result in spontaneous abortion) end in induced abortion, and another 9% result in unplanned births (WHO, 2004).

Unintended pregnancy poses significant public health risks. One consequence of unwanted pregnancy is induced abortion. In the mid-1990s, the abortion rate in Nigeria was estimated at 25 per 1,000 women. Approximately 760,000 abortions occurs in 2006, because abortion is illegal in Nigeria except to save a woman's life, many abortions are conducted under unsafe conditions and carry a substantial risk of maternal morbidity and mortality. It is estimated that about 25% of women who have abortions in Nigeria experience serious complications. (Bankole A et al, 2006).

According to national surveys, Nigerian women and couples want fewer children than they once did: Between 1990 and 2003, the mean desired number of children declined from 5.8 to 5.3.Even so, levels of contraceptive use remain low: In 2003, only 7% of married women used a modern contraceptive method and another 6% relied on a traditional or folk method. The combination of low contraceptive use and smaller desired family size implies high levels of unmet need for family planning in Nigeria. Indeed, among married women of reproductive age, 32% do not want to have a child in the near future but are not using a modern contraceptive method, and are therefore at risk of unwanted pregnancies (UN, 2013).

Research on reasons for family planning nonuse in Nigeria generally points to women's perceived lack of need for contraception, fear of side effects and opposition to contraception on personal or religious grounds. Less is known about the circumstances surrounding women's unwanted pregnancies and their reasons for seeking to terminate some of these pregnancies. The limited evidence available from small studies in various parts of Nigeria generally points to such

reasons as a wish to space births, economic constraints, the desire to remain in school and not being married (Oye-Adeniran, 2014)

A few studies that have tried to assess the determinants and perceived consequences of unwanted pregnancy and abortion in the community have found that it presents a problem of considerable magnitude. There is a need to conduct a study of this profile (involving both rural and urban dwellers) in order to increase community awareness on the extent of this calamity. In Nigeria, the determinants and perceived consequences of unwanted of unintended pregnancy among women in diverse social and economic situations, in both urban and rural areas, are poorly understood due to lack of data.

The purpose of this study is to examine the current incidence of unwanted pregnancy among women of reproductive age in eight states in Nigeria and to explore the factors associated with it. We utilize an approach that is designed to minimize underreporting and to elicit reports of all unwanted pregnancies, regardless of their outcomes. In addition, we explore women's reasons for not wanting a pregnancy, the barriers they face to effective contraceptive use, and their use of abortion to terminate unwanted pregnancies. Furthermore, we examine the level of risk of unwanted pregnancy and the reasons given for not practicing contraception by women who are at risk.

2.4. FACTORS ASSOCIATED WITH UNINTENDED PREGNANCY

2.4.1. Level of Education

Education has also been considered as one of the important determinants of unintended pregnancy, but there are conflicting data regarding the association between level of education and unintended pregnancy (Adhikari R, 2009)

The level of education play a part in determining the rate of unwanted pregnancy and induced abortion, e.g. the level of education of parents, especially the mother, may have an influence on the adolescent towards teenage pregnancy as she acts as a role model (Vundule et al., 2001) which may be a preventive factor of the early pregnancy. Education, on the other hand, is a major protective factor for early pregnancy: the more years of schooling, the fewer early pregnancies. Birth rates among women with low education are higher than for those with secondary or tertiary education (David 2006; finer, et al 2006). This is supported by several studies which have shown that level of education have an influence on the rate of unwanted pregnancy and, a study done in Kenya reported that women with no education had first sexual intercourse three years earlier than their counterparts with at least a secondary school education (Advocate for Youth, 2005). Similarly in Malawi, 63% of adolescents with no education .The same applies for Tanzania whereby there is a variation in the age at first birth by the level of education which ranges from 18.7 years among women with no education to 23 years among women with at least secondary education (TDHS, 2010). Marriage is also delayed if teenagers further their education to secondary and postsecondary education. The level of unintended pregnancy reduces with increase in educational level. Yearly, unintended pregnancy contributes to as many as 10,000 girls to drop out of school in Kenya, (CSA 2008). According to Mboup and Sasha (1998) found that in many SSA countries, women with no schooling have about two to three children more than women with secondary or higher education. According to Gupta and Mahy (2003), young women with no education are over three times as likely to have started childbearing by age 19 than those who have secondary and higher education (32% versus10%). Results from their study also reinforced other previous findings that improving girl's education is a key instrument for raising ages at first birth, but suggest that increases in schooling at lower

levels alone bear only somewhat on the prospects for fertility decline among women, a concept that Finer and Zolna, (2011) found in their studies. Women with high education are more likely to desire smaller families and have a stronger motivation to practice contraceptive. They are also better informed about available contraceptive options and sources and likely to use contraceptive effectively. Therefore, educated women are much more likely to have planned pregnancies (Bongaarts, 1997). Women with no formal education or who had not completed primary school were more likely to have had an unwanted pregnancy than women with a primary schooling (Eggleston, 1999). On the other hand, some studies have shown that there is positive relationship or no significant association between mother's education and unintended pregnancies. For example, in Nigeria, women with a university education reported three times more likely to experience unintended pregnancy compared to those with no education (Okonofua, et al., 1999). Similarly, in Japan, Malawi, Kenya and Nepal there was no significant association between the experience of unintended pregnancy and women's education (Goto, et al., 2002; Adhikari et al. 2009; Ikamari et al., 2013; Palamuleni 2014). One possible explanation is that better educated women have a stronger motivation than other women to space their children or to delay the onset of a first birth. Expanding access to formal education is generally seen as a crucial intervention for preventing early childbearing among women. Policy and decision-makers often implicitly assume a causal flow from girl's education to lower pregnancy rate. Empirical results indicate that girls' education level has significant influence on the probability of early birth, with no schooling adolescents and those with primary school level education being more vulnerable (Ikamari et al., 2013).

Among the variables used as proxies for access to sex education, availability of church forums that educate young women about sex and family life issues reduce probability of unintended

pregnancy (Were, 2007). Contraceptive use increases dramatically with increasing level of education. 60% of married women with at least some secondary education use a contraceptive method compared with 40% of women with incomplete primary education and only 14% of those who never attended school. The more educated the woman the higher the tendency to use the contraceptives and the lower the unintended pregnancy. Even the research conducted by undergraduate student in demography and social statistics, Federal University Oye Ekiti revealed women with lower education tend to have unwanted pregnancy. (Palamuleni,2014).

2.4.2. Contraceptive Use Failure

Contraception is the deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse. The major forms of artificial contraception are barrier methods, of which the most common is the condom; the contraceptive pill, which contains synthetic sex hormones that prevent ovulation in the female; intrauterine devices, such as the coil, which prevent the fertilized ovum from implanting in the uterus; and male or female sterilization. Unintended pregnancy can result from contraceptive failure, non-use of contraceptives, and less commonly, rape. Further, it can create serious health consequences for women, children and family (Nwokocha, 2006; Kost, et. al. 2012; Ikamari et. al2013). Also, the high level of unintended pregnancy and childbirth among women stem largely from barriers in accessing and using contraception, non use or incorrect use of contraceptives and/or noticeable contraceptives failure and lack of adequate information about pregnancy prevention, (Bankole and Malarcher, 2010).

Worldwide, approximately 85 million pregnancies (40% of all pregnancies) were unintended in 2012. In the developing world, 74 million unintended pregnancies occur annually, of which a sizable share, 30%, are due to contraceptive failure among women using some type of

contraceptive method (whether traditional or modern). This includes both method-related failures (i.e., failure of a method to work as expected) and user-related failures (i.e., failure stemming from incorrect or inconsistent use of a method). Detailed information on contraceptive failure rates is critical to inform improvements in provision of contraceptive information, supplies and services, which can help women and couples to use methods correctly and consistently. The majority of unintended pregnancies occur when a pregnancy is not planned or wanted and yet effective contraception is not being used, that is, when a woman has an unmet need for contraception. Singh and Darroch (2012) estimate that, on average, 79 percent of unintended pregnancies occur for this reason, i.e. because of an unmet need for effective methods. The reasons why a woman is not using contraception when she does not want to become pregnant, i.e. why she has an unmet need, vary considerably.

According to 2013 NDHS report; Younger women (age 15-19) and women living in the North East are least likely to know of a contraceptive method (67% and 73%, respectively). As expected, knowledge of contraceptive methods is higher among women living in urban areas (95%) than among those living in rural areas (78%). Among the states, knowledge of contraceptive methods is lowest for women in Niger (56%) and in Kebbi (51%). Similarly, knowledge of contraceptive methods is lowest among women with no education and those in the lowest wealth quintile (72% and 67%, respectively). Among men, there are only small differences in knowledge of any contraceptive method by age group, but the differentials are greater by place of residence, zone, educational level, and wealth quintile shows the percentage distribution of all women, currently married women, and sexually active unmarried women who are currently using specific family planning methods, according to age. Overall, 15% of currently married women in Nigeria are using a contraceptive method, an increase of only 2 percentage

points since the 2003 NDHS. Most of these contraceptive users rely on a modern method (10%); 5% use traditional methods. Injectable (3%), male condoms (2%), and the pill (2%) are the most commonly used modern methods. Other modern methods are used by 1% of women or less. Interestingly, 3% of currently married women use withdrawal as a method of contraception. The use of contraceptive methods among currently married women increases with age from 2% among women age 15-19 to 22 among women age 40-44, after which it falls to 13% among women age 45-49. As expected, the use of family planning methods is higher among sexually active unmarried women than among currently married women (68% versus 15%). In addition, more sexually active unmarried women (55%) than currently married women (10%) use modern family planning methods. There is also a notable difference between sexually active unmarried women and currently married women in use of the pill (8% versus 2%).

A very important factor is the low level of contraceptive use. Majority of unintended pregnancy in developing countries occur among women using traditional method or no contraception, multiple barriers in effective use among women such as fear of side effect, cultural taboos/norms, influence of partner, limited access/cost and so on. Poverty and lack of education contributes to lower contraceptive use. In addition, a desire to limit family size to enable the family to provide a better education for the children, the increased participation of women in the labour force, and urbanization are other factors leading to desire of Nigerian women to have a predetermined number of children

2.4.3. Place of Residence

Regional variation exists in regard to unintended pregnancy due to different socio-cultural pattern and practices. Equally, urban and rural distinction was considered important because of

differences in access to health facilities, cultural beliefs, living situations and opportunities (Palamuleni 2014).

Research studies have suggested that rural women are more likely than urban women to experience unintended pregnancy. For example, the study conducted in Peru showed that the proportion of having unintended pregnancy was 32% in rural area compared to only 13% in the capital city (Mensch, et al., 1997). Similarly, a study conducted in Kenya showed that the proportion of having unintended pregnancy was 17% in urban area relative to 16% in the rural area. Further, young motherhood is slightly more common in urban areas than in rural areas. Contraceptive use has been more prevalent in urban areas than rural areas hence the reason why unintended pregnancy has been high in rural than in urban areas, (Oduor, 2010). Women living in urban areas are more prone to use contraceptive methods, as compared to those who are living in rural areas. Studies from developing countries such as Nepal have found that women in rural areas experience unintended pregnancies more than those living in urban areas, which might be due to insufficient utilization of contraceptive methods. Whereas, the results of studies conducted in India showed that women from urban areas experienced more unintended pregnancies, as compared to those living in rural areas. Studies performed in Egypt and Nepal found no significant associations between place of residence and unintended pregnancy. However, there are some contradictions findings in the study conducted in Ecuador. It showed that residence in rural and non metropolitan urban areas independently lowered the likelihood of both unwanted and mistimed pregnancy compared to two largest cities of the country (Eggleston, 1999). Finally, in Nigeria the rate of unintended pregnancies seemed to be highest (27.57) south south. South west geopolitical zone has the second highest rate of unintended pregnancy (18.12%). North central has 16.43% rate of unintended pregnancy, followed by North West geopolitical zone

(13.14%). Mothers who are from South west and South east had the lowest rate of unintended pregnancy (12.47%) and 12.27% respectively.

2.4.4. Marital Status

The status of a woman, married or unmarried is a key primary indicator in establishing the intention. Marriage reflects the regular exposure of women to the risk of pregnancy and is therefore important for the understanding of fertility. This factor gives an indicator to the age at which a woman got married. Populations in which age at first marriage is low tend to have early childbearing and subsequently give birth to more children, leading to high fertility rates which increased unintended pregnancy (Goto, et al., 2002).

In a study of Kuwait, women who had married before they were 18 years of old wanted about one child more than women who had married at age 21 or older (Shah, et al., 1998). Similarly, Study conducted in Shanghai, China showed that strong relationship between the desired timing of the first birth and wife's age at marriage. For example, 23% of wives who married before age 24 wished to postpone conception for more than one year, compared with 2% of wives who Married at age 30 or older (Che & Cleland, 2004). Sexually active unmarried women tend to think that they are "safe" from pregnancy as they have never been exposed to any, (Ikamari et al., 2013). Coast region has a lower median age at first marriage (below 20) compared to Central region, that is, women in Coast enter into marriage earlier than women in Central. Married women had a lower unmet need for contraceptives compared to the sexually active unmarried women, (KNBS and ICF Macro, 2010).

2.4.5. Number of Living Children

Studies have shown that women are less conscious and take minimal safety measures against unintended pregnancy prior to having any live birth. Soon after experiencing an unintended pregnancy it leads to uptake of contraception, (Fotso et al., 2014). In addition, women whose last Pregnancy was unintended were more likely to be using a modern method of contraception, Compared to their peers whose last pregnancy was intended, especially among the wealthier group. Among poor women, unintended pregnancy was not associated with subsequent use of contraception .High parity and unintended pregnancies were clearly linked. The more children a woman already had, the more likely she was to report that her current/last pregnancy was unintended. For example, in Nepal, unwanted birth is increased as birth order is increased. Similar findings have been observed in Iran. The proportion of unintended pregnancy has increased as increase the order of pregnancy (13.5% for first order of pregnancy to 58% for forth and higher order of pregnancy) (Abbasi-Shavazi, et al., 2004).

Kenyan women are adopting family planning at lower parities (i.e., when they have fewer children) than in the past. Among younger women (age 15-19), 10 percent used contraception before having any children and 3 percent started using contraception when they had one child. Similarly (age 20- 24), 22 percent used contraception before having any children and 25 percent started using contraception when they had one child. A study finding in Ecuador indicated that the likelihood of unintendedness increases with a woman's number of children. Further, the study showed that women with unwanted pregnancies had had an average of 3.7 previous births; while women with planned pregnancies had had 1.7 previous births, (Eggleston, 1999). Similarly, the study conducted in Harare showed that women at parity five presented more often with an unplanned pregnancy compare to other parity (Mbizvo, et al., 1997).

2.4.6. Religion

Coast region has diverse religious groups including Christians (Catholics and Protestants) and Muslims, traditionalists, among others. Muslim is the dominant religion particular in Malind and Mombasa. Central region is mainly dominated by Christians. Religion, just like culture, can shape key demographics of a population. It is well documented how different religious denominations react towards the use of modern contraception, entry into sex, marriage and abortion which then affect unintended pregnancy. In a Muslim community, virginity until marriage is emphasized but the high level of unintended pregnancy in Coast region clearly indicates early sexual debut and high unmet need for contraception, (Hofert and Hayes, 1997). Some studies have found that the relationship between religious affiliation and reproductive health behavior. Phillips and other (1989) showed in Bangladesh that Hindus are more likely to use sterilization than Muslim. The study in Greater Freetown, Sierra Leone has found the higher contraceptive prevalence rate among women affiliated with Catholics or another Christian religion than among those affiliated Islam (Amin, et al., 2004). Restriction about women activities also plays great role on contraceptive use and fertility planning. Islam restricts women's activities in ways that other religions do not (Caldwell, 1986). In contrast, Bhende and other (1991) in India showed that low contraceptive practice among Hindu than Muslim. The other study found that all non-catholic religious groups had slightly higher rates of contraceptive prevalence compared with Catholics in Kinshasa, Zaire (Shapiro, et al., 1994). Muslim women have the highest proportion of childbearing compared to other religions, (Oduor, 2010). Every religion has their own norm, value and belief about contraception and reproductive health issues including contraception. It can be concluded that religion may have influence on methods selection which has more or less affect on unintended pregnancy but it is difficult to generalize

as a common phenomenon. Religion values acts like a moral guide to people. Sermons influence the woman's attitude, values and decisions and are prohibitive of any sexual misconduct, (Odimegwa, 2005). According to a study by Gregory (2014), he noted that religion tend to unite friends with similar religiosity that enforce social ties and contribute to youths making positive choices amid negative peer influence. It has been shown that "religion in the home is a major factor in the social acquisition of youth religions values", including values about pregnancy, (Gregory, 2014).

2.5. PERCEIVE CONSEQUENCES OF UNINTENDED PREGNANCY

Unintended pregnancy is a global problem with substantial negative consequences for women, their families and society. In developing country setting, women who seek to abort unwanted pregnancy face the risk of serious long term health effects, including infertility and maternal death. A lot of consequences emerged from unwanted pregnancy but the chief of it is abortion. The perceived consequences of unwanted pregnancy are;

2.5.1. Affects the Lives of Women and Children

Various studies reveal that unintended pregnancy is linked with the increase in the morbidity and mortality in women and also with neglect in the care of child (Gessessew 2010; Singh 2012: David 2011: Cheng et al. 2009: Shapiro-Mendoza et al. 2005; Goto et al. 2005). A study conducted in rural India on the consequences of unintended pregnancy revealed that mothers reporting unwanted births were more likely than mothers reporting wanted births to receive inadequate prenatal care (Singh, Singh &Mahapatra 2013). In USA, women with unintended pregnancies were less likely to initiate prenatal care during the first trimester compared to women with intended pregnancies (Cheng et al. 2009). In USA, mothers with unintended pregnancies were more likely to consume less than the recommended amount of preconception

folic acid (Cheng et al. 2009). Study from Ethiopia provides evidence that unwanted pregnancy is associated with increased risk of maternal morbidity and mortality (Gessessew 2010). A study from USA revealed that women with unwanted pregnancies were more likely to smoke prenatally and smoke postpartum compared to women with wanted pregnancies. Moreover, they were more likely to report postpartum depression (Cheng et al. 2009). Earlier study on the social well-being on intended versus unintended pregnancy in USA found that pregnancy intention of women was significantly associated with the social support. Feeling happiness on having the baby were positively associated with all the domains of social support and negatively associated with family relationship problems and loneliness (Sable et al. 2007). Research from Bangladesh on intimate partner violence and unwanted pregnancy, miscarriage, induced abortion and stillbirth among a national sample of Bangladeshi women found that three out of four Bangladeshi women experience violence from husband, women experiencing violence are more likely to have unwanted pregnancy (Silverman et al. 2007).

One of the famous studies on the consequences of unintended pregnancy is "The Prague study". This study followed the development and mental well-being over 35 years of 220 children born between 1961 and 1963 in Prague, Czech Republic, to women twice denied abortion for the same unwanted pregnancy. Children were individually pair-matched at age 9 with 220 children born from accepted pregnancies. Five follow-up studies were conducted. Findings showed that differences in the psychological development between the subjects widened in time but were observed lesser in mid 30s. It was also observed that child from unwanted pregnancy are more prone to psychological problems compared to their siblings. Overall negative psychosocial development and mental well-being in adulthood was observed in children born from unwanted pregnancy (David, 2011). Cohort study from Northern Finland on unwanted pregnancy and

schizophrenia in child found that a cumulative incidence of 0.7% in children born from normal pregnancy compared with 15% for those born from unwanted pregnancies. The risk of later schizophrenia among unwanted children was raised compared with wanted or mistimed children (Myhrman et al. 1996). The results suggest that unwantedness may operate either directly as a psychosocial stress during development making children more liable to schizophrenia, or it may be a marker for behaviours associated with risk in either the mother or the child (Myhrman et al. 2003).

An unintended birth can have negative consequences for a mother's mental health and the relationship between the mother and father (Gipson et al., 2008; Logan et al., 2007). Among couples in a cohabiting relationship who had an unintended pregnancy resulting in a birth, one-third split up within two years of the child's birth (Logan, et al., 2007). Children born following an unintended pregnancy are significantly more likely to have mothers and fathers who suffer from depression, relationship conflict, and poor relationship quality compared to children born following a planned pregnancy, controlling for background factors (Logan, et al., 2007). Unintended pregnancy places both mothers and fathers at greater risk of educational hardship and failure to achieve education and career goals (Santelli, et al., 2003). Women who experience an unintended pregnancy may also be at increased risk of domestic violence compared to women who have an intended pregnancy (Pallitto, Campbell, &O'Campo, 2005).

2.5.2. Unsafe Abortion

Accordingly, the occurrence of abortion can be seen as one of the primary consequences of unintended pregnancy. Voluntary interruption of pregnancy is an ancient and enduring intervention that occurs globally whether it is legal or not.

Abortion is the ending of pregnancy by removing a fetus or embryo before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage; abortion may be caused purposely and is then called an induced abortion. The word abortion is often used to mean only induced abortions. A similar procedure after the fetus could potentially survive outside the womb is known as a "late termination of pregnancy". Unsafe abortion is a significant cause of maternal mortality and morbidity in the world, most unsafe abortions occur where abortion is illegal, or in developing countries where affordable well-trained medical practitioners are not readily available, or where modern contraceptives are unavailable.

The World Health Organization (WHO) published an estimate that in 2003 approximately 42 million pregnancies were voluntarily terminated, of which 20 million were unsafe. According to WHO and Guttmacher, approximately 68,000 women die annually as a result of complications of unsafe abortion; and between two million and seven million women each year survive unsafe abortion but sustain long-term damage or disease (incomplete abortion, infection (sepsis), haemorrhage, and injury to the internal organs, such as puncturing or tearing of the uterus). They also concluded abortion is safer in countries where it's legal, but dangerous in countries where it's outlawed and performed clandestinely. The WHO reports that in developed regions, nearly all abortions (92%) are safe, whereas in developing countries, more than half (55%) are unsafe. According to WHO statistics, the risk rate for unsafe abortion is 1/270; according to other sources, unsafe abortion is responsible for one in eight maternal deaths. Worldwide, 48% of all induced abortions are unsafe. The British Medical Bulletin reported in 2003 that 70,000 women a year die from unsafe abortion. Incidence of such abortions may be difficult to measure because they can be reported variously as miscarriage, induced miscarriage, menstrual regulation, mini-abortion, and regulation of a delayed or suspended menstruation.

Abortion accounts for 20%-40% of maternal deaths in Nigeria. An estimated 610,000 abortions are reported to occur in Nigeria annually. Unwanted pregnancy occurs in women of all ages but adolescents have been most affected. It has been reported that by the age of 45 years most women would have had at least one abortion. Married women also experience unwanted pregnancy, as they constituted z34.8% and 63.2% of abortion seekers in two studies respectively from South-western Nigeria.

It has been reported that some women use abortion as a means of child spacing instead of contraception. This may be as a result of low contraceptive prevalence rates despite reported hig

2.6. THEORETICAL FRAMEWORK

2.6.1. Theoretical perspectives on unintended pregnancy

Researchers have employed a number of theoretical frameworks in their attempts to explain the unintended pregnancy. Unintended pregnancy can be best understood within theoretical perspectives such as the social learning (cognitive) theory; health belief model; theory of planned behavior or reasoned action among others that have been widely applied by several scholars (Kungn'u 2013)

2.6.2. Social Learning (Cognitive) Theory

Social Learning Theory (SLT) posits that behavior is the result of reciprocal determinism the continuing interaction between a person, the behavior of that person, and the environment within which the behavior is performed. The constant interaction between these factors is such that a change in one has implications for the others. Behaviour can result from the characteristics of a person or an environment, and it can be used to change that person or environment as well. Behavior is viewed not in isolation, but rather as the outcome of the dynamic interaction of

personal and environmental variables. The two most important variables that Social Learning Theory takes into account are self-efficacy and modeling. Self-efficacy, or the confidence in one's ability to successfully perform a specific type of action, is considered by Bandura (the father of Social Learning Theory) to be the single most important aspect of the sense of self that determines one's effort to change behaviour.

According to Kung, 2013, People learn not only from their own experience, but from the actions and reactions of others as well are defined as imitation or modeling, a basic premise of Social Learning Theory. Other important variables include knowledge, skill, problem-solving, expectations, self-control, emotional coping, and perception of the environment, attitudes, beliefs, intent, and motivation. The term personal variable refers to an objective notion of all the factors that can affect an individual's behavior that are physically internal to that individual. Environmental variables include both social and physical. Social environment includes reinforcement, family members, friends and colleagues. Physical environment is the size of a room, the ambient temperature or the availability of certain foods in short, all the factors that can affect a person's behavior that are physically external to that person, (Bandura, 1997). In this research, it is hypothesized that personal characteristics such as age, education, occupation and environmental characteristics such as spouse, autonomy, and religion affect their contraceptive using behavior which affect unintended pregnancy.

2.6.3. Health Belief Model

The Health belief model (HBM) is a psychological model that was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The health belief model attempts to explain and predict health behaviors and it affirms that readiness for action stems from an individual's estimate of the threat of illness or, as applied

to a pregnancy prevention intervention, pregnancy and sexually transmitted diseases. The health belief model has four constructs representing the perceived threat and net benefits:

•Perceived susceptibility

•Perceived severity

•Perceived benefits and

•Perceived barriers.

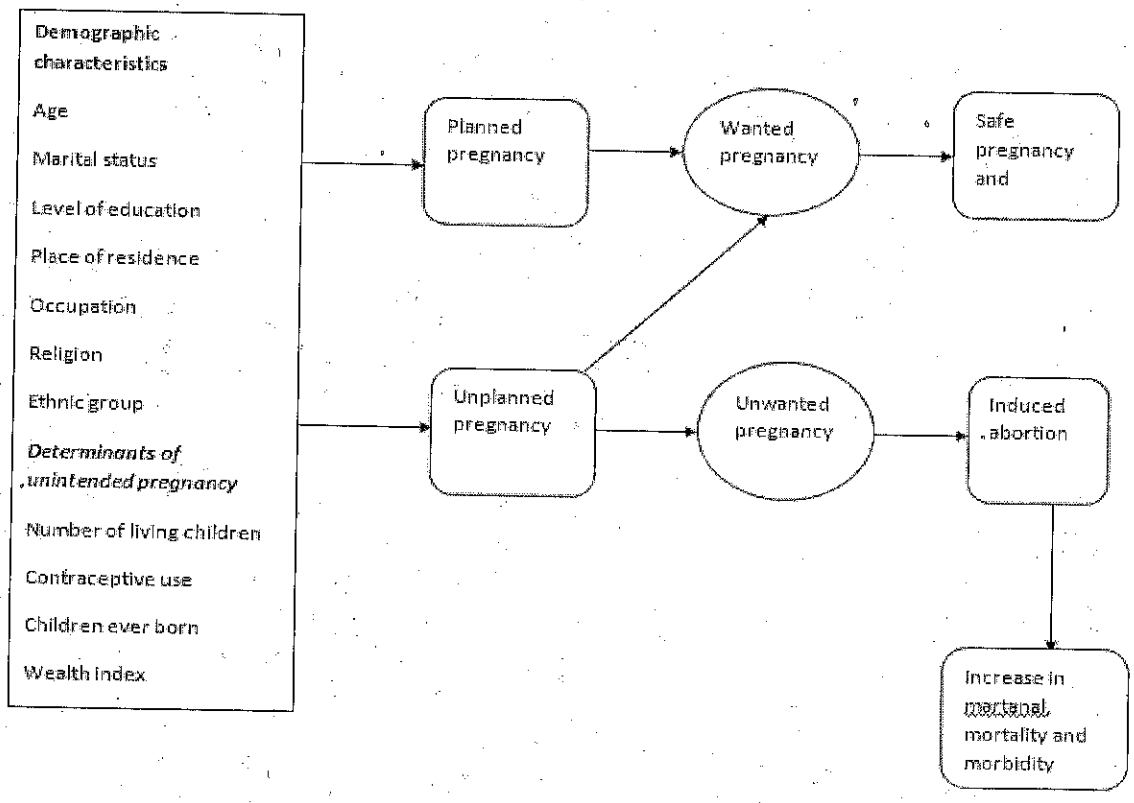
These concepts were proposed as accounting for people's readiness to act. Rosenstock and others in 1988 have added two more concepts: cues to action and self efficacy. Cues to action, would activate that readiness and stimulate overt behavior and self efficacy helps the health belief model better fit the challenges of changing habitual unhealthy behaviors. The health belief model proposes that individuals consciously consider and weigh all the different variables in deciding the actions they will pursue. A kind of cost-benefit analysis is thought to occur in which an individual weighs opposing or conflicting options. The cost side consists of susceptibility and severity factors, while the perceived benefits of taking action and the ability to overcome perceived barriers to action make up the benefit side. In applying this theoretical framework to a pregnancy prevention intervention, health belief model is based on the understanding that a person will take a health related action (i.e. use of family planning) if that person feels that a negative health condition (i.e. Unintended pregnancy) can be avoided. And has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e. using family planning will be effective at preventing Unintended pregnancy) and believes that he/she can successfully take a recommended health action (i.e. he/she can use family panning comfortably and with confidence).

2.6.4. Theory of Planned Behavior/ Reasoned Action

The theory of reasoned action (TRA) is developed by Adze and Fishbein in 1980. This theory was related to voluntary behavior. Later on behavior appeared not to be 100 percent voluntary and under control, this resulted in the addition of perceived behavioral control. With this addition the theory was called the theory of planned behavior (Ajzen, 1991). The theory of planned behavior is a theory which predicts deliberate behavior, because behavior can be deliberative and planned (Ajzan & Fishbein, 1980). Theory of reasoned action suggests that a person's behavior is determined by his/her intention to perform. Intention is the cognitive representation of a person's readiness to perform a given behavior, and it is considered to be the immediate antecedent of behavior. This intention is determined by three factors: their attitude towards the specific behavior, their subjective norms and their perceived behavioral control. For example, people's intention, perception, social pressure and belief are the factors affecting the contraceptive use. It is also associated with availability and accessibility of family planning information and services that can change knowledge, attitude and behavior of the people. As applied to an unintended pregnancy prevention intervention, factors from this theoretical framework that should be emphasized include attitudes (e.g., whether females view having a child early in life as a positive or negative event), perceived norms (e.g., what females believe their family and friends think they should do regarding delaying sexual activity and pursuing further education), and perceived personal control(e.g., whether females feel they have the negotiation skills to delay having sexual intercourse). Other factors to emphasize in educational, counseling, and media interventions include perception of consequences, perception of barriers to taking protective action, and perceived support from other people who matter to the females, such as his/her partner. Threat appraisal, in the form of personal vulnerability to pregnancy or

decision-making skills, should also be stressed in the intervention. Theory of reasoned action began to take hold in social science; however, this theory was not adequate and had several limitations (Godin & Kok, 1996). The limitations include; people who have little or feel they have little power over their behaviors and attitudes; factors such as personality and demographic variables are not taken into consideraytion; there is much ambiguity regarding how to define perceived behavioral control and this creates measurement problems; assumption is made that perceived behavioral control predicts actual behavioral control (Ajzan & Fishbein, 1980). This may not always be the case. Theory of planned behavior only works when some aspect of the behavior is not under volitional control. The longer the time interval between behavioral intent and behavior, the less likely the behavior will occur and lastly the theory is based on the assumption that human beings are rational and make systematic decisions based on available information. Unconscious motives are not considered. In general, according to this model, the more positive the attitude and the subjective norms are (towards cessation), and the greater the perceived control is, the stronger the individual's intention will be to prevent unintended pregnancy.

2.7. CONCEPTUAL FRAMEWORK



2.7.1. Narrative

The increase in the rates maternal mortality and morbidity due to unwanted pregnancy and induced abortion is associated with several factors. These factors have been identified in several studies and are described in the conceptual framework above. The factors can be categorized into two group's i.e. Demographic characteristics and determinants of unintended pregnancy

group's i.e. Demographic characteristics and determinants of unintended pregnancy

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter provides the details of the research methodology. It presents how the data were gathered alongside the methodological strategies employed in the sorting, categorization, and eventual analysis.

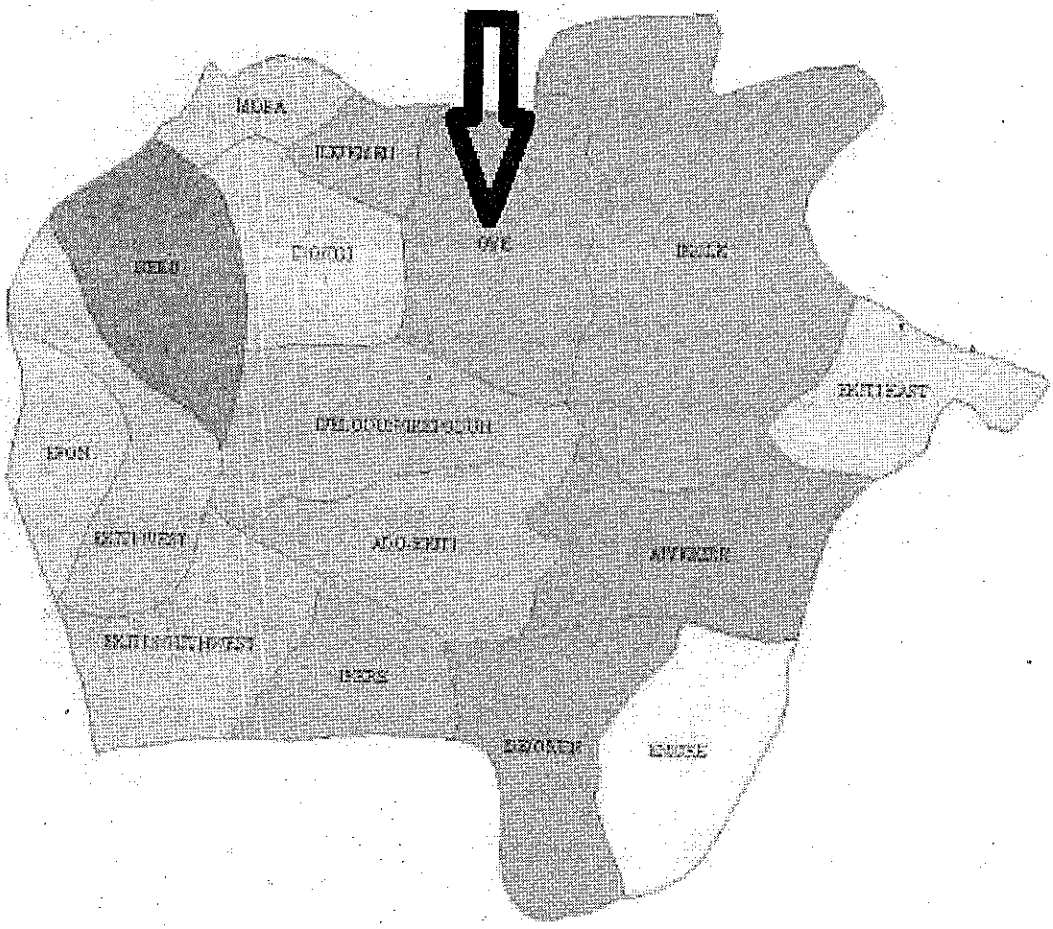
3.1 Research Design

The study is descriptive survey. The research was conducted among the women in Oye Local Government Area, Nigeria which comprised of Oye-Ekiti, Ilupeju Ekiti, Ayegbaju Ekiti, Itapa Ekiti, Osin Ekiti, and Ayede Ekiti. Three hundred (300) copies of a structured with open and close ended questionnaire were self-administered in all the villages.

3.2 Study location and positions

The study is Oye -Local Government Area in Ekiti State, Nigeria. The population of Oye Ekiti according to the 1952 national census was 13,696 (National Archive, Ibadan). 57,196 in 1963 and in 2006 the population was 168251(National population commission 2006). The origin of the Oye Ekiti which is also known as Obalatan land is associated with the founder of town ,Oloyemoyin who was born in Imore district of Ile ife (Owoyomi 1995)

The Oye-Local Government Area in Ekiti State, in South Western Nigeria. It comprises of the following towns and villages: Oye-Ekiti, Ilupeju Ekiti, Ayegbaju Ekiti, Ire Ekiti, Itapa Ekiti, Osin Ekiti, Ayede Ekiti, Itaji Ekiti, Imojo Ekiti, Isan Ekiti, Ilemoso Ekiti, Omu Ekiti, Ijelu Ekiti, Oloje Ekiti and a host of others. However, six (6) villages were selected. These were Oye-Ekiti, Ilupeju Ekiti, Ayegbaju Ekiti, Itapa Ekiti, Osin Ekiti, Ayede Ekiti .



The arrow in map indicate the study area in Ekiti State map

Figure 1: Map of Ekiti State, Nigeria Showing the study Area by Richard Akinyeye

3.3 Study Population

The target population for the study was women reproductive age (aged 15-49) in Oye-Local Government Area, Ekiti State Nigeria. Women within this age group are considered to participate particularly at a greater risk of unwanted pregnancy.

3.4 Sample Size and Sampling Procedure

3.4.1 Sample Size

The sample size was determined using the Leslie Fischer's formula for the calculation of sample size in populations greater than 10,000. The estimated proportion of target population from the reproductive age total population which is 26% or 0.26, this is firstly based on the projection from national population commission (26% or 0.26)

$$n = \frac{Z^2pq}{d^2}$$

Where n= minimum sample size

z= a constant at 95% confidence interval (1.96)

p= is the estimated proportion of target population from the total population which is 26% or 0.26

q= 1-p (1-0.26= 0.74)

d= desired precision at 5%; (0.05)

$$= \frac{(1.96)^2(0.26)(0.74)}{([0.05])^2}$$

$$= \frac{(3.8416)(0.26)(0.74)}{0.0025}$$

$$= \frac{0.73912384}{0.0025}$$

$$= 295.6495$$

Thus the calculated sample size is approximately 296 women. However, 300 questionnaires were administered

3.4.2 Sampling Procedures

Multistage random sampling method was used in selecting the study sample. Oye-Local Government Area has a total number of 15 villages and a host of others. Out of these local government areas, six (6) villages were randomly selected based on proximity. From each village, female reproductive aged between 15 to 49 years was used.

3.5 Data Collection Methods

Data was collected using semi structured questionnaire with open and closed questions. The questionnaire was translated in local language used by the majority of Oye-Local Government Area, Nigeria. While the questionnaire consist of socio-demographic characteristics of respondents and questions on sexual characteristics were unintended pregnancy and other factors determine unintended pregnancy and perceived consequences of unintended pregnancy among the respondents.

3.6 VARIABLES DESCRIPTION AND MEASUREMENT

The variables used for the study are classified into dependent and independent variables.

3.6.1 DEPENDENT VARIABLE; unintended pregnancy

VARIABLES	VARIABLES DEFINITION	MEASUREMENT
Unintended pregnancy	An unintended pregnancy is a pregnancy that is reported to have been either unwanted (that is, the pregnancy occurred when no children, or no more children, were desired) or mistimed (that is, the pregnancy occurred earlier than desired).	1. Wanted 2. Unwanted 3. undecided

3.6.2 INDEPENDENT VARIABLES;

Based on past studies, the following women's characteristics were selected as independent variables: age, wealth index, educational level, religion, place of residence, occupation, failure of use contraceptive methods , ethnicity, marital status , Current use of contraceptive.

VARIABLES	VARIABLES DEFINITION	MEASUREMENT
Women's age	Age of women of study in the population (15-49)	1. 15-19 2. 20-24 3. 25-29 4. 30-34 5. 35-39

		6. 40-44 7. 45-49
Residence of respondent	The area respondents live	1.Urban 2. Rural
Wealth index	The wealth index is a composite measure of a household's cumulative living standard.	1. Poor 2. Middle 3. Rich
Educational attainment	This is the level of education attained by the woman.	1.No formal education 2.Primary 4. Secondary 5. Post secondary
Occupation status	This is the occupation status of the woman	1. Employed 2. Self-employed 3. Retired 4. Unemployed 5. Others
Religion	The religion practiced by the respondent	1. Christianity 2. Islam 3. Traditional

		4. Others
Ethnicity	The ethnic of the respondent	1. Yoruba 2. Hausa/Fulani 3. Igbo
Failure to use Contraceptive	The use of contraceptive and respondent's intension	1. Strongly agree 2. Agree 3. undecided 4. Disagree 5. Strongly disagree
Current use of contraceptive	This is the current contraceptive use of any method by respondent	1.Strongly agree 2. Agree 3. undecided 4. Disagree 5. Strongly disagree

Marital status	The state of being married or not married by respondent	1.married 2.Single 3.widowed 4. Separated 5.Other

Source : Olaoluwa's 2018

3.6.3 Inclusive criteria

Women in reproductive age 15-49 in Oye local Government, Oye Ekiti, Ekiti State, Nigeria were allowed to participate in the survey.

3.6.4 Exclusive Criteria

Males in Oye Local Government regardless of the age were excluded from the survey.

3.7 Methods of Data Processing and Analysis

Data from the questionnaire was verified and cleaned up to minimize errors and missing values. Responses from questionnaire were coded and the codes were saved in the code book and used during the interpretation. Collected data were entered into the computer. To enhance accuracy, data cleaning which checked for the forgotten entries, consistency and outliers was done.

The data analysis was done using stata version 13.0. The frequencies of variables were generated and tabulations and percentages were used to illustrate study findings. Chi-square test was also employed to observe the association between the dependent variable and independent

variables. Chi-square was used because the dependent variables were dichotomized into ever had pregnancy or not and ever had an abortion or not.

3.7.1 Validity

The validity of an instrument is crucial in a study of this kind because it indicates the extent to which the research instrument measures what it claim to measure without any bias or distortion. To test the validity of the instrument, a copy of the questionnaire was submitted to the supervisor to examine whether the number and type of items in the questionnaire measured the concept or construct of interest (content validity).

3.8 Field Experience

Several limitation and constraint were encountered in the course of trying to generate correct and accurate data for this study. In the first instance, the study was conducted from seven villages which are Oye-Ekiti, Ilupeju Ekiti, Ayegbaju Ekiti, Itapa Ekiti, Osin Ekiti and Ayede Ekiti . It was discovered that most respondents from those communities could not actually read very well, this slowed down the pace of data collection as the researcher had to be reading out and explaining every item on the research instruments especially in Osin Ekiti and Itapa Ekiti. Another limitation is the problem of translating the questions which were written in English to local language of the respondents which is Yoruba language. But good care was taking to see that questions were well translated without losing their meanings. Also part of the limitation is the refusal of respondents to cooperate. The researcher had to employ the face to face method of questionnaire administration. This was time consuming and slowed the pace of data collection.

Although, the data collection is very hectic and stressful but somehow very interesting.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS, INTERPRETATION

4.0 Introduction

Data Presentation and Analysis of Results

This chapter focused on the presentation and discussion of the findings. The analysis was done in respect to the research questions. Simple percentages were used to present the univariate and bivariate results while the p-value was tested 0.05 level of significance using Pearson chi-square and multinomial logistic regression.

Research question 1: What is the level of unwanted pregnancy among the women in Oye Local Government Area, Nigeria?

Table 4.1.2 Distribution of the Study population by Unwanted Pregnancy and Selected Background Characteristics in the Study Area

VARIABLES	FREQUENCY	PERCENTAGE (%)
Current pregnancy		
Wanted	206	69.36
Unwanted	41	13.80
Undecided	50	16.84
Number of pregnancy		
1-4 times	228	76.00
5-7 times	54	18.00
8 above	18	6.00
Avoid of being pregnancy		
No	176	58.86
Yes	123	41.14
Why pregnancy		
failed method	51	41.80
Husband disagreed	35	28.69
stopped using the method	31	25.41
Others	5	4.10

Age of the respondents		
15-19	4	1.33
20-24	41	13.67
25-29	51	17.00
30-34	72	24.00
35-39	44	14.67
40-44	60	20.00
45-49	28	9.33
Level of education		
No formal Education	39	13.00
Primary	71	23.67
Secondary	114	38.00
Post secondary	70	23.33
Others	6	2.00
Marital status		
Married	232	77.33
Single	33	11.00
Widowed	25	8.33
Separated	6	2.00
Others	4	1.33
Religion		
Christianity	257	85.67
Islam	34	11.33
Traditional	9	3.00
Ethnic origin		
Yoruba	259	86.33
Hausa/Fulani	15	5.00
Igbo	24	8.00
Others	2	0.67
Employment status		
Employed	161	53.85
Self-employed	102	34.11
Retired	5	1.67
Unemployed	27	9.03
Others	4	1.34
Occupation		
Farming	119	40.48
Personnel manager	39	13.27
Civil servant	99	33.67
Vocational works	35	11.90
Others	2	0.68
Partner's Educational attainment		
No formal education	44	14.67
Primary	63	21.00
Secondary	71	23.67
	14	36.00

Post secondary Other		4.67
Partner religion Christianity Islam Traditional	 248 39 13	 82.67 13.00 4.33
partner's ethnic group Yoruba Hausa/Fulani Igbo Others	 261 12 26 1	 87.00 4.00 8.67 0.33
Place of residence Rural Urban	 209 91	 69.67 30.33

Source : Olaoluwa's 2018

4.1.2 Distribution of the Study population by Unwanted Pregnancy and Selected Background Characteristics in the Study Area

According to the respondent current pregnancy, most of the respondent's pregnancies are wanted 69.36%, 13.80% pregnancies are unwanted. Furthermore, in term of number of pregnancy the respondent have, majority of them have one to four times (76%), 5 to 7 times are 18% while eight above are 6%. Those that avoid of being are 41.14% while those that did not are 58.86%. Most of the respondents that avoid of been pregnant and still pregnant caused by failed method are 41.80%, husband disagreed by 28.69%, stopped using method by 25.41% while others causes by 4.10%.

According to the respondent age, 15-19 age group are 1.33%, 20-24 age group are 13.67%, 25-29 age group are 17%, 30-34 age group are 24%, 35-39 age group are 14.67%, 40-44 are 20% while 45-49 age group are 9.33%. Also, the result revealed that most of them have secondary

Certificates (38%), no formal education are 13%, primary educations are 23.67% and post secondary education is 23.33%. In the aspect of marital status, majority of the respondents are married 77.33%, also 11% are single, while separated are 2% and widowed are 8.33%. Apparently, majorities are Christian 85.67%, followed by Islam 11.33% and traditional are 3%. More so, majority of women in Oye local government are Yoruba (86.33%), followed by Igbo tribe (8%), Hausa/Fulani are 5% and other ethnic group are 0.67%. Most of the respondents are employed 53.85% while unemployed are 9.03%, 34.11% are self employed, 1.67% are retired and other are 1.34%. According to their occupation, 40.48% are farming, 33.67% are civil servant, and 13.27% are personnel manager while vocational works are 11.90%. Furthermore, the of partner educational attainment shows the percentage of Post secondary by 36.00% followed by Secondary by 23.67%, Primary 21.00%, No formal education by 14.67% and others with 4.67%. According to partner's religion, majorly Christian, 82.67%, followed by Islam 13.00%and traditional by 4.33% respectively. As for partner's ethnicity, Yoruba have the highest percentage of man by 87.00%, followed the Igbo by 8.67%, followed by the Hausa/Fulani with 4.00%, and then the others by 0.33%, for place of residence, rural Area by 69.67% while for the Urban area by30.33%.

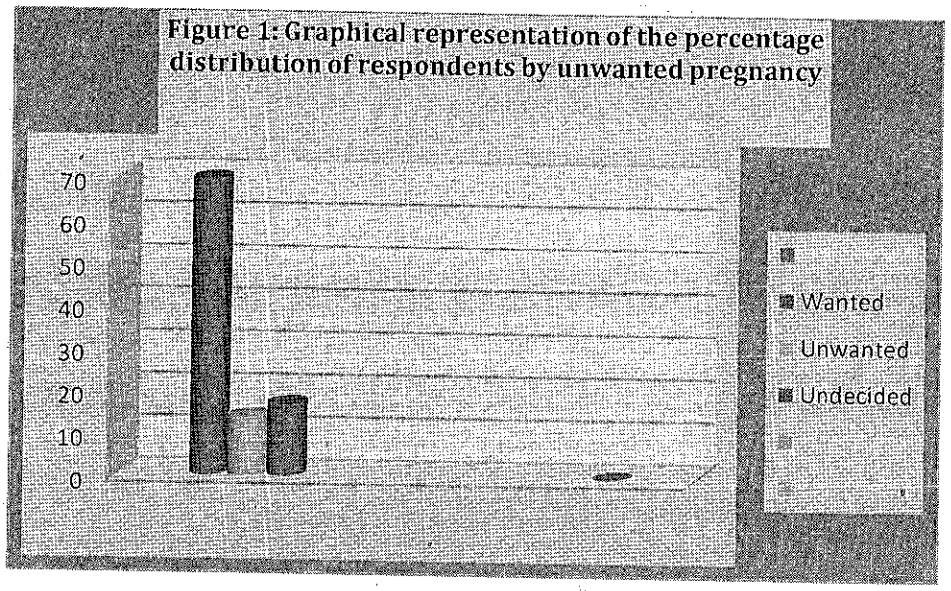


Figure 1: Graphical representation of the percentage distribution of respondents by unwanted pregnancy

Figure 1 is the graphical representation that depicts the percentage distribution of current pregnancy of women in Oye local government Area, Nigeria. From this representation, it can be noted that more pregnancy are wanted 69.36%, unwanted pregnancy are 13.80% while undecided are 16.84%.

Table 4.1.2 Distribution of the Study Population by Determinants of Unwanted Pregnancy in the Study Area

VARIABLES	FREQUENCY	PERCENTAGE (%)
Being in school		
strongly agree	27	9.00
agree	73	24.33
undecided	42	14.00
disagree	101	33.67
strongly disagree	57	19.00
Wealth status		
strongly agree	28	9.33
agree	79	26.33
undecided	39	13.00
disagree	97	32.33
strongly disagree	57	19.99
Failure to use contraceptive		
strongly agree	39	13.00
agree	79	26.33
undecided	41	13.67

disagree strongly disagree	80 61	26.67 20.33
Contraceptive use strongly agree agree undecided disagree strongly disagree	 40 58 47 84 71	 13.33 19.33 15.67 28.00 23.67

Source : Olaoluwa's 2018

4.1.2 Distribution of the Study Population by Determinants of Unwanted Pregnancy in the Study Area

The table 4.1.2 above showed that most of the respondents disagree that being in school does not responsible for unwanted pregnancy (33.67%), 19% strongly disagree, 14% undecided while 24.33% agree and 9% strongly agree. Many women disagree also in wealth status that it did not influence unwanted pregnancy 32.33%, followed by agree with 26.33%, undecided 13%, strongly disagree 19.99% while strongly agree are 9.33%. Furthermore, 13% strongly agree that failure to use contraceptive has impact on unwanted pregnancy, 26.33% agree, 13.67% undecided while 26.67% disagree and 20.33% strongly disagree. Finally, more women disagree that contraceptive use influence unwanted pregnancy 28%, strongly disagree 23.67%, undecided 15.67% while agree are 19.33% and strongly agree are 13.33%.

Table 4.1.3 Distribution of the Study Population by Perceives Consequences on Unwanted Pregnancy in the Study Area.

Research question 3: What is the perceive consequences of unwanted pregnancy among the women in Oye local Government Area, Nigeria?

VARIABLES	FREQUENCY	PERCENTAGE (%)
Unsafe abortion		
strongly agree	85	28.33
agree	127	42.33
undecided	17	5.67
disagree	33	11.00
strongly disagree	38	12.67
Low standard of living		
strongly agree	76	25.33
agree	136	45.33
undecided	26	8.67
disagree	36	12.00
strongly disagree	26	8.68
Lives of women and children		
strongly agree	74	24.67
agree	134	44.67
undecided	25	8.33
disagree	38	12.67
strongly disagree	29	9.67
Suicide		
strongly agree	58	19.33
agree	125	41.67
undecided	27	9.00
disagree	57	19.00
strongly disagree	33	11.00
Increases women stigma		
strongly agree	46	15.33
agree	129	43.00
undecided	50	16.67
disagree	48	16.00
strongly disagree	27	9.00

Reduces the couple's relationship and family cohesiveness		
strongly agree	58	19.33
agree	125	41.67
undecided	43	14.33
disagree	50	16.67
strongly disagree	24	8.00
High fertility		
strongly agree	45	15.00
agree	117	39.00
undecided	42	14.00
disagree	64	21.33
strongly disagree	32	10.67
Maternal mortality		
strongly agree	51	17.00
agree	109	36.33
undecided	54	18.00
disagree	56	18.67
strongly disagree	30	10.00

Source : Olaoluwa's 2018

4.1.2 Distribution of the Study Population by Perceives Consequences on Unwanted Pregnancy in the Study Area.

From the above table 4.1.3, more women agree that unwanted pregnancy leads to unsafe abortion 42.33%, 28.33% strongly agree, 5.67% undecided while 11% disagree and 12.67% strongly disagree. Also, more women agree that unwanted pregnancy leads to low standard of living 45.33%, 25.33% strongly agree, 8.67% undecided while 12% disagree and 8.68% strongly disagree. Also, from the table 44.67% agree that unwanted pregnancy affects the live of women and children, followed by strongly agree 19.33%, disagree 12.67%, undecided 8.33% and strongly disagree 9.67%. More women in Oye local government Area, Nigeria agree that

unwanted pregnancy leads to suicide 41.67%, 19.33% strongly agree, 9% undecided while 19% disagree and 11% strongly disagree. More so, from the table 43% agree that unwanted pregnancy increases women stigma, strongly agree are 15.33%, disagree 16%, undecided 16.67% and strongly disagree 9%. More women in Oye local government Area, Nigeria agree that unwanted pregnancy reduces the couple's relationship and family cohesiveness 41.67%, 19.33% strongly agree, 14.33% undecided while 16.67% disagree and 8% strongly disagree. In addition, 39% agree that unwanted pregnancy causes high fertility, strongly agree 15%, disagree 21.33%, undecided 14% and strongly disagree 10.67%. Finally, more women in Oye local government agree that unwanted pregnancy causes maternal mortality 36.33%, 17% strongly agree, 18% undecided while 18.67% disagree and 10% strongly disagree.

Figure 2: Graphical representation of the distribution of perceived consequences of unwanted pregnancy.

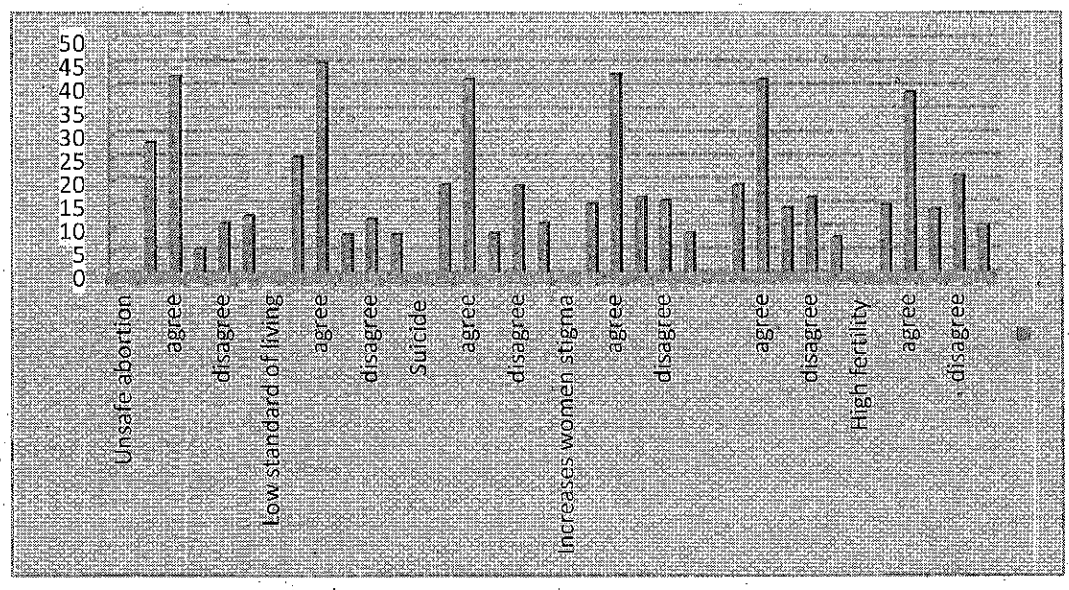


Figure 2 is the graphical representation that depicts the percentage distribution of perceived consequences. From this representation, it can be noted that agreed has the highest for all the perceived consequences such as unsafe abortion, low standard of living, suicide, increase women stigma, reduces couples relationship and high fertility.

4.2 Bivariate Analysis

This section presents the bivariate analysis of the relationship between determinants and unwanted pregnancy with the results of chi-square test of association.

Research question 2: What are the socio-demographic factors (age, marital status, education and location etc.) associated with unwanted pregnancy among women in Oye Local Government Area, Nigeria?

Table 4.2.: Distribution of Respondents by Determinants, Socio-Demographic Characteristics and Unwanted Pregnancy.

Background Characteristics	UNINTENDED PREGNANCY			Statistics
	WANTEDX	UNWANTED	UNDECIDED	
Age				
15-19	4(100)	0(0)	0(0)	
20-24	29 (70.73)	6(14.63)	6(14.63)	
25-29	33(66.00)	9(18.00)	8(16.00)	X^2= 10.8826
30-34	54(76.06)	7(9.86)	10(14.08)	p-value=
35-39	26(59.09)	9(20.45)	9(20.45)	0.539
40-44	37(13.56)	8(13.56)	14(23.730)	
45-49	23(82.14)	2(7.14)	3(10.71)	
Level of education				
No formal Education	21(55.26)	8(23.68)	9(23.68)	

Primary	49(71.01)	11(15.94)	9(15.94)	X^2= 7.9386
Secondary	77(67.54)	15(13.16)	22(19.30)	p-value=0.439
Post secondary	54(77.14)	7(10.00)	9(12.86)	
others	5(83.33)	0(0)	1(16.67)	
Marital status				
Married	169(72.84)	31(13.36)	32(13.79)	
Single	18(54.55)	7(21.21)	8(24.24)	X^2= 26.1848
Widowed	16(72.73)	0(0.00)	6(27.27)	p-value=0.001
Separated	2(33.33)	3(50.00)	1(16.67)	
Others	1(25.00)	0(0.00)	3(75.00)	
Religion				
Christianity	188(73.44)	26(10.16)	42(16.41)	X^2= 27.0231
Islam	15(44.12)	11(32.35)	8(23.53)	p-value=
Traditional	3(42.86)	4(57.14)	0(0.00)	0.000
Ethnic origin				
Yoruba	190(74.22)	32(12.52)	34(13.28)	X^2=25.1215
Hausa/Fulani	4(26.67)	4(26.67)	7(46.67)	p-value=
Igbo	11(45.83)	5(20.38)	8(33.33)	0.000
Others	1(50.00)	0(0.00)	1(50.00)	
Employment status				
Employed	124(77.02)	10(6.12)	27(16.77)	X^2=27.6343
Self-employed	57(57.58)	26(26.26)	16(16.16)	p-value=
Retired	5(100.00)	0(0.00)	0(0.00)	0.001
Unemployed	15(55.56)	5(18.52)	7(25.93)	
Others	4(100.00)	0(0.00)	0(0.00)	
Occupation				

Farming	72(62.07)	23(19.83)	21(18.10)	
Personnel manager	25(64.10)	8(15.38)	6(15.38)	X^2=28.7517
Civil servant	83(83.84)	4(4.04)	12(12.12)	p-value=
Vocational works	20(57.14)	6(18.14)	9(25.71)	0.000
Others	0(0.00)	0(0.00)	2(100.00)	
Partner's Educational attainment				
No formal education	24(55.81)	7(16.28)	12(27.91)	
Primary	43(70.49)	12(19.67)	6(9.84)	X^2=14.7019
Secondary	54(76.06)	10(14.08)	7(9.86)	p-value=
Post secondary	73(67.59)	12(11.11)	23(21.30)	0.065
Others	206(69.36)	41(13.80)	50(16.84)	
Partner religion				
Christianity	184(74.49)	24(9.72)	39(15.79)	
Islam	18(46.15)	11(28.21)	10(25.64)	X^2=30.1166
Traditional	4(36.36)	6(54.55)	1(9.09)	p-value=0.000
Partner's ethnic group				
Yoruba	190(73.64)	32(12.40)	36(13.95)	
Hausa/Fulani	4(33.33)	4(33.33)	4(33.33)	
Igbo	11(42.31)	5(19.23)	10(38.46)	X^2= 20.7858
Others	1(100.00)	0(0.00)	0(0.00)	p-value=0.002
Place of residence				X^2=10.3056
Rural	132(64.08)	36(17.48)	38(18.48)	p-value=0.006
Urban	74(81.32)	5(5.49)	12(13.19)	
Being in school				
strongly agree	19(70.37)	4(14.81)	4(14.18)	
agree	45(62.50)	11(15.28)	16(22.22)	
undecided	25(65.50)	4(10.00)	11(27.50)	X^2= 10.0710
disagree	71(70.30)	15(14.85)	15(14.85)	p-

strongly disagree	46(80.70)	7(12.28)	4(7.02)	value==0.260
Wealth status				
strongly agree	11(39.29)	9(32.14)	8(28.57)	
agree	50(64.10)	12(15.38)	16(20.51)	
undecided	21(56.76)	7(18.92)	9(24.32)	
disagree	74(56.76)	7(18.92)	9(24.32)	X^2=28.2172
strongly disagree	50(87.72)	2(3.51)	5(8.77)	p-value=0.000
Failure to use contraceptive				
strongly agree	23(58.97)	8(20.51)	8(20.51)	
agree	42(55.26)	14(18.42)	20(62.32)	
undecided	26(63.41)	7(17.07)	8(19.51)	X^2= 20.5458
disagree	64(80.00)	8(10.00)	8(10.00)	p-value= 0.008
strongly disagree	51(83.61)	4(6.56)	6(9.84)	
Contraceptive use				
strongly agree	32(57.50)	8(20.00)	9(22.50)	X^2= 19.8843
agree	32(56.14)	11(19.30)	57(24.57)	p-value= 0.011
undecided	26(57.78)	9(20.00)	10(22.22)	
disagree	69(82.14)	7(8.33)	8(9.52)	
strongly disagree	56(78.87)	6(8.45)	9(12.68)	

Source : Olaoluwa's 2018

4.2.: Distribution of Respondents by Determinants, Socio-Demographic Characteristics and Unwanted Pregnancy.

Result from table 4.2 above revealed that there is significant association between socio-demographic characteristics and unwanted pregnancy among women (P<0.05). There is no

association between age and unwanted pregnancy (X^2 =10.8826, P =0.539) whereby women age 40-44 years reported not to want the current pregnancy by 13.56%, age 35-39 years by 20.45%, age 45-49 years by 7.14%, age 20-24 years by 14.63% and age 25-29 years by 18% compare to those women that wanted and undecided the current pregnancy.

There is no significant association between level of education and unwanted pregnancy (X^2 =7.9386, P =0.439) whereby women with secondary educational attainment reported not to want the current pregnancy by 13.16%, primary by 15.94%, post secondary education by 10% and women with no formal education by 23.68 % compare to those women that wanted and undecided the current pregnancy. There is strong significant association between religion and unwanted pregnancy (X^2 =27.0231 , P =0.000) whereby Christian women reported the current pregnancy unwanted by 10.16% and Muslim women by 32.35%, traditional 57.14% compare to those women that wanted and undecided the current pregnancy. There is strong significant association between ethnic origin and unwanted pregnancy (X^2 =25.1215 , P =0.000) whereby Yoruba women reported the current pregnancy unwanted by 12.52% and Hausa/Fulani women by 26.67%, Igbo 20.38% compare to those women that wanted and undecided the current pregnancy. There is significant association between women employment status and unwanted pregnancy (X^2 =27.6343, P =0.001) whereby women with employed reported not to want the current pregnancy by 6.12%, self-employed by 15.94%, retired no unwanted pregnancy and women with unemployed by 18.52 % compare to those women that wanted and undecided the current pregnancy. Furthermore, There is strong significant association between women occupation and unwanted pregnancy (X^2 =28.7517 , P =0.000) whereby women with farming reported not to want the current pregnancy by 19.83%, personnel manager by 15.94%, civil servant 4.04% and women with vocational work by 18.14 % compare to those women that

wanted and undecided the current pregnancy. There is no significant association between partner educational attainment and unwanted pregnancy (X^2 =14.7019 , P =0.065) whereby women with partner secondary educational attainment reported not to want the current pregnancy by 14.08%, primary by 19.67%, post secondary education by 11.11% and women with no formal education by 16.28% compare to those women that wanted and undecided the current pregnancy.

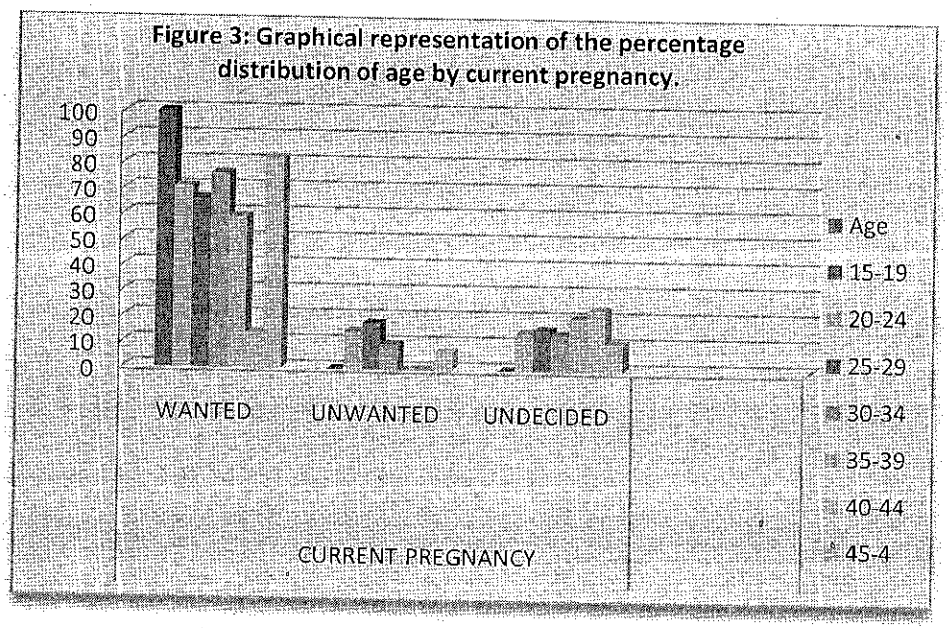
There is strong significant association between partner religion and unwanted pregnancy (X^2 =30.1166, P =0.000) whereby Christian women partner reported the current pregnancy unwanted by 9.72% and muslim women by 28.21%, traditional 54.55% compare to those women that wanted and undecided the current pregnancy.

Also, there is significant association between marital status and unwanted pregnancy (X^2 =26.1848, P =0.001) whereby married women reported the current pregnancy unwanted by 13.36%, widowed no unwanted pregnancy, separated 50% and single women by 21.21% compare to those women that wanted and undecided the current pregnancy.

There is significant association between partner ethnic origin and unwanted pregnancy (X^2 =20.7858, P =0.002) whereby Yoruba women partner reported the current pregnancy unwanted by 12.40% and Hausa/Fulani women by 33.33%, Igbo 19.23% compare to those women that wanted and undecided their current pregnancy. There is significant association between place of residence and unwanted pregnancy (X^2 =10.3056, P =0.006) whereby rural women reported the current pregnancy unwanted by 17.48% and urban women compare to those women that wanted and undecided their current pregnancy.

There is no significant association between being in school and unwanted pregnancy (X^2 =10.0710, P =0.260) whereby women that strongly agree reported not to want the current

pregnancy by 14.81%, agree by 15.28%, undecided by 10%, disagree 14.85% and women that strongly disagree by 16.28% compare to those women that wanted and undecided the current pregnancy. There is strong significant association between wealth status and unwanted pregnancy (X^2 =28.2172, P =0.000) whereby women that strongly agree reported not to want the current pregnancy by 32.14%, agree by 15.38%, undecided by 18.92%, disagree 18.92% and women that strongly disagree by 3.51% compare to those women that wanted and undecided the current pregnancy. There is significant association between failure to use contraceptive and unwanted pregnancy (X^2 =20.5458 , P =0.000) whereby women that strongly agree reported not to want the current pregnancy by 20.51%, agree by 18.42%, undecided by 17.07%, disagree 10% and women that strongly disagree by 6.56% compare to those women that wanted and undecided the current pregnancy. There is significant association between contraceptive use and unwanted pregnancy (X^2 =19.8843, P =0.011) whereby women that strongly agree reported not to want the current pregnancy by 20%, agree by 19.30%, undecided by 20%, disagree 8.33% and women that strongly disagree by 8.46% compare to those women that wanted and undecided the current pregnancy.



4.3 Multivariate analysis

The multivariate analysis using multinomial logistic regression was done to show the strength and the direction of the relationship between determinants and unwanted pregnancy among the women in Oye local government Area, Nigeria. The results are presented in RRR, associated p-values and confidence interval.

Table 4.3.1: Multinomial Logistic Regression Analysis of Socio-Demographic Characteristics and Unwanted Pregnancy.

Background Characteristics	Model 1(wanted)		Model 2 (Unwanted)	
	RRR	(Lower-Upper confidence interval)	RRR	(Lower-Upper .confidence interval)

Base Outcome	Undecided		Undecided	
Marital status				
Married	1		1	
Single	0.47	(0.14-1.58)	0.49	(0.10-2.33)
Widowed	o.59	(0.15-2.38)	3040	(0.10-2.32)
Separated	0.13	(0.12-4.78)	2.01	(0.90-44.85)
Others	0.39*	(0.00-0.99)	1630	(0.0-1.0)
Religion				
Christianity	1		1	
Islam	1.82	(0.38-8.59)	5.82	(0.77-43.8)
Traditional	40.7	(0.0-1.00)	537338	(0.0-1.0)
Ethnic group				
Yoruba	1		1	
Hausa/Fulani	0.35	(0.43-2.78)	0.39	0.39
Igbo	1.34	(0.17-10.32)	0.41	0.41
Others	0.27	(0.01-9.70)	4140	4140
Employment status				
Employed	1		1	
Self-employed	0.99	(0.34-2.85)	2.98	(0.69-12.94)
Retired	3465066	(0.0-1.0)	0.58	(0.0-1.0)
Unemployed	0.38	(0.99-1.44)	1.71	(0.27-10.91)
Others	24.1	(0.0-1.0)	0.90	(0.0-1.0)
Occupation				
Farming	1		1	
Personnel manager	1.51	(0.36-6.34)	1.02	(0.17-6.06)
Civil servant	1.55	(0.53-4.57)	0.46	(0.08-2.48)
Vocational works	0.56	(0.18-1.74)	0.59	(0.12-3.01)

Others	1480	(0.0-1.0)	4740	(0.0-1.0)
Religion				
Christianity	1		1	
Islam	0.25	0.25	1.22	(0.14-10.86)
Traditional	0.21	0.21	7.61	(0.33-178.05)
Partner Ethnic group				
Yoruba	1		1	
Hausa/Fulani	0.83	(0.69-9.94)	0.53	(0.03-8.30)
Igbo	0.14*	(0.21-0.99)	1.25	(0.11-13.98)
Others	6471324	(0.0-1.0)	1.34	(0.0-1.0)
Place of residence				
Rural	1		1	
Urban	1.19	(0.40-3.55)	0.61	(0.11-3.48)
Being in school				
strongly agree	1		1	
agree	0.93	(0.18-4.86)	1.35	(0.14-13.07)
undecided	0.93	(0.16-5.42)	0.42	(0.03-5.78)
disagree	1.57	(0.26-9.33)	1.79	(0.16-19.70)
strongly disagree	4.80	(0.54-42.62)	27.56	(1.50-504.96)
Wealth status				
strongly agree	1		1	
agree	4.66	(0.93-23.21)	0.43	(0.07-2.63)
undecided	2.47	(0.421-14.51)	1.70	(0.24-12.08)
disagree	2.85	(0.52-15.52)	0.51	(0.07-3.59)

Strongly disagree	4.48	(0.67-29.32)	0.25	(0.17-3.72)
Failure to use contraceptive				
strongly agree	1		1	
agree	0.21	(0.04-1.05)	0.27	(0.04-1.94)
undecided	0.36	(0.06-2.25)	0.50	(0.05-5.25)
disagree	1.04	(0.17-6.32)	0.10	(0.094-10.66)
strongly disagree	0.76	(0.13-4.48)	0.25	(0.02-3.13)
Contraceptive use				
strongly agree	1		1	
agree	1.66	(0.40-6.81)	1.93	(0.32-11.78)
undecided	2.28	(0.48-10.73)	2.29	(0.38-14.65)
disagree	1.94	(0.43-8.72)	0.73	(0.98-5.39)
strongly disagree	1.31	(0.30-5.66)	0.32	(0.04-2.47)

RC means the reference categories *P<0.05 **p<0.01 ***p<0.001

Source : Olaoluwa's 2018

4.3: Multinomial Logistic Regression Analysis of Socio-Demographic Characteristics and Unwanted Pregnancy.

Table 4.3 above showed the result of multinomial logistic regression of the effect of socio-demographic characteristics on unwanted pregnancy among women in Oye local government area, Nigeria. Result from Model 1, showed that; taking married women as the reference category (RC) there is significant relationship between others marital status and wanted pregnancy at 39% less likely to want the current pregnancy (OR=0.39, p<0.05). Also, on partner ethnic group, there is significant relationship between Igbo and wanted pregnancy at 0.14 times less likely to want the current pregnancy (OR=0.14, p<0.05).

4.4 Discussion of the finding

The study highlights that there was low level of unwanted pregnancy in the study area which was not in accordance with 1997 survey of women in south west Nigeria. This occurs as a result of high concentration of contraceptive use, level of education, place of residence and employment status.

Furthermore, marital status , religion , ethnic origin, employment status, occupation , partner religion , partner's ethnic group , place of residence, wealth status , failure to use contraceptive , contraceptive use were useful predictor of unwanted pregnancy in oye local Government Area. Also the major perceived consequences in the study areas are unsafe abortion ,low standard of living ,lives of women and children .

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

This chapter is the final part of this study; it provides a summary of the finding and proffers recommendation for subsequent researches.

5.1 Summary of the findings

The main aim of the study was to examine the determinant and perceived consequences of unwanted pregnancy among woman in Oye local Government Area of Ekiti State, Nigeria. The study area constituted women reproductive age (aged 15-49) in Oye-Local Government Area, Ekitil State, Nigeria.

The study revealed that 13.80% women had unwanted pregnancy which caused by failed method, husband disagree to use any method and stopped using the methods. Also, 41.14 percent of the women tried to avoid pregnancy. Out of women current pregnancy, 69.36 per cent are wanted. Majority of women in Oye local government have had one to four pregnancies, whereby they classified their first pregnancy as unwanted which caused by premarital sex. Women within this age group 35-39 are considered to have high unwanted pregnancy compare to other age group. Also, the study revealed that unwanted pregnancy resulted to unsafe abortion, causes low standard of living, affects the live of women and children, suicide, increase women stigma, reduces the couple's relationship and family cohesiveness, cause high fertility and increase maternal mortality. During the interviewed, some respondents say unwanted pregnancy also has its own positive consequences such as help couples to deliver their children within a limited time and also mention the positive effects of high fertility.

Univariate analysis in this study was carried out using tables of frequency and percentage distribution to describe the background and unwanted pregnancy characteristics, determinants and perceive consequences of unwanted pregnancy of the respondents.

Bivariate analysis was done using the chi-square table (χ^2) and cross tabulation to analyze the relationship between determinants and socio-demographic factors of respondents and the dependent variable (unwanted pregnancy). The bivarate analysis shows that there is relationship between marital status, religion, ethnic group, employment status, occupation, place of residence, failure to use contraceptive, contraceptive use, wealth status, being in school, partner's ethnic group and partner's religion.

Furthermore, multinomial logistic regression model was used for the multivariate analysis to analyze the effect of each determinant on the dependent variable.

Furthermore, the multivariate result revealed that the number of living children was significantly related with unintended pregnancy. While, age, wealth index, religion, knowledge of any contraceptive method, and educational level were to some extent significantly related with unwanted pregnancy

5.2 Conclusion

This study focused on finding the determinate and the perceived consequences of unwanted pregnancy among women in Oye Local Government Area, Nigeria. Results reveal that 13.80% of pregnancies are unwanted, which is a challenging issue. Economic condition of the family, educational status of women, numbers of previous births and place of residence were found to be significant associated with the unintended pregnancy.

Conclusively, many factors contributed to the unwanted pregnancy. It may therefore be effective to focus family planning campaigns more intensively. Overall, there is low knowledge on

contraceptive use and most of them did not intend to use any method as a result of side effect. This can be done by focusing on information and educations on contraceptive use and provide family planning services. Unwanted pregnancy is clearly a public health issue, a gender issue, and a population issue; effectively addressing such a problem will result in multidimensional improvements for Nigeria.

5.3 RECOMMENDATIONS

Based on the findings from the study, I would recommend that

1. Different partners in partnership with the Government to address the issue of unemployment among women, to improve their economic status, hence for them to be able to take care of themselves as well as their children.
2. To conduct a qualitative study in the community especially rural settings in other to have an in depth discussion with regard to unwanted pregnancies and in order to compliment the findings from this study.
3. Government should address the issue of early marriage by investing in proper education and women empowerment
4. Health care providers should provide information, education; communication programs and improvements in counseling are needed to have knowledge on unwanted pregnancy.
5. Government should make sure that contraception is widely available to the women in Oye local government.
6. Family planning should integrate themselves with other health sector to promote contraceptive use and make it available for the women.

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APPENDIX

QUESTIONNAIRE

DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS FEDERAL UNIVERSITY OYE EKITI, EKITI STATE, NIGERIA.

DETERMINANTS AND PERCEIVED CONSEQUENCES OF UNWANTED PREGNANCY AMONG THE WOMEN IN OYE LOCAL GOVERNMENT.

TO WHOM IT MAY CONCERN

Dear Madam,

This is a student's research project for the sole purpose of studying the above-mentioned topic. This exercise is purely for academic purpose and for the award of a degree. This also has nothing to do with you as a person and as such, information given by you will be treated confidentially.

Kindly provide sincere responses to these questions as much as you can. Your co-operation is highly needed.

Consent: Yes ☐ No ☐

Serial Number: .....

Date of interview: ....Day .....Month .....Year;

Area of interview: .....

Interview Outcome: Completed ☐ ot Completed ☐ Refused ☐

SECTION A

This section provides questions relating to the background characteristics of respondents. Please provide answers or tick(√) the most appropriate option as applicable to you.

1. Age at last birthday .....
2. Level of education: (1) none ☐ (2) primary ☐ (3) secondary ☐ (4) post secondary ☐ (5) Others (specify) _____
3. Marital status: (1) Married ☐ (2) single ☐ (3) widowed ☐ (4) separated (5) others specify.....
4. What is your religion: (1) Christianity ☐ (2) Islam ☐ (3) Traditional ☐ (5) others (please specify).....
5. Your ethnic origin: (1)Yoruba ☐ 2) Hausa ☐ (3)Igbo ☐ (4)Others (please specify).....
6. What is your employment status? (1) Employed ☐ (2) Self-employed ☐ (3) Retired (4) Unemployed ☐ (5) Others specify.....
7. If **Q6** is employed, what is your occupation? .....
8. What is your spouse's / partner level of educational attainment? (1) None ☐ (2)primary ☐ (3)secondary ☐ (4) post secondary ☐) others specify _____
9. What is your spouse/partner religion? (1) Christianity ☐ (2) Islam ☐ (3) traditional ☐ (4) other specify _____
10. What is your partner's ethnic group? (1) Yes ☐ 2) No ☐
11. What is your place of residence? (1) rural ☐) urban ☐

SECTION B

This section provides questions relating to the unwanted pregnancy. Please provide answers or tick(√) the most appropriate option as applicable to your parents.

1. How many times have you been pregnant? _____
2. Would you refer to any of your pregnancy as unwanted? (a) Yes ☐ No ☐
3. If your answer to above question is yes, one(s) _____ which one? (a) First ☐ (b) Second ☐ (c) Third ☐ d) Fourth ☐) If others state _____
4. Did you use any attempt to prevent pregnancy during the time proceeding the pregnancy? (a) No ☐ b) Yes ☐
5. If yes.....? Why did you still become pregnant.....
6. How would you classify your current pregnancy (1) wanted ☐ (2) Unwanted ☐ (3)Undecided ☐
7. Please can you tell me when you had your last pregnancy month..... Year...
8. Did you use any method to avoid being pregnant? (1) No ☐ Yes ☐
9. If yes...? Why did you still become pregnant (1) Failed method ☐ (2) Husband disagreed ☐ (3) I stopped using the method ☐ (4) other please specify.....

SECTION C

This section provides questions relating to the determinants of unwanted pregnancy. Please provide answers or tick(√) the most appropriate option as applicable to your parents.

SA= strongly agree A= Agree U= undecided D= Disagree SD= strongly disagree

S/N	ITEMS	SA (1)	A (2)	U (3)	D (4)	SD (5)
1	I had unintended pregnancy because of age factors					
2	Educational attainment has effects on my unwanted pregnancy					
3	Being in school incorporate to my unwanted pregnancy					
4	Because of the occupation I had mistimed pregnant					
5	Place of residence has impact on my last unplanned pregnancy					
6	Some of my pregnant are not wanted as a results of wealth status					
7	Wealth index determine my pregnancy					
8	My religion slightly determine my mistimed pregnancy					
9	I had unwanted pregnancy based on failure to use contraceptives					
10	Contraceptive use contributed to my unplanned pregnancy					
11	I am a victim of unwanted pregnancy due to the low standard of living					
12	My ethnic group allow me to have unwanted pregnancy					
13	The society am livings influences me to have mistimed pregnancy					
14	I got unplanned pregnancy due to marital status					

SECTION D

This section provides questions on consequences of unwanted pregnancy. Please provide answers or tick(√) the most appropriate option as applicable to your parents.

SA= strongly agree A= Agree U= undecided D= Disagree SD= strongly disagree

S/N	ITEMS	SA (1)	A (2)	U (3)	D (4)	SD (5)
1	Unwanted pregnancy leads to unsafe abortion					
2	Unwanted pregnancy leads low standard of living					
3	Unwanted pregnancy leads Affects the lives of women and children					
4	Unwanted pregnancy leads Suicide					
5	Unwanted pregnancy leads increases women stigma					
6	Unwanted pregnancy leads Reduces the couple's relationship and family cohesiveness					
7	Unwanted pregnancy leads High fertility					
8	Unwanted pregnancy leads Maternal mortality					