KNOWLEDGE OF ADOLESCENTS ON ABORTION IN LAGOS UNIVERSITY TEACHING HOSPITAL COMPLEX

by

ELIZABETH NKUGBO AKINDE

submitted in partial fulfilment of the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: MRS JE TJALLINKS

JOINT SUPERVISOR: DR MLM SENGANE

NOVEMBER 2009

Student number: 3585-998-9

DECLARATION

I declare that **KNOWLEDGE OF ADOLESCENTS ON ABORTION IN LAGOS UNIVERSITY TEACHING HOSPITAL COMPLEX** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE **DATE** ....

(EN AKINDE)

KNOWLEDGE OF ADOLESCENTS ON ABORTION IN LAGOS UNIVERSITY TEACHING HOSPITAL COMPLEX

STUDENT NUMBER:	3585-998-9
STUDENT:	ELIZABETH N AKINDE
DEGREE:	MASTER OF ARTS
DEPARTMENT:	HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR:	MRS JE TJALLINKS
JOINT SUPERVISOR:	DR MLM SENGANE

ABSTRACT

The study sought to assess the knowledge of adolescents regarding abortion in a selected area in Lagos Nigeria. The researcher used a non-experimental, exploratory, descriptive research design for the study. One hundred adolescents participated in the study.

The study found that many adolescents will not admit to having had an abortion. Moreover, the respondents gave different meanings for abortion, had inadequate knowledge of abortion and sexual and reproductive health. Cultural taboos and religious beliefs have a great impact on adolescents' sexual behaviour. Most adolescents would not access abortions services because they regard it as killing an innocent baby.

Efforts should be strengthened to make contraceptives and family life education available and accessible to the adolescents.

KEY CONCEPTS

Abortion; backstreet or unsafe abortion; birth control; Lagos University Teaching Hospital; post-abortion services; reproductive health.

ACKNOWLEDGEMENTS

I am grateful to God for giving me the opportunity to complete this study, and give Him thanks and praise.

I would also like to give my thanks to the following persons for their invaluable support and unending encouragement:

- My supervisors, Mrs J Tjallinks and Dr Sengane, for their patience and understanding, and all they taught me
- Prof GH van Rensburg, for her knowledge in reviewing some of the chapters
- Dr UU Alberts, for assistance and support
- My first friend at Unisa, Mr M Liebenberg, for his words of encouragement
- Prof Steffens, for reviewing the questionnaire
- Mrs S von Moltke, for her expert advice on chapter 4
- The Management of Lagos University Teaching Hospital, for giving me time for the project and also allowing me do the research in LUTH
- Prof Ekanem (Department of Community Health), Dr B Oye-Adeniran (Department of OB/GYN) of College of Medicine University of Lagos for going through the questionnaire allowing me access to materials and works done on abortion
- My immediate boss (Principal School of Midwifery), for her understanding and support throughout the period of this study
- My daughter, Funmilayo, for always telling me mummy come on you can do it and for always helping me arrange my work on the computer before I send it
- My student, Chiamaka, for helping me mobilise the field workers
- My husband, Dr Joseph Akinde, for his financial support
- My family and friends, who encouraged me and never gave up supporting and believing in me.
- Mrs M Marchand, for critically and professionally editing the manuscript.
- Mrs R Coetzer, for so professionally and patiently formatting and correcting the manuscript

To you all, my sincere thanks and love, and I wish you all strength in you endeavors-may people be as caring and helpful to you as you have been to me.

Dedication

This work is dedicated to God almighty for His infinite mercy and grace throughout the period of this course.

Table of contents — Page

Chapter 1

Orientation to the research

1.1 INTRODUCTION ... 1

1.2 BACKGROUND TO THE STUDY ... 3

1.2.1 Legality of abortion in Africa ... 3

1.2.2 Nigeria ... 4
1.2.3 Maternal health care facilities in Lagos State ... 8
1.2.4 Adolescents' rights in Nigeria ... 10
1.2.5 Strategic plan to reduce maternal mortality in Nigeria ... 11

1.3 RATIONALE FOR THE STUDY ... 11

1.4 PROBLEM STATEMENT ... 12

1.5 RESEARCH QUESTION ... 12

1.6 PURPOSE OF THE STUDY ... 13

1.7 OBJECTIVES OF THE STUDY ... 13

1.8 SIGNIFICANCE OF THE STUDY ... 13

1.9 RESEARCH DESIGN AND METHODOLOGY ... 13

1.9.1 Research design ... 14
1.9.2 Population and sample ... 14
1.9.3 Data collection ... 14
1.9.4 Data analysis ... 15

1.10 ETHICAL CONSIDERATIONS ... 15

1.11 RELIABILITY AND VALIDITY ... 15

1.12 DEFINITION OF KEY TERMS ... 16

1.13 OUTLINE OF THE STUDY ... 17

1.14 CONCLUSION ... 18

Table of contents Page

Chapter 2

Literature review

2.1 INTRODUCTION 19

2.2 RATIONALE FOR A LITERATURE REVIEW 19

2.3 CONCEPTS IDENTIFIED IN THE LITERATURE RELATED TO THE STUDY 20

2.3.1 Reproductive health 20
2.3.2 Overview of reproductive health 20
2.3.3 Adolescence 21

2.3.3.1 Refining peer relationships 22
2.3.3.2 Responding to appropriate sexual role 22
2.3.3.3 Sexual characteristics of adolescents 23
2.3.3.4 The development of the adolescent 23
2.3.3.5 Adolescents' reaction to puberty 24
2.3.3.6 Promotion of adolescent health 24
2.3.3.7 Problems of adolescent pregnancy 25
2.3.3.8 Socio cultural aspects of adolescent pregnancy 25
2.3.3.9 Cultural aspects of adolescent pregnancy 26
2.3.3.10 Reasons for adolescents seeking abortion 27
2.3.3.11 Dilemma of the pregnant adolescent 28

2.3.4 Maternal mortality and abortion 29
2.3.5 Abortion 29

2.3.5.1 Induced abortion 30
2.3.5.2 Religion and abortion 31

2.3.6 Abortion laws 31

2.3.6.1 Abortion law in the United States (US), Canada and the United Kingdom (UK) 31
2.3.6.2 Abortion laws in Africa 32
2.3.6.3 Abortion Law in Nigeria 32
2.3.6.4 Trends towards legalisation of abortion 34

2.3.7 Client rights and abortion 34
2.3.8 Professional issues of the midwife 37

2.3.8.1 Ethics in midwifery 38
2.3.8.2 Midwife's scope of practice 38
2.3.8.3 Professional accountability 39
2.3.8.4 Midwives as advocates 39

2.3.9 Strategies for reducing unsafe abortion 39

2.3.9.1 Adolescent empowerment 39
2.3.9.2 National policy 40
2.3.9.3 Outlawing of abortion 41

Table of contents Page

2.4 CONCLUSION ... 42

Chapter 3

Research methodology

3.1 INTRODUCTION ... 43

3.2 RESEARCH SETTING ... 43

3.2.1 Geographical area ... 43

3.3 RESEARCH APPROACH ... 44

3.4 RESEARCH DESIGN ... 44

3.4.1 Exploratory ... 45
3.4.2 Descriptive ... 45
3.4.3 Survey ... 45

3.5 RESEARCH PURPOSE, OBJECTIVES AND QUESTION ... 46

3.6 POPULATION ... 47

3.7 SAMPLE AND SAMPLING ... 47

3.7.1 Inclusion criteria ... 48

3.8 DATA COLLECTION ... 49

3.8.1 Characteristics of structured data collection ... 49
3.8.2 Rationale for using structured data collection ... 49
3.8.3 Data-collection technique ... 50
3.8.4 Data-collection instrument ... 51
3.8.5 Rationale for selecting the instrument ... 51

3.9 PRE-TEST ... 52

3.10 MEASURES TO ENSURE RELIABILITY AND VALIDITY ... 52

3.10.1 Reliability ... 53
3.10.2 Validity ... 53

3.11 DATA ANALYSIS ... 54

3.12 ETHICAL CONSIDERATIONS ... 55

3.12.1 Permission to conduct the study ... 55
3.12.2 Informed consent ... 56
3.12.3 Respect for persons as autonomous individuals ... 56
3.12.4 Justice ... 56
3.12.5 Beneficence ... 57

Table of contents Page

3.12.6 Confidentiality ... 57
3.12.7 The rights of the institution were protected ... 58
3.12.8 Scientific honesty of the researcher was assured ... 58

3.13 CONCLUSION ... 58

Chapter 4

Data analysis and interpretation

4.1 INTRODUCTION ... 59

4.2 SECTION A: DEMOGRAPHIC DATA ... 59

4.2.1 Item 1: Respondents' age ... 60
4.2.2 Item 2: Respondents' school attendance ... 60
4.2.3 Item 3: School-going respondents' highest class passed to date ... 61
4.2.4 Item 4: Non-school-going respondents' activities ... 62
4.2.5 Item 5: Respondents' ethnic groups ... 63
4.2.6 Item 6: Respondents' religious affiliations ... 63
4.2.7 Item 7: Discussion of sex with family ... 65
4.2.8 Item 8: Family members with whom respondents discussed sex ... 66
4.2.9 Item 9: Topics discussed with family members ... 67

4.3 SECTION B: ADOLESCENCE ... 68

4.3.1 Item 10: Respondents' understanding of the term "adolescence" ... 68

4.4 SECTION C: SEXUALITY ... 69

4.4.1 Item 11: Respondents' experience of sexual intercourse ... 69
4.4.2 Item 12: If answer to item 11 was "Yes" how old were you? ... 69
4.4.3 Item 13: Reasons for sexual intercourse ... 70
4.4.4 Item 14: Previous pregnancies ... 71

4.5 SECTION D: ABORTION ... 71

4.5.1 Item 15: Previous abortions ... 71
4.5.2 Item 16: Place where abortion was performed ... 71
4.5.3 Item 17: Respondents' awareness of a family member/friend/someone in the community who has had an abortion ... 71
4.5.4 Item 18: Respondents' reaction to knowledge of a family member/ friend/someone in the community having had an abortion ... 72
4.5.5 Item 19: Age at time of abortion ... 73
4.5.6 Item 20: Feelings about abortion ... 73
4.5.7 Item 21: Reasons for not undergoing an abortion ... 73
4.5.8 Item 22: Reasons (conditions) for having an abortion ... 73
4.5.9 Item 23: Opinions on abortion ... 75
4.5.10 Item 24: Sources of information on abortion ... 76
4.5.11 Item 25: Termination of the pregnancy ... 77
4.5.12 Item 26: Intention in case of non-termination ... 78
4.5.13 Item 27: Attitude towards an abortion ... 79

Table of contents Page

4.5.14 Item 28: Decision on termination of pregnancy ... 80
4.5.15 Item 29: Methods of abortion ... 81
4.5.16 Item 30: Abortion service providers ... 82
4.5.17 Item 31: When education on sex and abortion should be included in school ... 83
4.5.18 Item 32: Knowledge about post-abortal care ... 83
4.5.19 Item 33: Knowledge about types of post-abortal care ... 84
4.5.20 Item 34: Meaning of post-abortal care ... 84
4.5.21 Item 35: Availability of post-abortal services ... 85

4.6 SECTION E: KNOWLEDGE OF LEGALITY/LEGALISATION OF ABORTION ... 85

4.6.1 Item 36: Legality of abortion in Nigeria ... 85
4.6.2 Item 37: Meaning of legalisation of abortion ... 86
4.6.3 Item 38: Utilisation of abortion services ... 86
4.6.4 Item 39: Utilisation of abortion services if legal ... 87
4.6.5 Item 40: Advantages of the availability and use of abortion services ... 88
4.6.6 Item 41: Circumstances under which abortion should be allowed ... 89
4.6.7 Item 42: Circumstances under which a woman should end an unwanted pregnancy ... 90
4.6.8 Item 43: Taboos against abortion ... 91
4.6.9 Item 44: Adolescents' ability to access abortion services in Nigeria ... 91
4.6.10 Item 46: The restriction on abortion ... 91
4.6.11 Item 47: Adolescents' right to decide whether to have an abortion ... 92

4.7 CONCLUSION ... 92

Chapter 5

Findings, limitations and recommendations

5.1 INTRODUCTION ... 93

5.2 FINDINGS ... 94

5.2.1 Demographic information ... 94

5.2.2 Knowledge regarding reproductive health ... 95
5.2.3 Knowledge on abortion ... 96
5.2.4 Legislation on/Legalisation of abortion ... 99

5.3 IMPLICATIONS OF THE STUDY ... 100

5.3.1 Implications for midwifery ... 101

5.4 LIMITATIONS OF THE STUDY ... 101

5.5 RECOMMENDATIONS ... 101

5.5.1 Media sensitisation campaign, information and public meetings ... 101
5.5.2 NGOs and community-based organisations ... 102
5.5.3 Provision of care for unwanted pregnancies through comprehensive client-oriented reproductive health services ... 102
5.5.4 Provision of adequate and quality health facilities ... 102
5.5.5 Primary prevention of unwanted pregnancies ... 103

Table of contents Page

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH 103

5.7 CONCLUSION 104

BIBLIOGRAPHY 105

List of tables Page

Table 4.1 Respondents' highest class passed to date 61

Table 4.2 Respondents' activities 62

Table 4.3 Family members with whom respondents discussed sex 66

Table 4.4 Topics respondents discussed with family members 67

Table 4.5 Respondents' understanding of the term "adolescence" 68

Table 4.6 Whether respondents had had sexual intercourse 69

Table 4.7 Respondents' age at first sexual intercourse 69

Table 4.8 Respondents' reasons for sexual intercourse 70

Table 4.9 Respondents' experience of abortion 71

Table 4.10 Respondents' reaction to knowledge of a family member/friend/ someone in the community having had an abortion 72

Table 4.11 Respondents' reasons (conditions) for having an abortion 73

Table 4.12 Respondents' opinions on abortion 75

Table 4.13 Respondents' source of information on abortion 76

Table 4.14 Respondents' intentions if not about to terminate an unintentional pregnancy 78

Table 4.15 Respondents' attitude towards friends who had undergone an abortion 79

Table 4.16 Respondents' views on who should decide when a pregnancy should be terminated 80

Table 4.17 Respondents' views on the method of abortion 81

Table 4.18 Respondents' views on abortion service providers 82

Table 4.19 Respondents' views on when education on sex and abortion should be included in school 83

Table 4.20 Respondents' awareness of post-abortal care 83

Table 4.21 Respondents' knowledge of types of post-abortal care 84

Table 4.22 Respondents' understanding of post-abortal care 84

Table 4.23 Respondents' knowledge of the availability of post-abortal services 85

Table 4.24 Respondents' opinion of legality of abortion in Nigeria 85

Table 4.25 Respondents' understanding of the meaning of legalisation of abortion 86

Table 4.26 Respondents' conditions for accessing abortion services 86

Table 4.27 Respondents' willingness to utilise abortion services if legal 87

List of tables Page

Table 4.28 Respondents' reasons for the availability and use of abortion services 88

Table 4.29 Respondents' views on circumstances under which abortion should be allowed............................ 89

Table 4.30 Respondents' views on circumstances under which a woman should end an unwanted pregnancy.. 90

Table 4.31 Respondents' perception of the effect of taboos against abortion... 91

Table 4.32 Respondents' views on whether adolescents should be allowed to access abortion services in Nigeria.. 91

Table 4.33 Respondents' agreement or disagreement with the restriction on abortion..................................... 91

Table 4.34 Respondents' views on adolescents' right to decide on abortion 92

List of figures Page

Figure 1.1 Map of Nigeria ... 7
Figure 1.2 Map of Lagos State ... 8
Figure 4.1 Respondents' age ... 60
Figure 4.2 Respondents' school attendance ... 61
Figure 4.3 Respondents' ethnic groups ... 63
Figure 4.4 Respondents' religious affiliation ... 64
Figure 4.5 Respondents' discussion of sex with family ... 65
Figure 4.6 Respondents' awareness of a family member/friend/someone in the community who had had an abortion ... 72
Figure 4.7 Respondents' consent to termination of unintentional pregnancy ... 77

List of abbreviations

ADON	Association for Development Options
AIDS	Acquired Immune Deficiency Syndrome
ARFH	Association for Reproductive and Family Health
CAUP	Campaign for Unwanted Pregnancy
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CHESRAD	Centre for Health Training Research and Development
COMPASS	Community Participation for Action and Social Services
D & C	Dilation and curettage
HIV	Human Immune-deficiency Virus
IPPF	International Planned Parenthood Federation
LUTH	Lagos University Teaching Hospital
NGOs	Non-government organisations
NMA	Nigeria Medical Association
NMCN	Nursing and Midwifery Council of Nigeria
PHC	Primary health care
SPSS	Statistical Package for Social Sciences
STDs	Sexually transmitted diseases
Unisa	University of South Africa
USA	United States of America
WACNJ	West Africa College of Nursing Journal
WHO	World Health Organization

List of annexures

Annexure A Requesting permission from the Chief Medical Director of LUTH to conduct the research

Annexure B Consent obtained from the Chief Medical Director of LUTH to conduct the research

Annexure C Written consent of respondents

Annexure D Questionnaire

Annexure E Clearance certificate (Health Studies, Research and Ethics Committee, Unisa)

Chapter 1

Orientation to the research

1.1 INTRODUCTION

Abortion is the termination of a pregnancy by the removal or expulsion from the uterus of a foetus or embryo, resulting in or caused by its death (Fraser, Cooper & Nolte 2006:977). An abortion may occur spontaneously due to complications during pregnancy or may be induced, in humans and other species. In the context of human pregnancies, an abortion induced to preserve life or for any other reason is termed an elective abortion. The term *abortion* most commonly refers to the induced abortion of a human pregnancy, while spontaneous abortions are usually termed miscarriages. The methods of abortion are either medical and surgical or unsafe abortion. Women seeking to terminate their pregnancies sometime resort to unsafe methods, particularly where and when access to legal abortion is being barred, as in Nigeria.

More than 14 million adolescent women give birth each year. A large proportion of these pregnancies are unwanted, and it is estimated by the World Health Organization (WHO 1999:3) that as many as 4.4 million abortions are sought by adolescent girls each year.

Over 600 000 abortions are performed annually in Nigeria, despite restrictive abortion laws, and some sources say that over 60% of these are performed on adolescents between the ages of 15 and 24 (Federal Ministry of Health [FMOH] 2001:7). Eighty percent of pregnancies in unmarried girls in Nigeria are unplanned (Oye-Adeniran 2005:2). A community-based study in Nigeria found that at least one-third of women who obtained abortions were adolescents (Fatusi 2004:5).

Unsafe abortions can have dire consequences for women, their families and society as a whole (Akinrinola, Oye-Adeniran, Singh, Adewole, Wulf, Sedgh & Hussein 2006:4). More than 70 000 women die each year as a result of unsafe abortion; 23 000 of these occur in sub-Saharan Africa. In Nigeria, one in eight deaths related to pregnancy and 11% of maternal deaths are due to unsafe abortion (Fatusi 2004:5).

All over the world, efforts are being made to legalise abortion. However, abortion in Nigeria is illegal. Procurement of abortion can earn both the provider and the client fourteen (14) years' imprisonment with or without a fine (Atsenuwa 2005:3). Otoide, Oronsaye and Okonofua (2001:77) point out that the performance of an abortion is illegal under Nigerian criminal law unless the woman's life is threatened by the pregnancy. As a result, induced abortions are usually obtained clandestinely, and are frequently unsafe. Unsafe abortions are often the end result of an unwanted pregnancy, which in turn is often the result of lack of knowledge of such matters as safe contraception. This trend is most profoundly demonstrated among adolescents.

There is mounting pressure on the federal government to legalise abortion services to enable women in need of the service to access it. The Campaign against Unwanted Pregnancy (CAUP), a non-governmental organisation (NGO), is mobilising and educating people on the need to legalise abortion (Oye-Adeniran, Long & Adewole 2004:217).

Because of Nigeria's complex political system, the state of Lagos may not be allowed to legalise abortion in isolation. Nevertheless, NGOs, human rights activists and concerned individuals are endeavouring to legalise abortion through awareness campaigns, workshops and by lobbying political office holders. In 1991, backed by the Nigeria Medical Association, the FMOH made a proposal on reform of abortion law (Oye-Adeniran et al 2004:217). In 1994 the Nigerian government committed itself to reducing maternal mortality by signing on the Program of Action at the International Conference on Population and Development in Cairo. Yet a recent analysis found that, while the government has adopted policies aimed at reducing maternal mortality by 75% by 2015, those policies have not been implemented effectively (Abella 2009:1).

Nigeria's maternal mortality rate is the second-highest in the world after India – 1 100 maternal deaths per 100 000 live births. The country is home to 2% of the global population, but 10% of all maternal deaths take place in Nigeria (*Maternal death rate puts Nigeria in spotlight* 2010:1). Up to one-third of maternal deaths are due to unsafe abortions and two-thirds of these are adolescents between the ages of 15 and 24 years. Hospital-based studies have shown that in Nigeria up to 80% of patients with abortion-related complications are adolescents (FMOH 2001:7).

Unsafe/illegal abortions contribute to maternal mortality, particularly when not controlled by acceptable rules and regulations to ensure the health and safety of the mother. In a study on morbidity and mortality following induced abortion in Nnewi, Nigeria, Ikechebelu and Okoli (2003:1) found that 1.3% of the admissions during the period 1996 and 2000 were due to illegal induced abortions, with a mortality rate of 5.3% for induced abortion. This accounted for 21.1% of the total maternal deaths. The mean age of the women was 20.6 years; however, 55.3% of the patients were adolescents (between 15 and 24 years). It is also significant that 45.1% of the mid-trimester abortions occurred in this group. General sepsis, haemorrhage, pelvic infection with peritonitis and abscess formation, uterine perforation, and gut injury were the major complications encountered.

In order to reduce the maternal mortality rate in Nigeria, it is essential that clients be allowed to make informed choices regarding their reproductive health and abortion per se. Abella (2009:1) reports that Nigeria still has one of the lowest rates of births assisted by trained health providers in West Africa. Furthermore, although reproductive services may be available, there is lack of access to contraceptive services and lack of education.

Deaths from unsafe abortions are preventable (FMOH 2003:44). Efforts to protect adolescents from uninformed decisions should be made. Adolescents have the right to life and their opinion should be considered when making decisions that affect them. Efforts are now being made to provide rules and regulations for abortion in Nigeria. As mentioned above, in 1991, backed by the Nigeria Medical Association (NMA), the FMOH proposed reform of the abortion law (Oye-Adeniran, Long & Adewole 2004:217).

1.2 BACKGROUND TO THE STUDY

1.2.1 Legality of abortion in Africa

In Africa, abortion laws differ. For example, in Egypt, Libya and many African countries, abortion is prohibited or permitted only to save a woman’s life. In Sudan, abortion is permitted only to save a woman’s life and in one or more special cases such as rape, incest, or foetal impairment or abnormality. In Gambia and Ghana, abortion is permitted on physical and mental grounds. In Tunisia and Cape Verde, abortion is only permitted on broad socio-economic grounds and on health grounds, or without restriction as to

reason within gestational limits (Population Reference Bureau 2005:3). Throughout sub-Saharan Africa, induced abortion is highly restricted, with few countries permitting abortion for reasons other than a threat to the mother's life.

Data on the extent of induced abortion in sub-Saharan Africa is inconsistent and there is substantial under-reporting. Community-based surveys tend to produce gross underestimates, as the nature of the subject and the illegality of the procedure discourage accurate reporting. Hospital surveys are limited. A community-based study conducted among women of childbearing age in Nigeria reported that only 5.6% of the women admitted that they had ever had an induced abortion (Rasch, Silberschmidt, Mchumvu & Vumilia 2000:52).

1.2.2 Nigeria

Demography and geography

Nigeria is the most populous country in Africa, accounting for approximately one-sixth of Africa's people.

Nigeria is a large country in West Africa, situated on the Gulf of Guinea, north of the equator. The country covers about 923 786 km^2 . Nigeria is bordered by Cameroon on the east, Benin on the west, Niger and Chad on the north, and the Atlantic Ocean on the south. There are many rivers in Nigeria but the two main rivers are the Niger and the Benue (http://www.lonelyplanet.com/maps/africa/nigeria/map_of_nigeria.jpg) (accessed on 04.04.2007).

Climate

Nigeria has a tropical climate with warm temperatures throughout the year. The northern part is generally hotter and drier than the south. Nigeria has two main seasons, the dry and the rainy season. The rainy season lasts from April to October in most parts of the country, though it usually extends for a longer period in the south.

Population

The United Nations estimated that Nigeria's population in 2005 was 141 million, and predicted that it would reach 289 million by 2050. Nigeria has recently undergone the start of a population explosion owing to higher fertility rates (Demographics of Nigeria 2010:1).

Age structure

The age structure in Nigeria is as follows:

- 0-14 years: 44% (male 27 181 020; female 26 872 317)
- 15-64 years: 53% (male 33 495 794; female 32 337 193)
- 65 years and over: 3% (male 1 729 149; female 1 722 349) estimated in 2000

Birth rate

The birth rate in Nigeria is as follows:

- 43 births/1 000 population (estimated in 2008)

Infant mortality rate

The infant mortality rate in Nigeria is as follows:

- 74.18 deaths/1 000 live births (estimated in 2000)

Total fertility rate

The total fertility rate in Nigeria is as follows:

- 5.9 children born/woman (estimated in 2008)

(Demographics of Nigeria 2010:3).

Religions

The main religions in the country are the Muslim religion, Christianity and African traditional religions, with about 15% of the population practising traditional religion based on the worship of many gods. People throughout the country may combine Christian or Islamic with traditional beliefs.

Education

About 50% of Nigeria's adults can read and write. The official language is English, which is taught in schools. A form of broken English locally called Pidgin English is also spoken. Most Nigerians speak more than one language, namely the language of their ethnic group, English and any other language. Nigeria has more than 250 different ethnic groups, each with its own distinct language. The three most widely used languages are those of the three largest ethnic groups: Hausa, Yoruba and Igbo.

Resources

Nigeria is an oil-rich country. Crude oil is found widely and is drilled in the Niger Delta area in the south of the country.

Government

Nigeria is a developing country, divided into six geo-political zones, and further into 36 states including the federal capital territory, Abuja (*World Book Encyclopaedia* 1997:410-418). Each state is divided into local government areas. There are 774 local government areas in the country. Each local government area has at least one comprehensive health centre. The states own the general hospitals while the federal government and, in some cases, states own the specialist and teaching hospitals. The local government areas are under the states, and the states are under the federal government. The states are not totally independent of the federal government This is why it may not be easy for any particular state to legalise abortion without the support of the federal government. Therefore the pressure is on federal government to legalise abortion so that the law will be passed from the federal government to the state

government. There are also mission hospitals, private hospitals and maternity homes all over the country (see figure 1.1).

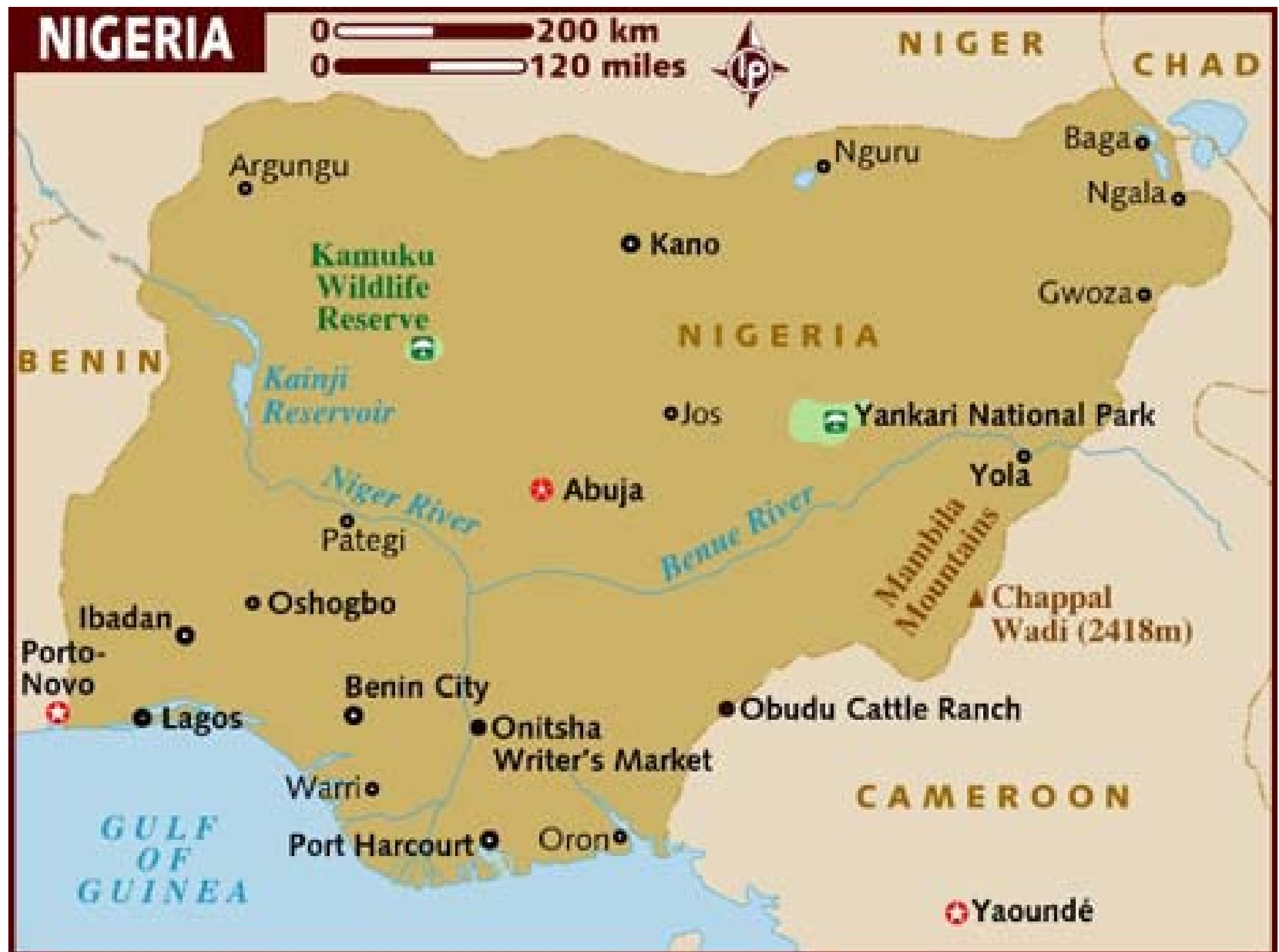


Figure 1.1 Map of Nigeria

Source: (http://www.lonelyplanet.com/maps/africa/nigeria/map_of_nigeria.jpg (accessed on 04.04.2007)

Lagos State of Nigeria

Lagos State, the former administrative headquarters of Nigeria, is the country's largest and most commercial centre. It is in the southwest geo-political zone, is an island with many creeks and lagoons and covers a geographical area of 300 km^2. It is the most populous area in Nigeria, with an estimated population of 9 013 534 (4 678 020 males and 4 335 514 females) (National Population Commission 2006:11). Lagos State has 27 local government areas (see figure 1.2).

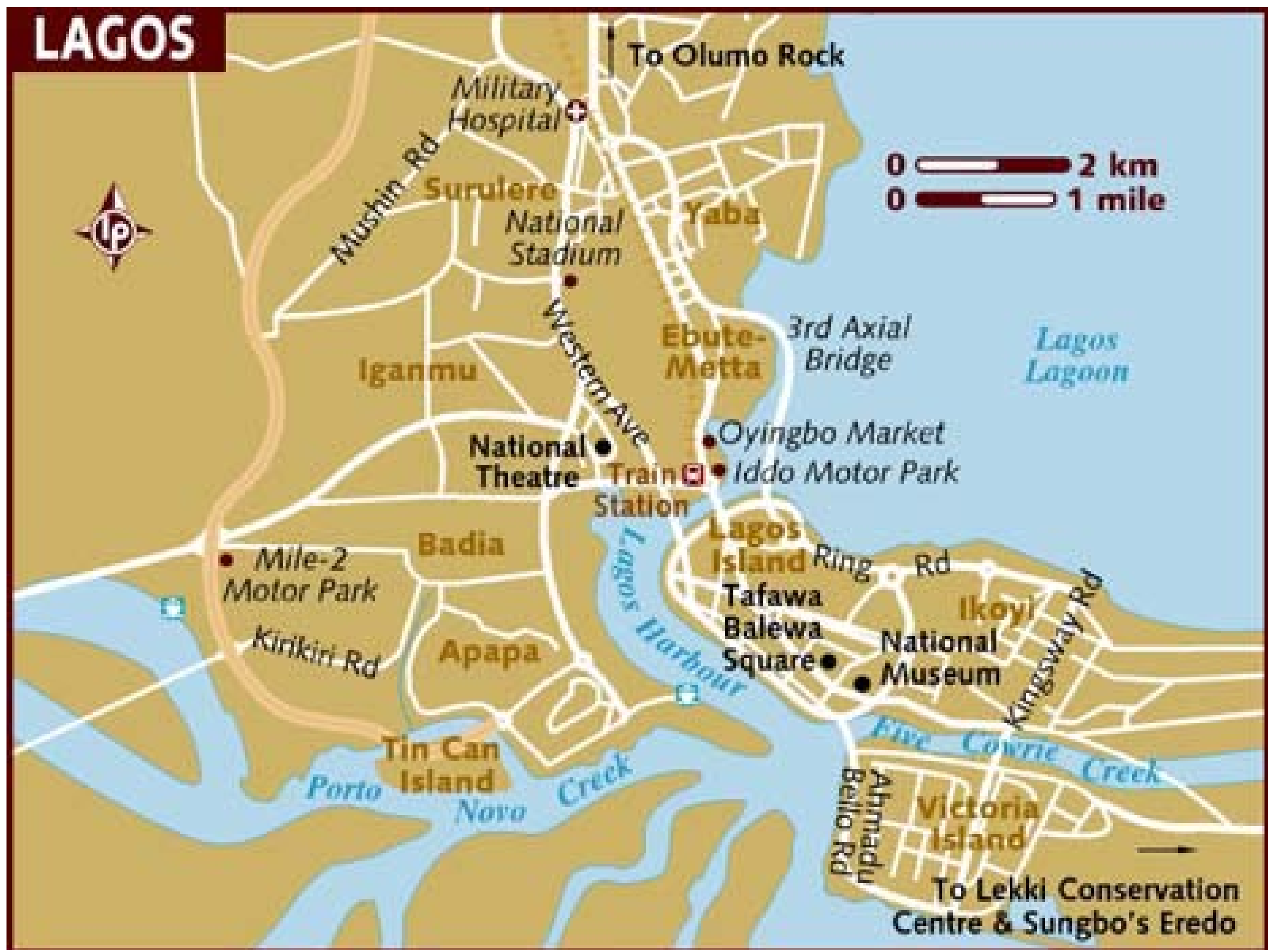


Figure 1.2 Map of Lagos State

Source: (http://www.lonelyplanet.com/maps/africa/nigeria/map_of_nigeria.jpg)
(accessed on 04.04.2007)

The study was conducted in Lagos University Teaching Hospital (LUTH) complex in Idi-araba, Lagos, Nigeria which is between Mushin and Mainland local government areas.

1.2.3 Maternal health care facilities in Lagos State

The health care facilities in Lagos State include 884 private, 74 primary, 13 secondary and 2 tertiary institutions in addition to health centres (Fatusi & Ijadunola 2003:vii).

Health centres

Health centres offer family planning services, run infant welfare clinics, treat minor ailments and run antenatal services. They do not undertake maternal deliveries, as they do not offer 24-hour services.

Comprehensive health centres serve as referral centres for patients from a health centre. One of the functions of a comprehensive health centre, for instance, is to take over the management of pregnant clients after 36 weeks or if there is any complication before 36 weeks.

Comprehensive health centres are found in all 27 local government areas. The personnel (human resources) include nurses and midwives, community health workers and domestic staff. There may be a medical officer (doctor) who is permanently attached or who visits two or three times a week, or there may not be a doctor. The nurses and midwives there are usually well trained and well orientated to their scope of practice. Patients are referred from home and farms.

A comprehensive health centre is a primary health care (PHC) facility that treats minor ailments; offers maternity services, infant welfare clinic, family planning services, including post-abortion care, and voluntary counselling for Human Immune-deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), and runs 24-hour services. However, it does not perform major surgical procedures like Caesarean sections or laparotomies that may require blood transfusion or major anaesthesia. It also does not admit a patient for more than 72 hours, but refers patients to general hospitals or speciality hospitals.

General hospitals in 20 local government areas

General hospitals are second-level hospitals. They offer the same services as comprehensive health centres and, in addition, treat all ailments except malignant conditions, perform major surgery, and have facilities for blood transfusion and other laboratory services. The workforce includes all categories of health workers including resident doctors. Patients come from lower-level health facilities, such as the

comprehensive health centres, as well as from home. General hospitals run 24-hour service and patients can be admitted there for as long as their condition requires.

Teaching hospitals

A teaching hospital is a tertiary institution that offers the above services as well as specialist services in all fields of medicine and services in all branches of medicine, treats all cases including malignant diseases, and offers all laboratory services. It is a referral centre and the LUTH, for instance, receives patients from Lagos and outside Lagos. It is also a training centre for colleges of medicine of affiliated universities. All the health institutions offer reproductive health services, including post-abortion care.

1.2.4 Adolescents' rights in Nigeria

Reproductive rights are a series of legal rights and freedoms relating to reproduction and reproductive health. The World Health Organisation defines reproductive rights as follows: "Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely on their reproductive processes". All persons have such rights. Adolescents in Nigeria also are entitled to rights, including (FMOH 2003:11-12) the right to:

- reproductive and sexual health as components of overall lifelong health
- sexual and reproductive decision making, including choice of marriage partners, family formation and determination of the number, timing and spacing of children and all the means to exercise those choices
- sexual and reproductive security, including freedom from sexual violence and coercion and the right to privacy

Most adolescents are not aware of their human rights with regard to their reproductive health (FMOH 2001:35).

1.2.5 Strategic plan to reduce maternal mortality in Nigeria

In the strategic plan to reduce maternal mortality in Nigeria (FMOH 2003:3), one of the objectives was a reduction of 50% in maternal mortality by the year 2006. Adolescents who seek abortion services do so secretly, usually consulting illegal practitioners, and in unsafe conditions, leading to death or morbidity in most cases. Adolescents are a country's most important group, and can significantly alter and improve the socio-economic and political situation of the country (FMOH 2001:5). In fact, recognition of the importance of adolescents is an indication of their potential to influence the course of human history (FMOH 2004:5). Post-abortion care services are available for adolescents in Nigeria. Health workers are trained to provide such services (FMOH 2004:6). The Community Participation for Action and Social Services (Compass) an NGO, has embarked on massive training of health workers in post-abortion care (FMOH 2004:6).

1.3 RATIONALE FOR THE STUDY

Worldwide, an estimated 19-20 million unsafe abortions take place every year; 97% of these are in developing countries. Despite its frequency, unsafe abortion remains one of the most neglected global public health challenges (Grimes, Benson, Singh, Romero, Ganatra, Okonofua & Shah 2006:2).

Adolescent pregnancy has been found to have negative long-lasting health, social and economic consequences on the life of the adolescent. Pregnant adolescents are often expelled from school and may not have an opportunity to be reabsorbed into the school system. This will hinder adolescents' future developmental opportunities as well as their quality of life (FMOH 2001:34).

Most adolescents are not aware of their human rights with regard to their reproductive health (FMOH 2001:35). The researcher, therefore, considered it would be helpful to investigate Nigerian adolescents' knowledge about abortion. The adolescents in the study were those living in the area of the Lagos University Teaching Complex.

1.4 PROBLEM STATEMENT

As a result of gathering the information and statistics quoted in the introduction, and of her experience of the consequences of unsafe abortion while working at the LUTH Complex, the researcher came to the conclusion that pregnancy among unmarried adolescents is a serious reproductive health problem in Nigeria, as in all developing countries.

As described above, the health and social consequences of unwanted or unintended adolescent pregnancies include increased risk of maternal death, pregnancy and birth-related complications. Furthermore, adolescents keep the pregnancies secret/away from their parents or guardians with consequences such as lack of support and increase in unsafe abortions. The socio-economic consequences include education and job termination, stigmatisation, loss of self-esteem and perpetuation of the poverty gap and cycle (Amobi & Igwegbe 2004: 93).

Understanding the extent of adolescents' knowledge or lack of knowledge about abortion at the LUTH Complex should help policy makers to develop programmes to meet the challenges (Amobi & Igwegbe 2004:93).

The researcher found no study on adolescents admitted to the LUTH Complex in the past for unintended/unwanted/unsafe abortions.

1.5 RESEARCH QUESTION

In order to examine the research problem, the researcher formulated the following question:

What is the level of knowledge of adolescents at the LUTH Complex regarding abortion?

1.6 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the knowledge regarding abortion of adolescents admitted to the LUTH Complex.

1.7 OBJECTIVES OF THE STUDY

The specific objectives of this study were to

- explore adolescents' knowledge about their reproductive health
- determine the knowledge about abortion in adolescents
- determine adolescents' knowledge of abortion legislation in Nigeria
- identify unsafe practices regarding abortion

1.8 SIGNIFICANCE OF THE STUDY

The researcher found no previous studies undertaken at the LUTH Complex in Nigeria on adolescents' knowledge about abortion. Assessing adolescents' knowledge of their right to take decisions affecting their reproductive health might help identify groups of clients at risk and hence lead to improved health care for adolescents. Allowing adolescents to make their own decisions regarding abortions may improve the quality of lives and alleviate the detrimental effect of illegal abortions on the community and health services. Contributing information that might lead to legalising termination of pregnancy would assist towards the reduction of maternal mortality from unsafe or illegal abortions.

1.9 RESEARCH DESIGN AND METHODOLOGY

The researcher adopted a quantitative approach. In quantitative studies, researchers collect and analyse numerical information statistically. Quantitative research is a formal, objective, rigorous, systematic process for generating information about the world. It is also used to conduct and describe new situations, events, and concepts in the world (Burns & Grove 2005:27). In the case of this study, the researcher wished to examine Nigerian adolescents' knowledge about abortion.

1.9.1 Research design

The researcher used a non-experimental, exploratory, descriptive research design for the study. The purpose of such a design is to provide an explicit description of the phenomenon explored so that it can be addressed (Burns & Grove 2005:211).

1.9.2 Population and sample

The study was conducted at the LUTH Complex at Idi-arba in Lagos in Nigeria. The following services form part of the LUTH complex: a gynaecological clinic; nurses' sickbay; staff clinic; and family planning clinic. The LUTH Complex was chosen because it is a referral centre and provides many services that adolescents can utilise.

The target population was adolescent female clients utilising the services of the LUTH Complex at Idi-araba in Lagos in Nigeria, those who worked or lived in the LUTH Complex and those who utilised recreational facilities in the LUTH Complex. The sample was drawn from the target population. A non-probability sampling design using convenient sampling was used to select the sample. The sample consisted of 100 adolescents. The researcher selected subjects who met the inclusion criteria. To be included in the study, the respondents had to be female adolescents between 13 and 17 years old, and be able to speak Yoruba, Ibo, Pidgin and English, the languages with which the researcher is conversant (see chapter 3, section 3.5).

1.9.3 Data collection

Data collection is a "systematic way of gathering information which is relevant to the research purpose or questions" (Burns & Grove 2005:56). The researcher collected data using a structured, pre-tested interview schedule. A structured interview schedule enables the researcher to be consistent in asking questions and the data yielded is easy to analyse (Brink 2006:149) (see chapter 3, section 3.7). The researcher administered the interview schedule.

1.9.4 Data analysis

A professional statistician at the University of South Africa (Unisa) used the Statistical Package for Social Sciences (SPSS) Version 13.0 computer program to analyse the data, and descriptive statistics presented by means, frequencies and percentages were used to present the data.

1.10 ETHICAL CONSIDERATIONS

Pera and Van Tonder (2005:3) define ethics as "a code of behaviour considered correct". The following principles were considered in this study: permission to conduct the study, respect for persons as autonomous individuals, confidentiality and anonymity, avoiding harm, justice, and informed consent (see chapter 3, section 3.9).

1.11 RELIABILITY AND VALIDITY

Burns and Grove (2003:198-200) describe validity as "the degree to which the instrument measures what it is supposed to measure". The researcher focused on content validity, which is the degree to which the items in an instrument adequately represent the universe of the content. The structured interview schedule was given to clinical staff dealing with abortion and to staff with research experience to determine whether the items in the interview schedule measured the levels of knowledge relating to abortion.

Pre-testing the instrument was carried out to obtain information to improve the interview schedule and to assess the feasibility of the study. The respondents in the pre-test were similar to those in the study and it was done under similar settings but they were not included in the main study. Conducting a pre-test assisted the researcher to identify problems with the structured interview schedule and indicated the time needed to interview an individual, which was important in obtaining consent to participate in the study (Polit, Beck & Hungler 2001:33). Completion of the interview schedule took 40 minutes.

1.12 DEFINITION OF KEY TERMS

For the purposes of this study, the following terms are used as defined below:

Abortion

Abortion is the termination of a pregnancy by the removal or expulsion from the uterus of a foetus or embryo, resulting in or caused by its death. An abortion may occur spontaneously due to complications during pregnancy or may be induced. In the context of human pregnancies, an abortion induced to preserve the health of the pregnant female is termed a therapeutic abortion, while an abortion induced for any other reason is termed an elective abortion. In this study *abortion* is a response to unplanned/unsafe pregnancy (http://en.wikipedia.org/wiki/Abortion).

Adolescent

Collins English Dictionary (2001:20) defines *adolescence* as "the period in human development that occurs between the beginning of puberty and adulthood" and *adolescent* as "of or relating to adolescence; an adolescent person". In research articles referred to in the text various ages of the adolescents were mentioned, but in this study *an adolescent* refers to a person between the ages of 13 and 17.

Contraception

Contraception means "the intentional prevention of conception by artificial or natural means. Artificial methods in common use include preventing the sperm from reaching the ovum (using condoms, diaphragms, etc), inhibiting ovulation (using oral contraceptive pills), killing the sperm (using spermicidal substances), and preventing the sperm from entering the seminal fluid (by vasectomy). Natural methods include the rhythm method and *coitus interruptus*" (*Collins English Dictionary* 2001:346).

Knowledge

Collins English Dictionary (2001:856) defines knowledge as "the facts, feelings or experiences known by a person or group of people; the state of knowing; awareness,

consciousness or familiarity gained by experience or learning; specific information about a subject". In this study, knowledge refers to the information adolescents have regarding reproductive health, abortion, legalisation of abortion and their knowledge with regard to unsafe abortions and the consequences thereof.

Legalisation

To legalise means, "to make lawful or legal" and legalisation is the act of doing so (*Collins English Dictionary* 2001:888). For the purpose of this study, legalisation refers to making abortion services legally available without restriction.

Termination of pregnancy

Termination of pregnancy means the separation and expulsion, by medical or surgical means, of the products of conception in the uterus of a pregnant woman (Hord & Xaba 2001:32). The given definition is applicable to this study.

Unsafe abortion

Unsafe abortion is defined as a procedure for terminating an unintended pregnancy, either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both (Grimes et al 2006:1).

Unwanted pregnancy

Unwanted pregnancy refers to one that may not have been planned, that is therefore unintentional and possibly unwelcome for the pregnant woman. Such a pregnancy may occur as a result of contraceptive failure, non-utilisation of contraceptives, rape or incest (Okonofua, Odimegwu & Ajabor 1999:71).

1.13 OUTLINE OF THE STUDY

This chapter introduced the study and gave the background, described the purpose, objectives, research methodology, ethical considerations, reliability and validity of the study, and defined key terms.

Chapter 2 discusses the literature review undertaken for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 presents the data analysis and interpretation.

Chapter 5 concludes the study, presents conclusions and makes recommendations for future research.

1.14 CONCLUSION

This chapter explained the background to the study, stated the problem, discussed the purpose, objectives and significance of the study, defined key terms, briefly discussed the research design and methodology and ethical considerations, and outlined the study.

Chapter 2 discusses the literature review conducted on the knowledge of abortion and related topics of adolescents.

Chapter 2

Literature review

2.1 INTRODUCTION

This chapter describes the literature review conducted on topics related to unsafe abortion and adolescents' knowledge regarding abortion. As Polit and Beck point out (2004:88, 89), a literature review refers to "an extensive and systematic examination of books, publications and articles relevant to the research" and "involves the systematic identification, location, scrutiny and summary of written materials that contain information on a research problem". What is known about the topic and what has been done on the research topic are both reflected.

2.2 RATIONALE FOR A LITERATURE REVIEW

The rationale for a literature review is to gain knowledge about the research topic per se and existing research on similar topics. The purpose is to identify and define concepts and variables, formulate the problem statement, and select the research design and methodology. It also assists in forming a basis for comparison for data analysis and interpretation.

In this study, the literature review assisted the researcher to contextualise the problem and to formulate the research question (see chapter 1, section 1.5). Furthermore, it familiarised the researcher with the topic and helped to identify gaps and weaknesses in the literature in order to justify the present study. Brink (2006:67-68) points out that the researcher should discover what is known and what remains to be done in the field of study, or what could be replicated, or which findings might be compared and contrasted with the proposed study. The researcher should see the problem with a broader perspective and evaluate findings and their significance more effectively (Brink 2006:68).

During the literature review, the researcher became aware of unresolved research on the research topic, as well as the methodology and instruments used by other researchers. This indicated shortcomings identified in approaches and methods (Brink 2006:63) (see chapter 3 for full discussion of research design and methodology).

2.3 CONCEPTS IDENTIFIED IN THE LITERATURE RELATED TO THE STUDY

The review of literature revealed the following significant concepts related to the research topics of: reproductive health in the adolescent years, maternal mortality, abortion including unsafe abortion and abortion laws, client rights, professional issues of the midwife, and strategies to reduce unsafe abortion.

2.3.1 Reproductive health

The World Health Organization (WHO) (1999:4) defines reproductive health as "a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity in all matters related to the process". Reproductive health therefore implies that people are able to have a satisfying safe sexual life and that they have the capability to reproduce and freedom to decide if, when and how often to do so.

2.3.2 Overview of reproductive health

The majority (80%) of pregnancies in unmarried girls in Nigeria are unintended (Oye-Adeniran 2005:2). Over 600 000 abortions occur annually in Nigeria and more than 60% of them are performed on adolescents (Oye-Adeniran 2005:2).

The Advocates for Youth Organisation (2007) reports that, globally, over 148 000 teenage pregnancies end in induced abortion annually. In Nigeria adolescents suffer up to 80% of abortion-related complications and one-third of women who have an abortion are adolescents (Henshaw, Singh, Adewale, Oye-Adeniran, Iwere & Cuca 1998:4). For this reason educators, service providers and health professionals in communities worldwide advocate for adolescents to receive comprehensive sexuality education in order to help them become sexually healthy adults, practice safer sexual behaviours and reduce unintended pregnancy and abortion (http://www.siecus.org/pubs/guidelines/guidient/pdf (accessed on 04.04.2007)). The researcher is of the opinion that the formal

education system is one of the most effective mechanisms for disseminating life-saving and reproductive health information. Community structures also offer education to adolescents (Helman 2007:157). In Nigeria, however, many adolescents lack access to schooling, where they would have access to health education and counselling programmes to provide vital information on reproductive health issues (Fatusi 2004:5). In addition, discussion of the sexual and reproductive health of the adolescent is taboo; therefore it is either neglected or inadequately addressed.

2.3.3 Adolescence

As stated in Chapter 1, *Collins English Dictionary* (2001:20) defines *adolescence* as "the period in human development that occurs between the beginning of puberty and adulthood" and *adolescent* as "of or relating to adolescence". The WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood (WHO) (1999:4). *Mosby's Medical and Nursing Dictionary* (1986:29) defines adolescence as "the period in development between the onset of puberty and adulthood". It usually begins between 11 and 13 years of age, with the appearance of secondary sex characteristics, and spans the adolescent years, terminating at 18 to 20 years of age with the acquisition of completely developed adult form.

Adolescence is the transitional period from childhood to adulthood. (Berman, Snyder, Kozier & Erb 2008:280-288) describe adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. This period is characterised by physical growth, mental milestones and increased height and weight. Secondary sexual characteristics appear and continue until maturity. During this period the individual undergoes extensive physical, psychological, emotional and personality changes. Berman et al (2008) refer to the developmental tasks of adolescence as

- refining peer relationships
- responding to an appropriate sexual role
- accepting one's physique and effectively using the body

2.3.3.1 Refining peer relationships

As adolescents pull away from parents in search of identity, the peer group takes on a special significance. It may become a safe haven in which the adolescent can test new ideas and compare physical and psychological growth. In early adolescence (ages 11-13 years), the peer group usually consists of non-romantic friendships; as the young person moves into mid-adolescence (14-16 years) and beyond, the peer group expands to include romantic friendships (Mayo Clinic 2007). Mid-to-late adolescence (15-19 years) is characterised by a need to establish sexual identity through becoming comfortable with one's own body and sexual feelings (Berman et al 2008).

2.3.3.2 Responding to appropriate sexual role

Through romantic friendships, dating and experimentation, adolescents learn to express and receive intimate or sexual advances in a comfortable manner that is consistent with internalised values (Mayo Clinic 2007). A typical myth of the adolescent is that of the indestructible self: "It will never happen to me, only the other person". In this case "it" may represent becoming pregnant or incurring a sexually transmitted disease after having unprotected intercourse, causing a car crash while driving under the influence of alcohol or drugs and other risky behaviours (FMOH 2001:1-7).

Parents, teachers, health-care providers and religious leaders should provide adolescents with information about sexuality and reproductive health issues to guide them into becoming sexually healthy adults. Where this is not properly done they get distorted information from peers. Existing services are not established with young people in mind and young people are never involved in planning or evaluating the services (Irinoye, Oyeleye, Adeyemi & Tope-Ojo 2004). Policies and legislation do not favour the needs of the adolescent, hence the need for a review of policy with adolescent input. Discovery of unintended pregnancy in the adolescent can lead to crisis episodes, disrupting previous adjustment and requiring development of new coping methods which could lead to seeking abortion.

2.3.3.3 Sexual characteristics of adolescents

The FMOH (2001:1-7) describes the following sexual characteristics of adolescents:

- Adolescents are more likely to have sex with non-marital partners.
- Most adolescents are not ready for marriage by the time they have their first sexual encounter (reasons include being still in school, being too young for marriage).
- Adolescents are more likely to engage in transactional sex (reasons include not being mature enough for a stable relationship, still experimenting and so on).
- Adolescents are more likely to have more than one sexual partner (reasons include peer influence, unsteady romantic relationships).
- Adolescents are less likely to use condoms during sexual intercourse with non-marital partners (reasons include myths: "I cannot get pregnant with just this one", "I did it standing up", and so on).
- Adolescents are less likely to use condoms during sexual intercourse with sexual partners (reasons include experimentation sex, not being prepared for sex when it happens, being too shy to buy a condom, and so on).
- Adolescents are more likely to experience STI (sexually transmitted infection) symptoms.
- The first sexual intercourse is usually experimental and adolescents are usually not prepared for it and do not take any protective measures.

2.3.3.4 The development of the adolescent

Adolescence brings physical, emotional and social upheaval. During this age secondary sexual characteristics develop. The adolescent is eager to grow up and yet fearful of the implications.

The Mayo Clinic (2007) lists the following as adolescent development tasks:

- achieving new and more mature relationships with age-mates of both sexes
- achieving a masculine or feminine social role
- preparing for marriage or family life

- acquiring a set of values and ethical systems as a guide to a behaviour-developing ideology

2.3.3.5 Adolescents' reaction to puberty

Adolescence is the time when adolescents' self awareness reaches a peak with sexual awareness. They try to either hide or advertise changes in their body. There is an inner urge to sexual awakening. The girl in early adolescence may experience pleasant sensations and even tingling in the genital area.

The Mayo Clinic (2007) points out that adolescents engage in sexual relationships for pleasurable sensations, to satisfy their sexual drive, out of curiosity or a desire for conquest, as an expression of affection, or because of inability to withstand pressures to conform. Adolescents are limited in their knowledge and understanding of sexuality in the opposite sex. Adolescents are at the stage of life when the sexual aspects of interpersonal relationships become particularly important. Society places the responsibility on the girl for inhibiting the boy's sexual advances, therefore if she accedes (through the need to conform or gain acceptance), she is faced with fear of disease or pregnancy or just being labelled fast or bad, resulting in feelings of guilt or worthlessness. Adolescents need to know more about the mechanics of conception, gestation and birth and sexuality and to be helped to view the nature of sex as a powerful life force to be utilised (Mayo Clinic 2007).

2.3.3.6 Promotion of adolescent health

Adolescents are healthy individuals, eager to learn about themselves, and vulnerable to practices that may be hazardous to their health and wellbeing. They need someone to whom they can turn to for guidance. Health professionals have the opportunity to provide the adolescent with factual information and to clarify misconceptions and discuss health problems like teenage pregnancy, sexually transmitted infections, drugs and alcohol (FMOH 2001:1-7).

2.3.3.7 Problems of adolescent pregnancy

The maternal mortality rates for pregnant adolescents aged 15 and under are seven times higher than those of women aged 20 to 24. Girls under 15 years of age suffer more than their older counterparts (Fatusi 2004:5). The infant mortality rate in Nigeria is 121 deaths per 1000 live births for babies born to mothers aged 15 to 19, compared with 70 deaths per 1000 live births for mothers aged 20 to 29 (FMOH 2001:8).

The FMOH (2001:33-40) lists the problems of adolescent pregnancy as follows:

- Higher maternal and infant mortality rates.
- Limited education and employment opportunities when adolescents drop out of school because of developmental and reproductive health problems.
- Violence and crime as indicative of adolescent under-development, with consequent impact on national security and development.
- Constraints on infrastructure availability when national planning cannot keep up with increasing population.
- Uncertainty of political and economic stability.

2.3.3.8 Socio cultural aspects of adolescent pregnancy

Adolescents are likely to drop out of school as a result of pregnancy. This may lead to unemployment with a tendency to crime. Unintended pregnancy can lead to low self-esteem, which may result in drug, alcohol and other substance abuse and predispose the girl to violence and criminal activities, together with other antisocial behaviour (FMOH 2001:6).

South Africa, for instance, has a very high rate of adolescent pregnancy and parenthood. The average age of the adolescent mother is about 18 years (Cronje & Grobler 2003:666). Although many adolescent mothers do achieve a successful outcome of their pregnancy and parenting, mortality and morbidity amongst babies born to these mothers is increased and the mothers show a higher risk of developing complications such as hypertensive disorders and intrapartum complications (Fraser et al 2006:22). For many adolescent mothers, pregnancy and parenthood mean an early conclusion to their education, with consequently reduced career opportunities and

increased likelihood that they will find themselves socially excluded and living in poverty (Fraser et al 2006:22).

2.3.3.9 Cultural aspects of adolescent pregnancy

In Nigeria it is not culturally acceptable for a girl to get pregnant before marriage (Akinrinola et al 2006:42; Henshaw et al 1998:4; Irinoye et al 2004:25-30). There are widespread differences in the perceptions of conception, pregnancy and birth among different cultural groups (Elder 1998:51-62), such as that if one aborts a pregnancy one may not have children in future. The inherited belief system of a particular society informs members about the nature of conception, the proper conditions of procreation and child-bearing, the workings of pregnancy and labour, and the rules of pre- and post-natal behaviour.

Beliefs about the functioning of the body, and the nature of conception and pregnancy, especially when the woman is most likely to conceive, are a key aspect of any birth culture. In all societies, the division of the social world into “male” and “female categories means that boys and girls are socialised in different ways (Helman 2007:157). They are educated to have different expectations of life, to develop emotionally and intellectually in particular ways, and are subject in their daily lives to different norms and behaviour. Whatever the contribution of biology to human behaviour, it is clear that culture also contributes a set of guidelines, both explicit and implicit, that are acquired from infancy onwards, and tell the individual how to perceive, think, feel and act as either a male or a female member of society.

One of the most basic elements of social structure and an important part of the symbolic system of any particular society is the division of society into two gender cultures. In a study among Muslim Swahilis, Kenya, on the division of norms, Helman (2007:158) found that men considered women to “be sexually enthusiastic and sexually responsible, given the opportunity”. Women were expected to be dependent on men, but at the same time the men also feared the polluting power of their menstrual blood. Men were expected to support and therefore control both women and children. This control was considered most effective when exerted over the virginity of their unmarried daughters, but less effective when dealing with the faithfulness of their wives (Helman

2007:182-184). For an adolescent girl in that community, marriage and its consummation were the only way to female adulthood.

Different attitudes to contraception and abortion seem to vary widely between cultures. The particular "population policy" of a culture may include a widespread tolerance of abortion, acceptance of abortion under certain limited circumstances or strict taboos against it at any stage (Helman 2007:182-184). In the Western world, the debate on abortion centres on both whether the woman is entitled to control over her own body and fertility, and whether the foetus is regarded as a "person", with the same rights as other members of the society, or merely as an organ or collection of cells (Helman 2007:182-184). Abortion is a controversial issue in many societies, and there are many different cultural attitudes towards it. In Nigeria, as pointed out in Chapter 1, abortion is illegal.

2.3.3.10 Reasons for adolescents seeking abortion

According to the FMOH (2001:33-35), adolescents seek abortion for different reasons, including:

1. *Shame and stigma associated with unwanted pregnancy*. In Nigeria, pregnancy in an unmarried adolescent is seriously frowned upon. The girl is seen as a wayward person who sleeps around with men; even if she identifies the man responsible, as long as there is no marriage she is seen as a bad influence. Many parents advise their daughters to keep away from her so that they will not get pregnant outside of marriage. The girl is said to bring shame and stigma to the family. To avoid this shame and embarrassment, she resorts to abortion and because abortion is illegal in Nigeria except in some special cases, she goes to a backyard abortionist who might endanger her life.
2. *The desire to continue a school education*. To many adolescents, unwanted pregnancy marks the end of school/education. They are usually expelled from school if pregnant. After the abortion, returning to school immediately might be difficult. Some parents may refuse to pay school fees for the adolescent with an unwanted pregnancy with the excuse that they did not plan for the additional baby, so the adolescent is forced to fend for herself and her baby; in this case the

only option may be an abortion so that she can continue her education. She goes to a backyard abortionist.

3. *Pregnancy as a result of rape or incest*. In the Sudan, abortion is allowed in this case (Population Reference Bureau 2005:10). However, the Nigeria law on abortion does not cover these situations. The adolescent who is in this situation is likely to go for an abortion.
4. *Pregnancy endangering the health of the adolescent*. In this case the law allows the girl to have the pregnancy terminated. If the doctor attending to the girl does not have the skill for abortion services, he/she refers the girl to the source where she can access it.
5. *Pressure from the partner responsible for the pregnancy*. The partner may be an adolescent like herself and not yet ready for marriage, or an adult who is already married and does not want a commitment. In this case the adolescent girl is pressurised to procure an abortion.
6. *Uncertainty about of the paternity of the pregnancy*. Where the girl is not sure who is responsible for her pregnancy, she may consider an abortion.
7. *Fear of bearing forced into marriage*. In some parts of Nigeria, where unwanted pregnancy is taboo, girls are quickly married off to older men who have lost their wives or those whose wives cannot get pregnant. The girl may even be forced to marry a man who already has three to four wives still living with him. To avoid this, the adolescent seeks abortion.

Since abortion law is restricted in Nigeria and the reasons why adolescents seek abortion are not addressed in the law, most adolescents seek abortion from unsafe sources, thereby endangering their lives or even losing them in the process.

2.3.3.11 Dilemma of the pregnant adolescent

The decision to terminate a pregnancy is the woman's. All adolescents who are considering opting for termination of a pregnancy need adequate support and counselling before and after the procedure. The decision to terminate a pregnancy is usually a difficult one and often taken as a last resort. Culturally, in Nigeria any woman who goes for an abortion is seen as a wicked woman who can kill her own child. Adolescents most often resort to abortion because of fear of disappointing their parents and the community ("What will people say"?) and because they want to continue their

education. At times parents procure abortion for their adolescent girls. Most of these abortions are unsafe, as adolescents who need them cannot access abortion services openly because, as has been pointed out, both the provider and the client are liable to imprisonment if caught by the law.

2.3.4 Maternal mortality and abortion

The WHO (1999:5) defines maternal mortality as "the death of a woman during pregnancy, delivery or within 42 days of childbirth or termination of pregnancy, irrespective of the duration and site of pregnancy or from any cause related to or made worse by the pregnancy or its management".

About 19 million unsafe abortions take place annually all over the world; almost all of these in the developing world (Ahman & Iqbal 2002:13). In Africa, 4.2 million abortions are estimated to take place per year, with an unsafe abortion rate of 22 per 1000 women (Ahman & Iqbal 2002:19). It is estimated that about 40% of maternal deaths are from abortion and its complications; 68.8% of unwanted pregnancies end in induced abortion, and 80% of women who present with complications from induced abortions are adolescents (Okonofua et al 1999:67-77). Adolescent pregnancy is associated with higher risk of maternal morbidity and mortality and other socio-economic consequences.

Unsafe abortion is a major reproductive health problem in Nigeria; death from unsafe abortion is responsible for 11% of maternal deaths (Fatusi 2004:8).

2.3.5 Abortion

Abortion is the termination of a pregnancy before the foetus is viable (*Mosby's Medical and Nursing Dictionary* 1986:26). A foetus of less than 20 weeks gestation or weighing less than 500g is considered an abortus in the United States of America (Sherwen, Scoloverid & Weingarten 1999:446-471). *Collins English Dictionary* (2001:4) defines abortion as "an operation or other procedure to terminate pregnancy before the foetus is viable; the premature termination of pregnancy by spontaneous or induced expulsion of a nonviable foetus from the uterus". When performed safely, a medically induced abortion is one of the safest types of surgery.

Abortion can be spontaneous that is, the expulsion of products of conception occurring naturally and without external cause; 20% of all pregnancies end in spontaneous abortion (miscarriage). Some of these may be incomplete and require uterine evacuation. On the other hand, an abortion could be induced (that is, one that is artificially initiated by the use of medications or mechanical means for therapeutic or personal reasons).

2.3.5.1 Induced abortion

The abortion of concern in this study is the induced abortion. Induced abortion, if not done by a skilled health-care worker, can lead to incomplete abortion where parts of products of conception are retained. It can also lead to septic abortion when complication occurs in the course of abortion and infection sets in (Elder 1998:51-62).

Methods of inducing abortion include suction termination of pregnancy, manual vacuum aspiration, dilation and curettage and use of drugs like Misoprosol, Prostaglandin, and others. However, the adolescent may not seek abortion services where this service can safely be accessed, for various reasons such as the illegal nature of this service in Nigeria, not having enough money to go to private doctors and ignorance. Most adolescents resort to self medication or to a backstreet abortionist where the abortion is done by means of dangerous methods, including drinking local gin mixed with undiluted lime juice, inserting a bicycle spoke, hanger or sharp instrument into the vagina with the aim of destroying the foetus, and use of local herbs or concoctions (Oye-Adeniran, Long & Adewole 2004:18). These methods endanger the life of the adolescent. Worldwide, 30 million illegal abortions were performed in 1990; 20 million abortions are unsafely induced every year worldwide (Ahman & Iqbal 2002:13-17). Unsafe abortions cause a global average of 13% and in some countries up to 50% of all maternal deaths; this translates to 80 000 women dying each year, or more than 200 women every day (Akinrinola et al 2006:1-15).

Akinrinola et al (2006:4-5) recommend the following measures to prevent adolescent deaths from abortions:

- reviewing the existing law on abortion with input from the adolescents
- adequate sexuality education for adolescents

- improved access to family planning services

2.3.5.2 Religion and abortion

Collins English Dictionary (2001:1309) defines religion as "belief in, worship of, or obedience to a supernatural power or powers considered to be divine or to have control of human destiny; any form of institutionalized expression of such belief; the Christian religion; the attitude and feeling of one who believes in a transcendent controlling power or powers". Most world religions condemn abortion, though most consider abortion acceptable under very limited circumstances (see www./religion and abortion.com 4.13.2007). The Muslim faith has a negative perception of induced abortion and regards abortion as murder and wickedness (Okonofua et al 1999:77).

2.3.6 Abortion laws

2.3.6.1 Abortion law in the United States (US), Canada and the United Kingdom (UK)

According to Advocates for Youth (2007), each year 750 000 to 850 000 adolescents in the US become pregnant; of these pregnancies 74% to 95% are unintended. Over 148 000 adolescent pregnancies ended in abortion (http://www.advocatesforyouth.or/publications/factsheet/fsabortion.htm (accessed on 19.07.2007)). State laws in the US restrict adolescents' access to abortion; 43 states require an adolescent under age 18 to notify or obtain consent from one or both parents before she can obtain an abortion. The Supreme Court requires states with parental consent or notification laws to allow adolescents to obtain an abortion by appealing to another adult, such as a judge, doctor or minister (bypass procedures) (http://www.advocatesforyouth.org/publications/factsheet/fsabortion. htm (accessed on 19.07.2007)).

In Mexico, abortion is severely restricted by law and is allowed only in cases of rape, or when the woman's life is in danger (http://www.apha.confex.com/apha/128am/techprogram/paper/10028.htm (accessed 19.07.2007)).

Canada has no laws restricting abortion. Abortion is treated like any other medical procedure and is governed by provincial and medical regulations (http://www.prochoice.org/Canada/legal.htm (accessed on 19.07.2007)).

According to Advocates for Youth (2007), in England, Scotland and Wales abortion has been legalised. However, abortion remains illegal in Northern Ireland, where legislation only allows abortion on the following grounds:

- to save the woman's life
- to prevent grave permanent injury to the woman's physical or mental health
- under 28 weeks to avoid injury to the physical or mental health of the existing child(ren) (http://www.advocatesforyouth.org/publications/factsheet/fsabortion.htm (accessed on 19.07.2007))

2.3.6.2 Abortion laws in Africa

In Egypt and Libya, abortion is prohibited but may be permitted to save a woman's life. The same applies in many other African countries. In the Sudan, abortion is permitted only to save a woman's life and in special cases such as rape, incest or foetal impairment or abnormality. Spousal consent is required in some countries. In Gambia and Ghana, it is permitted on physical or mental health grounds and in special cases. In Tunisia and Cape Verde abortion is permitted on economic and health grounds (Population Reference Bureau 2005:1-4). In South Africa abortion is legal with certain conditions. Midwives are able to perform termination of pregnancy until 12 weeks' gestation. Pregnant women are able to choose to terminate their pregnancy until 12 weeks' gestation (Choice of Termination of Pregnancy Act no 92 of 1996). (South Africa 1996).

2.3.6.3 Abortion Law in Nigeria

According to the Nigerian Constitution, anyone aged below 17 years is a minor and has no legal status. The criminal code, the aspect of the law that addresses abortion, states that the age of consent to sexual intercourse is 14 years for boys and 16 years for girls unless the girl is married (Atsenuwa 2005:1-7). Though the law recognises adolescent

marriage and procreation, these still carry high risks for adolescent girls, especially in pregnancy, labour and child bearing.

Atsenuwa (2005) states that in Nigeria the law makes the following provisions:

1. **Criminal Code**: Section 228 states that any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses force of any kind or uses any other means whatsoever or permits any such things or means to be administered or used to her is guilty of a felony and liable to imprisonment for seven years.

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

2. **Penal Code:** Section 323: causing miscarriage: "Whosoever voluntarily causes a woman with child to miscarry shall if such a miscarriage be not caused in good faith for the purpose of saving her life be liable for imprisonment for a term …. A woman who causes herself to miscarry falls within the meaning of this section (Atsenuwa 2005:4).

   Thus legal abortion is restricted to one necessary for saving the life of the woman.

The Nigerian criminal and penal codes do, however, protect the sexual rights of the adolescent in other areas. They include laws relating to defilement, rape and indecent assault (Atsenuwa 2005:2).

2.3.6.4 Trends towards legalisation of abortion

To legalise means to "make lawful or legal; to confirm or validate (something previously unlawful)" (*Collins English Dictionary* 2001:888). In this study, it refers to freedom to access abortion services if adolescents so desire.

Since the 1980s there has been a clear trend towards the removal of barriers to abortion access, yet the right to choose abortion remains disabled or under threat in many parts of the world (Oye Adeniran, Long & Adewole 2004:209-217).

The history of the criminalisation of abortion indicates that the approach was, in part, informed by the need to protect women from unsafe abortions. The same law tends to work in reverse today, however, by exposing women more to the risk of unsafe abortion (Atsenuwa 2005:3). The 94% of developing countries with laws prohibiting abortions have the highest rates of maternal and foetal mortality from abortion-related cases (Oye-Adeniran, Long et al 2004: 209-217). Berer (2002:1-7) maintains that until a society accepts that women need abortion and that women and the abortion providers should not be punished for it, legal abortions will rarely be provided except in exceptional circumstance.

Noteworthy statistics are that In Ghana, abortion was legalised in 1995 and within six months the admission for septic and incomplete abortion dropped by 41%. A year after Romania legalised abortion in 1990, its abortion-related mortality rate dropped from 142 to 47 deaths per 100 000 live births (http://www.Healthline.com (accessed on 24.04.2007)).

2.3.7 Client rights and abortion

Collins English Dictionary (2001:1332) defines a *right* as "any claim, title, etc, that is morally just or legally granted as allowable or due to a person; anything that accords with the principles of legal or moral justice".

According to Berer (2002:5), clients' rights include:

- **Right to Medical Treatment**: This right would ensure that an adolescent who became pregnant would receive medical services and treatment (and those who had abortion-related illness would be adequately treated). This fully meets the current accepted standards of care and quality. Safe abortion services are not available, but post-abortion care is offered.
- **Right to Information:** This right should ensure access to medical information, An adolescent who is pregnant should be given information, education and counselling and given options which include:
  - accepting the pregnancy and giving birth to the child
  - accepting the pregnancy and giving up the baby for adoption after birth
  - opting for abortion

The client should not be deprived of any information that is essential to her health. Most adolescents in Nigeria are not even aware that this is their right.

- **Right to Choice:** A client has the right to accept or refuse any medication, investigation or treatment and to be informed of the likely consequences of doing so.
- **Right to Privacy:** A client has the right to her privacy and dignity; her religious and cultural beliefs should be respected. She has the right to have information relating to her medical condition kept confidential. The decision to have an abortion is a personal issue and should be kept so.
- **Right to Complaint:** The client has the right to make a complaint through channels provided for this purpose.

The International Planned Parenthood Federation (IPPF) charter of sexual and reproduction rights recognises the right to abortion and the following right (IPPF 2003:13):

- The right to decide whether to or when to have children, which states that "all women have the right to information, education and reproductive health, safe motherhood and safe abortion".

Other rights include

- the right to life, which means among other things that no women's life should be put at risk or endangered by pregnancy
- the right to liberty and security of the person, which recognises that all persons must be free to enjoy and control their sexual and reproductive life and that no person should be subject to forced pregnancy, sterilisation or abortion
- the right to privacy, meaning that all sexual and reproductive health care services should offer confidential reproductive choices (IPPF 2003:1)

Adolescent sexual and reproductive rights

According to Berer (2002:6), adolescents' sexual and reproductive rights should include the following:

- protection for a girl against forced marriage
- protection for a girl from gender-based violence
- direct increased action for adolescent reproductive and sexual and rights

In October 1996 the Catholic Bishops of England and Wales published a document called *The Common Good*, in which they state that all human rights flow from one fundamental right: the right to life; and the right to live encompasses the basic rights of all individuals, including the unborn (who have their own intrinsic value) (http//www.bbc.co.uk/print/ religion/ethics/abortion/religion (accessed on 19.07.2007)). The 1992 encyclical *Donum Vitae* (the gift of life) states that the "inalienable rights of the person must be recognised and respected by civil society and the political authority". These human rights depend neither on single individuals nor on parents; nor do they represent a concession made by the society and the state; they belong to human nature and are inherent in the persons by virtue of the creative act from which the person took his origin. Among such fundamental rights one should mention in this regard every human being's right to life from the moment of conception until death (http//www.bbc.co.uk/print/religion/ethics/abortion/relig_catholicism2.shtm (accessed on 19.07.2007)).

Rights and status of the unborn child

There is no law in Nigeria on the status of the unborn child. The researcher accessed the internet and the library, and no evidence was found on the status of the unborn child in Nigeria. However the law against abortion may be intended to protect the unborn child (Atsenuwa 2005:1-6).

Right to secure abortion

Induced abortion is restricted in Nigeria unless it is done to save the life of the mother. In this case it is the medical practitioner who confirms that the pregnancy is a threat to the life of the woman and can perform an abortion. A client is not free to walk into a health facility and ask for abortion services (Atsenuwa 2005:1-6).

2.3.8 Professional issues of the midwife

Professional issues are peculiar to professional groups such as those engaged in nursing, medicine and pharmacy (Anarado 2002:9); the four most important ethical principles of the nursing profession are autonomy, beneficence, non salience and justice.

1. *Autonomy*: It is the duty of the midwife to respect a client's autonomy and related concepts such as client individuality. The client should be allowed to make a choice about what is in her best interests. In Nigeria, where the law on abortion is restrictive, an ethical problem may arise for the midwife where a girl with an unwanted pregnancy opts for abortion.
2. *Beneficence*: This is commonly defined as doing good: midwives are obligated by their professional ethics to 'do good' that is to implement actions that benefit the clients and their support persons. A midwife will be bound by this principle to save a woman from dying from problems such as unwanted pregnancies.
3. *Non-salience*: This means the duty to do no harm. If a midwife deliberately withholds information concerning abortion from an adolescent then the midwife has breached this principle.
4. *Justice*: This means rendering to others their due. Midwives have a duty to fair distribution of resources and care of clients.

2.3.8.1 Ethics in midwifery

Professional ethics in midwifery covers certain formal and informal areas of responsibility peculiar to the profession which are not shared by members of the society (Anarado 2002:18).

Professional ethical guidelines require the midwife to care for her client in a non-judgemental manner (Nursing and Midwifery Council of Nigeria 2005:120-121). This would apply when caring for an adolescent terminating a current pregnancy or who has undergone termination in a previous pregnancy. The midwife is trained to provide care, to prevent harm to the pregnant adolescent. If a midwife has a conscientious objection to abortion she should refer the client to a source where she can access the service (Fraser & Cooper 2003:268). However, in Nigeria, much abortion is illegal though post-abortion care services are available. The midwife can render post-abortion care, but where she strongly objects to it she is expected to refer the client to another facility where the client can be taken care of. Midwives can make judgemental or insensitive comments or approaches by not offering adolescents a chance to discuss their situation privately and by not providing counselling on where they might find more specialised support.

2.3.8.2 Midwife's scope of practice

A midwife is a trained professional with special expertise in supporting women to maintain a healthy pregnancy and birth, and offering expert individualised care, education, counselling and support to a woman and her newborn throughout the childbearing cycle (http://www.cfmidwifery.org/midwifery/faq.aspx (accessed on 04.02.2007)). The scope of midwifery practice in Nigeria does not cover termination of pregnancy, hence a midwife in Nigeria is not permitted by law to perform an abortion.

The scope of her duties towards reducing maternal mortality or morbidity due to complications arising from an abortion includes (FMOH 2001:176):

1. providing information on abortion
2. providing information on the prevention of unsafe abortion
3. recognising complications of abortion

4. providing post-abortion care: post abortion care is included in the curriculum for the school of midwifery in Nigeria

2.3.8.3 Professional accountability

Professional accountability is defined as skilful, conscientious obligation to account for one's actions. The practising midwife is accountable for her own practice in whatever environment she is practising (Fraser & Cooper 2003:3-10). The midwife is expected to render services within her scope. She is accountable to the Nursing and Midwifery Council of Nigeria and to her employer (Ndatsu 1999:121).

2.3.8.4 Midwives as advocates

Advocacy literally means supporting or speaking on behalf of the client on an issue. Midwives are advocates of safe motherhood. They should support and encourage women on prevention of death from pregnancy or related issues. The adolescent needs freedom to access health facilities that offer adolescent reproduction health services. The midwife acts as an advocate for adolescents exercising their choice. The midwife interprets policy and can initiate a review of an existing one (Fraser & Cooper 2003: 77-95, 952-953). Many midwives advocate for removal of the barriers to safe abortion, towards achieving safe motherhood. The midwife creates awareness of the reproductive rights of the adolescents.

2.3.9 Strategies for reducing unsafe abortion

2.3.9.1 Adolescent empowerment

To empower is to "give or delegate power or authority to; authorize; to give ability to; enable or permit" (*Collins English Dictionary* 2001:511). Adolescent empowerment is an attitudinal, structural and cultural process whereby adolescents gain the ability, authority and power to make decisions and implement change in their own and other people's lives, including the youth and adults. These can be achieved through the promotion of the rights of all people, which should be the fundamental basis of all government- and community-supported policies and programmes in the area of reproductive health, including sexual health and family planning. Educating adolescents on their legal rights,

sensitising providers to adopt an empathetic attitude and exploring innovative ways of increasing access to safe services for unmarried women will reduce the death rate of adolescents due to unsafe abortion.

2.3.9.2 National policy

National policy can discourage unsafe abortion practices by promoting protection against unwanted pregnancy and conducting national health campaigns to publicise firstly the risks of unsafe abortion and secondly the need to recognise and seek treatment for abortion complications (WHO 1999:4). In Nigeria, there is no policy on abortion (Atsenuwa 2005). A caring government should put in place policies and programmes that enable women to take responsibility for and protect their sexual and reproductive health and it should facilitate their access to health information and services.

Adolescents should be aware of the law and the policies supporting their rights. They should understand that human rights are not conferred as favours on anyone; rather, they are entitlements with accompanying responsibilities. In Nigeria pressure is being mounted on the federal government to make abortion legal and to enable women who need the service to access it. The Campaign Against Unwanted Pregnancy (CAUP), Community Participation for Action in the Social Sector (COMPASS) and IPAS have been mobilising and educating people on the need to legalise abortion. Post-abortion care services are legal for women in Nigeria and health workers are being trained to provide such services. Non-governmental organisations such as the Association for Reproductive and Family Health (ARFH), the Centre for Health Training Research and Development (CHESRAD), and the Association for Development Options (ADON) are make concentrated efforts to make adolescents aware of the consequences of adolescent sexuality.

Specific objectives in reproduction health policy include reducing the level of unwanted pregnancies in all women of reproductive age by 50%. One of the ways to achieve this is by creating an enabling legal environment through reformation of the abortion law (Oye-Adeniran, Long & Adewole 2004:209-217).

Although the FMOH (1991) proposed the reform of the abortion law and the Nigeria Medical Association endorsed the proposal, it was never enacted. (Oye-Adeniran, Long & Adewole 2004:209-217).

2.3.9.3 Outlawing of abortion

A comprehensive global study of abortion has concluded that abortion rates in countries where it is legal and those where it is not are similar, suggesting that the procedure does little to deter women from seeking it (Berer 2002:31-35). Furthermore, it was found that abortion was safe in countries where it was legal, but dangerous in countries where it was outlawed and performed clandestinely. Globally, abortion accounts for 13% of women's deaths during pregnancy and childbirth, and there are 31 abortions for every 100 live births (Berer 2002:31-35). The World Health Organization in Geneva and Allan Guttmacher Institute in New York found that the law does not influence a woman's decision on whether to have an abortion (Akinrinola et al 2006:61). However, the legal status of abortion greatly affects the dangers involved. Where abortion is legal, it will be provided in a safe manner. Where abortion is illegal, it is likely to be unsafe, performed under unsafe conditions by poorly trained providers. Furthermore, the best way to reduce abortion rates would seem to be not to make abortion illegal but to make contraception more widely available. In Uganda, where abortion is illegal and sex education programmes focus only on abstinence, the estimated abortion rate was 54 per 1000 women in 2003, more than twice the US rate of 21 per 1 000 in that year (http//www.advocatesforyouth.org/publications/factsheet/fsabortion.htm (accessed on 19.07.2007)). The lowest abortion rate, 12 per 1000, was in Western Europe, which has legal abortion and widely available contraception. South Africa has undergone a substantial transformation in abortion law. Abortion was made legal in 1996, leading to a 90% decrease in mortality among young women who had abortions (Hord & Xaba 2001:3).

2.4 CONCLUSION

This chapter discussed the literature review conducted for the study. The review covered reproductive health, adolescence, maternal mortality, abortion and abortion laws, client rights, professional issues of the midwife, and strategies for reducing unsafe abortion.

Chapter 3 will describe the research methodology.

Chapter 3

Research methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology, including the setting, population, sampling and sample, data collection and analysis, validity and reliability of the data-collection instrument, and ethical considerations.

The purpose of the study was to explore and describe the knowledge of adolescents regarding abortion when admitted to the LUTH Complex in Idi-araba, Lagos, Nigeria.

3.2 RESEARCH SETTING

The research setting refers to "the surrounding environment in which the research takes place" (De Vos 2001:301). The study was conducted in the setting of the clinics of the Lagos University Teaching Hospital (LUTH) Complex, Idi-araba, Mainland Local Government Council of Lagos State. It is a tertiary institution and referral centre.

The research focused on adolescents who accessed and utilised clinics within the LUTH Complex.

3.2.1 Geographical area

Lagos is the former administrative headquarters of Nigeria and is Nigeria's largest commercial city. Situated in the south-west geo-political zone, it is an island with many creeks and lagoons and covers a geographical area of 300 km^2. It is the most populous city in Nigeria, with an estimated population of over 9 million people (National Population Commission 2006:34). At the time of writing, the final analysis of rural and urban population in the country and the states was not yet completed (National Population Commission 2006:35). Lagos state has 27 local government areas.

3.3 RESEARCH APPROACH

The researcher adopted a quantitative research approach in this study. Quantitative research is "a formal, objective, rigorous and systematic process for generating information about the world" (Burns & Grove 2003:271). It is useful for identifying current practice (Burns & Grove 2003:200). The specific questions addressed in this study would generate knowledge that could assist in formulating guidelines for legalising abortion in Lagos, Nigeria. Quantitative analysis involves the manipulation of numerical data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of relationships among them (Polit & Beck 2004:190).

3.4 RESEARCH DESIGN

According to Burns and Grove (2003:195), a research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of findings. A research design is "a plan for approaching a research question" (Polit & Beck 2004:730). It provides a set of guidelines and instructions to be followed in addressing the research problem. The main function of the research design is to enable the researcher to anticipate what the approximate research decisions should be so as to maximise the validity of the eventual results (Brink 2006:107). A quantitative, non-experimental, explorative, descriptive research design was considered most appropriate for this study in order to give a detailed description of the knowledge levels of adolescents regarding abortion at the LUTH Complex in Idi-araba, Lagos, Nigeria.

Therefore, the researcher used a non-experimental, exploratory, descriptive survey design. An exploratory descriptive study can generate valuable information about the phenomenon of interest. The study design allowed the researcher to remain objective as the study focused on measurable variables such as adolescents' knowledge about abortion in Nigeria.

3.4.1 Exploratory

Exploratory research searches for information about a topic "in order to gain more knowledge about it" (Neuman 1997:19). The researcher wished to explore the respondents' knowledge of reproductive health and abortion in Lagos, Nigeria in order to gain information and a better understanding of the youth's views on abortion and the legalisation thereof.

3.4.2 Descriptive

According to Neuman (1997:19), a descriptive study "seeks to give details about characteristics of a phenomenon of interest". At times, descriptive research is concerned with how and what is, or how what exists is related to some preceding event that has influenced or affected a present condition or event (Ofo 2005:8).

In descriptive studies, researchers plan either to assemble new information about an unstudied phenomenon or to gain more information about characteristics in a particular field of study, for the purpose of providing a picture of the situation as it naturally occurs (Burns & Grove 2003:480). The descriptive design used in this study involved describing, classifying and investigating the nature of the phenomenon of adolescents' knowledge of reproductive health and abortion in LUTH Complex, Idi-raba Lagos, Nigeria.

According to Brink (2006:111-112), a descriptive survey design may be utilised to study characteristics in a population for the purpose of investigating probable solutions to a research problem.

3.4.3 Survey

A survey refers to non-experimental research whereby information is gathered from a portion of the population and focuses on people's intentions, behaviour, knowledge, beliefs and values. Data in a survey is collected by way of self-report, and information on a person's background is collected for analysis, comparison and explanation (Brink 1996:109; Polit & Beck 2004:234).

The researcher selected a survey for this study for the following reasons:

- It was appropriate for the objectives of this study, as the aim was not to infer cause and effect, but to describe the nature of the research topic (Brink & Wood 1998:139).
- There was no active intervention on the part of the investigator that might produce researcher bias.
- According to Brink and Wood (1998:289), a survey design may be used to study characteristics in a population in order to investigate possible solutions to a research problem. In this study, the survey design was used to investigate the knowledge levels of adolescents on reproductive health and abortion in order to establish whether lack of knowledge regarding the phenomenon might lead to unsafe or criminal abortions.
- It was impartial; there was no prejudice in the selection of respondents participating in the research.
- The research data could be collected in the natural setting and in a short time, using a structured data-collection process (Brink 2006:151-152). In this study, the study setting was the LUTH Complex in Idi-araba where adolescents were questioned. Structured interview schedules were used to collect data (see Annexure D).

3.5 RESEARCH PURPOSE, OBJECTIVES AND QUESTION

The aim of the study was to explore and determine the respondents' knowledge regarding reproductive health and abortion. The researcher had to compile appropriate objectives and questions. In developing the data-collection instrument (the structured interview schedule), the researcher considered what exactly the study wished to discover and establish. A research question serves as a guide to researchers in their quest for answers to the problems being investigated (Nnamdi 1991:100-101).

The purpose of the study was to explore and describe the knowledge regarding abortion of adolescents admitted to the LUTH Complex.

The specific objectives of this study were to

- explore adolescents' knowledge about their reproductive health
- determine the knowledge about abortion in adolescents
- determine adolescents' knowledge of abortion legislation in Nigeria
- identify unsafe practices regarding abortion

The following research question guided this study:

- What is the level of knowledge about abortion of adolescents at the LUTH Complex, Lagos, Nigeria?

3.6 POPULATION

A target population is defined as the respondents that meet the designated set of criteria (Burns & Grove 2003:234). The target population in this study consisted of all the adolescents between 13 and 17 years old, who accessed and uitilised the outpatient clinics (gynaecology clinic, family planning clinic, and staff clinic) of the LUTH Complex at the time of this study.

3.7 SAMPLE AND SAMPLING

Sampling involves selecting a sub-section of a population that represents the entire population in order to obtain information regarding the phenomenon of interest. A sample is a sub-section of the population, which is selected to participate in a study. There are two methods of sampling, namely probability and non-probability sampling. In probability sampling, the selection of each respondent is assured, whereas in non-probability sampling, the probability of selection is unknown (Brink 2006:124; Polit & Beck 2004:341). Although probability sampling is mostly used in quantitative research, it was not a suitable method in this study. Given the sensitive nature of the phenomenon under investigation, it was not possible to obtain a sampling frame of all adolescents utilising the LUTH complex in order to do random sampling. Therefore, this study used the non-probability sampling method. This study used non-probability, convenience sampling to select the respondents. A convenient sample consists of using the most

readily available or most convenient group of subjects for the sample (Brink 2006:132-133). This method was chosen because it provided easy access to the respondents. In addition, it was simple, practical, economical and quick, and did not require an elaborate sample frame, which was not available (Burns & Grove 2003:99). The respondents were chosen from adolescent clients attending outpatient clinics when the researcher was present. The researcher checked the client cards to identify clients who fitted the inclusion criteria to make sure they were adolescents and could understand the questions to be asked from the structured interview schedule. All the respondents who were eligible were selected after obtaining their consent to participate in the study. The first respondent was randomly chosen on availability, and the sample consisted of one hundred adolescent respondents who met the inclusion criteria. The parameters of generalisability in the sample were negligible, since the study did not seek to generalise to the wider population. The study simply represented itself.

The size of the sample is "the total number of the respondents who actually participate in a study in relation to the accessible population" (Brink 2006:141). In determining a sample size, the precision of the data-collection instrument should be considered.

3.7.1 Inclusion criteria

Brink (2006:124) describes inclusion criteria as the "characteristics we want those in our sample to possess". The respondents chosen were all adolescent girls attending outpatient clinics (gynaecology clinic, family planning clinic, staff clinic) on Mondays to Fridays between 09:00 to 16:00, who could speak English and Pidgin English.

To be included in the study, the respondents had to be females between the ages of 13 and 17 years and who attended the

- Family Planning Clinic for contraception
- Gynaecology Clinic for reproduction problems, which might even be the aftermath of an unsafe abortion

3.8 DATA COLLECTION

Data collection is the process of collecting the data for a study (Burns & Grove 2003:298). Data was collected using a structured interview schedule as an instrument to collect data. Data collection took place from January 2008. Prospective respondents, namely those who fell within the parameters of the inclusion criteria in the LUTH Complex at the time of study, were approached and asked to participate in the study.

The researcher explained the nature, purpose and significance of the study to the respondents in their own home language before consent to participate was obtained. Both verbal and written consent was obtained before data collection. Data collection was done in a private room for those attending the clinics. The researcher collected data every day of the week, except Sundays, between 09:00 and 16:00.

3.8.1 Characteristics of structured data collection

Polit and Beck (2004:318) point out that in structured data collection:

- The wording used is pre-determined and standardised and the same method or instrument is used for all respondents.
- An indication is given beforehand as to what information will be collected and how it will be collected.
- The researcher develops the data-collection instrument beforehand.
- Data collected can be quantified with ease.
- Data collection is unobtrusive to a certain extent because the respondents are allowed to respond without interference.
- The researcher is required to have some knowledge of the expected behaviour.

3.8.2 Rationale for using structured data collection

Structured data collection allows for wide content coverage; for example, beliefs and attitudes that may not be easy to determine can be included as well as the respondents' personal background. Although a lot of effort is required in the preparation of the data-collection instrument, it can be used with ease and retrospective events or information

can be included (Polit & Beck 2004:320). In the study, the respondents were required to answer questions on their personal background, knowledge of abortion, sources of information on abortion accessible to them, and their risk behaviour regarding abortion.

The interview technique is direct and adaptable when seeking information about what people think, feel or believe (Polit & Beck 2004:320). The interview was therefore suitable for use in this study and enabled the researcher to collect data related to the objectives of the study.

3.8.3 Data-collection technique

Structured data collection requires that specific questions developed and written down beforehand are asked in the same order for all respondents. Questions should be unambiguous, understandable, simple and short. Questions should also range from general to specific; sensitive information should be asked last and the structured interview should not be too long. The researcher designs and records the range of possible responses and the content is carefully worded. Both open-ended and closed questions are included.

A questionnaire was not used in this study as the researcher was not sure whether the respondents would understand the terminology used in the data collection instrument and that each respondent had the same explanation. Furthermore, the researcher was not certain of the respondents' educational background and whether they could read and write.

The researcher approached every adolescent who attended one of the clinics used by adolescents at the LUTH Complex to participate in the study during January 2008. Although the respondents are classified as minors in Nigeria, the researcher built a ethical and moral relationship with them before data was collected. The researcher thus also ensured the respondents that the data will be kept confidential and that no links could be made to identify them. Every adolescent asked to participate received a letter with information about the study, and was requested to complete a consent form. The researcher also explained the purpose of the study to them. The researcher administered the structured interview schedules on the specific days when she was

present at these clinics during 2008. A hundred adolescents were interviewed and the completed interview schedules were handed to a statistician for data analysis. The open-ended questions were analysed and coded by the researcher.

3.8.4 Data-collection instrument

A data-collection instrument is a device for collecting the data or measuring the variables used for answering research questions and/or testing study hypotheses (Polit & Beck 2004:720, 729). A structured interview schedule was used as the data collection instrument. The structured interview schedule was divided into five sections, covering demographic data and respondents' knowledge of adolescence, sexuality, abortion and legalisation of abortion.

3.8.5 Rationale for selecting the instrument

The researcher used a self-designed structured interview schedule for data collection with the purpose of collecting information on the knowledge about abortion of the adolescents (the respondents) visiting in LUTH Complex in Idi-araba, Lagos. After an in-depth literature review, the researcher designed the structured interview schedule with the guidance of the supervisor, joint supervisor and the statistician. The final structured interview schedule was discussed with the supervisor, statistician and an expert in the field of abortion and research and accepted in terms of face and content validity.

The researcher chose a structured interview schedule in this study for the following reasons:

- Structured interview schedules were found to be less expensive to administer than conducting field interviews, as these would have required hiring and training interviewers/field workers.
- Anonymity was ensured during data collection, as the findings could not be linked with the respondents' names and that no name list would be kept.
- The structured interview schedule format was standardised for all respondents (Brink 2006:153).
- Face-to-face interviews can enhance the response rate by the interviewee.

3.9 PRE-TEST

A pre-test refers to “conducting a trial administration of a data-collection instrument to make sure that the instrument can be clearly understood by the respondents and that it captures the required data” (Polit & Beck 2004:328). The instrument can be refined, if necessary, after pre-testing to ensure that it captures the appropriate data. Conducting a pre-test also enables the researcher to determine how long it takes to complete the structured interview schedule. Moreover, pre-testing provides information that reveals whether there are any offensive, ambiguous or inadequately worded questions so that adjustments can be made where necessary (Polit & Beck 2004:328).

Pre-testing of the research instrument was conducted to ensure that the questions were clearly worded and free of major biases, and solicited the kind of information that the researcher envisioned (Polit & Beck 2004:327). For pre-testing, five adolescents from the outpatient clinic at LUTH participated. These respondents did not participate in the actual study.

The researcher pre-tested the instrument in order to

- check the content reliability of the instrument
- identify any latent problems
- assess whether the study was feasible
- assess whether the objectives of the study would be met

No changes were made after the pre-test, as the respondents understood the questions. The structured interview schedule was also given to expert researchers, including the researcher’s study supervisors, to scrutinise for validity and reliability.

3.10 MEASURES TO ENSURE RELIABILITY AND VALIDITY

Reliability and validity of research findings are important attributes to be ensured. The researcher had to ensure the validity and reliability of the instrument before data collection.

3.10.1 Reliability

Reliability refers to the consistency with which the instrument repeatedly measures what it is supposed to measure and yields the same results if used by other researchers. The quality and adequacy of an instrument determine its reliability (Polit & Beck 2004:416). The researcher obtained the supervisor's assistance to ensure that the instrument was reliable. In addition, pre-testing of the instrument was also conducted before the study.

3.10.2 Validity

The validity of an instrument is "the degree to which the instrument measures what it is supposed to measure" (Polit & Beck 2004:422). There are four types of validity, namely external, internal, content, and face validity.

- **External**

External validity refers to "the extent to which the findings of a study can be generalised to similar settings" (Brink 1996:124). To ensure external validity, the researcher tried to minimise the Hawthorne effect, which is a threat to external validity. The Hawthorne effect occurs when the subjects of a study behave in a certain way because they are aware that they are involved in the study. When subjects are aware that they are involved in a study, they may give responses that they believe are socially acceptable, but do not reflect their true experiences (Brink 2006:107). In the study, the respondents might have given desirable responses out of fear of lack of confidentiality leading to exposure of their risk behaviour and the ramifications that might have followed. To minimise the Hawthorne effect, the researcher explained the nature, purpose and significance of the study and assured the respondents that their identities would be protected. The respondents were therefore asked to give honest responses, as they would not be prejudiced because of their responses. Data was collected in an office at a normal day clinic setting to ensure minimal disturbance to the respondents.

- **Internal**

Internal validity refers to the degree to which the results of a study are a result of the independent variable rather than extraneous factors. The results of the study should be a true reflection of the knowledge among the youth and not be attributable to extraneous factors such as use of complicated language or lack of confidentiality or fear of exposure. Using certain types of sampling increases selection bias, which is a threat to internal validity. Selection bias refers to a situation where the researcher does not use random sampling and subtle differences between individuals participating in a study, such as personality and attitudes, may influence the outcome of the study. Because random sampling was not used in this study, biases could have resulted. The findings of the study were therefore not generalised. The structured interview schedule was constructed in simple language and was short to avoid boredom and tiredness, which can also be a threat to internal validity. Sensitive questions were asked at the end (Brink 2006:106, 156).

- **Content**

Content validity refers to whether an instrument measures what it is supposed to measure, looking at the items it contains (De Vos 2001:168). In this study, the structured interview schedule contained items that measured the aspects under study appropriately and adequately.

- **Face**

Face validity refers to "whether an instrument appears to measure the construct appropriately" (De Vos 2001:167). The instrument has to appear to be a relevant measure of the attributes of interest to the study, even to the respondents. The supervisor's guidance was sought to ensure face validity.

3.11 DATA ANALYSIS

Data analysis is "the systematic organisation and synthesis of research data" (Polit & Beck 2004:556). The data collected was used to evaluate the knowledge of adolescents

on abortion. Data analysis also entails categorising, ordering, manipulating and summarising the data and describing it in meaningful terms (Brink 2006:12). The completed structured interview schedules were given to the statistician, who used the SPSS computer program version 13 to analyse the data. The closed questions included in the structured interview schedule were coded for easy analysis by the computer. The researcher categorised the open-ended questions by hand. The findings were discussed and the data presented in the form of frequency tables and bar graphs (see chapter 4). Descriptive statistics are useful in arranging numerical data in an orderly and readable manner and allowed the researcher to make decisions about the nature of reality (Brink 2006:172-182).

3.12 ETHICAL CONSIDERATIONS

Pera and Van Tonder (2005:4) define ethics as "a code of behaviour considered correct". It is crucial that all researchers are aware of research ethics. Ethics relate to two groups of people; those conducting research, who should be aware of their obligations and responsibilities, and the 'researched upon', who have basic rights that should be protected. The study therefore had to be conducted with fairness and justice by eliminating all potential risks. The respondents must be aware of their rights. Ethical issues observed in a study may include "informed consent, right to anonymity and confidentiality, right to privacy, justice, beneficence and respect for persons" (Brink 2006:30-43).

The following ethical considerations were taken into account:

3.12.1 Permission to conduct the study

Consent was obtained from the Chief Medical Director of LUTH (see Annexure B) through the Research and Ethics Committee of LUTH and the UNISA Research and Ethics Committee (see Annexure E) to conduct the study. Daily permission was obtained from the unit manager and the respondents. The researcher's scientific honesty was assured.

3.12.2 Informed consent

The adolescents who visited the LUTH Complex, Lagos, Nigeria seeking care for reproductive problems did so probably without their parents' consent due to the sensitive nature of their sexual practices and the restrictive abortion laws in Nigeria. In Nigeria 13-17 year old adolescents are classified as minors. Therefore, the researcher built a relationship with the adolescents who were willing to participate in the study, assuring them that their names and diagnoses would be kept confidential.

The respondents were informed that participation was voluntary and they were free to withdraw should they so wish. The researcher assured the respondents that their entitlement to health services would not be affected by participation, withdrawal or refusal to participate. Prior to signing the consent, there was a period of question time to ensure that the respondents fully understood the explanations. At the end of the explanations, the respondents were asked to sign written consent (see Annexure C for an example of the consent form). Voluntary informed consent was obtained from all the respondents.

3.12.3 Respect for persons as autonomous individuals

Respect for persons is a basic human right. Respondents as autonomous individuals have the right to choose whether to participate or not in the research. *Collins English Dictionary* (2001:856) defines choice as "the act or an instance of choosing or selecting; the opportunity or power of choosing". The decision is to be made without coercion. Respondents were allowed to act independently by giving their informed consent to participate in the study. In this study, the researcher ensured that the respondents did so. Prior to the respondents' giving consent, the purpose of the study was fully explained to them in the language they were well conversant with. The respondents were informed of the instrument in the research.

3.12.4 Justice

Justice relates to "the fair treatment of those in the study" (Burns & Grove 2003:705). In this study, the respondents were treated fairly by giving them information prior to

participation and by giving them the option to withdraw from the study if they wanted to without any negative consequences regarding entitlement to health services. Selection of the sample following the guidelines of the inclusion criteria also ensured that all those who met the criteria had a fair chance to participate in the study.

3.12.5 Beneficence

Risks and benefits were highlighted. The purpose of the study and its general value were discussed with all the respondents.

The respondents' human rights were protected.

- Unisa Health Studies Research and Ethics Committee (see Annexure E) and the Research and Ethics Committee of Lagos University Teaching Hospital reviewed the proposal. The respondents were informed of the instrument in the research.
- No risks were identified.
- Respondents did not receive any remuneration for participating if the study.

The long-term benefits of the study were explained to the respondents.

3.12.6 Confidentiality

The researcher took the following measures to ensure confidentiality:

- No names were written on the interview schedule. Therefore no responses could be linked to a person.
- Raw hard-copy data was stored and locked in a safety cabinet in a secure locked office and later destroyed.
- The computer database was stored on a password computer and completed hard copies of the structured interview schedules were locked in a safety cabinet.

3.12.7 The rights of the institution were protected

The researcher obtained permission from the Chief Medical Director of LUTH (see Annexure B) through the Research and Ethics Committee of LUTH to conduct the study. The research report presented collated data and averages, and avoided providing information about individual clinics that might allow identification (Burns & Grove 2003). Data collected at the clinics was used to establish the respondents' knowledge regarding abortion in LUTH and did not permit identification of source.

The researcher also took the following steps to protect the rights of the institution:

- The research report presented collated data and averages, and avoided providing information about individual clinics that might allow identification (Burns & Grove 2003:165).
- Data collected at the clinics was used to establish the knowledge of adolescents regarding the legalisation of abortion in Lagos University Teaching Hospital and did not permit identification of source.

3.12.8 Scientific honesty of the researcher was assured

The researcher's scientific honesty was assured because

- data were not fabricated or manipulated during analysis
- the researcher did not commit plagiarism
- the contribution of others was acknowledged (Lo Biondo-Wood & Haber 2002:311-346).

3.13 CONCLUSION

This chapter described the research design and methodology, including the population and sample, data collection and analysis, data-collection instrument, the pre-test, and the ethical considerations.

Chapter 4 will discuss the data analysis and interpretation.

Chapter 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter presents the data analysis and interpretation. The purpose of the study aimed to explore and describe adolescents' knowledge of reproductive health, abortion and the legalisation of abortion, and make recommendations for health education and for further research.

The researcher collected data from the respondents using a structured interview schedule consisting of five sections:

Section A - Demographic data
Section B - Adolescence
Section C - Knowledge of sexuality
Section D - Knowledge of abortion
Section E - Knowledge of legalisation of abortion

A statistician analysed the data using the SPSS Version 13.0 computer program. Descriptive statistical tools such as frequency tables, bar charts, pie charts and percentages were used in the data analysis and summaries.

A total of 100 respondents were interviewed, using a structured interview schedule. In cases of YES/NO questions only those that responded were used to calculate the frequency and percentages of responses (eg, item 8).

4.2 SECTION A: DEMOGRAPHIC DATA

The demographic data collected included age, school attended, highest class passed, ethnic group, religious affiliation, and discussion of sex.

4.2.1 Item 1: Respondents' age

Table 4.1 indicates the respondents' age distribution.

Figure 4.1 indicates that of the respondents, 6% (n=6) were 13 years old; 15% (n=15) were 14; 21% (n=21) were 15; 26% (n=26) were 16; 12% (n=12) were 17, and 20% (n=20) were over 17. The majority (26%) of the respondents were 16 years old (see figure 4.1).

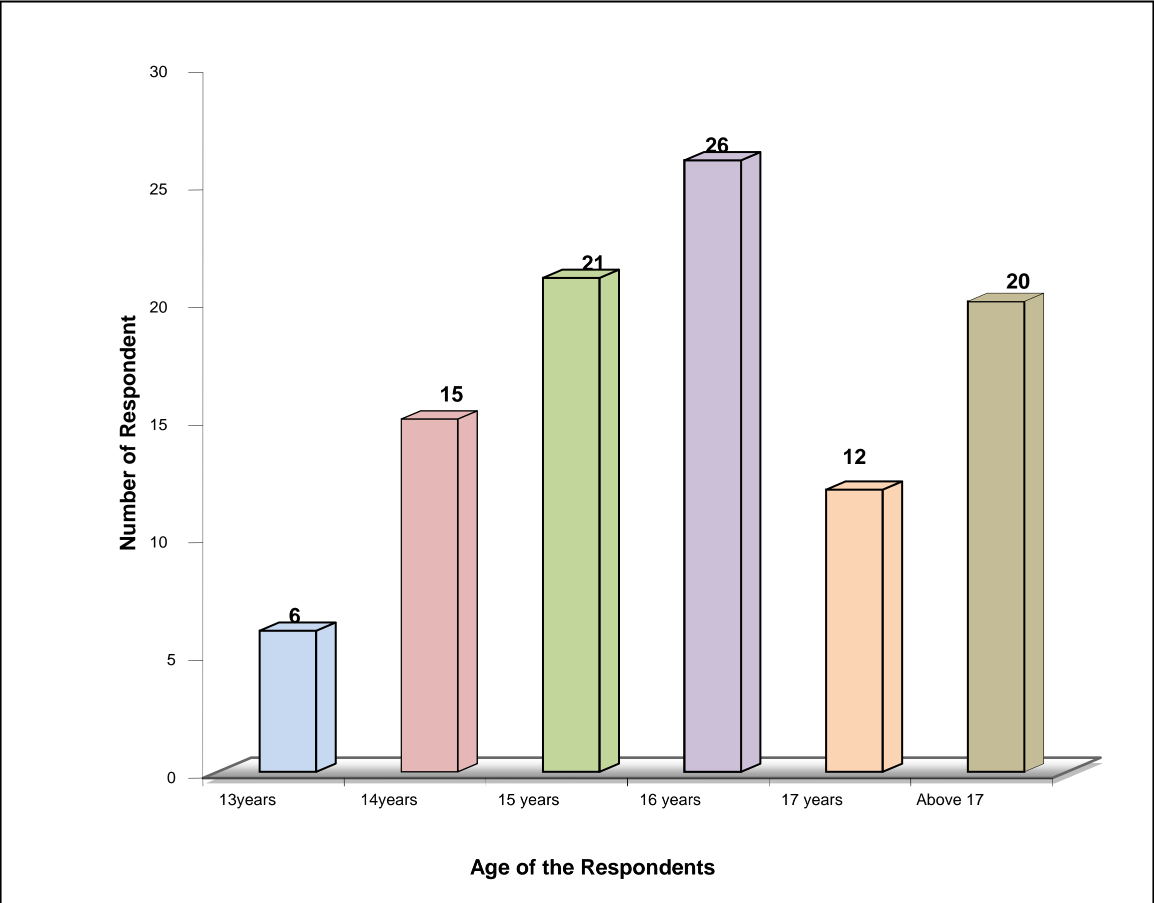


Figure 4.1
Respondents' age

4.2.2 Item 2: Respondents' school attendance

Of the respondents, 99% (n=99) attended school, and 1% (n=1) did not (see figure 4.2). The present findings have corroborated with the study done by Esere (2008:124) who indicated that adolescents attend school regularly.

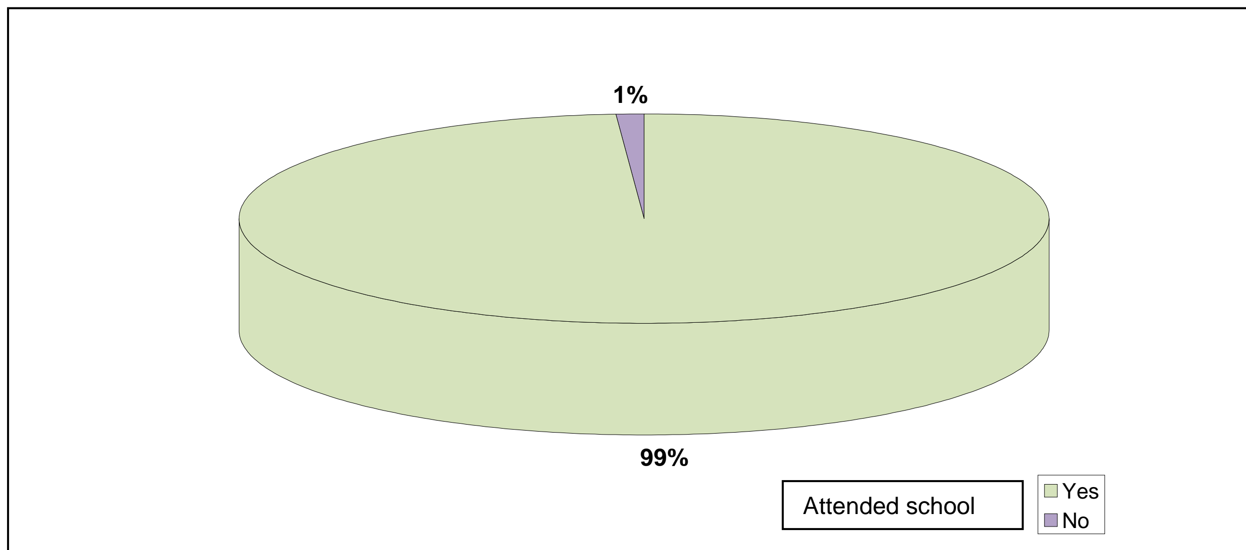


Figure 4.2

Respondents' school attendance

4.2.3 Item 3: School-going respondents' highest class passed to date

Table 4.1 Respondents' highest class passed to date

Level of schooling	Frequency of response	% of response
Junior Sec School 1	2	2%
Junior Sec School 2	0	0%
Junior Sec School 3	0	0%
Senior Sec School 1	25	25%
Senior Sec School 2	19	19%
Senior Sec School 3	45	45%
University	5	5%
Polytechnic	1	1%
Others	2	2%
Not attended school	1	1%
Total	**100**	**100%**

Of the respondents, 45% (n=45) were in Senior Secondary School 3; 25% (n=25) were in Senior Secondary School 1; 19% (n=19) were in Senior Secondary School 2; 5% (n=5) were at University; 2% (n=2) were in Junior Secondary School 1; 1% (n=1) was at the polytechnic college, and 3% (n=3) were in other forms of education. No respondents were in Junior Secondary School 2 and Junior Secondary School 3.

4.2.4 Item 4: Non-school-going respondents' activities

Table 4.2 Respondents' activities

Activity	Frequency of response	% of response
Work at a market	0	0%
Apprentice	0	0%
Work in a small scale enterprise	0	0%
Assist their parents	1	1%
Does nothing	0	0%
No response	99	99%
Total	**100**	**100%**

The only respondent (1%; n=1) who did not go to school claimed to be assisting her parents.

Otoide, Oransaye and Okonofua (2001:77-81) who undertook a study on "why adolescents seek abortion rather than contraception: evidence from focus group discussions" findings corroborated with the above findings in that schooling in Nigeria is strongly encouraged.

4.2.5 Item 5: Respondents' ethnic groups

Of the respondents, 55% (n=55) were Yoruba; 1% (n=1) was Hausa; 34% (n=34) were Ibo; none (0%; n=0) was Ijaw, 3% (n=3) were Edo; 5% (n=5) were Non Nigerian; 1% (n=1) was Ibibio, and 1% (n=1) was Efik. The majority (55%; n=55) were Yoruba (see figure 4.3).

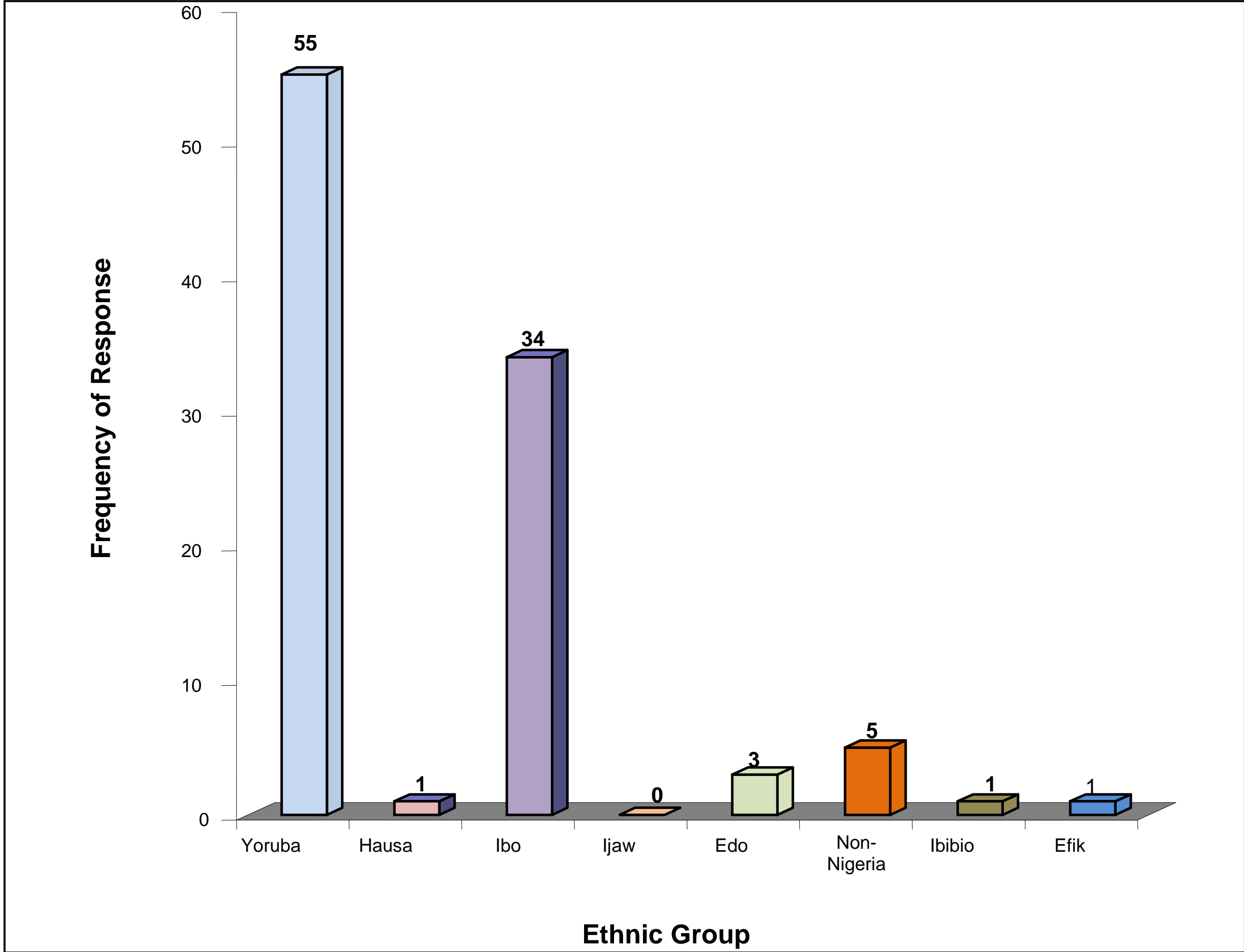


Figure 4.3

Respondents' ethnic groups

4.2.6 Item 6: Respondents' religious affiliations

A total of 100 (100%) respondents answered this question. Of the respondents, 24% (n=24) were Catholic; 4% (n=4) were Protestant; 32% (n=32) were Pentecostal; 7% (n=7) attended the White Garment Church; 0% (n=0) were traditional believers; 1% (n=1) was Seventh Day Adventist; 1% (n=1) was a Jehovah's Witness; 26% (n=26) were Islam, and 5% (n=5) indicated no religious affiliation. The majority of the respondents (32%; n=32) were Pentecostal (see figure 4.4).

Although 32% of the respondents were from the Pentecostal group Grimes, Benson, Singh, Romero, Ganatra and Okonofua (2006:4) indicated adolescents still resort to traditional religion and traditional methods to induce abortion. The customs and traditions of the community do not permit pregnancy before and outside marriage (Amobi & Igwegbe 2004:93).

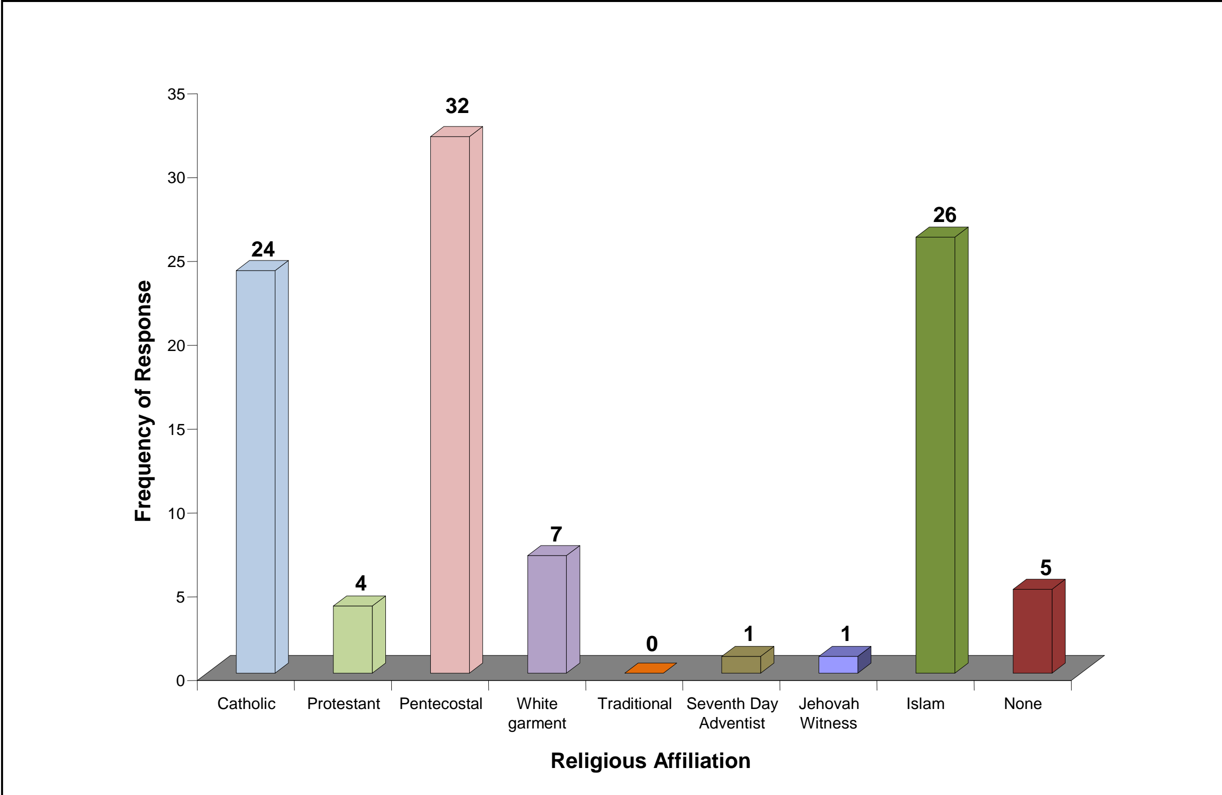


Figure 4.4

Respondents' religious affiliation

4.2.7 Item 7: Discussion of sex with family

A total of 100 (100%) respondents answered the question. Of the respondents, 72% (n=72) discussed sex issues with their families, and 28% (n=28) did not.

The majority of the respondents (72%; n=72) thus discussed sex issues with their families (see figure 4.5).

These findings are contrary to the findings of a study done by Amobi and Igwegbe (2004:95) on unintended pregnancy among unmarried adolescents and young women in Anambra State, South East Nigeria. It was found that 97% of the respondents experienced violence from family members when discussing sex.

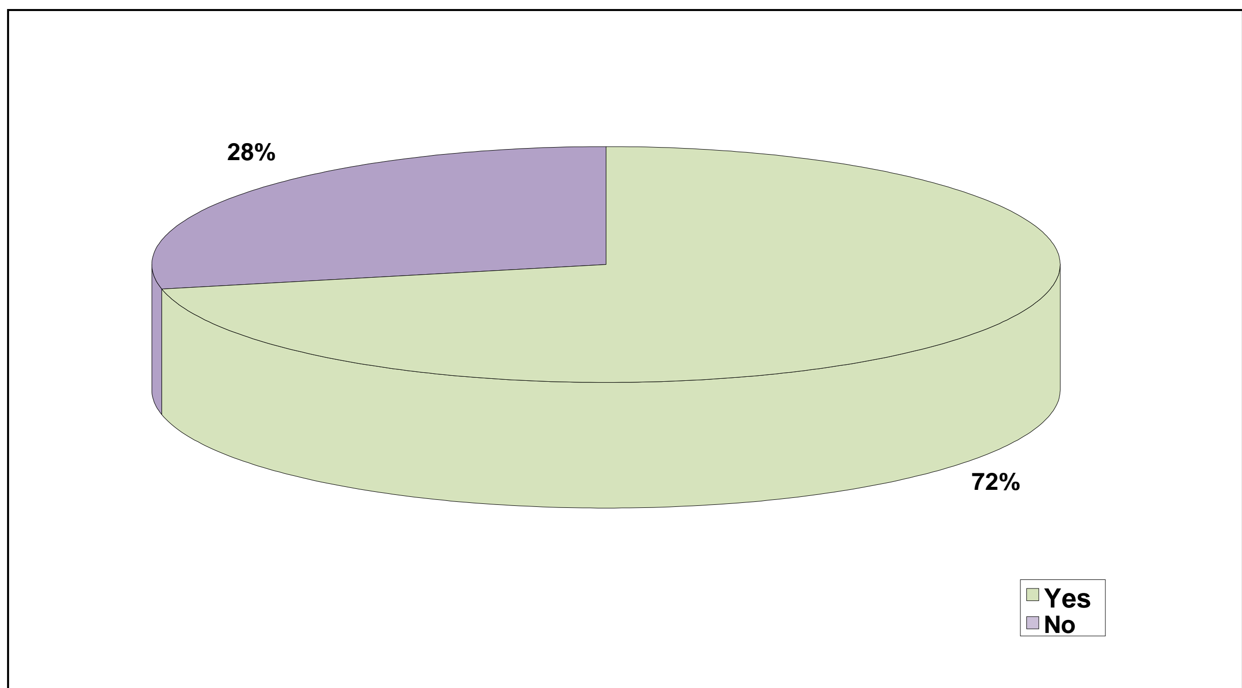


Figure 4.5

Respondents' discussion of sex with family

4.2.8 Item 8: Family members with whom respondents discussed sex

Table 4.3 Family members with whom respondents discussed sex

Family member	Frequency of response	% of response
Mother	30	30%
Father	0	0%
Brother	1	1%
Sister	13	13%
Aunty	4	4%
Friends	5	5%
Mother and sister	2	2%
Mother and aunty	4	4%
Mother and friend	2	2%
Brother and friend	1	1%
Mother, aunty and friend	1	1%
Mother, sister and friend	3	3%
Brother, sister and friend	1	1%
Aunty and friend	1	1%
Sister and friend	2	2%
Mother, sister and aunty	1	4%
Others	2	2%
No response	27	27%
Total	**100**	**100%**

A total of 73 respondents answered this item. Of these respondents, 30% (n=30) discussed sex with their mothers; 0% (n=0) discussed sex with their fathers; 1% (n=1) discussed it with her brother, and 13% (n=13) discussed sex with their sisters. Of the respondents, 4% (n=4) discussed sex with an aunt; 5% (n=5) discussed sex with friends; 2% (n=2) discussed sex with their mothers and sisters; 4% (n=4) discussed it with their mothers and aunts; 2% (n=2) did so with their mothers and friends, and 1% (n=1) did so with her brother and friends. The data also revealed that of the respondents, 1% (n=1) discussed sex with her mother, aunts, and friends; 3% (n=3) did so with their mothers, sisters and friends, and 1% (n=1) did so with her brother, sister and friends. Finally, of the respondents, 1% (n=1) discussed sex with an aunt and friends; 2% (n=2) discussed sex with their sisters and friends; 1% (n=1) did so with her mother, sister and aunt, and 2% (n=2) chose “Other”, but gave no details. Twenty-seven respondents did not complete the item.

4.2.9 Item 9: Topics discussed with family members

Table 4.4 Topics respondents discussed with family members

Topics discussed		Yes	No
Menstruation	Frequency n=62 (%)	57 91.9%	5 8.1%
Dating boy friends	Frequency n-53 (%)	41 77.4%	12 22.6%
Sexual morality	Frequency n=47 (%)	31 65.9%	16 34.1%
Conception	Frequency n=42 (%)	11 26.2%	31 73.8%
Birth control	Frequency n=40 (%)	17 42.5%	23 57.5%
Sexual intercourse	Frequency n=45 (%)	31 68.9%	14 31.1%
Bodily changes	Frequency n=48 (%)	33 68.8%	15 31.2%
Homosexuality	Frequency n=41 (%)	13 31.7%	28 68.3%
Abortion	Frequency n=42 (%)	21 50%	21 50%
Other	Frequency n=19 (%)	4 21.1%	15 78.9%

Table 4.4 lists the topics on the structured interview schedule and the number of respondents who did or did not discuss each one with family members. Of the respondents, 57 (91.9%) discussed *menstruation* with their family and 5 (8.1%) did not; 41 (77.4%) discussed *dating* with their family and 12 (22.6%) did not; 31 (65.9%) discussed *sexual morality* and16 (34.1%) did not, and 11 (26.2%) discussed *conception* and 31 (73.8%) did not. Furthermore, 17 (42.5%) discussed *birth control* with their family and 23 (57.5%) did not; 31 (68.9%) discussed *sexual intercourse* and 14 (31.1%) did not; 33 (68.8%) discussed *bodily changes* and 15 (31.2%) did not, 13 (31.7%) discussed *homosexuality* and 28 (68.3%) did not, and 21 (50%) discussed *abortion* with their family and 21 (50%) did not. Finally, 19 (100%) of the respondents selected "*other*" on the structured interview schedule, but gave no details of the specific topics. Of these respondents, 4 (21.1%) discussed "other" topics with their family and 15 (78.9%) did not.

Amobi and Igwegbe (2004:96) reported in their study on unintended pregnancies that the adolescents would rather discuss sexual issues with their peers than with family members.

4.3 SECTION B: ADOLESCENCE

4.3.1 Item 10: Respondents' understanding of the term "adolescence"

Table 4.5 Respondents' understanding of the term "adolescence"

Meaning of "adolescence"		Yes	No	Total
A period in life during which you are neither a child nor an adult	Frequency (%)	84 84%	16 16%	100 100%
A period of the individual's childhood	Frequency (%)	40 40%	60 60%	100 100%
Acquiring a masculine or feminine social role	Frequency (%)	54 54%	46 46%	100 100%
Accepting one's physique and using the body effectively	Frequency (%)	53 53%	47 47%	100 100%
Becoming emotionally independent of parents and other adults	Frequency (%)	46 46.%	54 54%	100 100%
Preparing for marriage and a family life.	Frequency (%)	65 65%	35 35%	100 100%
Selecting and preparing for a career	Frequency (%)	50 50%	50 50%	100 100%
Acquiring values and an ethical system to guide behaviour	Frequency (%)	49 49%	51 51%	100 100%
A period of emotional development	Frequency (%)	60 60%	40 40%	100 100%
Joining a peer group	Frequency (%)	40 40%	60 60%	100 100%
Other	Frequency (%)	-	-	-

All the respondents (100%; n=100) answered this item. Table 4.5 indicates the definitions provided on the structured interview schedule and the number of respondents who selected the various alternatives. Of the respondents, 84% (n=84) understood "adolescence" as a period in life when individuals were neither children nor adults; 40% (n=40) understood it as a period in an individuals' childhood; 54% (n=54) understood it as acquiring masculine or feminine social roles, and 53% (n=53) regarded it as accepting their physique and using their bodies effectively. Further, 46% (n=46) understood it as becoming emotionally independent of parents and other adults; 65% (n=65) understood it as preparing for marriage and a family life, and 50% (n=50) regarded it as selecting and preparing for a career. Finally, 49% (n=49) understood it as acquiring values and an ethical system to guide behaviour; 60% (n=60) understood it as a period of emotional development, and 40% (n=40) understood it as joining peer groups.

These findings concur with a study undertaken by Esere (2008:120 on the "effect of sex education programme on at-risk sexual behaviour of school-going adolescents in Ilorin, Nigeria. The adolescents in this study were able to manage the transformation from physiological and anatomical changes in adolescence which then results in reproductive maturity.

4.4 SECTION C: SEXUALITY

4.4.1 Item 11: Respondents' experience of sexual intercourse

Table 4.6 Whether respondents had had sexual intercourse

Have you had sexual intercourse?	Frequency of response	% of Response
Yes	89	89%
No	10	10%
No response	1	1%
Total	**100**	**100%**

Most of the respondents (99%; n=99) answered this item. Table 4.6 indicates that of the respondents, 89% (n=89) indicated having had sexual intercourse; 10% (n=10) indicated that they had not had sexual intercourse, and 1% (n=1) did not answer the question.

4.4.2 Item 12: If answer to item 11 was "Yes" how old were you?

Table 4.7 Respondents' age at first sexual intercourse

Age	Frequency of response	% of frequency of response
Under 8 years	1	1%
9 years	0	0%
10 years	0	0%
11 years	0	0%
12 years	0	0%
13 years	11	12%
14 years	5	6%
15 years	13	15%
16 years and above	48	55%
No response	**11**	**12%**
Total	**89**	**100%**

Table 4.7 indicates that a total of 89 (100%) respondents answered this question. Of the respondents, 1% (n=1) indicated having had sex when she was under 8 years old; 11% (n=11) had had sexual intercourse when they were 13; 5% (n=5) had had sexual intercourse at 14; 13% (n=13) had had sexual intercourse at 15, and 49% (n=49) had had sexual intercourse when they were 16 and older.

Esere (2008:120) indicated that by the time adolescents are 18, most adolescents in Nigeria are sexually active. These findings concur with the researcher's findings.

4.4.3 Item 13: Reasons for sexual intercourse

Table 4.8 Respondents' reasons for sexual intercourse

Reasons for sexual intercourse	Frequency	% of frequency of response
I love the boy	43	48%
Wanted to find out what it was about	16	18%
For love	8	9%
Raped	2	2%
Peer pressure	15	17%
Other	5	6%
No response	11	
Total (n = 89)	**100**	**100%**

Table 4.8 indicates the reasons for sexual intercourse given in the structured interview schedule and the respondents' responses. Of the respondents, 43% (n=43) had had sexual intercourse because *they loved the boy*; 16% (n=16) had *wanted to find out what it was about*, and 9% (n=8) had had intercourse *for love*. In addition, 2% (n=2) indicated that they had been *raped*; 15% (n=15) had been *pressured by peers*, and 5% (n=5) selected "*Other*" and indicated *ignorance* and *depression* as the reasons.

Amobi and Igwegbe (2004:92 indicated other reasons for entering sexual intercourse, for example, an old man may also force marrying a young girl to bear male children for him if he had no male children.

The reasons why the respondents did not complete the question is that matters relating to sex and sexuality are usually shrouded in. Secrecy and abortions are not legal in Nigeria (Esere 2008:120).

4.4.4 Item 14: Previous pregnancies

No respondents completed this question.

4.5 SECTION D: ABORTION

4.5.1 Item 15: Previous abortions

Table 4.9 Respondents' experience of abortion

Have you ever had an abortion?	Frequency of response	% of response
Yes	1	1%
No	99	99%
Total	**100**	**100%**

Of the respondents, 99% (n=99) indicated that they had not had abortions, while 1% (n=1) had had an abortion (see table 4.9).

Grimes et al (2006:204) indicated in a study on unsafe abortions: the preventable pandemic, that although 97% of unsafe abortions are in developing countries and that reliable data for the prevalence of unsafe abortions are generally scarce, especially in countries were access to abortion is legally restricted.

4.5.2 Item 16: Place where abortion was performed

Of the respondents, 1% (n=1) had had an abortion, and did not specify where.

4.5.3 Item 17: Respondents' awareness of a family member/friend/someone in the community who has had an abortion

Most of the respondents (51%; n=51) indicated that they were aware of some family member/friend/someone in the community who had had an abortion and 49% (n=49) indicated that they did not know of any family member/friend/someone in the community who had had an abortion.

Figure 4.6 illustrates the respondents' level of awareness of family members/friends/ community members who had had an abortion.

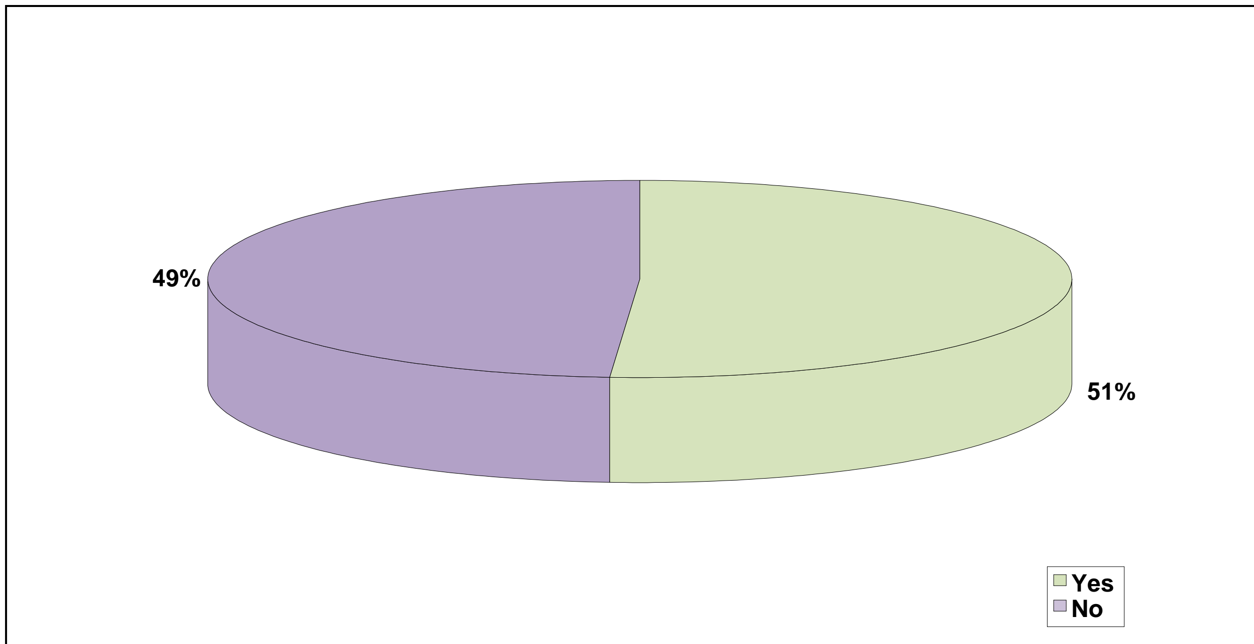


Figure 4.6

Respondents' awareness of a family member/friend/someone in the community who had had an abortion

4.5.4 Item 18: Respondents' reaction to knowledge of a family member/ friend/someone in the community having had an abortion

Table 4.10 Respondents' reaction to knowledge of a family member/friend/ someone in the community having had an abortion

Reaction to the abortion	Frequency of response	% of response
Shock	49	49%
Outrage	6	6%
Sympathy	31	31%
Relief	12	12%
Admiration	1	1%
Others	1	1%
Total	**100**	**100%**

Although only 51 respondents indicated knowledge of persons who had undergone abortions, all 100 respondents recorded reaction to abortions. Of the respondents, 49% (n=49) had been shocked at the news; 6% (n=6) had been outraged; 31% (n=31) had felt sympathy for those involved; 12% (n=12) had felt relief for those involved; 1% (n=1) admired those involved, and 1% (n=1) indicated that "it was not a big deal" that the person had had an abortion (under "Other").

4.5.5 Item 19: Age at time of abortion

Although one respondent mentioned that she had undergone an abortion, Item 19 was not answered by the respondent with regard to the age at the time of the abortion.

4.5.6 Item 20: Feelings about abortion

This item was not answered by the respondents.

4.5.7 Item 21: Reasons for not undergoing an abortion

Although one respondent reported that she had undergone an abortion, she did not comment on the reasons for undergoing an abortion.

4.5.8 Item 22: Reasons (conditions) for having an abortion

Table 4.11 Respondents' reasons (conditions) for having an abortion

Reasons (conditions) under which you would undergo an abortion		Yes	No
To save myself the shame of an unwanted pregnancy (n=49)	Frequency (%)	25 51%	24 49%
To continue my education/ apprenticeship (n=53)	Frequency (%)	31 58.5%	22 41.5%
If my boyfriend/husband supports it (n=48)	Frequency (%)	13 27.1%	35 72.9%
If the risk involved is reduced (n=44)	Frequency (%)	13 29.5%	31 70.5%
If nobody will know (n=45)	Frequency (%)	11 24.4%	34 75.6%
Pregnancy after being raped (n=53)	Frequency (%)	22 41.5%	31 58.5%
Bleeding as a result of tampered pregnancy (n=42)	Frequency (%)	13 31%	29 69%
Pregnancy as a result of contraceptive failure (n=42)	Frequency (%)	17 40.5%	25 59.5%
Pregnancy of doubtful paternity (n=41)	Frequency (%)	8 19.5%	33 80.5%
Pregnancy that I don't want (n=40)	Frequency (%)	13 32.5%	27 67.5%
If my parents insist that I terminate the pregnancy (n=43)	Frequency (%)	14 32.6%	29 67.4%
I don't know (n=37)	Frequency (%)	11 29.7%	26 70.3%

Respondents could choose more than one option. The totals and percentages were calculated on the number of options chosen by the respondents.

Table 4.11 indicates the respondents' responses to whether they would have an abortion for the given reasons. Not all the respondents answered each alternative in item 22. Table 4.11 depicts the number of responses received for each alternative.

Of the respondents, 51% (n=25) indicated that they would have an abortion *to avoid the shame and embarrassment of an unwanted pregnancy* and 49% (n=24) would not; 58.5% (n=31) would have an abortion *to continue their education/apprenticeship*, but 41.5% (n=22) would not; 27.1% (n=13) would have an abortion *if their boyfriend/husband supported it*, but 72.9% (n=35) would not, and 29.5% (n=13) would have an abortion *if the risk involved was reduced*, but 70.5% (n=31) would not.

Moreover, 24.4% (n=11) of the respondents would have an abortion *if nobody would know*, but 75.6% (n=34) would not; 41.5% (n=22) would have an abortion *if the pregnancy resulted after being raped*, but 58.5% (n=31) would not; 31% (n=13) would *if there was bleeding as a result of tampered pregnancy*, but 69% (n=29) would not, and 40.5% (n=17) would have an abortion *if the pregnancy resulted from contraceptive failure*, but 59.5% (n=25) would not.

Of the respondents, 19.5% (n=8) would have an abortion *if the baby's paternity were doubtful*, but 80.5% (n=33) would not. Moreover, 32.5% (n=13) would have an abortion *if the pregnancy was not wanted*, but 67.5% (n=27) would not, and 32.6% (n=14) would *if their parents insisted that they terminate the pregnancy*, but 67.4% (n=29) would not.

Finally, 37 (100%) of the respondents selected the option "*Don't know*". Of these, 29.7% (n=11) indicated that they would perhaps, while 70.3% (n=26) indicated they still would not have an abortion.

Grimes et al (2006:2) indicated in a study on unsafe abortion that reasons for seeking abortions varied: socio-economic concerns, including poverty, no support from the partner, and disruption of education and employment, so support from partner, family violence and pregnancy resulting from rape and incest. These findings concur with the findings of this study.

4.5.9 Item 23: Opinions on abortion

Table 4.12 Respondents' opinions on abortion

Meaning of abortion		Yes	No
It is terminating an unwanted pregnancy (n=40)	Frequency (%)	34 85%	6 15%
It is killing an innocent baby (n=39)	Frequency (%)	37 94.9%	2 5.1%
It is saving the woman's future (n=33)	Frequency (%)	6 18.2%	27 81.8%
It is a criminal act (n=34)	Frequency (%)	21 61.8%	13 38.2
It is murder (n=33)	Frequency (%)	24 72.7%	09 27.3%
I don't know (n=26)	Frequency (%)	6 23.1%	20 76.9%

Table 4.12 lists the options provided in the structured interview schedule and indicates the number of respondents who selected each one. Of the respondents, 85% (n=34) regarded abortion as *the termination of an unwanted pregnancy*; 94.9% (n=37) regarded it as *killing an innocent baby*; 18.2% (n=6) regarded it as *saving the woman's future*; 61.8% (n=21) considered it *a criminal act*, and 72.7% (n=24) considered it *murder*. Only 23.1% (6) of the respondents indicated that they did not know.

The results revealed that the respondents thus generally regarded abortion as killing an innocent baby.

In a study on why Nigerian adolescents seek abortion rather than contraception, Otoide et al (2001:78) found that the majority of the adolescents defined "abortion" as the act or process of terminating an unwanted pregnancy, a minority felt that abortion referred to the termination of pregnancy of 3 to 4 months using "instruments". The findings concur with the current study.

4.5.10 Item 24: Sources of information on abortion

Table 4.13 Respondents' source of information on abortion

Information		Yes	No
Father (n=60)	Frequency (%)	19 31.7%	41 68.3%
Mother (n=70)	Frequency (%)	41 58.6%	41.4 15%
Friends (n=59)	Frequency (%)	44 74.6%	15 25.4%
Doctor (n=59)	Frequency (%)	21 35.6%	38 64.4%
Nurse (n=63)	Frequency (%)	28 44.4%	35 55.6%
School (n=77)	Frequency (%)	55 71.4%	22 28.6%
Radio (n=61)	Frequency (%)	28 45.9%	33 54.1%
Television (n=74)	Frequency (%)	26 35.1%	48 64.9%
Newspaper (n=65)	Frequency (%)	31 47.7%	34 53.3%
Youth club (n=59)	Frequency (%)	24 40.7%	35 59.3%
Non-governmental organisation (n=58)	Frequency (%)	15 25.9%	43 74.1%
Church (n=69)	Frequency (%)	36 52.2%	33 47.8%
Other family members (n=62)	Frequency (%)	27 43.5%	35 56.5%
Grandparents (n=59)	Frequency (%)	30 50.8%	29 49.2%
Others (n=10)	Frequency (%)	7 70%	3 30%

Table 4.13 lists the options provided in answer to this item and depicts the number of respondents who selected each option. Of the respondents, 31.7% (n=19) indicated that their *fathers* were their sources of information on abortion; 58.6% (n=41) indicated their *mothers*; 50.8% (n=30) indicated their *grandparents*, and 74.6% (n=44) indicated their *friends*.

Of the respondents, 35.6% (n=21) indicated their *doctors*; 44.4% (n=28) indicated *nurses*, and 71.4% (n=55) indicated the *school*.

Moreover, of the respondents, 45.9% (n=28) indicated the *radio*; 35.1% (n=26) indicated *television*; 47.7% (n=31) indicated *newspapers*; 40.7% (n=24) indicated *youth clubs*; 25.9% (n=15) stated *non-government organisations (NGOs)*, and 52.2% (n=36) stated

churches. A total of 43.5% (n=27) indicated that other family members were their source of information.

Finally, 70% (n=7) of the respondents indicated "*others*", especially their *sisters*.

4.5.11 Item 25: Termination of the pregnancy

The respondents replied on whether they would terminate an unintentional pregnancy. Of the respondents, 90% (n=90) indicated that they would not terminate a pregnancy if it was unintentional and 10% (n=10) indicated that they would (see figure 4.7).

Although the majority (90%) of the respondents indicated that they would not terminate a pregnancy if unintended, Amobi and Igwegbe (2004:95) revealed in a study on unintended pregnancies 88% of the girls felt extremely worried with their pregnancy and 59.6% had intended to terminate the pregnancy.

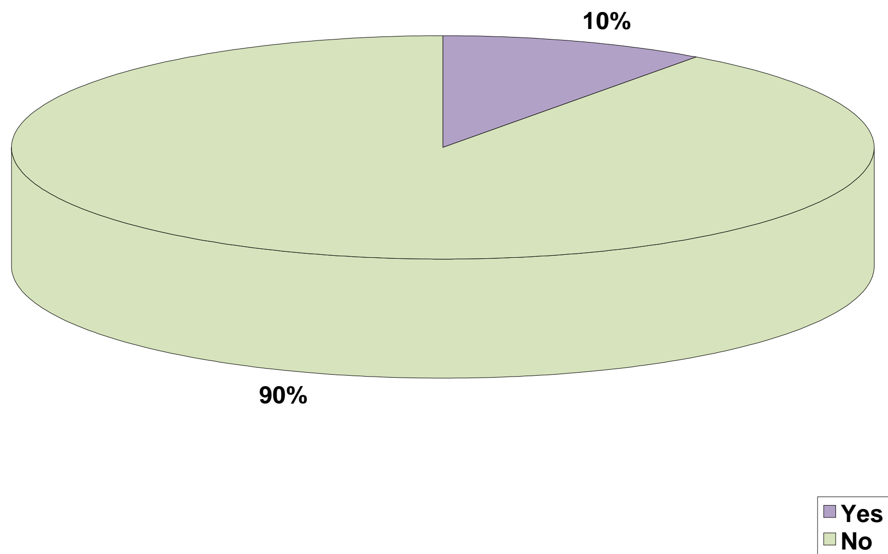


Figure 4.7

Respondents' consent to termination of unintentional pregnancy

4.5.12 Item 26: Intention in case of non-termination

Table 4.14 Respondents' intentions if not about to terminate an unintentional pregnancy

Respondents' intention		Yes	No
Deliver and keep the baby (n=91)	Frequency (%)	81 89%	10 11%
Deliver and give the baby to my parents (n=53)	Frequency (%)	38 71.6%	15 28.4%
Deliver and give the baby to my granny (n=47)	Frequency (%)	10 21.3%	37 78.7%
Deliver and give the baby to relatives (n=46)	Frequency (%)	4 8.7%	42 91.3%
Deliver and give the baby up for adoption (n=46)	Frequency (%)	4 8.7%	42 91.3%
Deliver and abandon the baby to the person responsible for the pregnancy (n=46)	Frequency (%)	6 13.0%	40 87%

Respondents could choose more than one option. The totals and percentages were calculated on the number of options chosen by the respondents.

Table 4.14 depicts the respondents' intentions if not to terminate an unintentional pregnancy. Of the respondents, 89% (n=81) would *deliver and keep the baby* but 11% (n=10) would not; 71.6% (n=38) would d*eliver and give the baby to their parents* but 28.4% (n=15) would not, and 21.3% (n=10) would *deliver and give the baby to their grandmother* but 78.7% (n=37) would not. Also, 8.7% (n=4) would *deliver and give the baby to relatives* but 91.3% (n=42) would not; 8.7% (n=4) would *deliver and give the baby up for adoption* but 91.3% (n=42) would not, and 13.0% (n=6) would *deliver and abandon the baby to person responsible for the pregnancy* but 87% (n=40) would not.

In a study done by Amobi and Igwegbe (2004:98) an unintended pregnancy among unmarried adolescents and young women in Anambra State, South East Nigeria, it was found that adolescents were coerced or forced to marry and this was a recurrent issue. These findings may concur with this study where 89% of the respondents reported that they would not terminate the pregnancy but also keep the baby. These decisions may be due to the fact that they would be forced to get married.

4.5.13 Item 27: Attitude towards an abortion

Table 4.15 Respondents' attitude towards friends who had undergone an abortion

Attitudes towards friends who had undergone an abortion		Yes	No
See her as a bad influence n=71	Frequency (%)	47 66.2%	24 33.8%
Dissociate yourself from the friendship n=67	Frequency (%)	38 56.7%	29 43.3%
Feel for her n=73	Frequency (%)	36 46.6%	39 53.4%
Encourage her to use some other contraceptive n=64	Frequency (%)	17 26.6%	47 73.4%
See her as a wicked person n=66	Frequency (%)	33 50%	33 50%
Report her to a law enforcement agent n=61	Frequency (%)	22 36.1%	39 63.9%
Other n=2	Frequency (%)	2 100%	0 0%

Table 4.15 lists the options regarding attitudes to friends who had had an abortion and the number of respondents who selected the various options. Of the respondents, 66.2% (n=47) indicated that they would see her as a bad influence; 56.7% (n=38) would dissociate themselves from the friendship, and 46.6% (n=36) indicated that they would feel for her. Furthermore, 26.6% (n=17) indicated that they would encourage her to use some other contraceptive; 50% (n=33) would see her as a wicked person, and 36.1% (n=22) would report her to a law enforcement agent. Finally, under "Other", 100% (n=2) of the respondents indicated that they would advise her.

From table 4.15 it is clear that the majority of the respondents (66.2%; n=47) would see their friend as a bad influence if they found out that she had had an abortion.

The findings of this study could significant to a study done by Amobi and Igwegbe (2004:95). This study was on unintended pregnancy among unwanted adolescents and young women. The reason why the adolescents of this study (6.2%) saw their friend as a: bad influence" after an abortion could be related to the major stressors identified by Amobi and Igwegbe. Stressors such as fear, stigmation, negative reaction and fear of school termination and parental disappointment.

Amobi and Igwegbe (2004:99) reported on a study on unwanted pregnancies that adolescents were discriminated against, experienced violence and psycho-social stress and forced marriage.

4.5.14 Item 28: Decision on termination of pregnancy

Table 4.16 Respondents' views on who should decide when a pregnancy should be terminated

Person who decides when pregnancy should be terminated		Yes	No
Yourself (n=67)	Frequency (%)	33 49.3%	34 50.7%
Doctor (n=64)	Frequency (%)	43 67.2%	21 32.8%
Family planning service (n=60)	Frequency (%)	24 40%	36 60%
Parent (n=62)	Frequency (%)	19 30.6%	43 69.4%
Class teacher (n=59)	Frequency (%)	7 11.9%	52 88.1%
The person responsible (n=60)	Frequency (%)	33 55%	27 45%
Friends (n=58)	Frequency (%)	15 25.9%	43 74.1%
Others (n=1)	Frequency (%)	1 100%	- -

Table 4.16 depicts the respondents' responses to who should decide when a pregnancy should be terminated. Of the respondents, 49.3% (n=33) indicated that they should decide for themselves when a pregnancy should be terminated; 67.2% (n=43) indicated that the doctors should decide for them, and 40% (n=24) indicated the family planning service. In addition, 30.6% (n=19) indicated that their parents should make the decision; 11.9% (n=7) indicated the class teacher; 55% (n=33) indicated that the people responsible for the pregnancy should decide, and 25.9% (n=15) indicated that their friends should decide. Finally, only 1 (100%) respondent selected "Other" and indicated that the decision to terminate the pregnancy should be left in God's hands.

Grimes et al (2006:4) found in their study an unsafe abortion, that women in developing countries still rely on traditional methods of abortion such as detergents, solvents, decoctions made from local or plant animal products, including dung. In settings such

as South Pacific and Equatorial Africa massaging and vigorous pummelling of the woman's lower abdomen is used. These findings concur with the above finds.

4.5.15 Item 29: Methods of abortion

Table 4.17 Respondents' views on the method of abortion

Method of abortion		**Yes**	**No**
Drink *ogogoro* (local gin) and lime to remove pregnancy (n=62)	Frequency (%)	25 40.3%	37 59.7%
Have a dilatation and curettage (D&C) done to remove pregnancy (n=68)	Frequency (%)	44 64.7%	24 35.3%
Take local herbs to remove pregnancy (n=61)	Frequency (%)	26 42.6%	35 57.4%
Have a manual vacuum aspiration done to remove pregnancy (n=61)	Frequency (%)	16 26.2%	45 73.8%
Use bicycle spoke or coat hanger to remove pregnancy (n=8)	Frequency (%)	7 87.5%	1 12.5%
Other (n=1)	Frequency (%)	1 100%	- -

Table 4.17 presents various methods of procuring an abortion and the number of respondents who selected them. Of the respondents, 40.3% (n=25) indicated that drinking *ogogoro* (local gin) and lime would abort the pregnancy; 64.7% (n=44) indicated undergoing dilatation and curettage (D & C), and 42.6% (n=26) indicated taking local herbs to abort. Of the respondents, 26.2% (n=16) indicated that having a manual vacuum aspiration would abort the pregnancy, whilst 87.5% (n=7) indicated that using a bicycle spoke or coat hanger would cause abortion. Finally, only 1 (100%) respondent selected "Other" and indicated that abortion should occur as God's will.

A study on why Nigerian adolescents seek abortion rather than contraception, Otoide et al (2001:77) findings concur with this study in that methods of abortions are the following: sharp metal instruments, a drip, drug use and herbs.

4.5.16 Item 30: Abortion service providers

Table 4.18 Respondents' views on abortion service providers

Abortion services		Yes	No
Have no conscience (n=66)	Frequency (%)	58 87.9%	8 12.1%
Are helping to reduce the shame of an unwanted pregnancy (n=63)	Frequency (%)	25 39.7%	38 60.3%
Are trying to save the woman's life (n=67)	Frequency (%)	12 17.9%	55 82.1%
Are dangerous to society (n=60)	Frequency (%)	41 68.3%	19 31.7%
Are encouraging prostitution (n=61)	Frequency (%)	45 73.8%	16 26.2%
Are murderers (n=72)	Frequency (%)	54 75%	18 25%
Are just doing their job (n=60)	Frequency (%)	21 35%	39 65%
Are very callous (n=58)	Frequency (%)	33 56.9%	25 43.1%
Are wicked people (n=64)	Frequency (%)	42 65.6%	22 34.4%

Table 4.18 presents different views on abortionists and the number of respondents that selected them. Of the respondents, 87.9% (n=58) indicated that abortion service providers had no conscience; 39.7% (n=25) indicated that abortion service providers helped to reduce shame from unwanted pregnancies, while 17.9% (n=12) indicated that they were trying to save the woman's life. Of the 100 respondents, 68.3% (n=41) indicated that abortion service providers were dangerous to society; 73.8% (n=45) indicated that they were encouraging prostitution, and 75% (n=54) indicated that they were murderers. Of the respondents, 35% (n=21) indicated that abortion service providers were just doing their job; 56.9% (n=33) indicated that they were callous, and 65.6% (n=42) indicated that they were wicked people.

4.5.17 Item 31: When education on sex and abortion should be included in school

Table 4.19 Respondents' views on when education on sex and abortion should be included in school

When to include education on sex and abortion		Yes	No
Junior Secondary School n=79	Frequency (%)	66 83.5%	13 16.5%
Senior Secondary School n=79	Frequency (%)	69 87.3%	10 12.7%
University/Polytechnic n=63	Frequency (%)	54 85.7%	9 14.3%
Other n=36	Frequency (%)	54 85.7%	9 14.3%

Table 4.19 depicts when education on sex and abortion should be introduced in school. Of the respondents, 83.5% (n=66) indicated that education on sex and abortion should be included in the junior secondary school curriculum; 87.3% (n=69) indicated in the senior secondary school curriculum; 85.7% (n=54) indicated the university/polytechnic curriculum, and 85.7% (n=54) indicated "Other" but did not specify.

From table 4.19 it is clear that the majority (87.3%; n=69) of the respondents indicated that education on sex and abortion should be introduced in senior secondary school.

4.5.18 Item 32: Knowledge about post-abortal care

Table 4.20 Respondents' awareness of post-abortal care

Had heard of post-abortal care	Frequency of response	% of response
Yes	19	19%
No	79	79%
No response	2	2%
Total	**100**	**100%**

Table 4.20 indicates that of the respondents, 19% (n=19) had heard of post-abortal care and 79% (n=79) had not.

4.5.19 Item 33: Knowledge about types of post-abortal care

Table 4.21 Respondents' knowledge of types of post-abortal care

Types of post-abortal care		Yes	No
Evacuation of the uterus, drugs, counselling, birth spacing method (n=36)	Frequency (%)	13 36.1%	23 63.9%
Drugs, counselling and birth spacing method (n=28)	Frequency (%)	11 39.3%	17 60.7%
Counselling and birth spacing method (n=26)	Frequency (%)	10 38.5%	16 61.5%
Counselling (n=26)	Frequency (%)	13 50%	13 50%
Birth spacing method (n=24)	Frequency (%)	6 25%	18 75%

Table 4.21 presents types of post-abortal care and the number of respondents who were aware of them. Of the respondents, 36.1% (n=13) were aware of evacuation of the uterus, drugs; counselling, and birth spacing methods as types of post-abortal care; 39.3% (n=11) were aware of drugs, counselling and birth spacing methods; 38.5% (n=10) were aware of counselling and birth spacing methods; 50% (n=13) were aware of counselling, and 25% (n=6) were aware of birth spacing methods.

4.5.20 Item 34: Meaning of post-abortal care

Table 4.22 Respondents' understanding of post-abortal care

Meaning of post-abortal care		Yes	No
Termination of pregnancy (n=31)	Frequency (%)	10 32.3%	21 67.7%
Taking care of complications of abortion (n=31)	Frequency (%)	12 38.7%	19 61.3%
Tracing a woman who has had an abortion (n=35)	Frequency (%)	17 48.6%	18 51.4%
Preventing unwanted pregnancy (n=29)	Frequency (%)	12 41.4%	17 58.6%
Preparing women for abortion (n=27)	Frequency (%)	20 74.1%	7 25.9%
I don't know (n=34)	Frequency (%)	13 38.2%	21 61.8%

Respondents could choose more than one option. The totals and percentages were calculated on the number of options chosen by the respondents.

Table 4.22 reveals that of the respondents, 32.3% (n=10) understood post-abortal care as the termination of pregnancy; 38.7% (n=12) understood it as taking care of complications of abortion, and 48.6% (n=17) indicated that post-abortal care was treating a woman who had had an abortion. Of the respondents, 41.4% (n=12) indicated post-abortal care was preventing unwanted pregnancy; 74.1% (n=20) understood it as preparing women for abortion, while 38.2% (n=13) indicated that they did not know what it meant.

4.5.21 Item 35: Availability of post-abortal services

Table 4.23 Respondents' knowledge of the availability of post-abortal services

Knowledge of the availability of post-abortal service		Yes	No
Health centres (n=46)	Frequency (%)	23 50%	23 50%
Government hospitals (n=39)	Frequency (%)	19 48.7%	20 51.3%
Private hospital (n=47)	Frequency (%)	33 80.2%	14 29.8%
Other (n=19)	Frequency (%)	9 47.4%	10 52.6%

Table 4.23 indicates the respondents' knowledge of the availability of post-abortal services. Of the respondents, 50% (n=23) indicated that post-abortal services were available in health centres; 48.7% (n=19) indicated that they were available in government hospitals; 70.2% (n=33) indicated in private hospitals, and 47.4% (n=9) indicated that they did not know.

Amobi and Igwegbe (2004:80) study on unintended pregnancy concurs with this study where respondents were aware of post-abortal services, but feared stigmatisation when attending these services.

4.6 SECTION E: KNOWLEDGE OF LEGALITY/LEGALISATION OF ABORTION

4.6.1 Item 36: Legality of abortion in Nigeria

Table 4.24 Respondents' opinion of legality of abortion in Nigeria

Legality of abortion in Nigeria	Frequency of response	% of response
Yes	28	28%
No	30	30%
No response	42	42%
Total	**58**	**100%**

Table 4.24 presents the respondents' knowledge of the legality of abortion in Nigeria. Of the respondents, 28% (n=28) indicated that abortion was legal in Nigeria, and 30% (n=30) indicated that abortion was illegal in Nigeria.

4.6.2 Item 37: Meaning of legalisation of abortion

Table 4.25 Respondents' understanding of the meaning of legalisation of abortion

Legalisation of abortion		Yes	No
It allows women free access to abortion services (n=27)	Frequency (%)	15 55.6%	12 44.4%
It provides abortion services to women (n=27)	Frequency (%)	14 51.9%	13 48.1%
It provides abortion services in government hospitals (n=27)	Frequency (%)	13 48.1%	13 48.1%
Other	-	-	-

Table 4.25 presents the respondents' understanding of the meaning of legalisation of abortion. Of the respondents, 55.6% (n=15) indicated that legalisation of abortion allowed women free access to abortion services; 51.9% (n=14) indicated that it provided abortion services to women, and 48.1% (n=13) indicated that it provided abortion services in government hospitals.

4.6.3 Item 38: Utilisation of abortion services

Table 4.26 Respondents' conditions for accessing abortion services

I would access abortion facilities		Yes	No
If I can access it easily (n=50)	Frequency (%)	14 28%	36 72%
If provided in a government hospital (n=44)	Frequency (%)	13 29.5%	31 70.5%
If I will not be arrested (n=45)	Frequency (%)	15 33.3%	30 66.7%
If provided by a qualified health professional (n=56)	Frequency (%)	30 53.6%	26 46.4%
If I have the support of my partner/husband (n=42)	Frequency (%)	14 33.3%	28 66.7%
If I have my parents' support (n=41)	Frequency (%)	14 41.5%	27 58.5%
Other (n=0)	Frequency (%)	-	-

Respondents could choose more than one option. The totals and percentages were calculated on the number of respondents that chose the option.

Table 4.26 depicts whether the respondents would access abortion services and under what conditions. Of the respondents, 28% (n=14) indicated that they would access abortion services if they were easily accessible, but 72% (n=36) would not; 29.5% (n=13) indicated that they would access the services if they were provided in a government hospital, but 70.5% (n=31) would not. Of the respondents, 33.3% (n=15) would access the services if they would not be arrested, but 66.7% (n=30) would not, and 53.6% (n=30) would access them if provided by qualified health professionals, but 46.4% (n=26) would not. Moreover, of the respondents, 33.3% (n=14) indicated that they would access abortion services if they had the support of their partner/husband, but 66.7% (n=28) would not. Finally, 41.5% (n=14) indicated that they would access abortion services if they had the support of their parents, but 58.5% (n=27) would not.

4.6.4 Item 39: Utilisation of abortion services if legal

Table 4.27 Respondents' willingness to utilise abortion services if legal

Utilisation of abortion services if legal	Frequency of response	% of response
Yes	18	18%
No	73	73%
No response	9	9%
Total	**100**	**100%**

According to table 4.27, 18% (n=18) of the respondents indicated that they would make use of abortion services provided they were legal, while 73% (n=73) would not. This finding would seem to indicate that even if abortion services were legalised in Nigeria, effective campaigns and public education would be needed before people would accept them.

Okonofua (1997:32) reported in a study on preventing unsafe abortion in Nigeria that abortion is not legally permitted in Nigeria except in circumstances where it is needed to save the life of a woman. The legal code carries a punishment of up to 14 years for those who breach the abortion law. These restrictive "forces" adolescents to utilise unsafe abortion services. These findings concur with the reasons stated by the respondents in this study why they are not willing to attend reproductive services.

4.6.5 Item 40: Advantages of the availability and use of abortion services

Table 4.28 Respondents' reasons for the availability and use of abortion services

Reasons for using abortion services		Yes	No
It will reduce the deaths of young women (n=35)	Frequency (%)	17 48.6%	18 51.4%
Women will access abortion services in a safe place (n=32)	Frequency (%)	12 37.5%	20 62.5%
Women have the right to do what they want to with their body (n=29)	Frequency (%)	7 24.1%	22 75.9%
People should be allowed to make choices (n=30)	Frequency (%)	17 56.7%	13 43.3%
It is a personal decision (n=30)	Frequency (%)	17 56.7%	13 43.3%
It is used as a family planning method (n=30)	Frequency (%)	24 80%	6 20%
It will reduce the number of abandoned children (n=29)	Frequency (%)	6 20.7%	23 79.3%
I don't know (n=29)	Frequency (%)	11 37.9%	18 62.1%
Other (n=20)	Frequency (%)	9 45%	12 55%

Respondents could choose more than one option. The totals and percentages were calculated on the number of respondents that chose the option.

Table 4.28 lists the reasons provided for the availability and provision of abortion services and the number of respondents who agreed with or selected them. Of the respondents, 48.6% (n=17) indicated that the availability and provision of abortion services would reduce the deaths of young women, but 51.4% (n=18) disagreed; 37.5% (n=12) indicated that women would access abortion services in a safe place, but 62.5% (n=20) disagreed, and 24.1% (n=7) indicated that women had the right to do what they wanted to with their body, but 75.9% (n=22) disagreed.

Of the respondents, 56.7% (n=17) indicated that people should be allowed to make choices, but 43.3% (n=13) disagreed; 56.7% (n=17) indicated that it was a personal decision, but 43.3% (n=13) disagreed, and 80% (n=24) indicated that abortion services were used as a family planning method, but 20% (n=6) disagreed. Of the respondents, 20.7% (n=6) indicated that abortion services would reduce the number of abandoned children, but 79.3% (n=23) disagreed.

Of the respondents who indicated that they did not know, 37.9% (n=11) selected the "Yes" option and 62.1% (n=18) selected the "No" option. Finally, a few respondents selected the "Other" alternative, without specifying what they meant or understood by this. However, of those respondents, 45% (n=9) selected the "Yes" option and 55% (n=12) selected the "No" option.

4.6.6 Item 41: Circumstances under which abortion should be allowed

Table 4.29 Respondents' views on circumstances under which abortion should be allowed

Circumstances under which an abortion should be allowed		Yes	No
If it is to save the woman's life (n=70)	Frequency (%)	49 69%	21 31%
If the woman has completed her family (n=59)	Frequency (%)	23 39%	36 61%
If the woman's husband/ boyfriend gives permission (n=56)	Frequency (%)	23 41.1%	33 58.9%
If the woman is under 18 years of age (n=56)	Frequency (%)	11 19.6%	45 80.4%
If the woman is above 21 years of age (n=55)	Frequency (%)	24 43.6%	31 56.4%
If the woman's pregnancy is likely to disrupt her education /apprenticeship (n=58)	Frequency (%)	23 39.7%	35 60.3%

Table 4.29 lists the alternatives provided and the number of respondents who selected them. Of the respondents, 69% (n=48) indicated that abortion should be allowed if it was to save the woman's life, but 31% (n=21) disagreed, and 39% (n=23) indicated it should be allowed if the woman had completed her family, but 61% (n=36) disagreed.

Of the respondents, 41.1% (n=23) agreed with allowing abortion if the woman's husband/boyfriend gave permission, but 58.9% (n=33) disagreed. Regarding the woman's age, 19.6% (n=11) agreed with abortion if the woman was younger than 18, but 80.4% (n=45) disagreed, and while 43.6% (n=24) agreed with abortion if the woman was over 21, 56.4% (n=31) disagreed. Finally, of the respondents 39.7% (n=23) agreed with allowing an abortion if the woman's pregnancy was likely to disrupt her education/apprenticeship, but 60.3% (n=35) disagreed.

4.6.7 Item 42: Circumstances under which a woman should end an unwanted pregnancy

Table 4.30 Respondents' views on circumstances under which a woman should end an unwanted pregnancy

Circumstances under which a woman should end an unwanted pregnancy		Yes	No
If the woman is raped (n=67)	Frequency (%)	39 58.2%	28 41.8%
If the pregnancy will endanger the woman's life (n=58)	Frequency (%)	40 69%	18 31%
If the foetus is grossly deformed (n=58)	Frequency (%)	27 46.6%	31 53.4%
If she does not want the pregnancy (n=48)	Frequency (%)	25 52.1	23 47.9%
If the person responsible for the pregnancy does not want it (n=58)	Frequency (%)	21 36.2%	37 63.8%
If her parents do not approve of the pregnancy (n=57)	Frequency (%)	22 38.6%	35 61.4%
Other (n=0)	Frequency (%)	-	-

Table 4.30 presents the respondents' views on various reasons for abortion. Of the respondents, 58.2% (n=39) agreed with abortion if a woman was raped, while 41.8% (n=28) disagreed; 69% (n=40) agreed if the pregnancy would endanger the woman's life, but 31% (n=18) disagreed; 46.6% (n=27) agreed if the foetus was grossly deformed, but 53.4% (n=31) disagreed.

Of the respondents, 52.1% (n=25) agreed with abortion if the woman did not want the pregnancy, while 47.9% (n=23) disagreed, and 36.2% (n=21) agreed if the person responsible for the pregnancy did not want it, but 63.8% (n=37) disagreed. Finally, 38.6% (n=22) agreed if the woman's parents did not approve of the pregnancy, but 61.4% (n=35) disagreed.

These findings are in accordance with the findings reported by Oknofua (1997:32).

4.6.8 Item 43: Taboos against abortion

Table 4.31 Respondents' perception of the effect of taboos against abortion

Taboos against abortion	Frequency of response	% of response
Yes	50	50%
No	46	46%
No responses	4	4%
Total	**100**	**100%**

According to table 4.31, 50% (n=50) of the respondents indicated that taboos affected abortion while 46% (n=46) did not.

4.6.9 Item 44: Adolescents' ability to access abortion services in Nigeria

Table 4.32 Respondents' views on whether adolescents should be allowed to access abortion services in Nigeria

Adolescents should be allowed to access abortion services in Nigeria	Frequency of response	% of response
Yes	87	87%
No	11	11%
No response	2	2%
Total	**100**	**100%**

Table 4.32 reveals that of the respondents, 87% (n=87) indicated that adolescents should be allowed to access abortion services in Nigeria while 11% (n=11) indicated they should not.

4.6.10 Item 46: The restriction on abortion

Table 4.33 Respondents' agreement or disagreement with the restriction on abortion

Agree with restriction on abortion	Frequency of response	% of response
Yes	53	53%
No	43	43%
No response	4	4%
Total	**100**	**100%**

According to table 4.33, of the respondents, 53% (n=53) indicated that they agreed with the restriction on abortion while 43% (n=43) disagreed with it.

4.6.11 Item 47: Adolescents' right to decide whether to have an abortion

Table 4.34 Respondents' views on adolescents' right to decide on abortion

Adolescents should decide whether to have an abortion	Frequency of response	% of response
Yes	40	40%
No	49	49%
No response	4	4%
Total	**100**	**100%**

Table 4.34 reveals that of the respondents, 40% (n=40) indicated that adolescents should decide for themselves whether to have an abortion, but 49% (n=49) disagreed.

Reproductive rights are one of the fundamental rights of a human being. The WHO advocated for reproductive rights with a primary emphasis on women's rights which includes family planning service, sex education and abortion. These recommendations concur with this study where 40% of the respondents should have the right to abortion which is less than 49% of respondents who reported that they do not have the right to decide on abortion. This finding could be attributed to the restrictive abortion laws in Nigeria on the one hand and respondents' knowledge of their rights on the other hand (http://www.en.wikipedia.org/wiki/Reproductive_rights (accessed on 18.02.2010)).

4.7 CONCLUSION

This chapter discussed the data analysis and interpretation, with the use of frequency tables, bar charts, pie charts and percentages.

Chapter 5 discusses the findings and limitations of the study, and makes recommendations for midwifery services and further research.

Chapter 5

Findings, limitations and recommendations

5.1 INTRODUCTION

The purpose of the study was to assess the knowledge regarding abortion of adolescents who visited the LUTH Complex. This knowledge should assist in handling abortion issues and finding ways of preventing unsafe abortions, which in turn should contribute to reducing maternal mortality and morbidity rates. This chapter discusses the findings and limitations of the study as well as the implications for midwifery and makes recommendations for practice and further research.

Research methodology

A quantitative, explorative, descriptive research design was considered most appropriate for this study in order to give a detailed description of the knowledge levels of adolescents regarding abortion at the LUTH Complex in Idi-araba, Lagos, Nigeria.

The following research question guided this study:

- What is the level of knowledge of adolescents at the LUTH Complex regarding abortion?

The specific objectives of this study were to

- explore adolescents' knowledge about their reproductive health
- determine the knowledge about abortion in adolescents
- determine adolescents' knowledge of abortion legislation in Nigeria
- identify unsafe practices regarding abortion

A structured interview schedule was used as the data collection instrument. The structured interview schedule was divided into five sections, covering demographic data, respondents' knowledge of sexuality, abortion and legalisation of abortion.

The data collected were used to evaluate the knowledge of adolescents on abortion. Data analysis also entails categorising, ordering, and summarising the data and describing it in meaningful terms (Brink 2006:12). The findings were discussed and the data presented in the form of frequency tables and bar graphs (see chapter 4).

5.2 FINDINGS

5.2.1 Demographic information

Respondents' age (Item 1)

The data revealed that 26% (n=26) of the respondents were 16 years old (see chapter 4, table 4.1). At this age many adolescents are in secondary school.

Respondents' school, work and apprenticeship (Items 2, 3 and 4)

The study found that of the respondents, 99% (n=99) were in secondary school and 1% (n=1) was not in school (see figure 4.2). Of the respondents 45% (n=45) were in senior secondary school 3; 5% (n=5) were at university; 1% (n=1) was at the polytechnic college, and 3% (n=3) were in apprenticeships. The only respondent (1%; n=1) who did not go to school indicated that she assisted her parents (see tables 4.2 and figure 4.2). Lagos is a cosmopolitan city, and public secondary schooling is free, so most adolescents are likely to be in school.

Respondents' ethnic groups (Item 5)

The study revealed that 55% (n=55) of respondents were Yoruba (see table 4.5). Lagos is a multiethnic city, but the predominant ethnic group is Yoruba, as reflected in this study.

Respondents' religious affiliations (Item 6)

The study revealed that 95% (n=95) of the respondents belonged to Christian denominations, Jehovah Witnesses and Islam. Only 5% (n=5) indicated having no religious affiliation (see figure 4.3). The respondents' religious nature, therefore, was likely to affect their views on abortion.

5.2.2 Knowledge regarding reproductive health

Discussion of sex-related topics with family and friends (Items 7, 8 and 9)

The study revealed that 72% (n=72) of the respondents discussed sex-related topics with family members and friends (see tables 4.3 and figure 4.5). The topic discussed most was menstruation (91.9% n=57), and the one discussed least was conception (26,2% n=11) (see table 4.4). This indicated that many of them did not know about conception by the time they were sexually active, and this would affect their understanding of the reproductive system and consequently also their understanding of abortion. Where adolescents do not have knowledge of their own bodies, they also do not have knowledge on how to care for themselves during a pregnancy and a possible abortion.

Respondents' understanding of adolescence (Item 10)

The study revealed that the respondents understood adolescence (see table 4.10). The respondents could select various options for the term adolescence, 84% (n=84) selected the meaning as "*A period in the life which you are neither a child nor an adult.* Sixty five percent (n=65) of respondents indicated that it could also be seen as "*Preparing for marriage and a family life*" and 60% (n=60) selected "*A period of emotional development*".

Respondents' experience of sexual intercourse and reasons for it (Items 11, 12 and 13)

The study revealed that 89% (n=89) of the respondents had had sexual intercourse. Forty-nine percent (n=49) of the respondents had had sexual intercourse when they were 16 and older, and only one respondent (1%) indicated having had sex when she was under 8 years old, through being sexually assaulted. Among the respondents who had sexual intercourse voluntarily, 43% (n=43) indicated they did it for love of the boy, 16% (n=16) did it out of curiosity, and 15% (n=15) did it because of peer pressure (see

table 4.8). Despite the religious nature of the average Nigerian family and radio jingles on abstinence ("Zip up"), adolescents actively engage in sexual issues. This is a strong indication that abortion and contraceptive issues should be openly discussed to address these groups of young women.

5.2.3 Knowledge on abortion

Respondents and abortion (Items 14 to 31)

Ninety-nine percent (n-99) of the respondents had not had an abortion (see table 4.9). Of the respondents, 51% (n=51) indicated that they knew someone who had had an abortion (see figure 4.6). The respondents' indicated various reactions to hearing about a family member's/friend's/member of the community's abortion. For example, 49% (n=49) were shocked; 6% (n=6) were outraged, and 31% (n=31) felt sympathy for the person (see table 4.10).

No response were given for the items 19 (age at time of the abortion), 20 (feelings about abortion) and 21(reasons for not having an abortion).

In item 22, the respondents were asked to indicate for which of the reasons provided they would have an abortion (see table 4.11). Many of the respondents indicated that they would have an abortion for various reasons, the predominant reasons being: to avoid shame (51% n=25), continue with education (58.5% n=53), if raped (41.5% n=22), and after contraceptive failure (40,5% n=17).

Regarding their understanding of abortion, the results revealed that 94.9% (n=37) of respondents regarded abortion as killing an innocent baby and 85% (n=34) regarded it as terminating an unwanted pregnancy (see table 4.12).

In item 23 the respondents were asked whether they would have an abortion for any of the reasons listed. Of the respondents who indicated that they would have an abortion, 24.4% (n=11) would have an abortion if nobody would know (see table 4.17). This raises the issue of rights. Some adolescents do not know their rights and Nigerian law is not very clear on the girl child. Women advocates are lobbying the National Assembly on passage and interpretation of the Children's Rights Bill (Oye-Adeniran, Long et al

2004:209-217). Of grave concern is the fact that because the respondents, like many adolescents, would not want anyone to know, they might resort to unsafe abortions.

Regarding their opinion of abortion (item 23), although several regarded it as the termination of an unwanted pregnancy (85% N=34) and as saving the woman's future, the majority of respondents (94.9% n=37) regarded abortion as killing an innocent baby (see table 4.12). Most religions condemn abortion and see it as murder, and the respondents' religious nature and upbringing upheld and promoted this view (Okonofua, Odimegwu & Ajabor 1999:67-77).

In item 24, resources of information on abortion, the predominant sources were friends (74.6% n=44), school (71.4% n=55) and others (70% n=7).

When asked (item 25) whether they would terminate an unintentional pregnancy, 90% (n=90) indicated that they would not, and only 10% (n=10) indicated that they would (see figure 4.7).

.

In item 26, the respondents were asked what they would do if they did not have an abortion. The majority of the respondents (89%; n=81) indicated that they would deliver and keep the baby (see table 4.14).

The respondents were asked what their attitude would be towards a friend who had had an abortion (item 27). Of the respondents, 66.2% (n=47) stated that they would view her as a bad influence and would keep away from her (see table 4.15). Some parents have been known to tell their daughters to keep away from such a friend (56% n=38) (FMOH 2001:6-7). This isolation could further compound an adolescent's psychological state. In a bid to access abortion services in complete secrecy, the adolescent might consult a back-street abortionist who might offer her an unsafe abortion.

The study revealed in item 28 that the respondents were not sure who should decide when to terminate a pregnancy (see table 4.16). Of the respondents, 67.2% (n=43) indicated that doctors should decide on termination since doctors can diagnose a pregnancy that threatens the woman's life, while 25.9% (n=15) indicated that their friends

should decide for them. This is the age where peer pressure is very strong and some adolescents' behaviour may be due to peer pressure (Whaley & Wong 1979:685-706).

The respondents were aware of different methods of abortion (item 29, table 4.17).Of the respondents, 40.3% (n=25) indicated that drinking *ogogoro* (local gin) and lime would abort the pregnancy; 64.7% (n=44) indicated undergoing dilatation and curettage (D & C), and 42.6% (n=26) indicated taking local herbs to abort. Of the respondents, 26.2% (n=16) indicated that having a manual vacuum aspiration would abort the pregnancy, while 87.5% (n=7) indicated that using a bicycle spoke or coat hanger would cause abortion. Finally, only 1 respondent selected "Other" and indicated that abortion should occur as God's will.

The respondents had mainly negative perceptions of people who offered abortion services (item 30, table 4.18). For example, 87.9% (n=58) indicated that abortion service providers had no conscience; 75% (n=54) indicated that they were murderers; 56.9% (n=33) indicated that they were callous, and 65.6% (n=42) indicated that they were wicked people. This is why health professionals who are trained to render abortion services do not practise them or let people in the neighbourhood know clearly that they offer such services. Advocates of abortion issues are afraid of what people will say about them.

The respondents agreed that education on sex and abortion should be included in the school curriculum (item 31, table 4.19). For example, 83.5% (n=66) indicated that education on sex and abortion should be included in the junior secondary school curriculum; 87.3% (n=69) indicated in the senior secondary school curriculum, and 85.7% (n=54) indicated the university/polytechnic curriculum. Most students are 14 and older by the time they are in senior secondary school and many are sexually active. This indicates that they should know about abortion, since death due to an unsafe abortion is common among adolescents (Oye-Adeniran 2005:18).

Respondents' knowledge of post-abortal care (Items 32, 33, 34, 35 and 38)

The study revealed that 79% (n=79) of the respondents had not heard of post-abortal care (see table 4.20). Those who had heard of it knew of various methods: for example, evacuation of the uterus, drugs, counselling and birth spacing methods (36.1% n=13)

(see table 4.21). However, the respondents did not clearly understand what post-abortal care meant. Table 4.22 reveals that of the respondents, 32.3% (n=10) understood post-abortal care as the termination of pregnancy; 38.7% (n=12) understood it as taking care of complications of abortion, and 48.6% (n=17) indicated that post-abortal care was treating a woman who had had an abortion. Of the respondents, 41.4% (n=12) indicated post-abortal care was preventing unwanted pregnancy; 74.1% (n=20) understood it as preparing women for abortion, while 38.2% (n=13) indicated that they did not know what it meant.

This strongly suggested the need for public campaigns and health information on post-abortal services. Furthermore, this stressed the need for clear sex education in the secondary school curriculum, including information on post-abortal services.

5.2.4 Legislation on/Legalisation of abortion

Respondents' knowledge of legalisation of abortion (Items 36, 37, 38, 39, 40, 41 and 42)

The study revealed that 30% (n=30) of the respondents knew that abortion was illegal in Nigeria (item 36). The respondents' understanding of the meaning of legalisation of abortion varied. Of the respondents, 55.6% (n=15) indicated that legalisation of abortion allowed women free access to abortion services; 51.9% (n=14) indicated that it provided abortion services to women, and 48.1% (n=13) indicated that it provided abortion services in government hospitals.

Of the respondents, 28% (n=14) indicated that they would access **(item 45)** abortion services if they were easily accessible, 29.5% (n=13) indicated that they would access the services if they were provided in a government hospital. Of the respondents, 33.3% (n=15) would access the services if they would not be arrested, and 53.6% (n=30) would access them if provided by qualified health professionals. Moreover, of the respondents, 33.3% (n=14) indicated that they would access abortion services if they had the support of their partner/husband. Finally, 41.5% (n=14) indicated that they would access abortion services if they had the support of their parents,

The respondents were aware that if abortion were legalised, it would be of benefit to women (see tables 4.24 and 4.25).

Of the respondents, 73% (n=73) stated that they would not make use of abortion services even if they were made legal (see table 4.27). This may be attributed to the fact that abortion is yet to be accepted in Nigeria.

Response to whether adolescents should be allowed to access abortion services (Item 44)

The study found that 87% (n=87) of the respondents agreed that adolescents should be allowed to access abortion services in Nigeria. This indicates the need for adolescents to be informed and to have the right and freedom to choose

Restriction on abortion services (Items 46 and 47)

The study found that 53% (n=53) of the respondents agreed with the restriction on abortion (item 46). Regarding whether adolescents should decide for themselves whether to have an abortion (**item 47**), 40% (n=40) agreed, but 49% (n=49) disagreed (see table 4.33 and 4.34).

5.3 IMPLICATIONS OF THE STUDY

Despite the religious nature of the average Nigerian family and radio jingles on abstinence, the findings proved once again that adolescents actively engage in sexual issues. The study found, however, that on the whole the respondents had inadequate knowledge regarding abortion and post-abortal services, and many did not fully understand the meaning of abortion. Although some would access abortion services if easily accessible, legal and offered in a government hospital, most also indicated that they would not use abortion services even if they were legalised, since they see abortion as “killing an innocent baby”. It appeared from the study that factors such as belief, religious teachings, prejudice and the general attitude towards discussion on abortion issues influence adolescents’ knowledge of abortion.

Even if abortion is legalised, unless there is a strong public enlightenment campaign for abortion it may take some time before a woman can consult a clinic and ask for the

service. Meanwhile efforts should be intensified in the campaign against unwanted pregnancies, emphasising prevention of unwanted pregnancy instead of termination of a pregnancy that has already occurred.

5.3.1 Implications for midwifery

The findings of this study indicate that midwifery practice should be based on the development of a sexual reproductive health programme aimed at improving public awareness of the importance of contraception as a way of preventing unwanted and unsafe pregnancies.

A further implication is that midwives should be well skilled in post-abortion care and services in order to be able to attend to emergencies as a result of unsafe abortions.

5.4 LIMITATIONS OF THE STUDY

The study was restricted to a selected area of Lagos (Idi-Araba), Nigeria. Therefore, the findings cannot be generalised to the whole country.

Despite the care taken by the researcher to reassure the respondents that they would remain anonymous, it is possible that the findings were still to some extent affected by the Hawthorne effect, and that some of the respondents gave what they believed to be a socially acceptable response. Such a limitation is to be expected in the case of such a sensitive subject.

5.5 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for health education and health management services, and for further research.

5.5.1 Media sensitisation campaign, information and public meetings

Education is essential if a government wants to reduce unsafe abortions. Unsafe abortion is a public health issue and, as such, health education in this regard should be

intensified, highlighting the incidence and impact of unsafe abortion in Nigeria while also taking into consideration the people's beliefs, attitudes and practices.

Health education should provide information on the legal status of abortion, the prevention of unwanted pregnancies, avoidance of unsafe abortions, and how to recognise and seek appropriate treatment for abortion complications.

To this end, the use of television and radio jingles and messages, as well as messages in newspapers and magazines, should be encouraged. Posters depicting the dangers of unsafe abortion should be prominently displayed in all health facilities.

5.5.2 NGOs and community-based organisations

In order to reduce the heavy toll of abortion-related maternal mortality and morbidity, the government, international agencies, and non-governmental organisations should collaborate in ensuring access to family planning and post-abortal care services.

5.5.3 Provision of care for unwanted pregnancies through comprehensive client-oriented reproductive health services

Health professionals and others should display and foster non-judgemental attitudes. Confidential counselling and emergency contraception should be available and their utilisation encouraged. Where appropriate, special attention should be given to the needs of young people, marginalised women, and those living in conflict situations and at risk of sexual abuse, rape and violence.

5.5.4 Provision of adequate and quality health facilities

High-quality services for treating and managing complications of abortion should be made available to all women. Key elements of post-abortion care include emergency treatment of post-abortion complications; family planning and counselling services, and links to comprehensive reproductive services. These services should be available 24 hours daily with specially trained staff, appropriate equipment, protocols for treatment procedures, and effective referral networks at every medical facility.

5.5.5 Primary prevention of unwanted pregnancies

Programmes should be implemented to reduce the rate of unwanted pregnancies in Nigeria. Such programmes should include provision of reproductive health information in schools, strengthening of family life values in the school curriculum, provision of contraceptives and counselling to adolescents, using formal methods and informed channels, peer counsellors, school clinics, youth club clinics and evening clinics.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher recommends the following topics for research into abortion in Nigeria:

- A multi-institutional and multi-disciplinary study on the prevalence and determinants of induced abortion in Nigeria and the true rates of abortion complications. The findings could assist in formulating policy on abortion and provide a baseline for monitoring changes in abortion morbidity and mortality in Nigeria.
- An investigation into the cost of illegal abortion in Nigeria in order to facilitate and inform health planning.
- An investigation into women's, health professionals' and men's attitudes towards abortion and abortion law.
- A qualitative and quantitative investigation to determine the abortion-seeking behaviour of women. Issues to be covered by such research include the characteristics of women seeking abortion, the nature of available clandestine abortion methods and services, and the processes that lead women to seek particular methods of abortion. Such research could be used to devise interventions to break the cycle at the point where dangerous abortion methods are used.
- An investigation into the socio-cultural context of unwanted pregnancies in Nigeria.
- Studies on:
  - the determinants of teenage sexuality and pregnancy
  - extramarital sexual relations

- barriers to the use of contraceptives

5.7 CONCLUSION

This chapter discussed the findings and limitations of the study and made recommendations based on the findings for practice and for further research. The study attempted to determine adolescents' knowledge of reproductive health abortion, as this is a critical factor in determining how adolescents handle abortion issues. The study found that the respondents had inadequate knowledge regarding abortion and many did not understand the meaning of abortion. Most indicated that they would not use abortion services, even if they were legalised, since they see abortion as killing an innocent baby. The study found that factors such as beliefs, religious teachings, prejudice and the general attitude towards discussion on abortion issues influence adolescents' knowledge of abortion.

The findings and recommendations of this study should benefit policy makers, midwives and, more importantly, adolescents and the vulnerable women of Nigeria.

BIBLIOGRAPHY

Ajabor, H. 1999. Assessing the prevalence and determinants of unwanted pregnancy. *Africa Journal of Reproductive Health* 30(11):67-77.

Abella, F. 2009. *Greater government action needed to reduce maternal mortality in Nigeria*. http://www.guttmachr.org/media/nr/2009/05/28/index/html.

Abortion.
http://en.wikipedia.org/wiki/Abortion.

Abortion and politics. http://www.politics science.

Abortion and rights. http://www.alternet.org/rights38763.

Adam, GK, Elhassan, EM, Ahmed, AM & Adam, I. 2008. Maternal and perinatal outcome in teenage pregnancies in Sudan. *Brief Communications*:170-171.

Adolescent development. http://www.MayoClinic.com.

Agbadudu, AB. 1994. *Statistics for business and social sciences*. Benin City: Uri.

Ahman, E & Iqbal, S. 2002. Unsafe abortion: worldwide estimates for 2000. *Reproductive Health Matters* 10(19):13-17.

Akinrinola, B, Oye-Adeniran, B, Singh, S, Adewole, IF, Wulf, D, Sedgh, G & Hussein, R. 2006. *Unwanted pregnancy and induced abortion in Nigeria: causes and consequences*. CAUP. New York: The Alan Guttmacher Institute.

Ama, JO. 1995. *A handbook of research for nurses*. Ibadan: University Press.

Amazigo, U, Silva, N, Kaufman, J & Obikeze, DS. 1997. *International Family Planning Perspectives* 23:28-33.

Amobi, I & Igwegbe, A. 2004. Unintended pregnancy among unmarried adolescents and young women in Anambra State, South East Nigeria. *African Journal of Reproductive Health* 8(3):92-102.

Anarado, AN. 2002. *Ethics and law in nursing practice*. Enugu: SNAAP.

Araoye, MO. 2004. *Research methodology with statistics for health and social sciences*. Ilorin: Nathadex.

Atsenuwa, A. 2005. *Abortion and the law in Nigeria*. Paper on Dissemination of WHO safe abortion technical and policy guidance for health systems. Lagos: Federal Ministry of Health (FMOH).

Balogun, OY. 2003. *Secondary school atlas*. 2nd edition. Lagos: Longman.

Bamidele, S0. 1999. *Intermediate statistics: theory and practice*. Ado-Ekiti: Petoa.

Barber, JM, Stokes, LG & Billings, DM. 1973. *Adult and child care: a client approach to nursing.* St Louis: Mosby.

Bennett, VR & Brown, LK. 1999. *Myles textbook for midwives*. 13th edition. London: Churchill Livingstone.

Berer, M. 2002. Making abortion a woman's right worldwide. *Reproductive Health Matters* 10(19):1-7.

Boardnet/archives/2005/04/02/33.

Brink, HI. 1996. *Fundamentals of research methodology for health care professionals*. Cape Town: Juta.

Brink, H. 2006. *Fundamentals of research methodology for health care professionals*. Cape Town: Juta.

Brink, PJ & Wood, MJ. 1998. *Basic steps in planning nursing research: from question to proposal*. 4th edition. Philadelphia: Lippincott.

Burns, N & Grove, SK. 2003. Understanding nursing research. Philadelphia: Saunders.

Burns, N & Grove, SK. 2005. *The practice of nursing research*. 5th edition. Philadelphia: Elsevier.

Chimaraoke, OI. 2005. The socio-cultural context of adolescents' notions of sex and sexuality in rural South-Eastern Nigeria. *Sexualities* 8(5):600-617.

Collins English Dictionary. 2001. 21st century edition. Glasgow: HarperCollins.

Cronje, HS & Grobler, CJF (eds). 2003. *Obstetrics in Southern Africa.* 2nd edition. Pretoria: Van Schaik.

Demographics of Nigeria. 2010.
http://en.wikipedia.org/wiki/Demographics of Nigeria

De Vos, AS (ed). 2001. *Research at grassroots: a primer for the caring professions*. Pretoria: Van Schaik.

Elder, MG. 1998. *Reproduction, obstetrics and gynaecology*. 1st edition. London: Blackwell.

Enabudoso, EJ, Charoro, EP, Ande, ABA, Ekpe, UP & Okohue, EJ. 2007. Five year review of complicated induced abortions in University of Benin teaching hospital, Benin City. *Tropical Journal of Obstetrics and Gynaecology* 9(1):no pages.

Esere, OM. 2008. Effect of sex education programme on at-risk sexual behaviour of school-going adolescents in Ilorin, Nigeria. *African Health Sciences* 8(2):120-125.

Fatusi, C. 2004. *Maternal mortality situation and determinants in Nigeria*. Abuja: FMOH.

Fatusi, AO & Ijadunola, KT. 2003. *National study on essential obstetric care facilities in Nigeria*. Abuja: FMOH.

FMOH (Federal Ministry of Health). 2001. *National curriculum on reproductive health for nurses and midwives*. United Nations Population Fund. Abuja: FMOH.

FMOH (Federal Ministry of Health). 2003. *Reproductive health situation in Nigeria*. Abuja: FMOH.

FMOH (Federal Ministry of Health). 2004. *Post-abortion care training curriculum for reproductive health professionals.* Abuja: FMOH.

FMOH (Federal Ministry of Health). 2005a. *Family planning training manual for physicians and nurses/midwives*. Abuja: FMOH.

FMOH (Federal Ministry of Health). 2005b. *Fact sheet on safe motherhood*. Abuja: FMOH.

FMOH (Federal Ministry of Health). 2006. *Training manual on safe motherhood*. Abuja: FMOH.

Fraser, DM & Cooper, MA. 2003. *Myles' textbook for midwives*. 14th edition. Elsevier: Churchill Livingstone.

Fraser, DM, Cooper, MA & Nolte, AGW (eds). 2006. *Myles' textbook for midwives*. African edition. Elsevier: Churchill Livingstone.

Ganatra, B & Hirve, S. 2002. Induced abortions among adolescent women in rural Maharashtra, India. *Reproductive Health Matters* 10(19):76-85.

Garcia-Moreno, C & Stöckl, H. 2009. Protection of sexual and reproductive health rights: addressing violence against women. *International Journal of Gynecology and Obstetrics* 106:144-147.

Grimes, DA, Benson, J, Singh, S, Romero, M, Ganatra, B, Okonofua, FE & Shah, IH. 2006. Unsafe abortion: the preventable pandemic. *Lancet* 4:1-13.

Helman, CG. 2007. *Culture, health and illness*. 5th edition. New York: Oxford University Press.

Henshaw, SK, Singh, S, Oye-Adeniran, BA, Adewale, IF, Iwere, N & Cuca YP. 1998. The incidence of induced abortion in Nigeria. *International Family Planning Perspectives* 24:4.

Hord, CE & Xaba, M. 2001. *Abortion law reform in South Africa*: *report of a study tour*. Johannesburg: IPAS South Africa.

http://www.advocatesforyouth.org/publications/factsheet/fsabortion.htm
(accessed on 19.07.2007).

http://www.apha.confex.com/apha/128am/techprogram/paper_10028.htm
(accessed on 19.07.2007).

http://www.bbc.co.uk/religion/ethics/abortion!religion/catholicism1.shtml.
(accessed on 19.07.2007).

http://www.cia.gov/cia/publications/factbook/rankader/2119rank.html
(accessed on 11.11.2006).

http://www.coolnurse.com.
(accessed on 19.07.2006).

http://www. en.wikipedia.org/wiki/list_of_Nigerian_states_by_population
(accessed on 11.11.2006).

http://www.en.wikipedia.org/wiki/Abortion-in-the-United Kingdom
(accessed on 19.07.2006).

(http://www.en.wikipedia.org/wiki/Reproductive_rights
(accessed on 18.02.2010))

http://www.ezanga.corn/search/index.php?s=1.8bokw=abortion.
(accessed on 11.11.2006).

http://www.ezanga.com/search/redir/directessays.com/view paper/91162.htm.
(accessed on 19.07.2006).

http://www.fao.org/AG/agl/sw/wpnr/reports/y_sf/z_ng/ngtb/zi.htm
(accessed on 11.11.2006).

http://www.healthline.com.
(accessed on 24.04.2007).

http://www.infopleae.com/ipa/A0764203.html
(accessed on 19.07.2007).

http://www.lifesite.net/idn/2006/aug/06080107.html
(accessed on 19.07.2007).

http://www.lonelyplanet.com/maps/africa/nigeria/map_of_nigeria.jpg
(accessed on 04.04.2007).

http://www.medlaw/.com/clientright.asp
(accessed on 19.07.2007).

http://www.planbaby.com/Abortion.html.
(accessed on 19.07.2007).

http://www.prochoice.org/Canada/legal.html
(accessed on 19.07.2007).

http://www.questia.com/library/science and technology/health-and medicine/women's health.2006.
(accessed on 04.04.2007).

http://www.siecus.org/pubs/guidiance/gadient/.pdf
(accessed on 04.04.2007).

http://www.sciencedirect.com
(accessed on 19.07.2007).

http://www.Whiteribbonalliance.com/pressroom.cfm.
(accessed on 19.07.2007).

Ikechebelu, JI & Okoli, CC. 2003. Morbidity and mortality following induced abortion in Nnewi, Nigeria. *Tropical Doctor* 33(3):170-172.

IPAS South Africa. 2003. *Issues in abortion care*. Johannesburg: IPAS.

IPPF (International Planned Parenthood Federation) 2000. *Sex wise*. International Planned Parenthood Federation, BBC World Service

IPPF (International Planned Parenthood Federation). 2003. Sexual and reproductive rights report. *IPPF Medical Bulletin* 37(4):1.

Irinoye, OO, Oyeleye, BA, Adeyemi, BA & Tope-Ojo, VA. 2004. Analysis of parents' and adolescents' concern and prescriptions for prevention and management of teenage pregnancy in Nigeria. *Africa Journal of Nursing and Midwifery* 6(1):25-30.

Kemp, BB, Pilliteri, A & Brown, P 1989. *Fundamentals of nursing: a framework for practice*. Philadelphia: Scott, Foresman.

Kozier, B, Erb, G, Berman, A & Snyder, S. 2008 *Fundamentals of nursing: concepts, processes and practice.* 8th edition. New York: Prentice-Hall.

LoBiondo-Wood, G & Harber, J. 2002. *Nursing research: methods, critical appraisal and utilization.* 5th edition. St Louis: Mosby.

Maternal death rate puts Nigeria in spotlight.2008, by Alison, R. *Health-Nigeria*.
http://us.oneworld.net/article/high-maternal-deat-rate-puts-nigeria-spotlight.

Mayo Clinic. 2007. *Adolescent development*. www.MayoClinic.com Bookstore.

Miller, FC. 2000. Impact of adolescent pregnancy as we approach the new millennium. *Journal of Pediatric and Adolescent Gynecology* 13(1):5-8.

Mosby's Medical and Nursing Dictionary. 1986. 2nd edition. St Louis: Mosby.

National Population Commission. 2006. *Statistics*. Abuja: NPC.

Ndatsu, RN. 1999. *Practising nursing and midwifery in Nigeria*. Ordinances and Laws, 1930-1992. Lagos: Nursing and Midwifery Council of Nigeria.

Neuman, WL. 1997. *Social research methods: qualitative and quantitative approaches*. 3rd edition. Nedham Heights, NJ: Allyn & Bacon.

NMCN – see Nursing and Midwifery Council of Nigeria.

Nnamdi, A. 1991. *Research methodology in the behavioural sciences*. Lagos: Longman.

Nursing and Midwifery Council of Nigeria. 2005. *Ethics of midwifery practice*. Lagos: Nursing and Midwifery Council of Nigeria.

Odimegwu, C & Ajabor, H. 1999. Assessing the prevalence and determinants of unwanted pregnancy. *Africa Journal of Reproductive Health* 30(11):67-77.

Ofo, JE. 2005. *Research methods and statistics in education and social sciences*. Lagos: Joja Educational Research.

Ogunleye, AO. 2000. *An introduction to research methods in education and social sciences*. Lagos: Sunshine.

Okonofua, F. 1997. Preventing unsafe abortion in Nigeria. *African Journal of Reproductive Health* 1(1):25-36.

Okonofua, FE, Odimegwu, C & Ajabor, H. 1999. Assessing the prevalence and determinants of unwanted pregnancy. *Africa Journal of Reproductive Health* 30(11):67-77.

Oladeji, D. 2007. Social influences as determinants of sexual attitudes and behaviours among adolescents of reproductive age in Nigeria. *Pakistan Journal of Social Sciences* 4(2):169-174.

Oladokun, A. 2005. *Creating a learning organization Ibadan: strategic leadership and management for population and reproductive health*. Lagos: Sunshine.

Omu, AE, Oronsaye, AU, Faal, MK & Asuquo, EE. 1981. Adolescent induced abortion in Benin City, Nigeria. *International Journal of Gynecology and Obstetrics* 19(6):495-499.

Otoide, VO, Oronsaye, F & Okonofua, FE. 2001. Why Nigerian adolescents seek abortion rather than contraception: evidence from focus-group discussions. *International Family Planning Perspectives* 27(2):77-81.

Oye-Adeniran, BA. 2005. *Magnitude of abortion in Nigeria, Lagos campaign against unwanted pregnancy*. Abuja: FMOH.

Oye-Adeniran, BA, Adewole, IF, Umoh, AV, Fapounda, OF & Iwere, N. 2004. Characteristics of abortion care seekers in South-Western Nigeria. *Africa Journal of Reproductive Health* 8(3):81-91.

Oye-Adeniran, BA, Adewole, IF, Umoh, AV, Iwere, N & Gbadegesin, A. 2005. Induced abortion in Nigeria: findings from focus group discussion. *Africa Journal of Reproductive Health* 9(1):133-141.

Oye-Adeniran, BA, Long, CM & Adewole IF. 2004. Advocacy for reform of the abortion law in Nigeria. *Reproductive Health Matters* 12:209-217.

Pera, SA & Van Tonder, S. 2005. *Ethics in health care*. 2nd edition. Pretoria: Juta.

Polit, DF & Beck, CT. 2004. *Nursing research: principles and methods*. 7th edition. Philadelphia: Lippincott, Williams & Wilkins.

Polit, DF & Beck, CT. 2008. Generating and assessing evidence for nursing practice. 8th edition.. Philadelphia: Lippincott, Williams & Wilkins.

Polit, DF, Beck, CT & Hungler, BP. 2001. *Essentials of nursing research*: *methods, appraisals and utilisation.* Philadelphia: Lippincott.

Population Reference Bureau. 2005. *Data sheets of the population reference bureau*. Washington, DC: UN.

Post-abortion care training curriculum for reproductive health professionals. 2004. Abuja Federal Ministry of Health.

Potter, P & Griffin Perry, A. 2001. *Fundamentals of nursing*. 5th edition. St Louis: Mosby.

Rasch, V, Silberschmidt, M, Mchumvu, Y & Vumilia, M. Adolescent girls with illegally induced abortion in Dar es Salaam: the discrepancy between sexual behavior and lack of access to contraception. *Reproductive Health Matters* 8(15):51-62.

Religion and Abortion. www.answers.com/topic/religion/abortion.

Religion and Ethics: Abortion.
www.bbc.co.uk/religion/ethics/abortion/religion/catholicism 1.shtml.

Reproductive rights.
htttp://en.wikipedia.org/wiki/Reproductive rights

Senanayake, P & Faulkner, KM. Unplanned teenage pregnancy. *Best Practice and Research Clinical Obstetrics and Gynaecology* 17(1):117-129.

Sherwen, LN, Scoloverid, MN & Weingarten, CT. 1999. 3rd edition. Connecticut: Appleton & Lange.

SOGON. 2004. High rate of maternal deaths in Nigeria is cause for alarm. *Safe Motherhood News* 1:13-14.

SOGO. 2005. *Ethical consideration in medical practice*. Ibadan: Oluyole.

Sokoya, GO. 2000. *Ethics and legal implications of health care: a handbook for professional nurses/midwives*. Ibadan: Oluyole.

South Africa. 1996. Choice on Termination of Pregnancy Act No 92. Government Gazette No 17602. Pretoria: Government Printer.

Status of the Unborn Child Bill. www.answers.com/status%20 of%20 the%20 unborn.

Udo, S. 2003: Introduction to research ethics. http://www.wits.acza/bioethics.

University of South Africa. Department of Health Studies. 2005 Tutorial Letter MNUALL-L/301/2005. Pretoria: University of South Africa.

Unsafe abortion. http://en.wikipedia.org/wiki/Unsafe_abortion.

West African College of Nursing. 2001. Sex and reproductive health policy and legislation. *West Africa College of Nursing Journal (WACNJ)* 5:17-18.

Whaley, LF & Wong, LD. 1979. *Nursing care of infants and children.* St Louis: Mosby.

WHO – see World Health Organization.

Women of our world. 2005. Washington DC: Population Reference Bureau.

World Book Encyclopaedia. 1997. Chicago: World Book Incorporation.

World Health Organization. 1999. *Reduction of maternal mortality*. WHO/UNFPA/ UNICEF/WORLD BANK Statement.

ANNEXURE A

School of Midwifery
LUTH

The Chief Medical Director
Lagos University Teaching Hospital
Thru: The Chairman Medical Advisory Committee
Lagos University Teaching Hospital

Thru: The Principal
School of Midwifery
Lagos University Teaching Hospital

PERMISSION TO CARRY-OUT A STUDY ON ADOLESCENT KNOWLEDGE REGARDING ABORTION IN A SELECTED AREA IN LAGOS

I hereby request for permission to carry out a study on adolescent knowledge regarding abortion within LUTH complex.

This is part of requirement in fulfillment of the award of Master Arts degree in Health studies with specialization in Advanced Midwifery and Neonatal Nursing Sciences of the University of South Africa.

Thank you sir for your favourable consideration.

EN AKINDE

LAGOS UNIVERSITY TEACHING HOSPITAL

PRIVATE MAIL BAG 12003, LAGOS, NIGERIA

Chairman:
PROF. B. C. UMERAH,
MB, FRCR, FICS, FMCR, FWACS.

Director of Administration:
O. A. O. ONABOWALE, B.Sc. MPA, AHAN, MNIM.

Chief Medical Director:
PROF. ONATOLU ODUKOYA, *B.D.S. (Lagos) M.M.Sc (Harvard), Cert. Oral Path.,(Harvard) FMCDS (Nig.), FWACS.*

Chairman, Medical Advisory Committee:
DR. D. A. OKE, B. Sc. (Hons), M.B.B.S. (Lagos), FMCP, *Diploma in Cardiology* (Tel-Aviv)

Cable and Telegrams: UNIHEALTH, YABA, LAGOS Telex No: 27636 Telephone: Lagos, 5453760 - 74 (15 Lines)

31st July, 2006

Ref. No. ADM/DCST/221/Vol. 19

Mrs. E. N. Akinde,
Asst. Chief Midwife Educator,
School of Midwifery,
L.U.T.H., Surulere.

APPROVAL OF RESEARCH & ETHICS COMMITTEE

I wish to refer to your request in respect of the above stated subject matter.

Approval has been granted you to continue with the study titled "ADOLESCENTS KNOWLEDGE REGARDING LEGALISATION OF ABORTION IN LAGOS UNIVERSITY TEACHING HOSPITAL".

Wishing you all the best in the study.

O. O. OLUBODUN (MRS),
for: CHAIRMAN, RESEARCH & ETHICS COMMITTEE.

PO Box 77615
DAR ES SALAAM

1 June 2006

Dear Participant

The aim of the study is to explore the factors that may influence clinical accompaniment of midwifery students in the postnatal wards during their clinical practice.

The results of the study may assist nurse tutors to be actively involved in the clinical accompaniment of midwifery students.

I would appreciate it if you could take part in my research project and to be an informant. The data will be gathered from you by means of a questionnaire.

Thank you for your willingness to be a participant.

Yours faithfully

RESEARCHER
MRS EN AKINDE

A G R E E M E N T

I, ... on this .... day of .... 2006 hereby consent to

- Complete the questionnaire developed by Mrs EN Akinde ………. on the topic **"KNOWLEDGE OF ADOLESCENT REGARDING ABORTION"** in Lagos University Teaching Hospital Complex, Idi-Araba, Lagos
- the use of data derived from these questionnaires by the researcher in the research report as she deems appropriate

I also understand that:

- I am free to terminate my involvement or to recall my consent to participate in this research at any time I feel like it
- information given up to the point of my termination of participation could, however, still be used by the researcher
- confidentiality will be maintained by the researcher and that the identity will not be linked to information
- no reimbursement will be made by the researcher for information given or participation in this project
- I may refrain from answering questions should I feel these are an invasion of my privacy
- by signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the researcher
- I will be given the original copy of this agreement on signing it

I hereby acknowledge that the researcher has

- discussed with me in detail the purpose of this research project
- informed me about the contents of this agreement
- pointed out the implication of signing this agreement

In co-signing this agreement, the researcher has undertaken to

- maintain confidentiality and privacy regarding the participant's identity and information given by the participant
- arrange in advance a suitable time and place for the completion of the questionnaire to take place
- safeguard the duplicate of this agreement

INFORMANT: .... **RESEARCHER: ....**

DATE: ....

THE KNOWLEDGE OF ADOLESCENT'S REGARDING ABORTION IN A SELECTED AREA IN LAGOS, NIGERIA

Number of questionnaire:

1	2	3

1 OBJECTIVES

The specific objectives of this study were to

- explore adolescents' knowledge about their reproductive health
- determine the knowledge about abortion in adolescents
- determine adolescents' knowledge of abortion legislation in Nigeria
- identify unsafe practices regarding abortion

2 ETHICAL CONSIDERATIONS

All information herewith provided will be treated confidentially. It is not necessary to indicate your name in this questionnaire.

3 INSTRUCTIONS

3.1 Please answer all questions.

3.2 Answer the questions by providing an "X" in the box corresponding to the chosen alternative.

3.3 Please answer all questions as honestly, frankly and objectively as possible.

3.4 Answer according to your own personal opinion and experience.

3.5 **Please return the questionnaire by ……………………. 2007.**

SECTION A: DEMOGRAPHIC DATA

1 How old are you?

For official use only

Age		ANSWER
1.1	13 years or younger	1
1.2	14 years	2
1.3	15 years	3
1.4	16 years	4
1.5	17 years	5
1.6	Older than 17 years	6

	4

2 Do you attend school?

For official use only

	YES	NO
School attendance	1	2

	5

3 If your answer was YES to question 2, what is the highest class you have passed to date?

For official use only

Level of schooling		ANSWER
3.1	Junior Secondary School 1	1
3.2	Junior Secondary School 2	2
3.3	Junior Secondary School 3	3
3.4	Senior Secondary School 1	4
3.5	Senior Secondary School 2	5
3.6	Senior Secondary School 3	6
3.7	University	7
3.8	Polytechnic	8
3.9	Other (please specify)...	9

	6

4 If you do not attend school, what do you do?

For official use only

Activities	YES	NO
4.1 Work at a market	1	2
4.2 Apprentice	1	2
4.3 Work in a small scale enterprise	1	2
4.4 Assist my parents	1	2
4.5 Nothing	1	2
4.6 Other (please specify)..........................	1	2

	7
	8
	9
	10
	11
	12

5 To what ethnic group do you belong?

For official use only

Ethnic group	ANSWER
5.1 Yoruba	1
5.2 Hausa	2
5.3 Ibo	3
5.4 Ijaw	4
5.5 Other (please specify).......................................	5

	13

6 What is your religious affiliation?

For official use only

Church which you belong to	ANSWER
6.1 Catholic	1
6.2 Protestant	2
6.3 Pentecostal	3
6.4 White garment	4
6.5 Traditional	5
6.6 Seventh-day Adventist	6
6.7 Jehovah Witness	7
6.8 None	8
6.9 Other (please specify).......................................	9

	14

7 Do you discuss sex with your family?

For official use only

	YES	NO
Discussion of sex	1	2

	15

8 To whom in you family do you discuss sex with?

For official use only

Discuss sex with	ANSWER
8.1 Mother	1
8.2 Father	2
8.3 Brother	3
8.4 Sister	4
8.5 Aunty	5
8.6 Friends	6
8.7 Other (please specify) …………………………….	7

	16
	17
	18
	19
	20
	21
	22

9 If your answer was YES to question 8, state the topics discussed with the family members.

For official use only

Topics	YES	NO
9.1 Menstruation	1	2
9.2 Dating and boyfriends	1	2
9.3 Sexual morality	1	2
9.4 Conception	1	2
9.5 Birth control	1	2
9.6 Sexual intercourse	1	2
9.7 Bodily changes	1	2
9.8 Homosexuality	1	2
9.9 Abortion	1	2
9.10 Other (please specify)..........................	1	2

	23
	24
	25
	26
	27
	28
	29
	30
	31
	32

SECTION B: ADOLESCENCE

10 What do you understand by the term "adolescence"?

For official use only

Term "adolescence"	YES	NO		
10.1 It is a period in the life of an individual during which you are neither a child nor an adult	1	2		33
10.2 It is a period of childhood of the individual	1	2		34
10.3 Acquiring a masculine or feminine social role	1	2		35
10.4 Accepting one's physique and using the body effectively	1	2		36
10.5 Becoming emotionally independent of parents and other adults	1	2		37
10.6 Preparing for marriage and a family life	1	2		38
10.7 Selecting and preparing for a career	1	2		39
10.8 Acquiring values and an ethical system as a guide to behaviour	1	2		40
10.9 Period of emotional development	1	2		41
10.10 Joining a peer group	1	2		42
10.11 Other (please specify)..........................	1	2		43

SECTION C: SEXUALITY

11 Have you had sexual intercourse?

For official use only

	YES	NO
Sexual intercourse	1	2

	44

12 If your answer was YES to question 11, how old were you?

For official use only

Age	ANSWER
12.1 8 years and younger	1
12.2 9 years	2
12.3 10 years	3
12.4 11 years	4
12.5 12 years	5
12.6 13 years	6
12.7 14 years	7
12.8 15 years	8
12.9 16 years and older	9

	45

13 If your answer was YES to question 11, state reasons for sexual intercourse.

For official use only

Reasons for sexual intercourse	YES	NO
13.1 I love the boy	1	2
13.2 Wanted to find out what it was about	1	2
13.3 For love	1	2
13.4 Raped	1	2
13.5 Peer pressure	1	2
13.6 Other (please specify).........................	1	2

	46
	47
	48
	49
	50
	51

14 Have you ever been pregnant before?

For official use only

	YES	NO
Pregnant before	1	2

	52

SECTION D: ABORTION

15 Have you ever had an abortion?

For official use only

	YES	NO
Abortion	1	2

	53

16 If your answer was YES to question 15, where did you have it?

For official use only

Place of abortion	YES	NO
16.1 At home	1	2
16.2 At a hospital	1	2
16.3 At a clinic	1	2
16.4 Doctor's house	1	2
16.5 At a chemist shop	1	2
16.6 Other (please specify)..........................	1	2

	54
	55
	56
	57
	58
	59

17 Are you aware of a family member/friend/someone in the community who has had an abortion?

For official use only

	YES	NO
Family member/friend/someone in the community who has had an abortion	1	2

	60

18 If your answer was YES to question 17, what reaction to the abortion did they portray?

For official use only

Reaction to the abortion	ANSWER
18.1 Shock	1
18.2 Outrage	2
18.3 Sympathy	3
18.4 Relief	4
18.5 Admiration	5
18.6 Other (please specify)	6

	61
	62
	63
	64
	65
	66

19 If your answer was YES to question 15, state your age at the time.

For official use only

Age of abortion	**ANSWER**
19.1 8 years or younger	1
19.2 9 years	2
19.3 10 years	3
19.4 11 years	4
19.5 12 years	5
19.6 13 years	6
19.7 14 years	7
19.8 15 years	8
19.9 16 years	9
19.10 17 years and older	10

	67

20 How did you feel after having an abortion?

For official use only

Feelings about abortion	**YES**	**NO**		
20.1 Guilty	1	2		68
20.2 Lonely	1	2		69
20.3 Afraid	1	2		70
20.4 Indifferent	1	2		71
20.5 Relieved	1	2		72
20.6 Sick	1	2		73
20.7 Sore	1	2		74
20.8 Anxious	1	2		75
20.9 Other (please specify) …………………	1	2		76

21 For which reasons would you not undergo an abortion?

For official use only

Reasons for not undergoing an abortion	**YES**	**NO**		
21.1 It is risky	1	2		77
21.2 It is against my conscience	1	2		78
21.3 My religion forbids it	1	2		79
21.4 It is against my culture	1	2		80
21.5 It is illegal	1	2		81
21.6 I may die in the process	1	2		82
21.7 My parents will reject me	1	2		83
21.8 Other (please specify)........................	1	2		84

22 For which reasons/conditions will you undergo an abortion?

For official use only

Reasons/conditions to undergo an abortion	YES	NO			
22.1 To save myself the shame of unwanted pregnancy	1	2			85
22.2 To continue my education/apprentice	1	2			86
22.3 If my boyfriend/husband supports it	1	2			87
22.4 If the risk involved is reduced	1	2			88
22.5 If nobody will know	1	2			89
22.6 Pregnancy after being raped	1	2			90
22.7 Bleeding as a result of tampered pregnancy	1	2			91
22.8 Pregnancy as a result of contraceptive failure	1	2			92
22.9 Pregnancy of doubtful paternity	1	2			93
22.10 Pregnancy as a result of incest	1	2			94
22.11 Pregnancy that I don't want	1	2			95
22.12 If my parents insist that I terminate the pregnancy	1	2			96
22.13 I don't know	1	2			97
22.14 Other (please specify).........................	1	2			98

23 What is your opinion about abortion?

For official use only

Meaning of abortion	YES	NO			
23.1 It is terminating unwanted pregnancy	1	2			99
23.2 It is killing innocent baby	1	2			100
23.3 It is saving the future of the woman	1	2			101
23.4 It is criminal act	1	2			102
23.5 It is murder	1	2			103
23.6 I don't know	1	2			104
23.7 Other (please specify).........................	1	2			105

24 Who informed you about abortion?

For official use only

Information	YES	NO			
24.1 Father	1	2			106
24.2 Mother	1	2			107
24.3 Friends	1	2			108
24.4 Doctor	1	2			109
24.5 Nurse	1	2			110
24.6 School	1	2			111
24.7 Radio	1	2			112
24.8 Television	1	2			113
24.9 Newspaper	1	2			114
24.10 Youth club	1	2			115
24.11 Non-government organisation	1	2			116
24.12 Church	1	2			117
24.13 Other family members	1	2			118
24.14 Grandparents	1	2			119
24.15 Other (please specify)..........................	1	2			120

25 If you fall pregnant unintentionally, will you terminate the pregnancy?

For official use only

	YES	NO			
Terminate the pregnancy	1	2			121

26 If your answer to question 25 is NO, what will you do?

For official use only

	YES	NO			
26.1 Deliver and keep the baby	1	2			122
26.2 Deliver and give the baby to my parents	1	2			123
26.3 Deliver and give the baby to my granny	1	2			124
26.4 Deliver and give the baby to a relative	1	2			125
26.5 Deliver and give the baby up for adoption	1	2			126
26.6 Deliver and abandon the baby to person responsible for the pregnancy	1	2			127
26.7 Other (please specify)..........................	1	2			128

27 If you find out your close friend had an abortion you will:

For official use only

Attitude towards friend who has undergone an abortion	YES	NO		
27.1 See her as a bad influence	1	2		129
27.2 Disassociate yourself from the friend-ship	1	2		130
27.3 Feel for her	1	2		131
27.4 Encourage her to be using other contraceptive	1	2		132
27.5 Continue with the friendship	1	2		133
27.6 See her as a wicked person	1	2		134
27.7 Report her to law enforcement agent	1	2		135
27.8 Other (please specify) ………………….	1	2		136

28 Who should decide when a pregnancy should be terminated?

For official use only

Person who decide pregnancy should be terminated	YES	NO		
28.1 Yourself	1	2		137
28.2 Doctor	1	2		138
28.3 Family planning service provided	1	2		139
28.4 Parent	1	2		140
28.5 Class teacher	1	2		141
28.6 The person responsible for the pregnancy	1	2		142
28.7 Friends	1	2		143
28.8 Other (please specify)………………….	1	2		144

29 In your view methods of abortion are …

For official use only

Methods of abortion	YES	NO		
29.1 Drinking ogogoro (local gin) and lime to remove pregnancy	1	2		145
29.2 Having a Dilation/Curretage (D&C) done to remove pregnancy	1	2		146
29.3 Taking local herbs to remove pregnancy	1	2		147
29.4 Having a manual vacuum aspiration done to remove pregnancy	1	2		148
29.5 Using bicycle spoke or coat hanger to remove pregnancy	1	2		149
29.6 Other (please specify) ………………….	1	2		150

30 In your own view, people who offer abortion services

For official use only

Abortion services	YES	NO			
30.1 Have no conscience	1	2			151
30.2 Are helping to reduce shame from unwanted pregnancy	1	2			152
30.3 Are trying to save the woman's life	1	2			153
30.4 Are dangerous to the society	1	2			154
30.5 Are encouraging prostitution	1	2			155
30.6 Are murderers	1	2			156
30.7 Are just doing their work	1	2			157
30.8 Are very callous	1	2			158
30.9 Are wicked people	1	2			159
30.10 Other (please specify)..........................	1	2			160

31 Education on abortion issues should be included in:

For official use only

Education on abortion issues	YES	NO			
31.1 Junior secondary school curriculum	1	2			161
31.2 Senior secondary school curriculum	1	2			162
31.3 University/Polytechnic curriculum	1	2			163
31.4 Other (please specify)..........................	1	2			164

32 Have you ever heard of post-abortal care?

For official use only

	YES	NO			
Hearing of post-abortal care	1	2			165

33 Which types of post-abortal care are you aware of?

For official use on

Types of post-abortal care	YES	NO			
33.1 Vacuatio of the uterus, drugs, coun-selling, birth spacing method	1	2			166
33.2 Drugs, counselling and birth spacing method	1	2			167
33.3 Counselling and birth spacing method	1	2			168
33.4 Counselling	1	2			169
33.5 Birth spacing method	1	2			170

34 If your answer was YES to question 35, what is post-abortal care?

For official use only

Meaning of post-abortal care	YES	NO			
34.1 It is termination of pregnancy	1	2			171
34.2 It is taking care of complications of abortion	1	2			172
34.3 It is treating a woman who has had an abortion	1	2			173
34.4 It is preventing unwanted pregnancy	1	2			174
34.5 Preparing women for abortion	1	2			175
34.6 I don't know	1	2			176
34.7 Other (please specify)	1	2			177

35 Where are post-abortal services available in your area?

For official use only

Availability of post abortal services	YES	NO			
35.1 Health Centres	1	2			178
35.2 Government Hospital	1	2			179
35.3 Private Hospital	1	2			180
35.4 Other (please specify)...........................	1	2			181

SECTION E: KNOWLEDGE ON LEGALISATION OF ABORTION

36 Is abortion is legal in Nigeria.

For official use only

	YES	NO			
Legality of abortion in Nigeria	1	2			182

37 If your answer was YES to question 38, what is legalisation of abortion?

For official use only

Legalisation of abortion	YES	NO			
37.1 It allows women free access to abortion	1	2			183
37.2 It provides abortion services to women	1	2			184
37.3 It provides abortion services in government hospitals	1	2			185
37.4 Other (please specify).........................	1	2			186

38 Under which circumstances will you access abortion facilities?

For official use only

Access to abortion facilities	YES	NO			
38.1 I can access it easily	1	2			187
38.2 It is provided in a government hospital	1	2			188
38.3 I will not be arrested	1	2			189
38.4 It is provided by a qualified health professional	1	2			190
38.5 I have the support of my partner/ husband	1	2			191
38.6 I have my parent's support	1	2			192
38.7 Other (please specify)..........................	1	2			193

39 Would you make use of the abortion services if it is made legal in Nigeria?

For official use only

	YES	NO			
Usage of abortion services if legal	1	2			194

40 If your answer was YES to question 41, please answer the following question:

For official use only

Reasons for using abortion services	YES	NO			
40.1 It will reduce the death of young women due to unsafe abortion	1	2			195
40.2 Women will access abortion in a safe place	1	2			196
40.3 Women have the right to do what they want with their body	1	2			197
40.4 People should be allowed to make choices	1	2			198
40.5 It is a personal decision	1	2			199
40.6 It is a used as a family planning method	1	2			200
40.7 It will reduce rate of abandoned children	1	2			201
40.8 I don't know	1	2			202
40.9 Other (please specify)......................	1	2			203

41 Under what circumstances should a woman be allowed to end an unwanted pregnancy according to the law?

For official use only

Circumstances under which an abortion should be allowed	YES	NO			
41.1 If it is a threat to the woman's life	1	2			204
41.2 If the woman has completed her family	1	2			205
41.3 If the woman's husband/boyfriend gives permission	1	2			206
41.4 If woman's' parents accompany her to the hospital	1	2			207
41.5 If the woman is under 18 years of age	1	2			208
41.6 If the woman is above 21 years of age	1	2			209
41.7 If the pregnancy is likely to disrupt the woman's education/apprenticeship	1	2			210
41.8 Other (please specify) ……………………	1	2			211

42 Under which circumstances should a woman end an unwanted pregnancy?

For official use only

Circumstances under which a woman should end an unwanted pregnancy	**YES**	**NO**
42.1 If the woman is raped	1	2
42.2 If the pregnancy will endanger the woman's life	1	2
42.3 If the fetus is grossly deformed	1	2
42.4 If she does not want the pregnancy	1	2
42.5 If the person responsible for the pregnancy does not want it	1	2
42.6 If her parents does not approve of the pregnancy	1	2
42.7 Other (please specify) ………………..	1	2

	212
	213
	214
	215
	216
	217
	218

43 Are their any taboos (religious, social, cultural) in your cultural/ethnic group against abortion?

For official use only

	YES	**NO**
Taboos against abortion	1	2

	219

44 If your answer was YES to question 45, in your own words state these taboos (religious, social, cultural).

....

....

45 Should adolescents be allowed to access abortion in Nigeria?

For official use only

	YES	**NO**
Adolescents should be allowed to access abortion in Nigeria	1	2

	220

46 I agree with the restriction on abortion.

For official use only

	YES	**NO**
Agree with restriction on abortion	1	2

	221

47 Should adolescents have a say in the decision whether or not to have an abortion?

For official use only

	YES	NO
Adolescents' decision having an abortion	1	2

	222

48 In your own words explain what you understand by the term "legal abortion"?

....
....
....
....
....

49 In you won words explain what is meant by "abortion".

....
....
....
....
....

THANK YOU FOR YOUR PARTICIPATION

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
Faculty of Human Sciences
CLEARANCE CERTIFICATE

Date of meeting: 10 June 2005 Project No: 35859989

Project Title: Adolescents' Knowledge Regarding Legalisation of Abortion in Lagos University Teaching Hospital, Nigeria

Researcher: Ms EN Akinde

Supervisor/Promoter: Mrs JE Tjallinks

Joint Supervisor/Joint Promoter: Dr MLM Sengane

Department: Health Studies

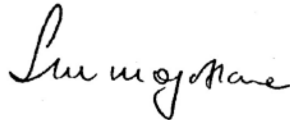
Degree: MA Health Studies

DECISION OF COMMITTEE

Approved √ **Conditionally Approved** ☐

Date:

Prof TR Mavundla
RESEARCH COORDINATOR



Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE A

Requesting permission from the Chief Medical Director of LUTH to conduct the research

ANNEXURE B

Consent obtained from the Chief Medical Director of LUTH to conduct the research

ANNEXURE C

Written consent of respondents

ANNEXURE D

Questionnaire

ANNEXURE E

Clearance certificate (Health Studies, Research and Ethics Committee, Unisa)