PREVALENCE AND DETERMINANTS OF ABORTION AMONG ADOLESCENTS IN OYE EKITI, NIGERIA.

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A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS, FACULTY OF SOCIAL SCIENCES, FEDERAL UNIVERSITY, OYE-EKITI, NIGERIA

IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF BACHELOR OF SCIENCE (B.Sc) HONS IN DEMOGRAPHY AND SOCIAL STATISTICS

DECEMBER, 2018

CERTIFICATION

This is to certify that OYEDELE MOTUNRAYO ELIZABETH of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic PREVALENCE AND DETERMINANTS OF ABORTION AMONG ADOLESCENTS IN OYE EKITI, NIGERIA in partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision

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EXTERNAL EXAMINER **DATE**

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DEDICATION

The project is dedicated to most high, the supremacy God who has never for once left me to my own during the course of my study in this institution, May his name alone be exalted.

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the help of my maker, I want to acknowledge the most Supreme Being, God Almighty for His grace, love and mercies throughout my stay in Federal University Oye Ekiti, Ekiti State. Special thanks to my counsellor, my director, my guardian in person of Holy Spirit without you in my life, this work would have been a mirage.

I deeply acknowledge the unremitting guidance and assistance proffered to me by my hardworking and affable supervisors, Dr.Odusina E.K and Dr Shittu S.B whose inspiration moulded a dream from its formative stage to this actuality I pray that the Lord Almighty will never forget your labour of love. My appreciation also goes to my powerful HOD, Dr. Mrs. L.F.C Ntoimo, God bless you ma, you are what a responsible daughter could ever ask for as a mother. Also Mr Babalola and Mr Soji who have groomed, nourished and refined my mental ability over the years and also the non-academic staff members, God bless you sirs.

I specially show deep appreciation to the best parents in the world, Mr and prophetess Oyedele, Thanks for believing in me and for your support, prayers, love and care in all aspects. You will eat the fruit of your labour in Jesus Name. God will continue to bless you. My gratitude also goes to my siblings; Ayomide, Ayowole, Mayowa and Diekolope, thanks for believing in me. I also want to appreciate Clement Oyinkansola who has been with me through thick and thin, thanks for staying with me all through, God bless you for me my light.

Special thanks to my loving friends Adenike, Tayelolu, Demilade, thank you for your prayers, encouragements and supports May the Lord bless you real good.

I also appreciate Pemisire, kike, Funmi, Tosin, Bimmy, Toyin, Tola, for their friendly support at all times, God bless you big times, Amen.

I am also very grateful to Bishop Ola Mike, for standing by me, for his support and encouragement, May the Lord prosper your ways. I also want to appreciate Pa Emiola for his fatherly advice at all times, you will see the children of your children sir, God bless you for me. I also appreciate the members of my fellowship Christ Apostolic church, thanks for the privilege given to me to serve in various capacities. My appreciation also goes to my precious and hardworking friend and brothers, Ridwan Shittu, and Olabode paul thanks for your love and encouragement, this research would not have been possible without you, God bless you sir. Finally, I appreciate all Demography and Social Statistics students for giving me the opportunity to serve as the vice president of the association, God bless you all.

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LIST OF ACRONYMS

AHI	Action Health Incorporated
AIDS	Acquired Immune Deficiency Syndrome
CDCC	Communicable Disease Control Centre
GHC	Global Health Council
HDI	Human Development Index
HIV	Human Immuno deficiency Virus
ICPD	International Conference On Population And Development
MDG	Millennium Development Goals
NDHS	Nigeria Demographic And Health Survey
NGO	Non-Governmental Organization
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
UN	United Nation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

ABSTRACT

The study examined prevalence and determinant of adolescence practice of abortion in Oye Ekiti, Nigeria using self-administered questionnaire. Two hundred and twenty-two adolescence were interviewed and analysed in the course of the study. Data were analysed at uni-variate level using simple frequency distribution table and the result showed that larger portion of the respondents had formal education 83.3% and had also indulged in abortion at least once 89.6%. The bi-variate analyses showed that there is no significant relationship between the following socio-demographic factors (age, level of education, employment status, fathers level of Education, mothers level of Education, living with parent) and abortion. Results from the multivariate analysis revealed that, respondents who were Muslims are 0.42 times less likely to experience adolescent abortion compared to Christian adolescents (0R 0.42, $P<0.05$). In conclusion, the prevalence of sexual intercourse and the rate at which abortion is being practiced should be looked into. I recommend that the use of condom should be taken seriously for those that are sexually active from tender age to prevent them from having unwanted pregnancy.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 INTRODUCTION

This chapter is introductory background to the research. It provides the background to present study, the research problem that necessitated the work, the aims and objectives, the methodology and to the expected contributions to knowledge among other things.

1.1 BACKGROUND TO THE STUDY

Abortion is the termination of a pregnancy associated with the death and expulsion of a fetus from a uterus before it reaches the stage of viability. An abortion may occur spontaneously in normal parlance and it is called a miscarriage. It may also be done on purpose in which it is often called an induced abortion. The issue of abortion has attracted substantial attention in recent times in Nigeria and everywhere in the world; abortion has therefore become a global issue (Alimson, 2001). The major concern in most of the discussions on abortion and related situation draws heavily from the fact that abortion constitutes severe danger to a woman's health, but at the same time when performed by medical specialist (i.e. abortion specialists) abortions are safe for the woman, and relatively simple. Religious institutions are against the abortion process as they believe that abortion is a process of committing murder and murderer are seen as sinners (Knight, 2003). Why the society frowns at it is because of the inherent fact that if the phenomenon is not regulated it would impact negatively on the population growth and also on the welfare of women (Barreto, 1992).

Abortion is therefore forbidden in many societies especially the traditional ones. The "abrupt removal" or premature termination of babies are said to be as a result of certain factors. Most societies therefore recognize the importance of medical factors in pregnancy termination. According to the Oxford medical Dictionary, induced abortion can be performed for reasons that fall into four general categories.

i. To preserve the life of physical or mental well-being of the mother.

ii. To prevent the completion of a pregnancy that has resulted from rape or incest.

iii. To prevent the birth of a child with serious deformity or genetic abnormality.

iv. To prevent a birth because of the age of a woman, therefore, a girl whose body has not formed properly for child birth, or a woman who has passed her child bearing age, as it could be dangerous for the two.

Abortions that are performed to preserve the well-being of the female or in case of rape or incest are therapeutic or justifiable abortions. Induced abortion is accepted in some countries but in other countries it is highly forbidden. However, other factors (economic, social, educational, and family size) have equally become prominent in respect to abortion or pregnancy termination. Both male and female students are supposed to be sexually responsible since a lot of students in today's society are already sexually active, but females always carry the bulk of the responsibility as they are the ones who would be greatly affected by the mistake (Alimson, 2001). For instance, a female student who forget to take necessary pregnancy precautions and therefore gets pregnant may resort to an abortion for the following reasons;

i. to complete her education,

ii. to avoid becoming a mother prematurely, as well as the responsibility attached to it,

iii. to avoid being negatively labelled by the society has been "loose" and;

iv. fear of having a child out of wedlock. (Almison, 2001:)

1.2 STATEMENT OF THE PROBLEM

If an investigation or a study is carried out on the category of people that indulge in abortion, the result will definitely prove that it is adolescents and youths. The minority will be older people (especially those who have passed the age of child bearing.) Several causes have been identified as inducing abortion other than medical. The phenomenon in most countries is frowned at it. In Nigeria for example the abortion Act of 1967 as amended In 1982 states the following reasons for permitting abortion.

1. If the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy was terminated, the pregnancy should be terminated.

2. If the termination is necessary to prevent grave permanent impurity to the physical or mental health of the pregnant woman, it should be terminated.

3. If the pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk greater than if the pregnancy were terminated of injury to the physical of mental health of the existing children of the family of the pregnant woman, it should be terminated.

4. If there is substantial risk that if the child were born it would suffer from much physical or mental abnormality as to be serious by handicapped, the pregnancy should be terminated (George, 2004:)

The act therefore permits under certain conditions the abortion of a pregnancy. Mindful of the social stigma of having unwanted pregnancies, many young girls who become pregnant seek abortion as the only way to end unwanted pregnancies. This however, has serious health risks, which sometime leads to death to young girls. For instance, unsafe abortion results in various complications such as hemorrhage, perforation of the uterus, secondary esterify and even death. It is also obvious that unsafe abortion has a devastating health impact as measured by deaths, illnesses, injuries and the cases of emergency care (Expanding Access to safe Abortion, 1993).

There are serious health risks involved in child bearing as an adolescent or teenager. For instance, teenagers face greater risk of pelvic bone immaturity, prolonged labor and difficult birth. The fear of been sent out of School or dropping out of school because of unwanted pregnancy makes adolescence involve in abortion, they go to quack doctors because it is cheap or sometimes administer drugs and this either kills them or destroys their womb. Money in this case is also a problem. George (2004) has clearly observed that about 72.5% of those involved in abortion are female students, 17.5% are unmarried women, while about 4.3% are housewives, therefore this study seeks to look at the extent of prevalence and determinant of abortion among

adolescent by looking at the reason why people involve in abortion and why it is still being patronized by members of the society.

1.3 RESEARCH QUESTIONS

This study will seek answers to questions such as:

i. What proportion of adolescent has ever engaged in sexual intercourse in Oye Ekiti, Nigeria?
ii. What proportion of adolescent has ever engaged in abortion within Oye Ekiti, Nigeria?
iii. What is the influence of age on the practice of abortion among adolescent in Oye Ekiti, Nigeria?
iv. What other socio-demographic factors influence abortion among adolescent girls in Oye Ekiti, Nigeria?

1.4 OBJECTIVES OF THE STUDY

1.4.1 General Objectives

The main objective of this study is to identify the causes of abortion among adolescent with focus on the Oye Ekiti.

1.4.2 SPECIFIC OBJECTIVES

1 To investigate the proportion of adolescent who had engaged in sexual intercourse in Oye Ekiti, Nigeria.

2 To ascertain the proportion of adolescent that has ever engaged in abortion in Oye Ekiti, Nigeria.

3 To examine the influence of age on the practice of abortion among adolescent in Oye Ekiti, Nigeria.

4 To examine other socio-demographic factors influencing the practice of abortion among adolescents in Oye Ekiti, Nigeria.

1.5 SIGNIFICANCE OF THE STUDY

In spite of the wide array of literature on pregnancy and abortion on adolescent, it has been observed even if sadly that not much has been done in the area of adolescent pregnancy and abortion. This work focused on the adolescent of Oye Ekiti which ranges from the age of 10-19years. The tendency for adolescent people to be involved in pre-marital sex coupled with their access to induced abortion has been viewed as increasing their risk of unplanned and too early pregnancy, HIV Aids, infection and other Sexually Transmitted Disease (STD) as well as unsafe induced abortion (United Nation,1999).

Past studies on adolescent pregnancy have focused extensively on several issues range from the illegal status of abortion to poor and the wide array of people who carry out unsafe abortion (Okonofua, 1993). Thus Okonufua consider mainly service factors as responsible for the high abortion related mortality in Nigeria. Similarly, a number of studies have concentrated on the older members of the society, thereby giving little attention to adolescent, particularly adolescent girls who constitute a serious at-risk group within the society. Quite a number of studies have also focused extensively on married adolescent in all religious of the country where little attention has been given to adolescent from less privileged areas, particularly rural communities like Oye Ekiti that are usually subjected to neglect in terms of infrastructural facilities in the South West region of the country. This research work therefore seeks to address this gap.

The problem that emanate from adolescent pregnancy and abortion in Oye Ekiti is enormous, but much under reported this is due to the fact that majority of female adolescent mainly because of social, economy, and cultural norms are not opened to discuss on the sensitive issue of adolescent pregnancy and abortion in the community of the country. An understanding of the magnitude of adolescent pregnancy and abortion in Oye Ekiti as well as the factors that are associated with them is very crucial in designing and implementing intervention that could be modified to youth needs, thereby contributing in the attainment of the MDG5 (reduction maternal mortality).

Therefore, the result will be useful in raising or reviewing national policy and guidelines regarding the prevention of pregnancy and abortion among adolescent in Oye Ekiti.

1.6 DEFINITION OF TERMS

Abortion: This is the termination of a pregnancy associated with the death and expulsion of a fetus from a uterus before it has reached the stage of viability (in human beings, usually about the 20th week of gestation).

Induced Abortion: This refers to an abortion that is brought about purposefully. Abortion can be induced for medical reasons or because of an elective decision to end the pregnancy.

Adolescence: According to the world health organization, adolescent are persons between the age of 10-19years and the broader term youth encompasses individual within the age range of 10-19years, while a combination of individual aged 10-19 years are referred to as young persons.

The guidelines for comprehensive sexuality education in Nigeria (1996) identified four developmental levels namely:

Level 1: childhood ages 6 through 8

Level 2: pre-adolescence ages 9 through 12

Level 3: adolescent ages 13 through 17

Level 4: young adult ages 18 through 24

Other scholars further attempted to sub-divide adolescence into following categories

- Pre-puberty (before age 10)
- Early adolescence (ages 10-14)
- Middle adolescence(ages 15-19),and
- Late adolescence or young adulthood (ages 20-24) { James Traore, 2001}

In the place of these sub-categories, three groups are sometimes used to describe adolescent such as - lower teens (10-12), middle teens (13-15), and, upper teens (15-19).

For the purpose of this study however, adolescent in their middle and upper teens (13-19) will be considered appropriate for this study. Adolescent is the period between childhood and adulthood; adolescent are no longer children but are not yet adults. It is also the period of physical and psychological development from the onset of puberty to maturity. Adolescence in the girl child is the transitional period when she develops into full maturity, a female adolescent is therefore a young girl at this transitional period of her life.

Adolescent sexuality: This refers to sexual feelings behavior and development in adolescent and it's a stage of human sexuality. It is also a very vital aspect of every teenager's life. Sexuality and sexual desires usually begins to appear along with the onset of puberty. The expression of sexual desire among adolescent might be influenced by family values and influenced the culture and religion they have grown up in, social engineering, social control, taboo, and other kind of social mores.

Pregnancy: This is the state of conception by concealing fetus in the womb.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION

This chapter achieves a review of literature related to this study. Various works associated with the key terminologies in this work as well as the theoretical frame work are discussed.

2.1 HISTORY AND ORIGIN OF ABORTION

The history of abortion according to anthropologists, dates back to the ancient times, as abortion in some form, has existed in the human race for millennia. Ancient tribes would sometimes be forced to more quickly, and pregnant women could slow the entire tribe down. Abuses of the woman's abdomen, and later abuse through excessive horseback riding, could cause the baby to be born prematurely. This baby was either then killed or left to die. Unfortunately, the mother also frequently died when giving birth (Gluion,1985). Today abortion is much safer for the mother, but just as deadly to the child. There were evidence to show that historically, pregnancies were terminated through a number of methods, including the administration of abortificient herbs, the use of sharpened implements, the application of abdominal pressure, and other techniques.

Historically, culture plays an important role in the behaviour of people or groups with culture varieties as equally differential approaches to the issue of abortion. Hundreds of thousands of years ago there were no pregnancy tests and no tools to perform early term abortions. By the time an abortion was performed, the baby was delivered, primitively but alive, and then the abortion process would be completed by infanticide of a born child (Gluion,1985). Until 19th century, methods of abortion no matter how remotely modern did not appear and the state did not prohibit abortion until the 19th century but the traition of women's right to early abortion was rooted in U. S Society by then (George, 2004).

2.1.2 FORMS AND NATURE OF ABORTION

Abortion is not just a simple medical procedure. For many women, it is a life changing event significant physical, emotional, and spiritual consequences. Most women who struggle with past abortions say that they wished they had been told of all the facts about the abortion and the risk (Henshaw, Singh and Haas, 1999). The programme of the action of the 1994 conference on population and development held in Cairo urged government and other relevant organizations "to deal with the health impact of unsafe abortions as a major public health concern and to reduce the recourse of abortion through expanded and improved family planning services" (U.N Conference on population and Development, 1994).

However, in spite of the recommendation of the conference, abortion forms and nature varied across culture and countries all over the world. There are different ways and abortion can be performed. Different methods are used under different circumstances and after different developments of the embryo or fetus. No method of abortion is 100% successful.

2.1.3 THE SEVERITY OF ABORTION COMPLICATIONS AMONG ADOLESCENTS.

Today, abortion is one of the most common gynecological experiences; perhaps the majority of women will undergo an abortion in their lifetimes. Safe abortions (those done by trained providers in hygienic settings) and early medical abortions (using medication to end a pregnancy) carry few health risks. However, every year, close to 20 million women risk their lives and health by undergoing unsafe abortions. At least 25% of these women face a complication with permanent consequences and close to 66,500 women die. This is especially true for women in developing countries who are faced with resource challenges as well as negative social, religious and cultural pressure. In fact, Grimes, Benson, Singh, Romero, Ganatra, Okonofua, Shah (2003) report that nearly all unsafe abortions (97%) are in developing countries with millions facing permanent complications. Importantly, a significant proportion of unsafe abortions in Nigeria and other developing countries involve students. Pachankis confirms that students in developing countries remain the major vulnerable group most likely to have abortions and suffer abortion stigma. Adanu, Tweneboah (2006) also recounts the imperfect knowledge on the effects and causes of abortions among students in schools.

2.1.4 ASSOCIATED RISK FACTORS OF ABORTION COMPLICATIONS

Throughout the years, right from the point that the first abortion was carried out, different methods and ways of aborting were found, both local and medical. The Medical practical became more advanced forming more ways and processes of abortion and some of these are; suction Aspiration, Dilation and Curettage (D and C), Dilation and Evacuation (D and E), salt poisoning (Saline Injection) etc. All of these methods are surgical and can result in complications so the doctors have to be extremely careful as there are a lot of risks involved (Barreto, 1992).

Abortion complication have brought about a lot of awareness, some of the risks involved include; death, breast cancer, cervical ovarian and liver cancer, cervical lacerations, placenta previa, handicapped newborns in later pregnancies, and lower general health (Fagbemi, 2001). Effect occurs with induced abortion, whether surgical or pill. These include abdominal pain and cramping, nausea, vomiting, and diarrhea. Abortion also carries the risk of significant complications and damage to organs. Serious complications occur in less than 1 out of 100 early abortions and in about 1 out of every 50 later abortions. Complications may include: Heavy bleeding, infections, sepsis, anesthesia and damages to internal organs (Strahan, 1997).

2.1.5 DETERMINANT FACTOR FOR ADOLESCENTS SEEKING INDUCED ABORTION.

An unwanted or unplanned pregnancy is at the start of the abortion decision making process. This happens when the pregnancy is regarded as unacceptable or inconvenient, or is a source of internal conflict (Frejka et al., 1989). There may be considerable ambivalence towards the pregnancy, given that women may experience a confluence of mixed emotions rather than a clear-cut rejection of the pregnancy. Consequently, the decision to terminate the pregnancy may be complex. Related factors at the individual level, which may influence the decision-making process, include socioeconomic and religious characteristics, the use or non-use of contraceptives, the stage in the woman's reproductive life-cycle, her relationship with the father of the child (married or not), and whether the sexual act was voluntary. Other factors that influence the decision-making process are related to having access to abortion services, which

are particularly relevant in Latin America and the Caribbean where abortion is essentially illegal. In addition to these two types of factors, there are macro-level factors associated with the sociopolitical context where the women live. Some of the most commonly declared reasons for having an abortion are the following (Alan, 1994):

- A woman is unable to raise a child because she and her partner receive a low salary, have unstable jobs or are unemployed, or are students.
- The relationship between the woman and her partner is insufficiently stable for the couple to be sure of raising children together, or because the man stopped providing emotional and economic support to the woman when the pregnancy was discovered.
- The woman or the couple have all the children they want or they want another child, but not at this time.
- The pregnant adolescent or unmarried woman fears rejection by her family and society.
- Some young single women wish to attain a certain level of personal satisfaction before becoming mothers.
- In certain cases (the proportion seems to be very small), the pregnancy is the result of rape or incest, or the fetus is abnormal. The study of the socio-demographic characteristics of women who have abortions has occupied an important place in abortion research.

Different studies undertaken in the region (Mundigo, 1999) show that in contexts where family planning programmes have not been effectively implemented to prevent unwanted pregnancies, abortion occurs among older women, poor women, women with little education, and women with a large number of offspring (Mundigo, 1999). Another study in support of these findings was conducted among inhabitants of an urban fringe area of Mexico City (Benson et al, 1999). The age and parity of women who had an abortion were significantly higher than the average of those interviewed. On the other hand, where there is a widespread availability of contraceptive methods, women who abort are younger, have a higher educational level, and have a higher level of participation in the workforce (Mundigo, 1999).

In a study conducted in urban areas in Colombia, the highest incidence of abortion was observed in the 15 –19 year age group (Zamudio and Wartenberg, 1999). In this study the likelihood of having an abortion was directly related to the previous number of pregnancies. A study undertaken in Mexico (Romero et al., 1994) showed that the absence of a mother in the home approximately doubled the probability that an adolescent's pregnancy will terminate in an abortion. The role of the male partner in the decision-making process has not been widely studied. However, there is evidence that men play an important role in women's decisions to continue or terminate an unwanted pregnancy and that gender and power relations may unduly influence the woman's decision regarding abortion (Zamudio and Rubiano, 1994). The degree of instability in the relationship and disagreement over the decision to abort are also important elements in the decision to terminate a pregnancy. If access to abortion services is limited or not available, women in rural areas may self-induce an abortion. That is, they initiate a miscarriage using any number of abortion procedures and then go to the hospital to complete the procedure or seek the help of a home practitioner (Alan, 1994).

A similar process occurs on a smaller scale among poorer women in urban areas, although some of these women may turn to medical services or trained paramedics providing clandestine abortion services. Women with a higher level of economic resources generally have access to trained health professionals. In some cases, such as in Mexico (Zamudio and Rubiano, 1994), women use methods to "hurry up a late period" and many women interviewed for the study were aware of methods to induce menstruation. These methods are used even before the existence of a pregnancy has been established. There is little information on how many women want an abortion but cannot afford one and so continue with the pregnancy, fearful of using high-risk services or procedures. For some women there appears to be a lack of concern about or awareness of the risks involved in clandestine abortion services (Mundigo and Indriso, 1999).

However, little is known about the ways in which women understand and define the concept of safety. It would be very useful to understand how perceptions of safety are associated with the decision to undergo an abortion. A study in Mexico found that women face a non-secure abortion with a certain degree of anxiety (Benson J et al., 1996). As mentioned earlier, the decision-making process may be complex as it involves an interactive set of values, expectations, as well as conscious and subconscious fears (Frejka et al., 1989). These aspects vary by social

and cultural context; however, the decision-making process will always involve a certain degree of psychological tension and may pose a challenge to the social and psychological equilibrium of the woman, and sometimes her partner. There is also a lack of knowledge among women about different abortion techniques and their relative risks. In a study conducted in Cuba (Alvarez and Garcia, 1999), where abortion is legal and accessible, 40% of women had only a vague idea about abortion procedures or did not know what procedures were involved. Some 10% of women worried that an abortion could cause their death when in fact the rate of complications from safe abortion, as performed in Cuba, is extremely low.

Cuba is the only country in Latin America to have legalized abortion. In the rest of the region, abortion is penalized with exceptions only for certain cases. However, even when women meet the legal criteria for abortion (i.e. the pregnancy results from rape or incest, or the woman's health is endangered by the pregnancy, or there is congenital malformation in the fetus), opportunities for safely terminating the pregnancy are limited. Some countries such as Mexico and Brazil have made efforts to establish clinical procedures and provide access to abortion care for women who are eligible under the law. Generally, however, abortion services are limited to a few hospitals in urban areas.

Little is known about the ways women who meet the criteria for an abortion exercise that right. A study was conducted in Mexico documenting the steps to obtaining a legal abortion and the attitudes of physicians who performed the abortions (Ehrenfeld, 2000). However, the study did not indicate how many requests for abortion were denied; nor did it explore women's perceptions of the complexity of navigating the bureaucratic process or the quality of the services they received. Women who wish to have an abortion where it is not permitted by law may seek providers in the private health sector. A woman's access to these providers is determined by her economic status coupled with her knowledge of the availability of such providers or her ability to employ a network of informants to provide this information. The methods women use to identify service providers willing to perform an abortion are not well known. The role of informal social networks in this process is also not well understood. Further research is needed in Latin America to investigate the impact of social, political, and legal contexts on women's reproductive decisions. Further research is also needed to build on existing studies of the determinants of abortion seekers to better identify groups at risk of unwanted pregnancies.

2.1.6 THE PSYCHOLOGICAL EXPERIENCES OF INDUCED ABORTION.

Approximately 42 million women worldwide obtain legal, induced abortions each year. While many women experience emotional relief after abortion, over 30% experience significant psychological distress that does not remit over time (Asthen, 2009). Psychological distress after abortion includes higher rates of suicidal behavior, depression, anxiety, post-traumatic stress, and substance abuse disorders after abortion, compared with other pregnancy outcomes (Adenike, 1999). Specifically, young women under age 25 years are at highest risk for developing mental health problems after abortions, with one study estimating that psychological distress after abortion (PAD) occurs in up to 40% of these cases. While several studies found that pre-existing psychological problems are highly correlated to the severity of post-abortion distress, this generalization may not apply to younger women, who develop post-abortion distress primarily because of their youth as well as their emotional response to the abortion experience (Amate, 2002). Because of young women's developmental stage, they are vulnerable to a number of risk factors associated with post-abortion mental health problems.

Certain factors that are specific to this age group that can effectively predict post-abortion distress include younger age, single relationship status, lack of social support, concealment of the unwanted pregnancy and abortion, social pressure to have an abortion, immature coping skills, and repetitive abortions (Asthen, 2009). Repetitive abortions among younger women often occur as the result of their tendency to behaviorally act out emotions of guilt, grief, anger, or confusion after a first abortion, as compared with adult women who verbalize such emotions. Acting out behaviors after abortion include engaging in high-risk sexual behavior, such as unprotected, indiscriminate, and promiscuous sexual encounters, which often lead to more unintended pregnancies and abortions, as well as self-destructive behaviors and suicidal behaviors. Indeed, because women worldwide under age 25 years are most likely to experience their first abortion and have a 40% chance of experiencing another, young women are at high risk for experiencing PAD (Aka, 2000).

However, another risk factor, and one that is often overlooked, stems from the onset of the reproductive phase of the lifespan a phase in which young women are more biologically vulnerable to mood and anxiety disorders, and particularly during reproductive events.

2.1.7 CONTRACEPTIVE ACCEPTANCE AMONG ADOLESCENTS.

Adolescent sexual behaviour has been recognized as an important health, social and demographic concern in the developing world (Mukhopadhyay and Chaudhuri, 2010). Adolescent pregnancy is associated with adverse maternal, fetal and neonatal outcomes (Duvan, et al, 2010). Teenage girls who get pregnant suffer from social and economic consequence and they are more likely to drop out of school. Furthermore, unwanted pregnancy poses a big problem among young adult in developing countries (Sahin, 2008).

Majority of students who join universities in Nigeria are aged between 19 and 29 years (Jeckoniah and Mwageni, 2007). Most of female students are enrolled to university at their young age, this expose them to unplanned and unprotected sexual intercourse leading to unintended pregnancies, abortions and sexually transmitted infections (Silberschmidt and Rasch, 2006). The increased sexual risky behaviours of female University students has been attributed to movement from a restricted rural to a more liberal urban environment, age and marital status (Puri, 2006). A recent study in Tanzania reported a 34.4% contraceptive prevalence rate among women of reproductive age (15–49 years) (National Bureau of Statistics, 2010). Results from Demographic and Health Survey in Tanzania also reported contraceptive prevalence use rate of 19% among female aged between 20 and 24 years, and the teenager pregnancy rate of 44% (Tanzania Demographic and Health Survey, 2010).

Previous studies conducted in sub Saharan Africa have reported on risky sexual behaviours among African youths, particularly University students. For example, a study among university students in Madagascar by Rahamefy and colleagues revealed that 29% of the students reported to have 2 or more sexual partners and only 13.5% were consistently using the condom (Rahamefy et al., 2008). However, a slightly higher proportion (48.9%) of condom use was reported among university students in Lagos (Byamugisha et al., 2006). Low level of utilization of contraceptives has been associated with high rates of unwanted pregnancies and unsafe abortions among Sub-Saharan Africa youths (Biddlecom et al., 2007).

A study conducted among nursing female students at Calabar University in Nigeria revealed that 55% of students who were sexually active had knowledge of family planning especially condom use (37%). In a similar study, more than half (51%) of the students who had

unwanted pregnancy ended to abortion (Ndifon et al., 2006). Low utilization of contraception has also been attributed to limited capacity of the health care system and structure within which family planning services are offered (Masoda and Govender, 2013).

Furthermore, individual factors such as risk perception, fear of side effects, opposition from male partners, health service limitations and insufficient knowledge needed to make informed choices have been reported as barriers for utilization of contraception. As an attempt to curb the problem, Tanzania government policy on family planning has made an effort to ensure the availability of contraceptives services in its health Centres for men and women who are ready for and in need (Abiodun and Baloqun, 2009). In line with the government policy, the University of Dar es Salaam and Muhimbili established a project to target students and other youths in the surrounding communities by providing reproductive health services including contraceptives. However, the effectiveness of this program has not yet been evaluated.

There is high rate of teenage pregnancy and unsafe abortion in developing countries. The high rate which researchers identified could be significantly reduced if University students knew about a preventive measure they could adopt to avoid unwanted consequences. They need to know about birth control method, such as condom, which is worn by the male. The condom prevents pregnancy and also prevents transmission of sexually transmitted infections (STIs), like HIV/AIDS, among others.

In Nigeria, contraceptive use among adolescents is low (Okonofua, 1995 and Odujirin, 1991). This low rate could be attributed to ignorance because the topic of contraception and sexual health is seldom discussed at home or outside their homes and schools. University students who are mostly adolescents and young adults indulge in unprotected sexual activities because they lack adequate reproductive health information.

In contrast, some reports found that young people have enough information to prevent unwanted pregnancy and infection but they are either unable or unwilling to apply this information to their everyday life. This was confirmed by Sunmola, Dipeolu, Babalola, (2007) who found a wide disparity between contraceptive knowledge and use. In their findings, contraceptive knowledge rates were between 41.9% and 63.8% while usage rate was between

0.7% and 12.5%. The consequences of the non-usage include infection, whose complications can subsequently lead to infertility and even death.

The use of condom as a method of contraception for sexually active undergraduates is very important in order to curb serious, social, economic and health problems. Previous studies in sub Saharan Africa have demonstrated that University female students are at high risk of sexually transmitted infections including HIV, and they have high rate of unwanted pregnancy which results to high abortion rate. Despite this fact, there is limited information about sexual behaviour, contraceptive knowledge and use among female University students in Tanzania. This underscores the need to understand the sexual risk behaviour, knowledge and pattern of contraceptives use among this high risk group in order to promote proper use of contraception.

2.1.8 FACTORS CONTRIBUTING TO ABORTION

George (2001); Fagbemi (2001); Lucas (1985) and Norton and Walls (1983) have identified in their various contributions several factors that tend to induce abortion. These factors include; i)Medical, (ii)Economic, (iii) Education, (iv) Social/Cultural, and (v) Family size. George (2004) particularly noted that individual females resort to pregnancy abortion largely because of medical and economic factors. According to Ejidah (1999) the lack of use of contraceptives by teenagers and young people resorts in high level of pregnancies and abortions. To them abortion becomes the on alternative as they are unable to carry the pregnancy.

Furthermore, Makinwa-Adebusoye (1997) identified reasons why students indulge in abortion. These according to her include;

i. First, desire to remain in school; therefore complete her education. This is because she may have to stay home to have her baby and once she leaves the probability of coming back reduces.

ii. Second, financial concerns; having and caring for a child is expensive and she would lack the ability to provide for the baby since she has no source of income.

iii. Third, fear of social reprisal because of an out –of- wedlock pregnancy (International Family Planning Perspective, 1997) A study of about 106 students in high institutions in Calabar was made and it was observed that;

i. Majority (80%) of them perceived that abortions are necessary to the extent that they assist fellow students to get rid of unwanted pregnancies.

ii. About 80% of the respondents admitted that they would abort if they accidentally got pregnant.

iii. About 55% of them said they are not willing to use contraceptives but would not hesitate to abort if they get pregnant

iv. About 63% of them admitted that though abortions seems risky, there is still need to legalize it so as to assure that qualified personnel handle the matter. Adepojo (1991) also noted that the lack of preventive measure among youths indulging in sexual acts is prominent factor for inducing abortion.

Culture plays very significant roles in the lives of people. It performs a major regulatory behavior in which action(s) and reaction(s) of individuals are set or ordained. There are different societies and cultures all over the world and they all seem to frown down on abortion especially from the cultural and religious point of view (Bankole and Adebayo, 1999). In Nigeria, Christian, Islamic and traditional religious practices are against abortion and have equivocally restricted their members from indulging in it. These religious groups see abortion as nothing but "Murdering of unborn babies" (Bankole and Adebayo 1999).

2.2 THEORETICAL FRAMEWORK

2.2.1 THEORY OF REASONED ACTION

A pioneering figure in establishing rational choice theory in sociology was George Homans (1961), who set out a basic framework of exchange theory, which he grounded in assumptions drawn from behaviourist psychology. While these psychological assumptions have been rejected by many later writers, Homans's formulation of exchange theory remains the basis of all subsequent discussion. During the 1960s and 1970s, Blau (1964), Coleman (1973), and Cook (1977) extended and enlarged his framework, and they helped to develop more formal, mathematical models of rational action (Coleman, 1990).

Rational choice theory is an approach used by social scientists to understand human behavior. This approach has long been the dominant paradigm in economics, but in recent decades it has become more widely used in other disciplines. It is basically about how incentives and constraints affect behavior. Rational choice theory is based on several assumptions: One of those is individualism; it focuses on individual behavior. The second assumption is that individuals have to maximize their goals, and the third is the assumption that the individuals are self-interested. Keel (1997) describes the central points of this theory as follows: The human being is a rational actor, rationality involves an end/means calculation, people (freely) choose behavior both conforming and deviant, based on their rational calculations, the central element of calculation involves a cost benefit analysis: Pleasure versus pain or hedonistic calculus, choice, with all other conditions equal, will be directed towards the maximization of individual pleasure, choice can be controlled through the perception and understanding of the potential pain or punishment that will follow an act judged to be in violation of the social good, the state is responsible for maintaining order and preserving the common good through a system of laws (this system is the embodiment of the social contract), the swiftness, severity, and certainty of punishment are the key elements in understanding a law's ability to control human behavior.

The theory of reasoned Action by Fishbein and Ajzen (1980) was designed to explain not just health behavior but all volitional behaviours. This theory is based on the assumption that most behaviour of social relevance are under volitional (willful) control. In

addition, a person's intention to perform (or not to perform) the behavior is the immediate determinant of that behavior. The goal is not to predict human behavior but also to understand it.

According to this theory, a person's intention to perform a specific behavior or act like having an abortion is a function of two factors;

(i) Attitude (positive or negative) towards abortion and

(ii) The influence of the social environment (general subjective norms) on abortion.

The attitude towards abortion is determined by the person's belief that a given outcome will occur if she has no abortion and by the evaluation of the outcome. The social or subjective norm is determined by a person's normative belief about what important or "others think she would do and by the individuals motivation to comply with those other peoples wishes or desires.

Attitude towards abortion are functions of beliefs in this theory. If a person believes that having an abortion is a positive action (like finishing school), she would hard a favourable attitude towards having an abortion. On the other hand a person who believes that having an abortion would mostly lead to negative outcomes (like health problems) will hold an unfavourable attitude. These beliefs that foundation of a person's attitude towards abortion are referred to as behavioural beliefs. Subjective norms also a functions of beliefs. These are the person's beliefs that certain individuals and groups are for and against abortion.

2.2.2 THE PROTECTION MOTIVATION THEORY

This theory is hinged on the work of Roser (1983) it combines elements of health belief model and social cognitive theory in describing how fear developing from reproductive health communication are reprocessed and acted upon. The theory is hinged on two broad categories of response namely:

i The Threat Appraisal and

ii The coping Appraisal

The possible outcome of the appraisal processes is an intension to behave in either adaptive or maladaptive manner. Individuals are most likely to change their behaviour in response to a fear of arousing message if they believe they are susceptible to illness or health hazard and that situation will have severe consequences. The protection motivation theory establishes a relationship between knowledge about a particular outcome from intended act. Therefore, this theory is relevant to explain the incidence of induced abortion among youths in the society.

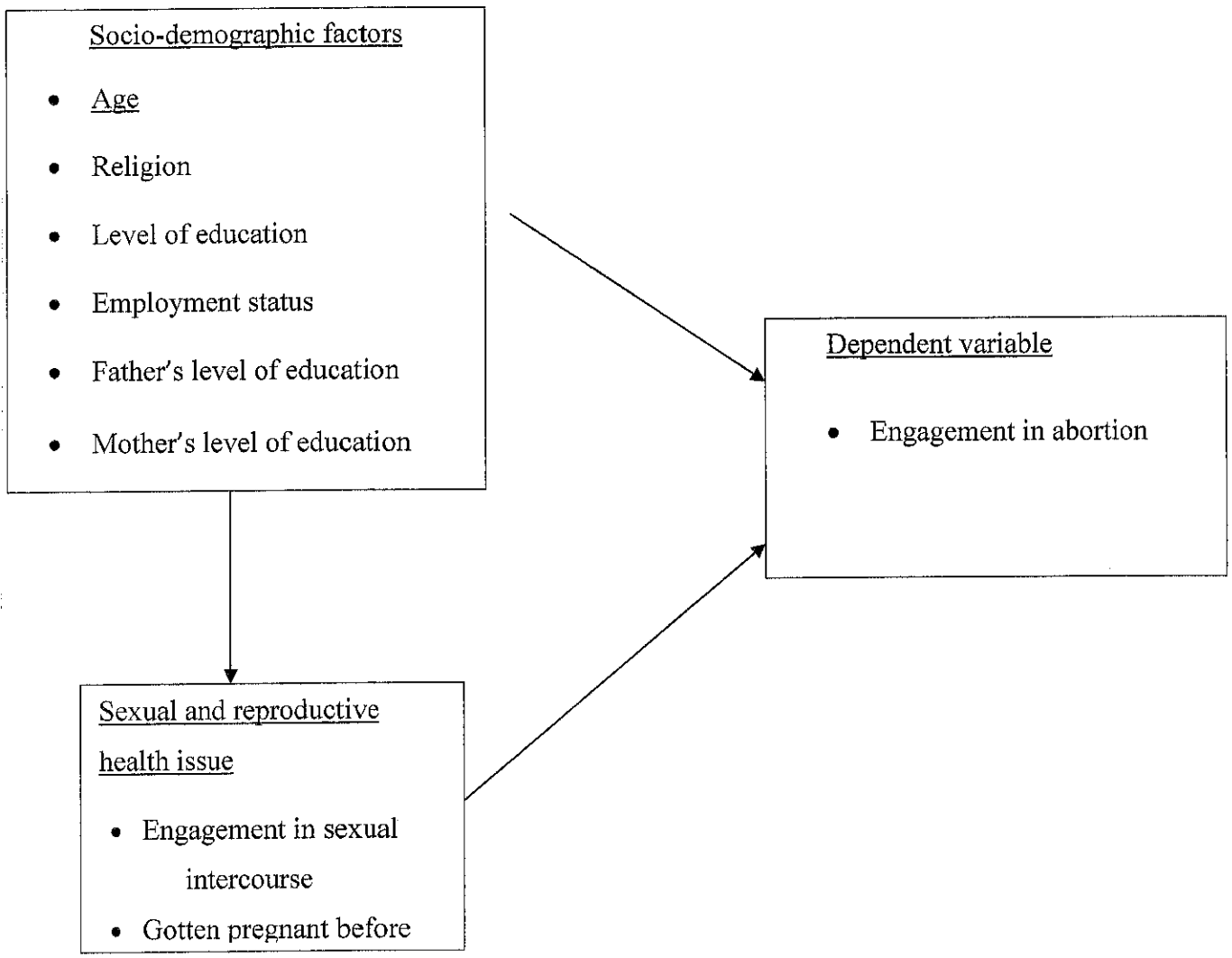
The theory of reasoned action is adopted for the is given the nature of it lucid explanatory provision on the subject matter. Abortion if often a carefully planned action evaluating the pros and cons, the decision arrived at to finally carryout an abortion is an afterthought.

2.3 CONCEPTUAL FRAMEWORK

Based on the literature reviewed, a social-demography factor, may be conceptualized as factors that shape unintended abortion of adolescent in Nigeria. It is anticipated that socio-demographic factors like age, religion, level of education, father's level of education, mother's level of education.

Below disclosed the conceptual framework adapted for this study.

Independent Variables



Source: Moturayo's Work, 2018.

2.4 STATEMENT OF HYPOTHESIS

H_o: there is no significant relationship between socio-demographic factors and abortion among adolescents in Oye local government Nigeria.

H_1: there is significant relationship between socio-demographic factors and abortion among adolescents in Oye local government, Nigeria.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

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

3.1 RESEARCH DESIGN

Research Design is the aspect of the research process which provides answers to the questions of what, why, how, where, when, who, etc. (Soyombo, 1999). In collecting the data, two main methods will be envisaged. Research design for this project are survey and non-survey methods. The former involves direct contact between the researcher and the subjects which entails questioning and answering, while the latter involves collection of data about subjects without necessary asking them questions.

For the purpose of this study, the survey research method is adopted as it is very useful. The survey research method becomes acceptable because it will enable the researcher to directly investigate the phenomenon. Survey methods are divided into two surveys: Cross sectional Survey and longitudinal surveys. Hence, due to the scope and context of this study, the Cross-sectional survey is the one adopted.

3.2 STUDY LOCATION

Oye is a town and headquarter of Oye local government area in Ekiti state, Nigeria. Oye Local Government Area was carved out from the defunct Ekiti North Local Government on 17 May 1989.

3.3 POPULATION OF THE STUDY

The target population for the study was female adolescents aged 10-19 years of age in Oye Ekiti. Girls within this age are considered to participate particularly at a greater risk of adolescence abortion.

3.4.1 SAMPLE SIZE

In 2013 demographic and health survey(DHS) in Nigeria, level of abortion (p) was 92.3%. therefore, p=0.923. The sample size was determined using the lesie Fischer's formular for the calculation of sample size in population greater than 10,000.

$n=z^2pq/d^2$

where n= minimum sample size

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

p= proportion of sexuality active

q=1-p(1-0.156=0.077)

$$= \frac{(1.96)^2 (0.923) (0.077)}{(0.05)^2}$$

$$= \frac{3.8416*0.923*0.077}{0.0025}$$

$$= \frac{0.27302635}{0.0025}$$

$$= 109.21$$

Expecting a response rate of 85%, an adjustment of the sample size estimate to cover for non-response rate was made by adding 85% of the estimated sample size to the sample size to arrive at the desired sample size.

85/100= 0.85

=0.85*109.21

= 92.83

92.83+109.21 =202.03

Thus calculated sample size is approximately 202 adolescents, however, 219 questionnaires were administered.

3.4.2 SAMPLING TECHNIQUE

The simple/accidental random sampling method is use to obtain information and data from the sample of two hundred and twenty two female adolescents from the age range of 10-19 years from Oye Ekiti. The reason for adopting this method is that, it enables the researcher to pick or select respondents as they are sighted.

3.5 DATA COLLECTION METHODS

Data was collected using semi structured questionnaire with open and closed ended questions. The questionnaire will contain questions on the socio-demographic characteristics of respondents, questions on the general knowledge of abortion and questions on the perceived causes and complications of Abortion among adolescents.

3.6 Study variable

3.6.1 Dependent variable

1 Ever had abortion

3.6.1 Independent Variable

1Age

2Religion

3Educational status

4 Employment status

5 Fathers highest level of education

6 Mothers highest level of education

7 Currently living with parent

3.6.2 SOCIO-DEMOGRAPHIC VARIABLE

VARIABLES	VARIABLES DEFINITION	MEASUREMENT
Age	Age of women of study in the population (15-49)	1. 10-13 2. 13-16 3. 17-19
Level of Education	This is the level of education attained by the respondent.	0. No education 1. Primary 2. Secondary 3. Post-secondary
Mothers highest level of education	This is the highest level of education attained by mother's of the respondents.	0. No education 1. Primary 2. Secondary 3. Post-secondary
Fathers highest level of education	This is the highest level of education attained by father's of the respondents.	0. Primary 1. Secondary 2. Post-secondary
Occupation status	This is the occupation status of the woman	1. Not employed 2. Employed
Religion	The religion practiced by the respondent	1. Christianity 2. Islam 3. Others
Ethnicity	The ethnicity of the respondent	1. Yoruba 2. Hausa/Fulani 3. Igbo

SOURCE: Motunrayo's work, 2018

3.7.1 METHODS OF DATA PROCESSING AND ANALYSIS

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

The data analysis was done using stata version 12. The frequency of data 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 and independent variables.

3.7.2 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, female adolescents that I approached were felling too reluctant to fill the questionnaire because of the content of the questionnaire. Also, the researcher had to employ the face to face method of questionnaire administration as this was time consuming and slowed the pace of data collection.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 INTRODUCTION

A total of 222 questionnaires were administered in the course of this study, in which 219 questionnaires were used in analyzing the data. The data was analyzed using Uni-variate, Bi-variate analyses and Multivariate.

4.1 UNIVARIATE ANALYSIS

This section provide a brief summary of some socio-demographic of the respondent using simple analytical technique.

4.2 SOCIO –DEMOGRAPHIC PROFILE OF RESPONDENTS

The sample comprises of respondents of Oye Ekiti

Table 4.1 Distribution of Respondents by Socio-Demographic Characteristics

SOCIO-DEMOGRAPHY CHARACTERISTICS

Background Characteristics	**Frequency (N=222)**	**Percent%**
Age grouping		
10-13	2	0.9
14-16	77	34.8
17-19	143	64.4
Religion		
Christianity	129	58.1
Islam	73	32.9
Traditional	20	9.0
Educational Status		
No formal Education	8	3.5

Primary	21	9.5
Secondary	129	58.1
Post-Secondary	64	28.9
Employment status		
Working	37	16.7
Not working	185	83.3
Father's Education		
No formal Education	39	17.6
Primary	14	6.3
Secondary	78	35.1
Post-Secondary	91	41.0
Mother's Education		
No formal Education	37	16.7
Primary	22	9.9
Secondary	78	35.1
Post-Secondary	85	38.3
Living with parent		
Yes	160	72.1
No	62	27.9
TOTAL	**222**	**100.0**

SOURCE: Motunrayo's Work, 2019

Table 4.1 illustrates information on the socio-demography profile of respondents. A total of two hundred and twenty-two were interviewed. The age of the respondents revealed that majority of the respondents were age group 17-19 (64.4%), while others (0.9%) and (34.8%)

falls within the age group 10-13 & 14-16 respectively. It was also revealed that majority of the respondent were Christians (58.1%), 32.9% of the respondent practice Islam, and 9.0% respondent are traditionalist.

Furthermore, 3.5% of the respondent had no formal education, 9.5% are in primary sc hool, 58.1% are in secondary school, and 28.9% attain post-secondary school. The result of the analyses revealed that 16.7% of respondent are currently working, while 83.3% of respondents are not working. The majority of respondents fathers' education are post-secondary (41.0%) while 35.1% had secondary education, 6.3% had primary education and 17.6% of respondents fathers' had no formal education. 38.3% of the respondent reported that their mothers' level of education is post-secondary,35.1% of the respondents mothers' completed their secondary education, 9.9% of completed their primary education while 16.7% of the respondent reported that their mothers have no formal education. 72.1% of the respondent are currently living with their parents while 27.9% reported that they are not living with their parent.

Table 4.2 REPRODUCTIVE HISTORY

Background characteristics	**Frequency**	**Percent%**
Engagement in sexual intercourse		
Yes	151	68.00
No	71	32.0
Total	**222**	**100.0**
Gotten pregnant before		
Yes	85	38.3
No	137	61.7
Total	**219**	**100.0**

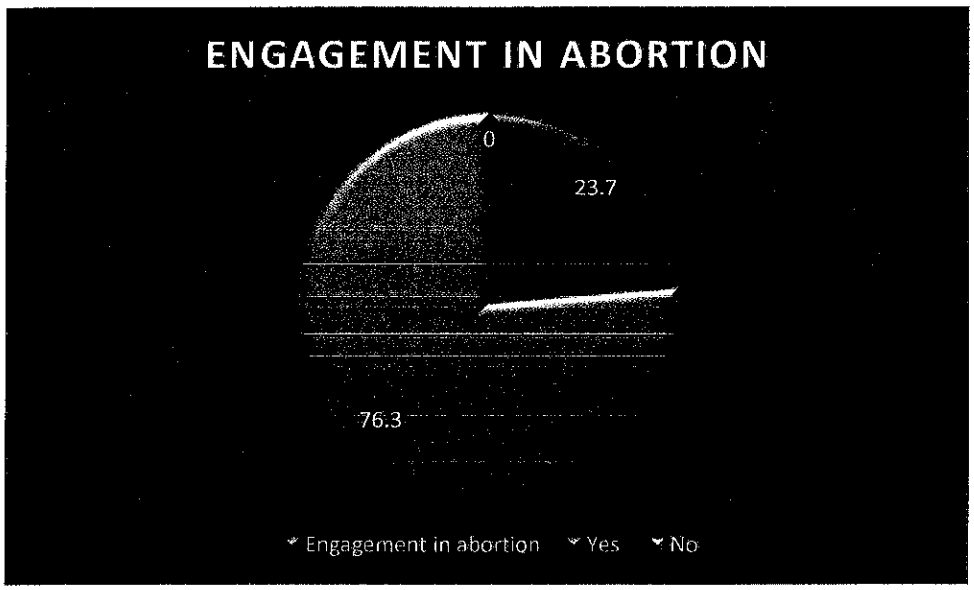
Outcome of the pregnancy		
Induced	10	11.0
Threatening	49	53.9
Delivery	32	35.1
Total	**91**	**100.0**
Engagement in abortion		
Yes	52	23.7
No	157	76.3
Total	**219**	**100.0**
Abortion indulging		
Yes	199	89.6
No	23	10.4
Total	**222**	**100.0**
Fear of becoming a mother		
Yes	212	95.5
No	10	4.5
Total	**222**	**100.0**

SOURCE: Motunrayo's Work,2019

Table 4.2 shows that 68.0% reported themselves to have engaged in sexual intercourse against 32.0% respondents who has not engaged in sexual intercourse. 38.3% reported themselves to have gotten pregnant before while 61.7% respondent said they have not gotten pregnant before. Out of those that have gotten pregnant before, 11.0% engaged in induced abortion, 53.9% engaged in threatening abortion while 35.1% had child delivery. 23.7% of respondent also reported to have engaged in abortion against 76.3% who have not had abortion.

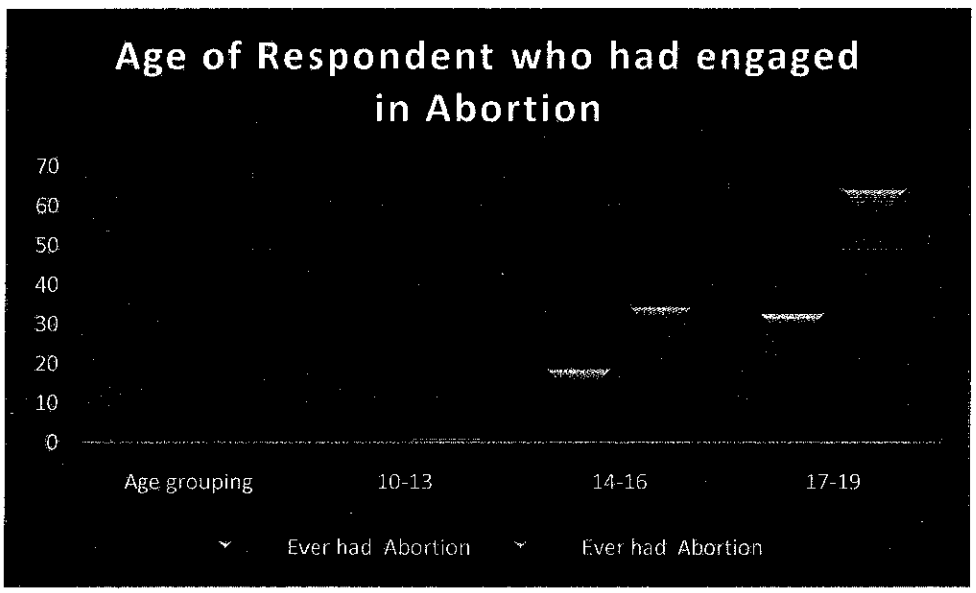
95.5% of respondent have the fear of becoming a mother at a tender age against 4.5% who doesn't have the fear of becoming a mother at a tender age 36.2%.

Fig 4.2.1



In fig. 4.2.1 respondents who had not engaged in abortion has higher percentage than those who had engaged in abortion.

Fig 4.2.2



In fig 4.2.2 age group 17-19 has a higher percentage of respondent involve in abortion while age group 10-13 is very low.

Table 4.3 DISTRIBUTIONS OF RESPONDENTS ACCORDING TO REASONS FOR INDULGING IN ABORTION

Background characteristics	Frequency(222)	Percent%
Abortion most risky in a chemist		
Yes	80	36.2
Don't know	142	63.8
Abortion most risky in a hospital		
Yes	16	7.2
No	206	92.8
Abortion most risky by quack doctors		
Yes	127	57,2
Don't know	95	42.8
Abortion most risky in clinic hospital		
Yes	20	9.00
Don't know	202	91.00
Total	**222**	**100.0**

SOURCE: Motunrayo's Work, 2019

Table 4.3 shows that most of the adolescents reported that they don't know whether abortion is risky in a chemist by 63.8% and those that said yes to abortion risky in a chemist were 36.2%. Also, 92.8% of respondent said abortion they don't know if abortion is most risky in a hospital and 7.2% of respondents said that abortion is most risky in hospitals. 57.2% of respondent said that abortion is most risky by quack doctors against 42.8% who said they don't know if abortion is risky under the influence of quack doctors.

Table 4.4 DISTRIBUTIONS OF RESPONDENTS ACCORDING TO REASONS FOR INDULGING IN ABORTION

Variables	Frequency	Percent%
Death		
Yes	128	57.66
Don't know	94	42.34
Loss of fertility		
Yes	129	58.4
Don't know	93	41.6
Infection and disease		
Yes	59	26.6
Don't know	163	73.4
Severe injury and impairment		
Yes	45	20.3
Don't know	177	79.7
Total	**222**	**100.0**

SOURCE: Motunrayo's Work, 2019

In table 4.4, some certain set of respondents that were interviewed have the higher percentage of 57.7 and said that part of the repercussion of abortion is death while 42.3% of the respondent interviewed said that they don't know if death is part of the repercussion of abortion. Also, part of the respondent that said that loss of fertility is one of the risk of abortion were 58.4% and the percentage of respondent that said they don't know were 41.6. Some certain set of respondent that doesn't see infection and diseases as part of repercussion of abortion were 73.4% and 26.6% of the respondent said that infections and diseases are part of the risky

outcome of abortion. Also some certain percentage of respondents 79.7 said that severe injury and impairment is not part of the risky situations of having abortion while 20.3 said that it is part of the repercussion of abortion.

Table 4.5 PERCEPTIONS ABOUT ABORTION

Variables	Frequency	Percent%
Abortion tantamount to murder		
Yes	128	57.7
Don't know	194	42.3
Abortion is evil		
Yes	58	26.1
Don't know	164	73.9
Abortion is unaccepted		
Yes	28	12.6
Don't know	194	87.4
Abortion is against the law		
Yes	25	11.3
Don't know	197	88.7
Total	**222**	**100.0**

SOURCE: Motunrayo's Work, 2019

In table 4.5 Part of the respondent interviewed (57.7%) have the perception that abortion is tantamount to murder against 42.3% who said that they don't know if it is tantamount to murder. Also percentage of those who said that they don't know it abortion is evil is 73.9% while proportion of respondent that said that it is evil is 26.1%. Furthermore, 87.4% of respondent said

that they don't know if abortion is unaccepted while 12.6% of the respondent said that abortion is unaccepted in the society. Lastly, 88.7% of the respondent interviewed said that they don't know if it is against the law while 11.3% of the respondent said that it is against the law.

Table 4.6 DISTRIBUTIONS OF RESPONDENTS ACCORDING TO REASONS FOR INDULGING IN ABORTION

Variables	Frequency	Percent%
On medical grounds		
Yes	10	4.5
Don't know	212	95.5
On economic grounds		
Yes	28	12.6
Don't know	194	87.4
On educational grounds		
Yes	106	47.8
Don't know	116	52.3
Fear of the unknown		
Yes	42	19.0
Don't know	179	81.0
Denial of the supposed father		
Yes	83	37.4
Don't know	139	62.6
Religious belief		

Yes	31	13.5
Don't know	191	86.0
Stigma of unwanted pregnancy		
Yes	81	36.5
Don't know	141	63.5
Total	**222**	**100.0**

SOURCE: Motunrayo's work, 2019

Part of the adolescent interviewed said that they don't know if student indulge in abortion under medical grounds which has the percentage of 95.5% against 4.5% respondent that said that adolescent indulge in abortion under medical grounds. Also 87.7% said that they don't know if adolescent indulge in abortion under economic grounds while 12.6% said that adolescent indulge in abortion under economic grounds. 52.2% of respondent said that they don't know if adolescent indulge in abortion under educational grounds against 47.8 who said adolescent indulge in abortion under educational grounds. 81.0% of respondent said that they don't know if adolescent indulge in abortion under fear of unknown against 19.0% who said adolescent indulge in abortion under the fear of unknown. 62.6% of respondent said that they don't know if adolescent indulge in abortion under the denial of the supposed father against 37.4% who said adolescent indulge in abortion under the fear of the supposed father. Also, 86.0% of respondent said that they don't know if adolescent indulge in abortion under religious belief but 13.5% of the respondent said that religious belief is one of the reason why adolescent indulge in abortion. Lastly, 63.5% of respondent said that they don't know if adolescent indulge in abortion under the stigma of the unwanted pregnancy while 36.5% of the respondent said that stigma of the unwanted pregnancy is one of the reason why adolescent indulge in abortion.

Table 4.7 Bi-variate Analyses showing the relationship between socio-demographic characteristics and ever had abortion.

Background Characteristics	Ever had Abortion		Total	Significant Test
	Yes	No		
Age grouping				
10-13	0(0.00%)	0.9(1.2%)	2(0.9%)	Chi2(6)= 5.81
14-16	19(36.6%)	34.8(33.5)	75(34.3%)	Pr = 0.444
17-19	33(63.4%)	64.4(65.3%)	142(64.8%)	
Religion				
Christianity	23 (44.2%)	105(62.9%)	128(58.5%)	
Islamic	25 (48.1%)	46(27.5%)	71(32.4%)	Chi2(2)=7.67
Tradition	4 (7.7%)	16(9.6%)	20(9.1%)	Pr=0.022
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Educational status				
No formal education	4 (7.7%)	4 (2.4%)	8(3.6%)	
Primary	6 (11.5%)	15(9.0%)	21(9.6%)	Chi2(3)=8.60
Secondary	34 (65.4%)	92(55.1%)	126(57.5%)	Pr=0.07
Post- secondary	8 (15.4%)	56(33.5%)	64(29.3%)	
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Employment status				
Working	6 (11.5%)	25(15.0%)	31(14.1%)	Chi2(1)= 2.08
Not working	46(88.5%)	142(85.0%)	183(85.9%)	Pr=0.555
Total	**52 (100%)**	**167(100%)**	**219(100%)**	

Fathers highest level of edu.				
No formal education	10(19.2%)	29(17.4%)	39(17.8%)	
Primary	6(11.5%)	7(4.2%)	13(5.9%)	Chi2(3)=7.43
Secondary	21(40.4%)	55(32.9%)	76(34.7%)	Pr=0.115
Post- secondary	15(28.9%)	76(45.5%)	88(41.6%)	
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Mothers highest level of edu				
No formal education	12(23.1%)	24(14.4%)	36(16.4%)	
Primary	7(13.5%)	13(7.8%)	20(9.1%)	Chi2(3)=5.02
Secondary	16(30.8)	62(37.1%)	78(35.6%)	Pr=0.285
Post- secondary	17(32.7%)	68(40.7%)	82(38.9%)	
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Living with parent				
Yes	40(76.9%)	118(70.7%)	158(72.2%)	Chi2(1)=0.77
No	12(23.1%)	49(29.3%)	61(27.9%)	Pr=0.379
Total	**52 (100%)**	**167(100%)**	**219(100%)**	

SOURCE: Motunrayo's Work, 2019

Bi-variate analysis on opinion of adolescent among age (10-19) in Oye Ekiti on the prevalence and determinant of adolescence practice of abortion in table 4.2 shows that the age range 17- 19 carry the major way (64.8%) of engaging into abortion against those that are not (64.8%), also age 14-16 of adolescent age that had the percentage of 36.6 engaged into abortion against those that are not, while the least of age group of respondent that does not engaged in abortion were 10-13 having the percentage of (0.9%) against those that engaged in abortion.

Therefore, there is no significant positive relationship between the age of respondent and ever had abortion. (X^2= 5.81), p-value =0.444>0.005) since p-value is greater than 0.005%.

The table also shows that 62.9% of the respondents who are Christians had not engaged in abortion as against 42.2% of Christians who had engaged in abortion. Respondent who are Islam that had engaged in abortion were 48.1% aligned with those that are not (27.5%), also the traditional religions that does not engaged in abortion were (9.6%) against those that engaged in abortion (7.7%) . Therefore, there is positive significant relationship between religion and ever had abortion. (X^2= 7.66), p-value =0.022<0.005) since p-value is lesser than 0.005%.

Furthermore, some of the respondent interviewed who falls to the category of no formal education having the percentage of 2.4 said that they had not engaged in the practice of abortion against 7.7% of the respondent who said that they have engaged in abortion. Also, 11.5% who were in primary school said that they have engaged in abortion against 9.0% who said they had not engaged in abortion. 65.4% of respondent who were in secondary school said that they had engaged in abortion against 55.1% who said that they had not engaged in abortion. Finally, 33.5% of the respondents interviewed who were in post- secondary had not engaged in abortion against 15.4% who had engaged in abortion. Therefore, the relationship between respondents level of education and ever had abortion is not significant (X^2= 8.60), p-value =0.07>0.005) since p-value is lesser than 0.005%.

Also, 15% of the respondents interviewed who are working said that they had not engaged in the practice of abortion while 11.5% of the respondents working had engaged in the practice of abortion. 88.5% of the respondents interviewed who were not working said that they had engaged in the practice of abortion while 85.0% of the respondent not working said that they

had engaged in the practice of abortion. Therefore, the relationship between respondents employment status and ever had abortion is not significant (X^2= 2.08), p-value =0.555>0.005) since p-value is lesser than 0.005%.

Table 4.3 also shows that some respondents whose father's highest level of education is no formal education who had engaged in abortion were 19.2% against 17.4% respondents who had not engaged in abortion. 11.5% of respondent whose father's highest level of education is primary school had engaged in abortion while 4.2% of respondents whose fathers highest level of education is primary have not engaged in abortion. 40.4% of respondents whose fathers highest level of education is secondary had engaged in abortion against 32.9% of respondents who had not engaged in abortion. Finally, 45.5% of respondents whose fathers highest level of education is post-secondary had not engaged in abortion while 28.9% of respondents had engaged in abortion. Therefore, the relationship between fathers highest level of education and ever had abortion is not significant (X^2= 7.43), p-value =0.115>0.005) since p-value is lesser than 0.005%.

Furthermore, the table also shows that some respondents whose mother's highest level of education is no formal education and who had engaged in abortion were 23.1% against 14.4% respondents who had not engaged in abortion. 13.5% of respondent whose mother's highest level of education is primary school had engaged in abortion while 7.8% of respondents whose mother's highest level of education is primary had not engaged in abortion. 37.1% of respondents whose mother's highest level of education is secondary had not engaged in abortion against 30.8% of respondents who had engaged in abortion. Finally, 40.7% of respondents whose mother's highest level of education is post-secondary had not engaged in abortion while 32.7% of respondents had engaged in abortion. Therefore, the relationship between mothers highest

level of education and ever had abortion is not significant (X^2= 5.02), p-value =0.285>0.005) since p-value is lesser than 0.005%.

Respondents who are living with parent and that had engaged in abortion were 76.9% against 70.7% respondents that had not engaged in abortion. Also respondents who aren't living and had not engaged in abortion were 29.3% while 23.1% of respondents who are not living with parent had engaged in abortion. Therefore, the relationship between respondents living with parent n and ever had abortion is not significant (X^2= 0.77), p-value =0.379>0.005) since p-value is lesser than 0.005%.

Table 4.8 DISTRIBUTION OF RESPONDENTS BY PRACTICE OF ABORTION AND REASONS FOR ENGAGING IN ABORTION.

Variables	**Abortion**		**Total**	**Significant test**
	Yes	**No**		
On medical grounds				
Yes	3 (5.8%)	7(4.32%)	10(4.6%)	
Don't know	49(94.2%)	160(95.8%)	209(95.4)	Chi2(1)=0.23
Total	**52 (100%)**	**167(100%)**	**219(100%)**	Pr=0.634
On economic grounds				
Yes	6(11.5%)	22(13.2%)	28(12.8%)	Chi2(1)=1.0
Don't know	46(88.5%)	145(86.8%)	191(87.2%)	Pr=0.758
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
On educational grounds				
Yes	26(50%)	79(47.3%)	105(47.9%)	Chi2(1)=0.12
Don't know	26(50%)	88(52.7%)	114(52.1%)	Pr=0.734
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Fear of the unknown				
Yes	10(19.6%)	32(19.2%)	42(19.3%)	Chi2(1)=0.01
Don't know	41(80.4%)	135(80.8%)	176(80.7%)	Pr=0.944
Total	**52 (100%)**	**167(100%)**	**219(100%)**	
Denial of the supposed father				

Yes Don't know **Total**	16(30.8%) 36(69.2%) **52 (100%)**	66(39.5%) 101(60.5%) **167(100%)**	82(37.4%) 137(62.6%) **219(100%)**	Chi2(1)=1.30 Pr=0.255
Religious belief Yes Don't know **Total**	8(15.4%) 44(84.6%) **52 (100%)**	23(13.8%) 144(86.2%) **167(100%)**	31(14.2%) 188(85.8%) **219(100%)**	Chi2(1)=0.46 Pr=0.793
Stigma of unwanted pregnancy Yes Don't know **Total**	19(36.5%) 33(63.5%) **52 (100%)**	61(36.%5) 106(63.5%) **167(100%)**	80(36.5%) 139(63.5%) **219(100%)**	Chi2(1)=0.00 Pr=0.999
Fear of becoming a mother Yes Don't know **Total**	49(94.2%) 3(5.8%) **52 (100%)**	161(96.4%) 6(3.6%) **167(100%)**	210(95.9%) 9(4.1%) **219(100%)**	Chi2(1)=1.17 Pr=0.558

SOURCE: Motunrayo's Work,2019

Respondents that indulged in abortion under medical grounds who had engaged in abortion were 5.8% against 4,2% who had not engaged in abortion. Therefore, the relationship is not significant (X^2= 0.23), p-value =0.634>0.005) since p-value is lesser than 0.005%.

Respondents that indulged in abortion under economic grounds who had not engaged in abortion were 13.2% against11.5% who had engaged. Therefore, the relationship is not significant (X^2= 1.0), p-value =0.758.>0.005) since p-value is lesser than 0.005%.

Also, respondents that indulged in abortion under educational grounds and had engaged in abortion were 50% against 47.3% who had not engaged in abortion. Therefore, the relationship is not significant (X^2= 0.12), p-value =0.734.>0.005) since p-value is lesser than 0.005%.

Respondents that indulged in abortion under fear of the unknown and had engaged in abortion were 19.6% against 19.2% who had not engaged in abortion. Therefore, the relationship is not significant (X^2= 0.01), p-value =0.944.>0.005) since p-value is lesser than 0.005%.

Furthermore, respondents that indulged in abortion under the fear of denial of the supposed father and had not engaged in abortion were 39.5% against 30.8% who had engaged in abortion. Therefore, the relationship is not significant (X^2= 1.30), p-value =0.255.>0.005) since p-value is lesser than 0.005%.

Also, respondents that indulged in abortion under religious belief and had engaged in abortion were 15.4% against 13.8% who had not engaged in abortion. Therefore, the relationship is not significant (X^2= 0.46), p-value =0.793.>0.005) since p-value is lesser than 0.005%.

Respondents that indulged in abortion under the stigma of unwanted pregnancy and had engaged in abortion were 36.5% against 36.5% who had not engaged in abortion which means there were equal percentages of respondents that had engaged and had not engaged in abortion Therefore, the relationship is not significant (X^2= 0.00), p-value =0.999.>0.005) since p-value is lesser than 0.005%.

Finally, respondents that indulged in abortion under the fear of becoming a mother and had not engaged in abortion were 96.4% against 94.2% who had engaged in abortion. Therefore, the relationship is not significant (X^2= 0.46), p-value =0.793.>0.005) since p-value is lesser than 0.005%.

TABLE 4.9 LOGISTICS REGRESSION ON ABORTION AND SELECTED VARIABLES

Variables	Odd Ratio	(Lower-Upper Confidence interval)
Religion		
Christian (RC)	1.00	
Islam	0.43*	(0.228-0.86)
Traditional	0.94	(0.34-2.62)
Evil as a perception to abortion		
Yes (RC)	1.00	
Don't know	0.44*	(0.23-0.84)
Economic grounds as condition indulge in abortion		
Yes (RC)	1.00	
Don't Know	0.28**	(0.12-0.66)

SOURCE: Motunrayo's Work,2019

The table above, shows that the multivariate analysis of the relationship between the dependent variable and independent variables. The binary logistic regression technique was to establish the relationship between response variable (view of an adolescent (10-19) on whether the respondents have knowledge on sexual practice and abortion and also selected explanatory variable. Table 4.9 therefore shows the odd ratios, confidence intervals, standard errors and p-values. The result shows that respondents who are Muslims are 0.42 times less likely to experience adolescent abortion to Christians adolescents (RC). OR=0.42, P<0.05 that means, the relationship is not statistically significant.

Also, adolescents that reported don't know to unaccepted as a perception to Abortion 3.22 times are more likely to experience adolescent abortion than those that said yes to unaccepted as a perception to abortion (RC)

Finally, adolescent that reported don't know to abortion as against the law were 0.32times less likely to experience adolescent abortion to those that said yes to abortion as against the law(RC).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION.

5.0 INTRODUCTION

This chapter present the summary, conclusion and recommendation drawn from the analysis of the research data.

5.1 SUMMARY OF FINDINGS

The aim of the study was to examine the association between abortion among adolescents in Oye Ekiti, Nigeria. The survey respondents were selected by using simple-random sampling technique.

The study identified that 68.0% of the study population have engaged in sexual intercourse as against 32.0% respondents who have not had sexual intercourse. Also, 38.3% of the respondents who have not gotten pregnant at one point or the other in their life while 61.7% of the respondents have not experienced any form of pregnancy.

Furthermore, 53.9% of the respondents have engaged in threatening abortion as of the time of study. Conclusively, 12.6% of the respondents said that abortion is unaccepted in the society, while 57.7% have the opinion that abortion is synonymous to murder.

The bi-variate analysis showed that respondents that indulged in abortion under medical grounds had no significant relationship with those that had not engaged in the act of abortion. Also, there is no significant relationship between respondents that indulged in abortion under the stigma of unwanted pregnancy.

Table 4.3.1 showed that binary logistics regression of abortion and why adolescent indulges in it. From the model, it was revealed that Muslims are 42% less likely to experience adolescent abortion compared to Christians.

5.2 CONCLUSION

The study has examined the prevalence of sexual intercourse and the rate at which abortion is being practiced. Also, some of the factors that could be responsible for such act and the feelings that follows. Religion as the only variable according to this study serves as a determinant to adolescent abortion in Oye Ekiti.

5.3 RECOMMENDATIONS

Consequent upon the findings of this study, the following are our recommendation:

- There should be a standing policy against abortion
- The use of condom should be taken seriously for those that are sexually active from tender age to prevent them from having unwanted pregnancy.
- The religious bodies should be allowed to teach sound moral doctrines to adolescents.

5.4 AREA OF FURTHER STUDY

This study focused exclusively on abortion among adolescents aged 10-19 in Oye Ekiti. Further studies in this area should be extended to other parts of the country.

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FACULTY OF SOCIAL SCIENCES
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PREVALENCE AND DETERMINATS OF ADOLESCENCE PRACTICE OF ABORTION IN OYE EKITI

Dear Sisters,

I am a final year student in the Department of Demography and Social Statistics, Federal University, Oye Ekiti, carrying out a study on the topic "Prevalence and Determinants of Abortion among adolescents in Oye Ekiti Nigeria". This study is in partial fulfillment of the requirements for the award of B.Sc. Degree in Demography and Social Statistics. You are humbly requested to give your candid and sincere opinion on the subject matter as your response will be treated with strict confidence.

Thank you for your co-operation.

Yours sincerely,

Oyedele, Motunrayo Elizabeth.

Please tick (√) or mark (x) and render other necessary comments as appropriate.

SECTION A: SOCIO-DEMOGRAPHIC ATTRIBUTES OF RESPONDENTS

1. Age as at last birthday .....
2. What is your Religion? Christianity.....1 Islam.....2 Traditional.....3 Others specify 4
3. What is your highest level of education? No formal education.....1 Primary.....2 Secondary.....3 Post-secondary.....4 others(specify).....5
4. What is your Employment status? Working.....1 Not working.....2
5. What is your father's highest level of Education? No formal education.....1 Primary.....2 Secondary.....3 Postsecondary.....others(specify).....
6. What is your mother's highest level of Education? No formal education.....1 Primary.....2 Secondary.....3 Post-secondary.....4 others(specify).....5
7. Are you currently living with your parent? Yes.....1 No.....2

SECTION B:REPRODUCTIVEHISTORY

Please tick (√) or mark (x) and render other necessary comments as appropriate.

8. Have you ever engaged in sexual intercourse? Yes.....1 No.....2
9. Have you ever got pregnant before? Yes.....1 No.....2
10. If yes, what was the outcome of the pregnancy?

    Induced abortion.....1 Threatening abortion.....2 Delivery.....3
    Others(specify).....4
11. Have you ever engaged in abortion? Yes.....1 No.....2
12. If yes, when last did you abort? .....

SECTION C: ASSOCIATED FACTORS ON ABORTION

Please tick (√) or mark (x) and render other necessary comments as appropriate.

13. Is indulging in abortion risky? Yes.....1 No.....2
14. Under what condition is it mostly risky? In a chemist/Patent drug store .....1 In a hospital.....2 Quack doctor.....3 Clinic or maternity.....4 Others (specify).....5
15. What are the associated risks of abortion (Multiple answers allowed)? Death.....1 Loss of fertility.....2 Infection and disease.....3 Severe injury and impairment.....4 Others (specify) 5

    What is the general perception about abortion? It is tantamount to murder.....1 It is evil.....2 It is unaccepted.....3 It is against the law.....4. Others (Specify).....5;
17. Under what conditions do students indulge in abortion? (Multiple answers allowed) On medical grounds.....1 On economic grounds.....2 On educational grounds.....3 Fear of the unknown.....4 Denial of the supposed father.....5 Religious belief.....6 Stigma of unwanted pregnancy.....7 Others (specify) 8
18. Does the fear of becoming a mother at a tender age influence individual's desire to terminate an unwanted pregnancy? Yes.....1 No.....2