
Dissertation

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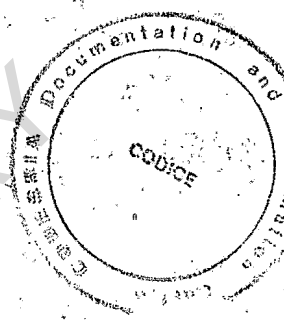
# Incidence of induced abortion among adolescents in Port Harcourt city: knowledge attitude and practice

MAY, 1997

# INCIDENCE OF INDUCED ABORTION AMONG ADOLESCENTS IN PORT HARCOURT CITY: KNOWLEDGE ATTITUDE AND PRACTICE






BY

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MAY, 1997.

## DEDICATION

To my precious mother,

Whose love, care and understanding

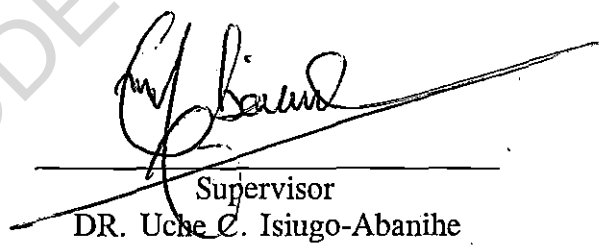
Are worthy of emulation.

## CERTIFICATION

I certify that this work was carried out by

EJIMADU DOROTHY NGOZI under my supervision in the Department of Sociology, University of Ibadan for a Masters degree in Demography.





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**Ejimadu Dorothy Ngozi**

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## ABSTRACT

This study which involved 752 adolescents aged 13-24 years has attempted to examine the knowledge, attitude and practice of induced abortion in Port Harcourt City. In all, six hypotheses were tested using logistic regression model.

The study found that the rate of sexual activity and sexual networking among the adolescents is high. Contraceptive use is low and condoms and pills were the most common modern contraceptives used. Other traditional methods like alcohol, white quinine, lime, herbs etc. were also used. It was also found that the rate of abortion practice is high and the estimated rate of abortion is 15%. In all, about 90% of the girls who get pregnant out of wedlock resort to abortion, and the major reason for pregnancy termination is the desire to remain in school. We also found that those who have had induced abortion also experienced abortion complications and most of them did not receive proper post-abortal counselling. Private hospitals and pharmacist shops were found to be the major sources of abortion and contraceptive services.

The majority of the adolescents have negative attitudes toward abortion and its legalization. Education, religion, age and socio-economic status were found to have significant influence on sexual activity, contraceptive use, premarital pregnancy and induced abortion and legalization of abortion. The rate of abortion

is higher among in-school adolescents than those out-of-school. It was found that catholics are more likely to be sexually active, use contraceptives and have induced abortion than protestants.

We also discovered that discussion with parents on sexual matters reduced the rate of sexual activity and induced abortion. As regards what should be done to reduce the incidence of pre-marital pregnancy and induced abortion in Nigeria, the most important suggestion given is the introduction of sex education.

The foregoing suggests that the government needs to adopt drastic measures which will help reduce the incidence of induced abortion among adolescents with its consequent maternal morbidity and mortality. To this effect, we made some recommendations.

# CHAPTER ONE

# INTRODUCTION

## 1.1 BACKGROUND OF STUDY

Abortion is the oldest known cure for unwanted pregnancy and has been practised in almost all societies worldwide and throughout history with the use of various traditional methods. The ancient Greek, for instance, advocated for abortion to regulate population size and maintain stable social and economic conditions. Whatever the specific reasons for the practice of abortion in various countries of the world, the overriding determining factor leading to abortion is unwanted pregnancy. Given the high prevalence of unintended pregnancies, induced abortion procedures are frequently performed worldwide, but with serious consequences for individuals and health systems in countries without free access to safe abortion (Sai, 1978).

The issue of unsafe abortion in sub-Saharan Africa is of special interest and demands serious attention. The problem is likely to worsen because of increased modernization and urbanization which tend to severe young people from once tenaciously held tradition of premarital chastity and family organizations, thus, encouraging sexual intercourse at an earlier age without effective practice of contraception.

Moreso, the restrictive nature of abortion law in most developing countries makes it difficult for adolescents to obtain safe abortion services. Consequently,

when confronted with unintended or unplanned pregnancy, most young women resort to unsafe illegal procedures through self-induction or the use of unqualified abortion providers. This, however, has led to a high level of abortion-related maternal morbidity and mortality, which in turn results in unquantifiable human suffering and a tremendous strain on limited health resources.

Okonofua and Ilukoma (1991) report that unsafe induced abortions are responsible for as many as 50 percent of maternal deaths in some regions, making it the major killer of women especially in developing countries, including Nigeria. Thus unwanted pregnancy and unsafe induced abortion re regarded by policy-makers and social analysts as major public health and social problems in sub-Saharan Africa (Okonofua et al, 1995). In view of this fact, consistent efforts are being made in contemporary societies to document the existence of the problem and to quantify the extent of the associated health and social consequences on women of reproductive age.

In Africa, induced abortion is presently regarded as a major cause of social and clinical problems. In large cities like Lagos and Nairobi, the increase in numbers of induced incomplete abortions reaching the hospital is of epidemic proportion (Toubia, 1991). Women under age twenty account for 45-65 percent of in-hospital abortions (Okagbue, 1990). It should be noted that the in-hospital reports are just the tip of the iceberg of what may be going on in the

communities. A study of sexual activity among adolescent females in Lagos revealed that 24 percent of sexually active respondents have had at least one abortion (Odujirin, 1991). Briggs (1991) reported that most abortion cases emanate from the big cities of Southern Nigeria, such as Lagos, Ibadan and Port Harcourt. It ranges from 6 per cent in Ibadan to 50 per cent in Lagos.

It has been reported that most of the maternal deaths that occur in the country are as a result of clandestine abortions. Nearly 20,000 out of 50,000 maternal deaths estimated to occur annually are attributable to complications of unsafe induced abortion (Okonofua and Ilukoma, 1991). Similarly, a former Minister of Health, Professor Olikoye Ransome Kuti, during the 37th meeting of the National Council of Health held in Lagos in 1991, reported that Nigeria has the second highest maternal mortality rate in the world; and 50 per cent of these deaths resulting from illegal abortions occur in teenagers and young women (Ibid).

It is estimated that between 2.2 and 50 per cent of maternal deaths that occur in leading maternity centres in Nigeria are due to induced abortion (Okonofua et al, 1995), and management of abortion complications in these hospitals is a daily major routine. Esiet (1996) found that teenagers account for 80 per cent of abortion complications treated in Nigerian hospitals annually. Some of these complications include pelvic inflammatory disease, infertility, ectopic

pregnancy, sepsis, hemorrhage, uterine perforation, cervical trauma, chronic morbidity and psychological impairment.

The foregoing clearly indicates that female adolescents are at high risk of abortion and this is because of their high level of sexual activity. Despite the high prevalence of abortion and abortion-related health problems and deaths in Nigeria, nothing has been done at official levels to reverse the trend.

Recently, however, reproductive health advocates and researchers have called for the liberalization of the abortion law in the country, to reduce the incidence of illegal abortion and its attendant complications. Before such steps can be taken, there is need to understand the factors predisposing Nigerian youths to premarital sexuality pregnancy and induced abortion so as to design an effective intervention programme that will address the needs of adolescents. In view of this, therefore, an examination of their knowledge of, attitudes toward abortion and abortion law and practice of abortion is a necessary beginning. This is the focus of this study.

## 1.2 STATEMENT OF THE PROBLEM

Unsafe induced abortion is a human concern associated with active sexuality. Many adolescents are sexually active beginning at very early ages. The Association for Reproductive and Family Health (1990) reported that the mean age of initiation of sex is thirteen (13) years. Incidentally, many of these adolescents do not regularly or correctly practice contraception since Nigerian law does not permit adolescents to have access to contraceptives.

Consequently, many of them experience unanticipated negative outcomes including premarital pregnancy. Worse still, because of the restrictive nature of the abortion law, many of the female adolescents resort to unsafe clandestine abortions, thereby endangering their lives and health.

Thus, unsafe induced abortion has become a social and health problem to study rather than a means of managing unwanted pregnancy. However, African policy makers and health authorities are expressing concern over the numbers of clandestine abortions going on in different parts of sub-Saharan Africa, and the resulting morbidity and mortality associated with such practices.

A study of sexual activity among adolescent females in Lagos showed that 24 pr cent of sexually active respondents have had at least one abortion (Odujirin, 1991). Similarly, a study of a Nigerian secondary school found that 30.2 per cent of the girls have had an induced abortion (Coeytaux, 1988). Another survey

showed that 41 per cent of sexually active women age 14-25 reported that they have had induced abortion, while 30 per cent in a similar study involving 530 school girls admitted having had illegal abortions (Liskin, 1985).

In fact, illegal induced abortion has been described by Durojaiye (1996) as a school girls' problem in Nigeria. Most women who present with problems of induced abortion in Nigeria are young, unmarried, nulliparous teenagers who are often in school (Briggs, 1991). According to report from Federal Ministry of Health (1994), over 60 per cent of patients presenting at Nigerian hospitals with abortion and abortion-related complications are adolescent girls in school.

Despite the fact that the number of illegal induced abortion and its associated maternal mortality and morbidity are on the increase, nothing has been done at the official levels to reverse the situation. Major activities in this area so far, were those carried out by charitable and non-governmental organizations. The Nigerian medical practitioners, under the auspices of Nigerian Medical Association, have continued to agitate for the liberalization of the abortion law, so as to reduce the number of unsafe abortions and the related complications.

However, some efforts have been made by the Government to increase women's use of contraceptive, but these methods remain unavailable to those who probably need them most - never-married adolescents. There is also no reproductive health education targeted on the major group at high risk of abortion,

and no clear policy exists on how to counsel adolescent girls with premarital pregnancy. Hence, Professor Ransome-Kuti stated that "...Teenagers are not given effective sex education: what they probably get is moral instruction, which does not go to the heart of the matter, nor does it suppress the strong and violent sexual urge experienced at that vigorous age" (Okonofua and Ilukoma, 1991).

Worse still, it is not even known what the feelings of adolescents are toward abortion and the liberalization of the abortion law. In view of this therefore, this study will attempt to answer the following research questions:

Why do adolescents indulge in unsafe induced abortion?

What factors motivate them to seek abortion services?

Do they approve of pregnancy termination and under what conditions? Are they aware of the after-effects of induced abortion? What do they know about contraceptives, and how do they get them? What are their feelings toward induced abortion and the liberalization of the abortion law in Nigeria?



## 1.3 OBJECTIVES OF STUDY

### GENERAL OBJECTIVES

The ultimate objective of this study is to examine adolescents' knowledge of, attitudes toward and practice of induced abortion. Their sexual activities and networking will also be examined.

**SPECIFIC OBJECTIVES**

1. To determine the level of adolescent sexuality, premarital pregnancy and practice of induced abortion among adolescents in Port Harcourt.
2. To identify the factors that motivate adolescents to terminate pregnancy.
3. To describe their knowledge of abortion and modern contraceptive methods and services available in the city.
4. To determine the attitudes of adolescents toward induced abortion, the abortion law and its liberalization.
5. To make recommendations based on the findings that will help policy makers in arriving at rational decisions on the issue of induced abortion in the country.



## 1.4 SIGNIFICANCE OF STUDY

Most studies on abortion in Nigeria have tended to concentrate on the South-Western part of the country. This study together with previous studies, will therefore provide a broad-based data with which categorical deduction can be made on the incidence and prevalence of abortion in the country. In addition, being a community and household based study, it will provide useful information on several teenage girls who carry out induced abortion themselves or utilize the services of non-professional abortionists and traditional healers. Thus, the result,

in addition to hospital based studies, will be used as an accurate indicator of the magnitude of the incidence of abortion among female adolescents in Nigeria.

The significance of this study also lies in its ability to yield information on the knowledge of, attitudes toward and practice of induced abortion among adolescents as well as their feelings towards abortion liberalization in Nigeria. It will also contribute to existing knowledge on adolescent sexuality and highlight the factors that are responsible for the practice of abortion.

It is hoped that the result of this research will identify the unmet need for sex education, counselling and contraceptive use among Nigerian teenagers during their precarious transition from adolescent life to responsible adulthood.

A study of this nature is relevant in that the result is expected to assist government in formulating and implementing socially acceptable sex and reproductive health education programmes and contraceptive service, in and out-of-school for the youths; and thus bolster the actualization of the new Nigeria's population policy package. The relevance also lies in the fact that the result can be used to lobby for effective change in the abortion code book of the country and to design effective intervention programmes for adolescents.

Finally, this study is significant because it will be another contribution to the existing body of knowledge on demographic research as well as a motivating guide to future research on reproductive health of adolescents.

## 1.5 DEFINITION OF CONCEPTS

The following concepts used in this study will be operationally defined so as to avoid ambiguity and misinterpretation.

**Induced Abortion**: A deliberate expulsion of an embryo or foetus before it reaches viability especially in the first three months of pregnancy.

**Maternal Mortality:** Death of women during or within forty-two days of pregnancy from causes related to pregnancy and its management.

**Abortion Law:** Rules and regulations guiding abortion procedures and practice.

**Unwanted Pregnancy:** Pregnancy not planned for emotionally, socially and economically.

**Premarital Pregnancy**: Pregnancy out of wedlock.

**Reproductive Health:** Sai and Nassim (1989) defined it as "the ability of men and women to undertake sexual activity safely, whether or not pregnancy is desired, and if desired, for the women to carry the pregnancy to term safely, deliver a healthy infant and be prepared to nurture it".

**Adolescent**: The state or process of growing up or the period of life from puberty to maturity. For the purpose of this research, it is those between age 13-24 years.

**Sexuality**: Is an expression of emotion that include love and caring common to both men and women. A universal human attribute linked to ego satisfaction and related to the preservation and continuation of life itself (Mundigo, 1995).

# CHAPTER TWO

## REVIEW OF RELEVANT LITERATURE

The purpose of this review is to examine some empirical findings concerning adolescents sexual behaviour, knowledge and practice of contraception, premarital pregnancy, the practice and prevalence of unsafe abortion and its associated complications including maternal morbidity and mortality.



## 2.1 ADOLESCENTS' SEXUAL BEHAVIOUR

Available data reveal that age at menarche is declining in both developed and developing countries. This decline has been attributed to better diet and improved health and general cleanliness due to rising standards of living (Gray, 1983).

On the other hand, past studies showed that there is increasing movement towards sexual permissiveness. Sexual behaviour has been described as the most important human activity and literature reveals that premarital sexuality and sexual behaviour of adolescents are better studied in Nigeria than the sexual behaviour of married people. (Oronsaye et al, 1982): Nichols et al, 1986).

Premarital sex is not only common in some societies in Nigeria but also increasing with more youths beginning sexual activity at younger ages (Gyepi-Garbrah, 1985). The mean age of initiation of sex is 13 years (Association for

Reproductive and Family Health, 1990). The Nigerian Demographic Health Surveys (1990) reported that median age at first intercourse for girls is just over 16 years. By age 18, 63 per cent and by age 20 approximately 80 per cent of women have experienced intercourse (Isiugo-Abanihe, 1993). A study in Benin City as reported by Durojaiye (1996) showed that 55 per cent of secondary school girls had sexual intercourse before age 16. Similarly, Orubuloye et al, (1994) in a study of commercial sex workers found that the majority of the women involved are under 25 years. Most of them were 16 or 17 years old when they had their first sexual encounters and most had it with boys of similar age. A Lagos study (Oloko and Omoboloye, 1993) revealed that about 4 per cent of secondary school students in Lagos experienced their first sex at the age of 10 and 36.4 per cent did so between age 15 and 16 years. A similar study in Calabar found that a quarter of the youths have already experienced their first sexual contact before age 15 (Ogbuagu and Charles, 1993).

There are differences in adolescent pre-marital sexual activity by gender and socio-economic status. Generally, in Nigeria and other countries, males are found to be more involved in premarital sex than females. For instance, an Ibadan study showed 49 per cent of 16 years old boys with premarital sexual experience as against 28 percent of girls of same age (Ladipo et al, 1983). In a later work, Nichols et al, (1986) reported that 79 per cent and 55 per cent

respectively of male and female adolescent respondents in Ibadan had experienced sexual relations.

Association for Reproductive and Family Health (1990) also reported that 7 out of every 10 males and 5 out of every 10 females attending secondary school in Nigeria are sexually active or have had sexual relations at least once. A Calabar study revealed that at age 17, 62 per cent of men and 54 per cent of women have had sex (Ogbuagu and Charles, 1993). Makinwa-Adebusoye (1992) found in a similar study of Enugu, Kaduna, Lagos, Onitsha and Zaria that 50 per cent of sexually active single men and 40 per cent of comparable females have had their first sexual encounter by age 17.

However, the above differences may be due to faulty age reporting and/or refusal by female teenagers to report their premarital sexual experience due to shame or psychic reasons. Naturally, females mature faster biologically than males. In addition, while boys reported coitus with many sexual partners and casual acquaintances, girls appear to have their first and subsequent sexual relations with steady boyfriends or fiances (Lewin, 1982; Liskin, 1985). In the same Lagos study, Oloko and Omoboloye (1993) reported that most of the senior secondary school students in Lagos who had experienced sex had more than two partners. Generally, males are more likely to have had sexual intercourse with more than one partner (58 pr cent Vs 32 per cent) than females about a quarter

of men and 3 different sexual partners, compared with only 9 per cent of females (Makinwa-Adebusoye, 1992).

The poor and less educated youths are found to be more involved in premarital sexuality. According to available data, they see sex, pregnancy and motherhood role as alternatives to schooling and/or job (Dickens and Allison, 1983; Kreipe, 1983). However, this conclusion should be interpreted with caution, given their lack of exposure and tendency to hold tight the old sexual and marriage ethics of the society.

Pre-marital sexuality in Nigeria also varies by ethnicity. This may be as a result of differences in cultural norms. A study showed that probability of entering into premarital relations among the Yoruba, Igbo and Efik with the Igbo having the lowest probability (37 per cent). Close to half of Yoruba women, and more than half of Efik women, reported pre-marital sex (Isiugo-Abanihe, 1993). The age pattern of initiation of sex also varies by ethnic background, with the Efik starting earliest, followed by the Yoruba, and then other ethnic groups, and the Igbo starting relatively late.

Data from other countries suggest the increase in adolescent premarital sexual activity too. In Liberia, 82 per cent of women age 15-19 have had intercourse, while in Botswana, Ghana, Mali, Togo and Uganda, 50 per cent or more have (Population Reference Bureau, 1992). In many sub-Saharan countries,

age at first intercourse has increased slightly. A Ugandan study (Agyei et al, 1992) found that 75 per cent of males and 68 per cent of females age 15 - 19 have been sexually active, with mean age at first intercourse for males and females as 15.1 and 15.5 years respectively.

Available evidence in some of these countries (both developed and developing) show that the percentage of males with premarital sexual experience is slightly higher than the percentage of females with similar experiences. According to Woods et al, (1985), 62 per cent of male Liberians in Monrovia aged 14 to 17 years reported sexual involvement, as against 46 per cent females of same age group. From the preliminary findings of 1984, study involving unmarried young people age 14-21 in Monrovia, 69 per cent of the women and 82 per cent of the men have already had sexual relations. The pattern is the same in Mexico City where 42 per cent of boys age 15-19 were sexually experienced compared with 8 per cent of girls (Liskin, 1985).

Cultural norms relating to premarital sex vary among countries. In Burundi and Mali, 2 and 1 per cent respectively of single women age 15-19 have had sexual intercourse. This implies that the cultural norms relating to premarital sexuality in these countries are very strict or rigid. This is unlike Botswana and Liberia with 60 and 46 per cent respectively.

It has been observed that premarital sexual activity among young women is more common in developed countries, African and the Caribbean than in Latin America or Middle East, Liskin (1985) reported that in the late 1970s in the United States, Netherlands, France and England, 40 to 50 per cent of girls have had intercourse by age 17; in Sweden about 80 per cent have. In Mexico City, about 8 per cent of unmarried girls age 15-19 reported premarital sex. In South Korea and Thailand, less than 6 per cent of unmarried girls are sexually active by age 19. In the United States in 1971, 26 per cent of unmarried 15-19 year old girls surveyed have had sexual intercourse, and by 1982, the percentage had increased to 43. Similarly, recent studies showed an increase in the percentage of young women in Latin America reported as having had sexual intercourse. Herold et al, (1992) found that 35.4 per cent of young women in the survey in Santiago Chile admitted having had premarital sexual intercourse.

While appreciating the past studies on premarital sexuality, it should be noted that there is no indepth study of the cultural, social and economic factors predisposing Nigerian youths to early sexuality. The only explanation from few available studies so far is rapid urbanization and modernization. Also, there exists very few studies on sexual networking which is one of the issues this research will address. This will help further research on STDs and HIV/AIDS which are problems associated with premarital sexuality.

## 2.2 KNOWLEDGE AND PRACTICE OF CONTRACEPTION BY UNMARRIED ADOLESCENTS

One of the crucial factors mediating between sexual activity rates and pregnancy rates among adolescents is contraceptive prevalence. Jones (1986) observed that premarital pregnancy rates among adolescents in developed countries are not directly related to levels of sexual exposure, mainly, because of variation in levels of contraceptive prevalence. Factors that affect prevalence in both developed and developing countries include external ones such as the laws and regulations and social policies that determine access to contraception.

In some developing countries like Nigeria, teenage women are not given access to contraception. As a young girl or boy becomes more experienced or continues to be sexually active, he or she is more likely to start using some form of contraception if pregnancy is not desired. Data from surveys that elicited information on contraceptive use at first intercourse and subsequent behaviour showed that a vast majority of young people were unprotected at their first sexual encounter but that many used contraception at a later stage (Senderowitz and Paxman, 1985; Van Nimwegen and Moors, 1986).

In spite of increasing premarital sexual activity, contraceptive use among adolescents is generally low especially in countries with restrictive abortion law. Nichols et al. (1986); Herold et al, (1992) found that many adolescents are still

engaging in sexual relations without benefit of contraceptive protection. Inadequate knowledge is the most common reason for non-use of contraceptives.

Actual knowledge of reproductive health by never married adolescents is, however, limited judging by the proportion of the respondents that correctly identify the period a woman is most likely to conceive during the monthly menstrual cycle (Adeokun, 1979). Results of his analysis revealed that only 40 per cent of the women who reported hearing about Condom were able to describe it. Waszak (1993) maintained that knowledge about sexuality and how contraceptive methods work remains limited among adolescents. He suggested that sex education courses, a more open atmosphere about sexuality, the use of peer educators and explicit information on contraception can help. This suggestion is necessary because, success in contraception requires full knowledge of all aspects of contraception, that is, usage, potential side effects and subsequent fertility.

Another reason for low use of contraceptives is lack of access (Daly et al, 1994). Nigerian law does not permit adolescents to have access to contraceptives. Because of lack of adequate information on contraception, most adolescents in and out-of-school are left to pick up whatever bits of information about fertility and contraception from friends, school mates and media. Sources of such information according to Liskin (1985) are often "incomplete, misleading and wrong" and tend to bolster widespread myths and misconception about fertility and contraception

in many areas. For instance, some girls in Nigeria take large quantities of vitamin pills after intercourse, thinking that they will prevent pregnancy (Ezimokhai et al., 1981). In addition, there are widespread fears about their side effects (Ladipo et al., 1983; Zelnik and Kantner, 1979).

Generally, providers of contraceptives on their own part lack understanding about the barriers that teenagers experience when they consider using contraceptives. According to Waszak (1993), these barriers include:

**Inexperience:** When an adolescent begins to experiment with sex, certain contraceptive methods such as withdrawal, will be particularly hard to use correctly. Also, these adolescents may not think of themselves yet as "sexually active" and hence may be more receptive to using a one-time protection (i.e. condoms) than a "family planning" method, such as Oral contraceptives or Norplant.

**Guilt and Embarrassment:** Adults do not approve of unmarried adolescents being sexually active. Hence, teenagers often feel guilty and embarrassed to admit they are sexually active or to talk about contraception openly.

**Peer Pressure:** Peer norms about what is currently fashionable or "cool" influence teenagers significantly. Hence, teenagers worry

about being embarrassed by using contraceptives such as condoms when the partner is involved.

**Communication difficulties:** Many of the contraceptive methods most accessible and most familiar to teenagers require good communication - condoms, periodic abstinence, withdrawal, non penetrative sex and complete abstinence.

These barriers notwithstanding, some teenagers still practice contraception. In most surveys, less than 50 per cent of sexually active youths on the average admit ever using any form of contraception. The proportion varies across space from Costa Rica's and Kenya' low 10 per cent to over 90 per cent in Australia and some developed countries (Liskin, 1985).

Among those that reported ever using contraceptive, only a few admit contracepting currently. On the aggregate, only 35 per cent of the sexually active women in sub-Saharan Africa and 19 per cent of the men were currently using contraception (Gyepi-Garbrah, 1985). Herold et al. (1992) in a Santiago study, found that only 20.3 per cent of females and 18.7 per cent of males reported using contraceptive at first intercourse. The use of contraceptives doubled with age at first premarital intercourse from 13.5 per cent among females and 15.2 per cent among males aged under 18 to 26.1 per cent among females and 30.1 per cent among males aged 18-24.

A study in Ibadan (Nichols et al., 1986) showed that 71 per cent of those adolescent females who had experienced sexual relations within the last months had ever used contraception and 61 per cent were currently using. About 44 per cent of males claimed that they had ever used while 41 per cent were currently contracepting. In Monrovia, Liberia, while 45 per cent of sexually active school girls aged 14-17 reported ever-used contraception, only 37 per cent were currently using contraceptives. For those out-of-school, only 14 per cent reported ever-used and 12 per cent were currently contracepting (Woods et al., 1985; Gyepi-Garbrah, 1985). In Kenya, only 4 per cent of married women aged under 20 years and 7 per cent of those aged 20-24 years used contraception. According to Liskin (1985), a Kenyan survey found that of more than 100 girls who become pregnant, 65 per cent had never received any information about contraception.

Mpangile et al., (1993) found that there was also inverse relationship between levels of knowledge and age; 89 per cent of the young women age 17 or less knew nothing of contraception. Only one teenager out of 150 in the study sample knew six or more methods of family planning. Almost half of the current students had no knowledge of contraceptive methods. In Botswana, only 22 per cent of sexually active young unmarried women used a modern contraceptive method (Population Reference Bureau, 1992).

These studies on contraceptive use among adolescents seem to concentrate more on the use of contraceptives by females. For better comparison and adequate information on contraceptive use, there is need for indepth studies involving male adolescents as well. It is also necessary to find out the sources of contraceptive services available to adolescents since past studies seemed to be silent about where they obtain contraceptive services.

## 2.3 PREMARITAL PREGNANCY

The rising premarital sexual permissiveness and low use of contraceptive have resulted in increasing number of non-marital unwanted pregnancies and clandestine births.

Premarital pregnancy is one of the greatest problem female adolescents face. Pregnancy may endanger their health, marriage and even their chances of education. However, premarital pregnancy is becoming a common phenomenon among unmarried adolescents in most areas (Nichols et.al, 1986); Gyeni-Garbrah, 1985). Durojaiye (1996) reported that 2 out of every 5 secondary school girls interviewed admitted to at least one previous pregnancy; 150 out of every 1000 women who gave birth in Nigeria are 19 years old and under.

In Ibadan, 47 per cent of the sexually active young women have had at least one pregnancy (Ladipo et.al., 1983). Gyepi-Garbrah (1985) found in a

Monrovia study, that over half of the sexually active young women have become pregnant. The incidence of premarital pregnancy is higher for non-students being about 67 per cent. For students it is about 40 per cent. A report by Friedman (1993) in Network showed that of every 20 teenage women in Senegal, five have given birth and one is pregnant.

Zelnik and Kantner (1980) reported a rise between 1976 and 1979 in the proportion of premarital pregnancies occurring among those who reported that they had always used a contraceptive method (from 10 per cent to 14 per cent) as well as among never-users (from 50 per cent to 62 per cent); Never-users comprised half of all teenagers who have had a premarital first pregnancy. The study also found that the level of premarital pregnancy among teenagers almost doubled between 1971 and 1979, and grew by one-fourth between 1976 and 1979. It increased from 9 per cent in 1971 to 13 per cent in 1976 and to 16 per cent in 1979.

However, premarital pregnancy has been found to cause school drop-outs, especially among females, which concomitantly reduces the chances for more education, better job and earning prospects outside the house (Liskin, 1985). In Nigeria and some other sub-Saharan African countries, pregnancy is not condoned in primary and secondary school system. Thus teenage pregnancy disrupts and/or

brings to a halt the educational development of pregnant young female with consequent blissful future career prospects.

According to Oronsaye et al.(1982), 52 per cent of the 127 pregnant school girls studied were expelled from school. 20 per cent refused to return to school due to shame, 15 per cent could not return due to parental refusal to pay their tuition and 8 per cent ended up in forced marriage. Similarly, Gabriel (1995) reporting the outcome of a 1992 Ministry of Health and Social Services country-wide survey, maintained that nearly half of Namibia's young women have their first child before they are 20 years old. According to the study, most young women have their first child around the age of 16. Consequently, if a school girl becomes pregnant, she is forced to leave school leading into a cycle of emotional, physical and economic social hardships. Gabriel (1995) further mentioned the consequences of teenage pregnancy which include: increased health risks for the young mother and her baby, rejection by family and community and attitude of many of the would-be fathers who show little responsibility for their children.

Generally in both developed and developing countries, there is a low estimate for the number of adolescents who become pregnant because they do not include pregnancies ending in abortion. Hence, Zelnik and Kantner (1980) in their study among sexually experienced blacks, found that premarital pregnancy declined between 1971 and 1976 but increased between 1976 and 1979. The

reason given for the decline was underreporting of pregnancies that ended in abortion. A report by Friedman (1993) revealed a low estimate of teenage pregnancies among teenage African women. The percentage of teenage women who have given birth in Nigeria, Uganda and Zimbabwe is 24 per cent, 30 per cent and 16 per cent respectively, while the corresponding percentage of teenage women who were pregnant at the time of survey is 5 per cent for Nigeria, 7 per cent for Uganda and 4 per cent for Zimbabwe.

From the few Nigerian studies on premarital pregnancy, it is obvious that little or nothing has ben done to find out what the feelings of adolescents are toward premarital pregnancy as well as their reasons for not carrying such pregnancies to full term. This is one of the major questions that will be answered in this study.



## 2.4 INDUCED ABORTION

Induced abortion is one of the major problems associated with adolescent sexuality. A survey of the world abortion situation from the available evidence reveals that abortion has been the most widely practised method of fertility control in virtually every country no matter its culture, politics or religion. A rough estimate suggests that every year, more than 35 million women have induced abortions legal and illegal (Hall, 1970).

Many adolescents are too young, too poor and too inexperienced to care for a child. Consequently, they resort to illegal induced abortion. However, certain surveys and sample studies give a clue to the magnitude of abortion in both developed and developing countries. Reports from many developing countries suggest that the incidence of induced abortion among adolescents has not only increased but has become endemic (Gyepi-Garbrah, 1985).

Adolescent abortion in Nigeria is on the increase. Women under age 20 account for 45-65 per cent of in-hospital abortions (Okagbue, 1990). She found that in five sample hospitals in Lagos, 125 abortions were recorded in one month; 81 abortions were recorded in four hospitals in Oyo State, 150 abortions in 2 hospitals were recorded in Ogun State and 100 cases were recorded in Ondo State within the same period. In Port Harcourt, and Enugu, 80 and 103 cases were recorded respectively over a period of one month in two hospitals.

Okonofua (1991) found that abortion cases account for 14 to 57 per cent of gynecological admissions in some Nigerian hospitals. In cities like Lagos, the increase in numbers of induced abortions reaching the hospital is of epidemic proportion (Toubia, 1991). Briggs (1991) observed that the proportion of induced abortion in Nigeria is very high. It ranges from 6 per cent in Ibadan to 50 per cent in Lagos.

A study of sexual activity among adolescent females in Lagos showed that 24 percent of sexually active respondents had, at least one abortion (Odujirin, 1991). A similar study found that 41 percent of sexually active women age 14-25 reported that they have had induced abortion, while 530 school girls said that they have had illegal abortions (Liskin, 1985). Okonofua et. al., (1995) in Ile-Ife and Jos study found that 20 percent of the women admitted having had an unwanted pregnancy, with approximately 60 percent of such pregnancies ending as successfully induced abortions. It was also found that abortion was equally practised by married as well as unmarried women.

According to Ladipo et.al, (1983) 9 out of every 10 sampled unmarried pregnant women in Ibadan have had an abortion. The ratio is highest for the University students. Over 60 percent of induced abortions performed from January 1974 to December 1979 were on adolescents, some as young as 12 years and many with a history of previous abortions or childbirth.

Certain ad hoc surveys and sample studies, give a clue to the magnitude of abortion in certain countries. In Kenya where young women age 15-24 make up about half of the female population of child-bearing age, 84 per cent of all septic abortion cases admitted for treatment at Kenyatta National Hospital are adolescents (Aggarwal and Mati, 1980). In Soviet Union, according to Mehlan (1970), some 6 million abortions take place every year. While no official figures

have been published in the People Republic of China, the total number of abortions is believed to be about 5 million per year.

In Hungary, the official estimates put the total number of abortions as exceeding 100,000 a year (Szabady, 1968). While Hungary has an extremely liberal abortion law, some women still resort to illegal abortion. Since the peak year of 1955 when 2 million abortions were performed, the incidence of abortion in Japan has ben declining gradually possibly for the twin reasons of more widespread use of contraception and the government's pronounced fear of labour shortage (Petersen, 1969). In India, before the liberal law of 1971 was passed, there were according to Petersen also, some 5 million abortions a year; in the United States of America, before the present liberal abortion laws in some states were passed, estimates of induced abortion ranged from 700,000 to 2,000.000 a year.

According to Thomlinson's (1965) summary of several studies in the 1960s, about one out of every 5 pregnancies of United States terminated in illegal induced abortion. The estimates of illegal abortions in West Germany for 1967 ranged between one and 3 million. In Great Britain before 1967 Act was passed, an estimate put the total number of induced abortions at 100,000 a year. In Canada the annual figure is about 50,000.

For Catholic countries, Italy probably leads the list with an estimated 650,000 to 900,000 illegal abortions in 1967, while for France, the average annual figure varies between 250,000 ad 300,000; of 200,000 abortions that take place in Chile annually, two-thirds are induced, illegal abortions in Argentina and Uruguay in 1967 totalled 500,000 and 100,000 a year (International Consultants' Report, 1970).

In Latin America, induced abortion is the fourth most commonly used method of fertility regulation. Estimates of the number of induced abortion performed each year in Latin America range from 2.7 to 7.4 million or from 10 to 27 per cent of all abortions preformed in developing world (Paxman et.al, 1993). In Peru, the Ministry of Health observed in its 1981 report that clandestine, illegal abortion is a serious public health problem, with high human and social costs. The report estimated the total number of induced abortions to be 27,000 annually with a ratio of 137 induced abortion to 1,000 live births (Paxman et.al, 1993). Frejka et al. (1989) concluded that more than one-half of the women in some Latin American countries will experience at least one induced abortion during their lifetimes.

In many countries, abortion law is restrictive and as such many school girls resort to illegal clandestine abortions from unqualified abortionists, who operate under poor hygienic conditions. Odujirin (1991) found that more than half

of the abortion procedures are carried out by non professional providers. Only 48 per cent had the procedure performed by a medical doctor. Similarly, Daly et al, (1974) reported that adolescents lack funds and tend to get riskier abortions from non-professional providers.

According to Barnett (1993), a Nigerian girl fearful of parental disapproval and expulsion from school seeks an abortion from a women who advises her to drink cow's milk with bitter herbs. Also, a young Brazilian prostitute tries to induce abortion by swallowing misoprostol; and a Bangladeshi youth seeks an abortion from a village midwife, who uses roots cut from a neem tree to dilate cervix.

In Latin America, abortion is more commonly induced by substandard methods ranging from the use of herbal abortifacient to the insertion of catheters or metal sounds into the uterus. A woman seeking to terminate an unwanted pregnancy may resort to progressively more dangerous methods as this contemporary account from Chile illustrates:

> "First, I had two injections of Metheergin. Afterwards for days, I drank before breakfast red wine boiled with borage and rue to which I added nine aspirins. My body was full of pimples but I did not abort. A few days later, I drank cement water. It did not work either. Then I went to a lady who inserted a rubber Catheter into

me. I had to use it, after all the things I did, I could not keep the child because he could have malformations" (Weisner, 1990).

Abortifacient herbs and plants are among the oldest and most widespread means used for inducing abortion. According to Barker and Rich (1992), adolescents cite abortifacient as including salt, alum and potash, often combined with drugs or alcohol.

## 2.5 CONSEQUENCES OF UNSAFE ABORTIONS

Each year, millions of young women in developing and industrialized countries seek similar unsafe abortions as a remedy for unwanted pregnancies. By doing so, they put themselves at risk for serious health problems. Unsafe induced abortion is not only costly in terms of finance, equipment and personnel, it contributes to the tragic loss of human lives.

It is estimated in Nigeria that induced abortion is responsible for between 2.2 and 50 per cent of maternal deaths that occur in leading maternity centres (Okonofua et.al., 1995). A review of maternal deaths over a 13 year period in one hospital in Nigeria showed that abortion was one of the three major causes of death. It was found that 91 per cent of the deaths were confirmed cases of induced procedures (Mpangile et al., 1993). Clinical reports and documented evidence (vide infra) show that maternal deaths related to illegal abortion range

from 2 per cent to about 20 per cent or more especially where illegal abortions are performed by unqualified persons under unsanitary conditions. For instance, 11 per cent of maternal deaths in Freetown hospitals in Sierra Leone are due to abortion (Gyepi-Garbrah, 1985). Worldwide, WHO has attributed the deaths of 200,000 women annually to unsafe abortion - 25 to 50 per cent of all maternal deaths (Mahler, 1987).

In Latin America, complications resulting from unsafe illegally induced abortion are considered the principal cause of death in women aged 15 to 35 years (Frejka et al., 1989). Overall, the range of abortion-related deaths in Latin America can be estimated to be between 4,500 and 11,000 per year (Royston and Amstrong, 1989).

According to Liskin (1985), in 10 hospitals in Zaire one of every 50 women admitted for complications of illegal abortion in 1982-83 died in the hospital. In Kenya's Kenyatta National Hospital between 1972 and 1977, 18 per cent of maternal deaths were directly related to illegal abortion. The death rate for unsafe abortion in one study is estimated to be as high as 1,000 per 100,000 procedures; and when performed by experienced providers, using aseptic techniques, the abortion death rate drops dramatically to less than one death (0.6) per 100,000 (Barnett, 1993).

Ladipo in Network (1993) says that hospitalizations "are only the tip of the iceberg". "Many don't make it to the hospital. They die at home or on the way. Unsafe abortion is a major health problem responsible for deaths in the prime of life". Maternal deaths in Africa attributable to abortion vary from below 10 percent to as high as 60 percent according to WHO estimates. In Nigeria, nearly 20,000 out of 50,000 maternal deaths estimated to occur annually are attributed to complications of unsafe induced abortion (Okonofua and Ilukoma, 1991).

Severe but non-fatal complications are also common and may have short and long-term consequences. According to Bernett in Network (1993) for girls and women who have unsafe abortions, two types of short-term health problems can occur: injuries from the procedure itself, such as perforation of the uterus, cervical lacerations or hemorrhage; and bleeding and infection caused by incomplete abortion or introduction of bacteria into the uterus. Long-term complications include increased risk of ectopic pregnancy, chronic pelvic infection and possible infertility. Esiet (1996) reported that the most common implications being recorded include sepsis, hemorrhage, chronic morbidity and psychological impairment.

While the risk of mortality and morbidity from unsafe abortion are high for women of all ages, they are especially high for adolescents. A study at the teaching Hospital in Enugu Nigeria showed that 71 per cent of women suffering

from complications of unsafe induced abortions were 20 years old or younger (Mpangile et.al., 1993). Ceoytaux (1988) found in a community based study in Lagos that there is increased in the number of adolescent women wish abortion complications. Similarly, during a 2-year period at the University of Ilorin Teaching Hospital, 264 women presented for complications from induced abortions. Of these, 74 per cent were adolescents with septic illicit abortion (Adetoro et.al., 1991).

According to Esiet (1996), teenagers in Nigeria account for 80 per cent of the cases of complications arising from unsafe abortions treated in Nigerian hospitals annually. Another study at the University of Calabar Teaching Hospital in Nigeria found that 72 per cent of patients hospitalized for abortion complications were under 20. About 58 per cent were students, and 11 per cent had undergone a previous unsafe abortion (Archibong, 1991).

In a study in Bolivia, of patients hospitalized for complications from induced abortions, about 39 per cent of the women under 18 years old had illegally provoked abortions. The figure was 30 per cent for women ages 18 to 19 (Balley et.al., 1988). In Zaire, a study of 2,465 women hospitalized for abortion complications showed that the proportion of induced abortions was greatest among women under 20. Among patients 18 or young, 58 per cent were treated for complications of induced abortion (Bongwele et.al., 1985). In

Cameroon, 32 per cent of emergency admissions at a local hospital were due to abortion-related complications and nearly 39 per cent of the patients with abortion-related complications were ages 11 to 19 (Leke, 1989). Similarly in Russia, 15.2 per cent of all illegal abortions performed on childless women involved girls 17 and under (Popov, 1993).

Concerned about this high rate of complications, several attempts have been made by social and policy analysts to liberalize the abortion law in Nigeria. Several publications by aforementioned researchers and others have provided persuasive arguments in support of liberalizations of the abortion law in the country, but this has not been possible. While surveys on the incidence of abortion have been conducted in some places in Nigeria, almost no attempt has been made to determine the level of knowledge and use of contraceptives, attitudes towards abortion and its liberalization among adolescents. Also, while studies have been conducted on the knowledge, attitude and practice (KAP) of family planning especially among adolescents, little is known about their KAP of abortion and its liberalization.

To my knowledge, there exist few attitude surveys on induced abortion. Therefore, there is need for a survey on knowledge, attitude and practice to elucidate the relationship between contraception and abortion, including consumer

awareness of where to go and how to obtain services and adolescents' preferences as to use of contraception and abortion.

## 2.6 RESEARCH HYPOTHESES

Based on the literature review and theories, the following hypotheses are stated, and testing their validity will be a major focus of this study, as it will help us to realize the stated objectives of the study.

1. Sexual activity increases with increasing age of adolescents.
2. As the age of adolescents increases, the use of contraceptives increases.
3. Adolescents who are highly religious are less likely to have premarital pregnancy.
4. Adolescents from families with high socio-economic status are less likely to have induced abortion than those from families with low socio-economic status.
5. Adolescents who are in school are less likely to be sexually active and have premarital pregnancy, but more likely to have had abortion relative to out-of-school adolescents.
6. The higher the level of education of adolescents, the higher their likelihood of supporting legalization of abortion.

## 2.7 THEORETICAL FRAMEWORK

In a study of this nature, there is need for a theoretical basis as a guide to the study. This is because, theory which indicates general principles guiding human behaviour, is an important part of the scientific process and provides a framework within which policies and programmes are formulated.

In view of this, therefore, for a better explanation and understanding of the incidence of unsafe abortion, it is necessary to examine the individual's behaviour in his/her immediate social environment and in relation to general societal values and norms. Within the context of this study, two theoretical perspectives which tend to explain human behaviour will be adopted.

1. The social action theory
2. Cultural transmission theory.

### 2.7.1 SOCIAL ACTION THEORY

Max Weber (1947: 88)

> "Action includes all human behaviour when and in so far as the acting individual attaches a subjective meaning to it. Action is social in so far as by virtue of the subjective meaning attached to it by the acting individual (or individuals), it takes account of

> the behavior of others and is thereby oriented in its course".

In addition, Allan Dawe (1978) maintained that:

> "The language of social action is thus the language of subjective meaning in terms of which social actors define their lives, purposes and situations; of the goals and projects they generate on the basis of their subjective meaning; of the means whereby they attempt to achieve their goals and realize their projects; of the social action upon which they embark in the prosecution of such attempts; of the social relationship into which they enter on the basis of their pursuit of goals and projects..."

The above definitions indicate that individual actions have subjective meaning and to explain behaviour or attitude from this perspective, there must be an understanding of the subjective meaning an individual attaches to his action. For every action an individual takes, there must be a purpose goal or end that he intends to achieve, but at the same time, this purpose or goal (subjective meaning) must take into consideration the behaviour of other people.

The adolescents sexual behaviour involves a purpose (goal) which they want to achieve. Similarly, their attitudes toward and practice of abortion involves an end which they want to achieve. Therefore, the subjective meaning in this case must be understood in order to provide an adequate explanation of why they take such actions. In other words, a proper understanding of why young people engage in risky sexual behaviour, support or disapprove unsafe abortion or even seek to terminate pregnancy must be located within the subjective meaning that they attach to their action.

Weber in his action theory identified "Zweck-rational" as an action that involves the rational weighing of alternative course of conduct in terms of their usefulness to the actor. In other words, whether the undesirable consequences would outweigh the benefits to be derived from the projected course of action.

In this case, the actor in pursuing his goal rationally calculates the avoidable means and chooses the most appropriate one in terms of cost and benefit to attain the desired goal. From this perspective, when for instance a never-married adolescent becomes pregnant, the need to keep the pregnancy or procure an abortion informs her course of action. Thus her choice involves weighing of the cost and the benefits of each alternative and the choice of the most appropriate one to achieve her desired goal.

Hence, the understanding of what determines the choice of a particular mode of behaviour which assists the actor to achieve his goals is very necessary. Of importance also is the understanding of the implications which such actions have for other people toward which the action is oriented.

However, various possible meanings, explanations and reasons which inform individual behaviour especially with regard to premarital pregnancy and unsafe abortion include lack of access to contraceptive, lack of reasonable means of livelihood, sex education and so on. On the other hand, actions oriented towards the behaviour of others include, parental disapproval of premarital pregnancy and avoidance of expulsion from school.



## 2.7.2 CULTURAL TRANSMISSION THEORY

Edward Taylor (1871) defined culture as:

> That complex whole which includes knowledge, beliefs, arts, morals, law, customs and any other capabilities and habits acquired by human beings as a member of society.
>
> (Edward B. Taylor Primitive Culture (1871)).

Similarly, Oke (1984) stated that culture is the distinctive way of life of a group of people, their complete design for living. By implication, this design for living or way of life includes their knowledge, belief, art, morals, law and

custom, which are transmitted by cultural agents and are acquired by the individuals in a society through the socialization process.

James and Vander (1979) asserted that individuals are essentially neutral at birth and if this is the case, it then means that they acquire these knowledge, beliefs, habits, ways of thinking, feeling and acting characteristics through their social (environmental) experiences. In view of this, adolescents sexual behaviour and practice of abortion may be described as behaviour acquired through social interaction in their environment.

The agents of socialization designed and institutionalized by the society through which cultural values, dos and don'ts are being transmitted include: the family and the educational system. Within the family, individuals learn the language and many of the basic behaviour patterns of his society. For instance, they learn fertility norms of premarital chastity and virgin marriage. Also sex is hardly discussed by elders in the presence of unmarried youths and on rare occasions when the subject is broached, adolescents are made to believe that sex is proper in marriage only and that reticence and passivity toward sex are valuable feminine traits (Liskin, 1985), M-358). This lack of sex education in the home may explain why adolescents indulge in risky sexual activities.

The family also helps the individuals to be integrated fully into the society through rites of passage, birth, naming ceremony, the rites of puberty and

marriage. The educational system is also another agent of cultural transmission. What is being taught at school is however, a continuation of a baking that began at home.

Since individuals behaviour is moulded by the values and norms of the society, it indicates that as these values and norms change, there will also be a change in patterns of behaviour. Thus as society changes due to industrialization, urbanization, modernization or westernisation, new values and cultural ideals evolve and are imbibed by individuals. In other words, traditional fertility norms, ethics and institutions as well as general life patterns undergo series of transformation.

Since socialization or cultural transmission is a long life process, individuals tend to imbibe these new norms and cultural values, which in effect severe them from constraints once applied by the society to regulate premarital sex, pregnancy and abortion. Other modernization variables as more formal education, especially for women, improved health medical services, introduction of new ideas, concepts and goods all compete with parents and traditional leaders for influence among young people (Population Crisis Committee, 1987).

One of the mechanisms by which cultural transmission operates is through observational learning. Through observation, children acquire a lot of information, but Hyde and Rosenberg (1976) observed that frequently they do not use this

information until a situation arises in adolescence or adulthood that calls for knowledge of particular behaviour.

For instance, through the mass media, especially television, programmes, adolescents acquire a lot of information regarding love, sex, pregnancy, abortion, marriage and relationships. In addition, Caldwell (1976) and Freedman (1979) argued that rather than modernization, westernisation (i.e. importation and diffusion of new ideas and mass infusion of European manners through mass formal education and the mass media), may alone or in combination with modernization create new aspirations, tastes and fertility behaviour in contemporary developing countries.

In sum, as the society becomes modernized, new values (nuclear family norms, sexual permissiveness, use of contraception and so on) are created and transmitted to individuals (adolescents).

# CHAPTER THREE

# METHODOLOGY

## Introduction

This chapter describes the area of study, research design, strategy, instruments and methods employed to produce data for this study. It also describes how the data were analyzed and the problems encountered in the course of this study.

## 3.1 STUDY AREA

The Place under study is Port Harcourt City, the capital of Rivers State, Nigeria's rich oil state. The city has the largest concentration of oil and allied industries, hence it is regarded as the heartland of the oil industry in Nigeria. By geographical location, it is in the South-eastern part of the country. It is made up of two local government areas namely: Port Harcourt Local Government Area (PHALGA) and Obio-Akpor Local Government Area (OBALGA) with a population of 406,738 and 239,145 respectively (Census News, 1996).

Port Harcourt is a cosmopolitan city and the major ethnic groups resident in the city include: Ikwerre, Kalabari, Ijaw, Ogoni, Igbo etc. There are, however, other ethnic groups from various parts of Nigeria residing there as well as non-Nigerians from different parts of the world. It has a dense population of young

people. Perhaps, one of the attractions of the youth is the large industrial base of the city, since Port Harcourt is second to Lagos in factory development.

The city has two Universities, many other higher institutions and a large number of secondary schools, hospitals and medical centres. Also patent medicine stores are seen in large numbers all over the city, together with numerous signboards advertising the services of traditional healers and medicine men, most of whom specialize in reproductive health problems and provision of abortion services. The majority of the residents are Christians while few of them are Muslims, especially those from the Northern part of the country.

## 3.2 CHOICE OF AREA

Port Harcourt was chosen because I live in the city and therefore conversant with the environment, and know that abortion is commonplace among adolescents. Secondly, existing studies on abortion in Nigeria have tended to concentrate on the South-western part of the country. This does not allow for a broad-based data with which categorical deductions can be made on the incidence and prevalence of abortion in the country.

## 3.3 RESEARCH DESIGN

The primary objective of this study is to examine the knowledge, attitudes toward and practice of induced abortion in Port Harcourt City. In view of this, the study was designed to be a community based and household survey of adolescents in and out-of-school. The reasons for this is because there is limited substantive community and household based data on the prevalence and determinants of premarital pregnancy and induced abortion in Nigeria. Most studies on abortion have been based on women and adolescents admitted in major hospitals.

There is often little or no information on several teenage girls who carry out induced abortion themselves, those who utilize private and smaller clinics and even the services of non-professional abortionists and traditional healers. Though most of these hospital-based studies have yielded interesting results, they cannot be generalized to the wider Nigerian context or used as an accurate indicator of the magnitude of the incidence of abortions in Nigeria (Okagbue, 1990). Based on this therefore, there is need for this study design, so as to provide a more accurate data on the extent of the practice of abortion among adolescents in Nigeria.

## 3.4 THE SAMPLE POPULATION, SIZE AND SAMPLING TECHNIQUE

The target population is adolescents aged 13-24 years in and out-of-school in Port Harcourt City. The sample size was initially nine hundred and thirty (930) respondents. Seven hundred (700) were females, while two hundred and thirty (230) were males. The number of female adolescents was higher because they are the group at risk of induced abortion. After the administration of the questionnaires, however, the number was reduced to seven hundred and fifty two (752) respondents due to incomplete and inconsistent responses.

The major sampling procedure adopted in this study was probability sampling. This was based on the understanding of the advantages of random sampling methods over non-probability techniques, especially for the purpose of drawing up a representative sample of the population under study. To give the study a wider geographical base, the two local government areas in the city were chosen. A list of schools in the two local government areas which was used as the sampling frame was obtained from the headquarters of each of the two local government areas. Obio/Akpor Local Government areas has a total of 17 schools while Port Harcourt Local Government has 15 schools. However, it was not possible to obtain a listing of households as at the time of this survey because many of the households especially those at the slum areas of the city lacked PHC

(Primary health Care) household identification numbers. Therefore, an insistence on finding one would have made this research a difficult if not impossible task.

To draw a representative sample of the schools, the simple random sampling method was used. Using the lucky dip procedure, a number was assigned to each school and the number representing each school was written on a piece of paper and put inside a container and shaken together. These papers were picked until the number of schools required from each local government was selected. A total of 6 schools were randomly selected from Obio/Akpor Local Government Area, while 5 schools were selected from Port Harcourt Local Government Area. On the whole, 5 girls secondary schools, 2 boys schools, 3 co-educational school and 1 college of Arts and Science were chosen.

Within each school, students in SS1 and SS2 were randomly selected and interviewed. A total of 50 students were interviewed n each of the schools. SS3 students were not included in the study because as at the time of this study, they had finished their school certificate examinations and had gone. Also, the students in the senior classes were used because perhaps they have a better understanding of abortion than those in the junior classes.

For the out-of-school adolescents, first of all, the city was divided into 3 zones namely; Bundu waterside, Boricamp and Elekahia. In each zone, purposive sampling was adopted to select some streets. Random sampling procedure was

used to select the households as well as the eligible respondents within each household.

## 3.5 DATA COLLECTION METHOD

A structured questionnaire of fifty-two questions was the data collection instrument used in this study. The questionnaire survey was carried out between July and August, 1996. It lasted for about 4 weeks. The questionnaire method was chosen because it is comparatively faster than indepth interview. Secondly, it is a more efficient method of obtaining responses from a larger number of sample within a short period of time. Finally, since this study is a sensitive one, it will help to eliminate bias which could probably occur if face to face interview was used.

The questionnaire was designed to elicit information on contraception, sexual activities and networking, pregnancy and abortion histories from adolescents aged 13-24 years. For practical purposes, the questionnaire was divided into five sections. Section A contains questions on the socio-demographic characteristics of the adolescents (age, marital status, religious background, educational level and parental characteristics). Section B collected information on knowledge of abortion and contraceptive use methods, while section C was

designed to explore adolescents' attitudes toward induced abortion and abortion law in Nigeria. Section D dealt with questions on sexual activity and networking.

The final part of the questionnaire, which is Section E, asked the key question of the survey, i.e. whether an adolescent had ever been pregnant or had been pregnant when she did not want to be. This question was also followed by a series of questions on how the adolescent dealt with the "premarital pregnancy". Specifically, if she said she had successfully terminated the pregnancy, she was asked to mention the practitioner who performed the termination and whether there were complications and how she treated herself. This part of the questionnaire also contained questions on whether she received post-abortion counselling and the nature of the counselling received. It also made provision for suggestion on how to reduce the incidence of premarital pregnancy and induced abortion in Nigeria.



## 3.6 SURVEY TEAMS

For the administration of the questionnaires, six female interviewers (aged 20-27) resident in Port Harcourt were recruited. Apart from the supervisory role played by the researcher, she was also involved in the administration of the questionnaires.

All the recruited interviewers were given some practical instructions by the researcher on how to go about the administration of the questionnaire. The description of the goals and objectives of the study as well as the administration techniques were explained to them. They were informed of the importance of their assignment. They were asked to collect the questionnaires from the respondents immediately after they were filled and also to insist on the questionnaires being filed on the spot. They were also instructed to explain the questions to the respondents if the need arises.

## 3.7 SURVEY EXECUTION

Before the questionnaires were administered in the various schools, permission to conduct the interview was sought from the designated principals. At least one visit was made to each school before the final interview was conducted. Only those respondents who agreed to participate in the survey were finally interviewed in each of the schools. For the out-of-school respondents, the purpose of the study was explained, and those who agreed to participate were interviewed.

## 3.8 DATA MANAGEMENT

At the end of the fieldwork, the completed questionnaires were collected for processing. Out of the 930 questionnaires administered, 178 were invalidated due to incomplete, inconsistent and non-response. However, 752 of the questionnaires which were deemed fit, were edited and coded by the researcher. The data were entered into the computer using version 6 of Epi-Info software.

For data analysis, SPSSPC version 4 software was used. Initially, univariate analysis was carried out to describe the socio-demographic characteristics of the respondents, their knowledge and attitudes toward induced abortion and the abortion law, pattern and use of induced abortion services and contraceptive use as well as sexual activity and networking. The univariate analysis was followed by bivariate analyses. Crosstabulations were performed to determine the relationship between different variables. Cross-tabulations yielded the relationships in percentages. Finally, the multivariate logistic regression was undertaken to further determine the relationship among different variables.



## 3.9 PROBLEMS OF THE STUDY

One of the problems encountered in this study was that of delay in the production of the questionnaires which was due to a breakdown of the cyclostyle. As a result of this, some of the questionnaires were administered late and during

the period of examination in some of the schools. This may have affected the responses as some of the students filled the questionnaires with divided attention.

Another significant problem was that associated with the respondents. Some of the respondents interviewed expressed ignorance of abortion or perhaps were not willing to give information concerning their private lives. As a result, some of the questions were not properly answered. There were many cases of non-responses and"don't know" answers. Furthermore, because of the sensitive nature of the study, it was difficult to elicit information on abortion histories of the respondents. Most of them did not understand the reason why people should ask questions on issues that are confidential and personal to them. Therefore, the researcher and her assistants had to spend much time explaining the purpose of the research and why they should answer the questions, and at the same time assuring them of anonymity.

In some cases, the pleas and persuasions wee not heeded, whereas in most situations, the individuals responded reluctantly. This notwithstanding, an appreciable number of adolescents were willing and responded to the questions satisfactorily. This was possible based on the realization that the researcher is using the information for academic purposes only, and that a time is coming when some of the students will also have to carry out a research.

Among other problems encountered is that of lack of co-operation on the part of some principals. Some refused to grant us permission to interview the students on the ground that it was examination period and therefore, the students should not be distracted. Some said that the nature of the questions is such that could corrupt the students. Because of this, we were faced with the problem of selecting some other schools that were not initially in the sample. However, in most cases, we were able to obtain permission after much explanations and pleas.

Some problems were also encountered with the out-of-school respondents. Some of them refused to fill the questionnaires in spite of our pleas and explanations, while some filled the questionnaires willingly. In sum, it is pertinent to mention that as a result of non-response, incomplete responses and rejection of questionnaires by respondents, this study may have underestimated abortion since it is likely that those who have had abortion would belong to these groups.

# CHAPTER FOUR

# PRESENTATION OF DATA AND DISCUSSION OF FINDINGS

## Introduction

This chapter presents analyses and discusses the substantial findings of our investigation into adolescents' knowledge, attitude toward and practice of abortion. The chapter is divided into three sections. In section one, socio-demographic characteristics of the sample are displayed through suitable tabular presentation techniques. Also, section one presents data on contraceptive use, sexual activity, pregnancy and abortion. In section two, the results of bivariate analyses are presented through cross-tabulation and discussed. Finally, in section three, the results of multivariate analyses are presented through logistic regression and the research hypotheses are tested and discussed.



## 4.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

### AGE COMPOSITION

The mean age of the adolescents drawn into the sample is 18.4 years. They were grouped into three age groups, early teens (less than 16 years old), mid teens (16-19) years old and late teens or young adults (20 years old and above).

The age distribution of the sample shows a greater proportion of the respondents within the age range 16-19 (mid teens). This is relevant to this study

because, this age group is very sexually active. Also, it is the age at high risk of premarital pregnancy and induced abortion.

## SEX COMPOSITION

The proportion of female adolescents drawn into the sample is higher than the proportion of male adolescents. This is because the females are the major group at risk of abortion and as such, the study was designed to include a larger proportion of female adolescents.

Table 4.1: **SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS**

| Characteristics | Number | Percent |
|---|---|---|
| Current Age: | | |
| < 16 | 147 | 19.6 |
| 16-19 | 424 | 56.4 |
| 20+ | 175 | 23.1 |
| No response | 6 | 0.9 |
| TOTAL | 752 | 100 |
| Sex: | | |
| Male | 157 | 20.9 |
| Female | 595 | 79.1 |
| TOTAL | 752 | 100 |

Table 4.1 continued

| Characteristics | Number | Percent |
|---|---|---|
| Religion: | | |
| No religion | 45 | 6.0 |
| Catholic | 262 | 34.8 |
| Protestant | 229 | 39.8 |
| Muslim | 28 | 3.7 |
| Traditional | 21 | 2.8 |
| Other | 61 | 8.1 |
| No response | 36 | 4.8 |
| TOTAL | 752 | 100 |
| Level of Education | | |
| No formal education | 8 | 1.0 |
| Primary Education | 8 | 1.0 |
| Secondary education | 183 | 24.3 |
| Tertiary education | 68 | 9.1 |
| Currently student | 483 | 64.3 |
| No response | 2 | 0.3 |
| TOTAL | 752 | 100 |
| Marital Status: | | |
| Married | 29 | 3.7 |
| Divorced | 8 | 1.1 |
| Separated | 7 | 0.9 |
| Cohabiting with a man | 19 | 2.5 |
| Never married | 685 | 91.3 |
| No response | 4 | 0.5 |
| TOTAL | 752 | 100 |
| Occupation | | |
| Student | 613 | 81.6 |
| Trading | 48 | 6.3 |
| Fashion designer | 16 | 2.1 |
| No response | 75 | 16.3 |
| TOTAL | 752 | 100 |

Table 4.1 continued

| Characteristics | Number | Percent |
|---|---|---|
| Family Socioeconomic Status | | |
| Low | 11 | 11.2 |
| Medium | 35 | 35.7 |
| High | 52 | 53.1 |
| TOTAL | 98 | 100 |

**RELIGION**

Overall, christians constituted 82.7% of the sample population, while Muslims constituted 3.7%. The greater proportion of the sampled population are Christians and this could be due to the fact that the south-eastern part of Nigeria is predominantly Christians while the North is predominantly Muslim. The proportion of protestants is slightly higher than catholics.

**EDUCATIONAL LEVEL**

As regards educational status, only 1.1% of the respondents had no formal education while 98.7% of the sample population had formal or basic education. The proportion of respondents who are currently students include both secondary school students and those in tertiary institutions. Therefore, the high proportion is due to the fact that the study was designed to draw a greater number of in-school adolescents into the sample. The reason for this is because, past studies showed that abortion is school girls' problem (Durojaiye 1996).

## MARITAL STATUS

The table indicated a greater proportion of never-married adolescents (91.3%). This is because the study was designed to be a population based survey of never married adolescents. Given that early marriage is not a common phenomenon in South-eastern part of Nigeria, and that most of the respondents are still in school, this report on divorce and separation may not be accurate. Those who admitted being divorced (1.1%) or separated (0.9%) may be people who have previously cohabited.

## OCCUPATION

The target population in this study is adolescents and since most of them are still students, the main occupation of the respondents is schooling. As a result, a greater proportion indicated that they are students (81.6%). Others are fashion designers or traders.

## FAMILY SOCIO-ECONOMIC STATUS

From the table, the majority of the adolescents (88.8%) are from medium and high socio-economic families. This indicates that a greater proportion of the respondents drawn into the sample are from upper and middle class families. This could be attributable to the urban nature of the study area. It is pertinent to

mention that composite household durables such as Television, refrigerator and car are among our crude measure of socio-economic status.

## 4.2 SOURCES OF INCOME

Rather than measure the income level of the respondents, they were asked howl they get money for their personal upkeep. In answering this question, 77.1% of the adolescents admitted that they get money from parents. Only 0.7% are self dependent, while 83.3% get their money from friends and relatives.



**Table 4.2 PERCENTAGE DISTRIBUTION OF RESPONDENTS BY SOURCES OF INCOME**

| Sources of Income | Yes | | No | | No Response | | Total | |
|---|---|---|---|---|---|---|---|---|
| | % | No. | % | No. | % | No. | % | No. |
| Parents | 56.3 | 424 | 41.0 | 308 | 2.7 | 20 | 100 | 752 |
| Mother only | 5.3 | 40 | 92.0 | 692 | 2.7 | 20 | 100 | 752 |
| Father only | 15.5 | 117 | 81.8 | 615 | 2.7 | 20 | 100 | 752 |
| Trading | 0.7 | 5 | 96.6 | 72 | 2.7 | 20 | 100 | 752 |
| Friends | 4.8 | 36 | 92.5 | 696 | 2.7 | 20 | 100 | 97 |
| Partner | 7.0 | 53 | 90.3 | 679 | 2.7 | 20 | 100 | 752 |
| Uncles | 22.8 | 81 | 63.1 | 224 | 14.1 | 50 | 100 | 355 |
| Other Relations | 48.7 | 173 | 37.5 | 133 | 13.8 | 49 | 100 | 355 |

As shown in the table, the proportion who depend on parents and other relations for money is high. Because most of the young people are solely dependent, it is likely that some parents may not be able to meet all their needs. As a result, some of the young girls in order to make ends meet may indulge in illicit sex. Past studies revealed that most female adolescents do so for material gains. It could also explain why they resort to illegal unsafe abortion, since most of them are too young and too poor to keep a child (Daly et al, 1994).

## 4.3 KNOWLEDGE OF ABORTION

To appraise the adolescents knowledge of abortion and where abortion services can be obtained, they were asked if they have ever heard of induced abortion. As shown in table 4.3, more than half of the adolescents have heard about induced abortion. About 54.7% admitted that they know places where abortion services can be obtained. In answering the question on knowledge of places where abortion services can be obtained, the respondents who did not initially admit that they know, mentioned the places where adolescents go for abortion. This indicates that more than 54.7% of the respondents are aware of places where abortion services are obtained. About 27.7% mentioned government

hospital, while 70.8% indicated private hospital. Those who mentioned self induction constituted 15.3% and 51.3 indicated other sources of abortion services.

The foregoing revealed that a high proportion of the adolescents in Port Harcourt City have heard about induced abortion and know places where abortion services can be obtained. There is also an indication that private hospitals are major sources of abortion services despite the high price charged for the services. This could be because private hospitals/clinics provide privacy since abortion is illegal in Nigeria.

Table 4.3: DISTRIBUTION OF RESPONDENTS BY KNOWLEDGE OF ABORTION AND PLACES OF ABORTION SERVICES

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Ever heard about induced abortion | | |
| Yes | 512 | 68.1 |
| No | 233 | 31.0 |
| No Response | 7 | 0.9 |
| Know places of abortion services | | |
| Yes | 411 | 54.7 |
| No | 341 | 45.3 |
| If Yes, where | | |
| Government hospital | 114 | 27.7 |
| Self medication | 291 | 70.8 |
| Quacks (non professionals) | 63 | 15.3 |
| Pharmacists/Chemists | 40 | 9.7 |
| Traditional Healers | 60 | 14.6 |
| Nurses | 61 | 14.8 |
| Others | 36 | 8.8 |
| | 14 | 3.4 |

## 4.4 CONTRACEPTIVE METHOD KNOWLEDGE, SOURCES AND USE:

As shown in table 4.4, 25.4% of the respondents admitted having knowledge of condoms while 18.8% know about pills. About 7.9% know other modern contraceptive methods and those who know traditional method constituted 8.9%/ About 39.0% do not know any contraceptive method at all. Generally, the result indicates low level of knowledge of contraceptive methods. This implies that adolescents in the City are not well informed about birth prevention.

From the table, it is clear that condoms and pills are the most well known modern contraceptives and this could be because, condom is the most widely advertised contraceptive in Nigeria. The mentioning of traditional methods such as Andrews liver salt (a laxative), white quinine, stout, hot drink (kai kai), herbs, lime etc, is an indication of their ignorance of what modern contraceptives are.

As shown in the table also, 40.8% of the respondents mentioned pharmacist shops as the major source of contraceptive methods. This is perhaps due to easy accessibility of these shops and since adolescents are not expected to go to the conventional family planning sources for service, it is easier and more convenient for them to obtain contraceptives in the pharmacy shops without protocols than in the government and private hospitals and family planning clinics.

**TABLE 4.4:** PERCENTAGE DISTRIBUTION OF RESPONDENTS BY CONTRACEPTIVE KNOWLEDGE, SOURCES AND USE

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Modern contraceptives known | | |
| Condoms | 191 | 25.4 |
| I U D | 13 | 1.7 |
| Spermicides | 19 | 2.5 |
| Diaphragm | 24 | 3.2 |
| Sterilization | 4 | 0.5 |
| Pills | 141 | 18.8 |
| Traditional Methods | 141 | 8.9 |
| Don't know any method | 219 | 39.0 |
| TOTAL | 752 | 100 |
| **Sources of Contraceptive methods** | | |
| **Government hospitals** | 117 | 15.6 |
| **Private hospitals** | 307 | 40.8 |
| **Pharmacist shops** | 115 | 15.3 |
| **Friends** | 99 | 12.2 |
| **Others** | 38 | 5.1 |
| **No response** | 76 | 11.0 |
| **TOTAL** | 752 | 100 |
| Ever used Contraceptives | | |
| Yes | 116 | 15.4 |
| No | 636 | 84.6 |
| TOTAL | 752 | 100 |
| Method ever used | | |
| Condoms | 49 | 41.4 |
| Pills | 38 | 32.8 |
| Other modern methods | 7 | 6.1 |
| Traditional method | 23 | 19.7 |
| TOTAL | 117 | 100 |

Table 4.4 continued

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Methods Currently being used | | |
| Condom | 37 | 4.9 |
| Pills | 27 | 3.6 |
| Other modern methods | 6 | 0.8 |
| Traditional method | 26 | 3.5 |
| Not currently using | 655 | 87.2 |
| TOTAL | 751 | 100 |

Table 4.4 also shows that 15.4% of the respondents had ever used modern contraceptives while 87.2% were not currently using. This implies that only 12.8% were currently using contraceptives. This result indicates that there is a very low use of contraceptive methods among the adolescents in Port Harcourt City. This finding is consistent with past studies as seen in the review of literature. This low use of contraception could be due to inadequate knowledge of and access to contraceptives. From the table, it is clear that condom and pills are the most commonly used method, followed by traditional method (pepper, alcohol, potash or Akanwu, tetracycline, chloroquine etc). This perhaps explains the large number of traditional healers all over the city.



## 4.5: RESPONSES TO ABORTION-RELATED QUESTIONS

In table 4.5, it is observed that 22.6% of the respondents supported the legalization of abortion in Nigeria, while 77.4% did not favour it. The major

reason given in favour of legalization of abortion is the avoidance of premarital pregnancy.

**Table 4.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY RESPONSES TO ABORTION-RELATED QUESTIONS**

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Legalise abortion | | |
| Yes | 170 | 22.6 |
| No | 581 | 77.4 |
| TOTAL | 751 | 100 |
| If Yes Why? | | |
| Avoidance of premarital pregnancy | 26 | 15.3 |
| To avoid shame and embarrassment | 3 | 1.8 |
| Restrict to married women | 2 | 1.2 |
| For birth control | 9 | 5.3 |
| To avoid child abuse | 5 | 2.9 |
| Avoidance of parental disgrace | 4 | 2.4 |
| Others | 99 | 58.2 |
| No response | 22 | 12.9 |
| TOTAL | 170 | 100 |
| If No, why? | | |
| It is murder | 168 | 29.0 |
| Abortion will be rampant | 19 | 3.2 |
| Dangerous to health | 76 | 13.1 |
| Causes sterility | 37 | 6.3 |
| It is a sin | 78 | 13.4 |
| Others | 203 | 35.0 |
| TOTAL | 581 | 100 |

Table 4.5 continued

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Is abortion right or wrong? | | |
| Right | 47 | 6.3 |
| Wrong | 700 | 93.6 |
| Don't know | 1 | 0.1 |
| TOTAL | 748 | 100 |
| Reasons for Right | | |
| High cost of child raising | 7 | 13.7 |
| Lack of means of livelihood | 3 | 5.9 |
| No response | 41 | 80.4 |
| TOTAL | 51 | 100 |
| Reasons for wrong | | |
| A sin against God | 113 | 15.1 |
| Leads to death | 183 | 24.4 |
| Dangerous to health | 165 | 22.0 |
| It is murder | 147 | 19.6 |
| Others | 142 | 18.9 |
| TOTAL | 750 | 100 |

About 58.2% of the respondents who supported legalization of abortion based their support on other reasons such as pleasure, avoidance of illegitimate children and abandonment of new born babies which is common in Nigeria. It is important to mention that pregnancy is not condoned in Nigerian secondary schools and once a teenage girl is pregnant, she is immediately expelled and many of them become dropouts. It is probably as a result of this, that some of the respondents supported the legalization of abortion. On the other hand, the main reasons for not favouring the legalization of abortion is because it is an act of murder (29.0%). About 13.4% said it is a sin. From these responses, it is obvious

that their reasons were based on their religious beliefs. Other reasons given for not supporting the legalization of abortion include promiscuity, maternal morbidity and mortality.

To further determine the adolescents attitude towards abortion, they were asked if abortion is right or wrong. As shown in the table, only 6.3% admitted that it is right, while 93.6% said it is wrong. Those who maintained that it is right, based their reasons on high cost of child rearing. Since most of the adolescents are dependent and jobless due to the Structural Adjustment Programme (SAP), and are not able to take care of a child; it becomes necessary to resort to abortion. This argument is consistent with the findings of a study by Daly et al, (1994).

The majority of the respondents (93.6%) maintained that abortion is wrong. This perhaps means that those who indulge in illegal unsafe abortion do so because they do not have good knowledge of reproductive health and sex education. About 46.4% said that abortion is wrong based on death and health reasons. This shows an awareness of maternal morbidity and mortality associated with induced abortion. Also, 15.1% of the respondents said it is wrong on the basis of religion. Therefore, it could be said that religion, among other variables, influences attitudes toward abortion.

## 4.6 CIRCUMSTANCES FOR APPROVING ABORTION AND FACTORS RESPONSIBLE FOR PREGNANCY TERMINATION

As shown in table 4.6, 43.0% of the respondents did not approve of abortion at all. This implies that most of the female adolescents who procure abortion do so perhaps against their will or to save face. Hence, the most important factors motivating abortion practice is avoidance of family disgrace mentioned by 54% of the respondents.

Table 4.6: **DISTRIBUTION OF RESPONDENTS BY CIRCUMSTANCES FOR APPROVING ABORTION AND FACTORS MOTIVATING ABORTION PRACTICE**

| Circumstances for approving abortion | % Yes | % No |
|---|---|---|
| It should not be allowed at all | 43.0 (323) | 57.0(428) |
| When a woman's health is in danger | 27.4 (206) | 72.6(545) |
| When pregnancy occurs from rape | 26.5 (199) | 73.5(552) |
| When an unmarried schoolgirl is pregnant | 22.2 (167 | 77.8(584) |
| Should be allowed at all times | 7.5 (56) | 92.5(695) |
| **Factors motivating abortion practice** | | |
| Avoidance of family disgrace | 54.1 (407) | 45.9 (345) |
| The desire to remain in school | 36.2 (272) | 63.8 (480) |
| Inability to raise a child alone | 27.7 (208) | 72.3 (544) |
| Lack of reasonable means of livelihood | 25.0 (188) | 75.0 (564) |
| Others | 9.2 (69) | 90.8 (683) |

This high proportion of the respondents who mentioned avoidance of family disgrace reflects the extent to which premarital pregnancy is abhorred by

some cultures. In Nigerian society, premarital pregnancy implies that a girl is not well brought up and having a birth out of wedlock implies that the girl may not get a good husband eventually. So to save parents or the family the embarrassment or social stigma, many young girls resort to abortion, often with the tacit approval of relatives.

## 4.7 RESPONSES TO SEXUAL INTERCOURSE QUESTIONS

From table 4.7, 46.1% of the sample population have had sex. This confirms the high rate of sexual activity among Nigerian youths as indicated by past studies. As shown in the table, almost half of the respondents had their first intercourse between 14-17 years. This is followed by those who had their first sexual encounter between 18-21 years (25.1%). The mean age at first intercourse is 15.1 years. By implication, a majority of the respondents have had sex at least once by age 17. The result also revealed that sexual activity is higher among those in their mid teens (14-17 years) than those in their early teens (10-13 years) and late teens (18-21 years). The reason for this could be because at mid teens, sexual urge is higher and young people are more sexually exploratory or inquisitive. Moreover, most of them are in school and away from home, and as a result, family and parental control tend to wane. Under such condition, the young people tend to adopt new sexual behaviour.

**Table 4.7:** DISTRIBUTION OF RESPONDENTS BY RESPONSES TO SEXUAL INTERCOURSE QUESTIONS

| CATEGORY LABEL | Number | Percent |
|---|---|---|
| Ever had sex | | |
| Yes | 347 | 46.1 |
| No | 405 | 53.9 |
| Age at first Intercourse | | |
| 10-13 | 58 | 16.8 |
| 14-17 | 160 | 46.1 |
| 18-21 | 87 | 25.1 |
| 22+ | 7 | 2.0 |
| No Response | 35 | 10.0 |
| TOTAL | 347 | 100 |
| Coital Frequency | | |
| Daily | 20 | 5.8 |
| 3-4 times a week | 36 | 10.3 |
| Twice a week | 23 | 6.7 |
| Once a week | 41 | 11.6 |
| Monthly | 53 | 15.4 |
| Once in a while | 114 | 32.8 |
| Other | 53 | 15.4 |
| No response | 7 | 2.0 |
| TOTAL | 347 | 100 |
| Number of Sexual partners in the past 4 weeks | | |
| 1 | 7 | 8.2 |
| 2 | 20 | 23.5 |
| 3 | 19 | 22.4 |
| 4 | 7 | 8.2 |
| 5 | 2 | 2.4 |
| 6 | 6 | 7.1 |
| 7 | 4 | 4.7 |
| 10 | 4 | 4.7 |
| 12 | 1 | 1.2 |
| No response | 15 | 17.6 |
| TOTAL | 85 | 100 |

Concerning coital frequency, 32.8% of the respondents indicated that they have sex once in a while. From the table, about 6% do it daily and about 23% do it at least twice a week. This could be a group of adolescents who are very active sexually. Generally, coital frequency is high. The fact that 10.4% had sex 3-4 times a week could mean having sex with more than one partner. As shown in the table also, 23.5% admitted having had 2 partners in the past 4 weeks while about 22.4% indicated 3 partners. From this result, it is clear that a large proportion of the adolescents have had more than one partner in the past 4 weeks. This implies a high rate of sexual networking among adolescents in Port Harcourt and the implication is common spread of sexually transmitted diseases. This could perhaps explain the large number of traditional healers all over the city and billboards advertising the cure of gonorrhea Syphilis etc.



## 4.8 TYPES OF SEXUAL PARTNERS

The respondents were also asked to identify their partner in the last act. As shown in table 4.8, 44.6% of the female adolescents had their last sexual encounter with a boyfriend, 9.6% with fiance and 27.7%, mentioned casual friends. This indicates that about 27.7% of the adolescents engaged in casual sex. For the 18.1% who did not respond, it could mean that they were involved in commercial sex and therefore could not identify their partners. The implication

of this also, is STD'S and HIV/AIDS transmission in Nigeria. This finding is consistent with the result of a study by Isiugo-Abanihe (1993) in Ekpoma, Owerri and Zaria. To still confirm that most of the female adolescents engaged in casual sex, about 15.9% and 18.7% admitted having none permanent and occasional relationship respectively with their partners. Those who admitted that they do not have any relationship at all with their partners are 9.5%.

**Table 4.8: DISTRIBUTION OF FEMALE ADOLESCENTS BY TYPE OF SEXUAL PARTNERS**

| Sexual Partners and Type of Relationship | Number | Percent |
|---|---|---|
| Partners in last sexual act: | | |
| Boyfriend | 37 | 44.6 |
| Fiance | 8 | 9.6 |
| Casual Friend | 23 | 27.7 |
| No response | 15 | 18.1 |
| TOTAL | 83 | 100 |
| Relationship with Partners | | |
| Permanent | 171 | 49.3 |
| Not Permanent | 55 | 15.9 |
| Occasional | 65 | 18.7 |
| No Relationship | 33 | 9.5 |
| No Response | 23 | 6.6 |
| TOTAL | 347 | 100 |



## 4.9: PREMARITAL PREGNANCY

Table 4.9 shows that 16.9% of the girls indicated that they have been pregnant. The reason for this premarital pregnancy could be lack of access to contraception since most of the girls are not contracepting.

Among the reasons given for not wanting the pregnancy, the desire to remain in school (66.7%) is the most common reason. Other reasons include abandonment by partner and the feeling that premarital pregnancy is not socially acceptable in Nigerian society. This indication to remain in school could explain the reason why abortion is regarded as school girls' problem in Nigeria since premarital pregnancy is not tolerated in the secondary schools. Also, the fact that some terminate pregnancy because of abandonment by partner could imply that some of them do not have permanent partners given the high rate of sexual networking.

## 4.9: DISTRIBUTION OF GIRLS BY PREMARITAL PREGNANCY

| CATEGORY LABEL | % YES | | % NO | |
|---|---|---|---|---|
| Ever been pregnant | 16.9 | (101) | 83.1 | (494) |
| Why pregnancy was unwanted? | | | | |
| No Reason | 13.7 | (14) | 86.3 | (88) |
| Still in school | 66.7 | (68) | 33.3 | (34) |
| High cost of rearing children | 2.9 | (3) | 97.1 | (99) |
| Abandoned by partner | 9.8 | (10) | 90.2 | (92) |
| Socially unacceptable | 5.9 | (6) | 94.1 | (96) |
| Premarital pregnancy | 4.9 | (5) | 95.1 | (97) |
| Others | 2.9 | (3) | 97.1 | (99) |

## 4.10: ACTION TAKEN AS A CONSEQUENCE OF PREGNANCY

To further determine what happened to the premarital pregnancy, the girls were asked what they did with the pregnancy. From their responses in table 4.10,

7.8% attempted abortion but failed while 86.3% had successful abortion. This indicates that there is prevalence of abortion in Port Harcourt City. However, the estimated rate of abortion in this study is 15%. Given the high rate of non response encountered, the incidence of abortion must have been underreported.

Among those who had successfully terminated a pregnancy, 43.5% have had one abortion, 17.4% (3 abortions) and 13.1% admitted having had five abortions. This result reveals that there are repeated abortions among the adolescents and this may account for the high maternal morbidity and mortality among teenage girls in Nigeria and pregnancy impairment when eventually married.



**Table 4.10: ACTION TAKEN AS A CONSEQUENCE OF PREMARITAL PREGNANCY AND NUMBER OF ABORTIONS**

| Action Taken | Number | Percent |
|---|---|---|
| Kept the Pregnancy | 5 | 4.9 |
| Attempted termination but failed | 8 | 7.8 |
| Attempted termination and succeeded | 88 | 86.3 |
| Others | 1 | 1.0 |
| TOTAL | 102 | 100 |
| Number of Abortions | | |
| One abortion | 10 | 43.5 |
| Two Abortions | 2 | 8.7 |
| Three abortions | 4 | 17.4 |
| Four and more abortions | 7 | 30.4 |
| TOTAL | 23 | 100 |

## 4.11: ABORTION COMPLICATIONS

As shown in table 4.11, 38.9% of the female respondents said they had bleeding after procuring abortion while 22.2% indicated other health problems like menstrual pains. Bleeding (hemorrhage) is the most common abortion complication mentioned and this may be due to repeated abortions or perhaps the abortions were carried out by non-professional abortionists.

**Table 4.11: DISTRIBUTION OF ADOLESCENT GIRLS BY COMPLICATIONS OF ABORTION**

| POST-ABORTAL COMPLICATIONS | Number | Percent |
|---|---|---|
| Bleeding | 7 | 38.9 |
| Stomachache | 3 | 16.7 |
| Fever/headache | 1 | 5.6 |
| Others | 4 | 22.2 |
| No response | 3 | 16.6 |
| TOTAL | 18 | 100 |

## 4.12 POST-ABORTAL COUNSELLING

The female adolescents who have had induced abortion were asked if they received counselling after the abortion and from whom. About 82.9% admitted that they received advice, while 17.1% did not receive any advice. Those who received advice from their mother constituted 10.9% whereas more than half (51.9%) were counselled by their friends. This result shows that the majority of the girls did not receive parental counselling. This could be because, they did not disclose the abortion experience to their mother. It could also mean that

adolescent girls discuss their problems more with their friends than their parents. Hence, the major content of the advice is how to prevent premarital pregnancy and use of contraceptives: It is pertinent to mention that some of these advice given by young people may be wrong and misleading hence the high rate of sexual activity, premarital pregnancy and induced abortion.

**Table 4.12: PERCENT OF GIRLS RECEIVING POST-ABORTAL COUNSELLING AND TYPE OF COUNSELLING RECEIVED**

| Advice | % Yes | | % No | | TOTAL | |
|---|---|---|---|---|---|---|
| Received any advice? | 82.9 | (73) | 17.1 | (15) | 100 | (88) |
| If Yes from Whom? | | | | | | |
| Mother | 10.9 | (8) | 89.1 | (65) | 100 | (73) |
| Friends | 42.4 | (31) | 57.6 | (42) | 100 | (73) |
| Doctor | 16.4 | (12) | 83.6 | (61) | 100 | (73) |
| Boy friend | 9.5 | (7) | 90.5 | (66) | 100 | (73) |
| Others | 20.5 | (15) | 79.5 | 58) | 100 | (73) |
| Content of advice | | | | | | |
| How to prevent pregnancy | 53.7 | (44) | 46.3 | (38) | 100 | (82) |
| Use of contraceptives | 28.0 | (23) | 72.0 | (59) | 100 | (82) |
| Where to seek abortion | 13.4 | (11) | 86.6 | (71) | 100 | (82) |
| Others | 12.2 | (10) | 87.8 | (72) | 100 | (82) |



## 4.13: SUGGESTIONS ON PREMARITAL PREGNANCY AND INDUCED ABORTION

Table 4.13 shows the response of respondents on the issue of what can be done to reduce the incidence of premarital pregnancy and induced abortion in Nigeria. About 20.2% suggested sex education, 14.9% mentioned use of

contraceptives and 13.8% suggested abstinence/self control. Others (27.8%) suggested that friendship between the opposite sex should be discouraged, young people should stop going to night clubs and that manufacturing of contraceptives should be prohibited. As shown in the table, the most common opinion, is that sex education should be introduced in schools and this confirms the fact that there is lack of sex and reproductive health education in schools.

**Table 4.13: SUGGESTIONS BY RESPONDENTS TO REDUCE INCIDENCE OF ABORTION AND PREMARITAL PREGNANCY**

| Suggestions | Number | Percent |
|---|---|---|
| Use of contraceptives | 112 | 14.9 |
| Sex education | 152 | 20.2 |
| Abstinence/Self control | 104 | 13.8 |
| Legalization of abortion | 5 | 0.7 |
| Check on private/government hospitals | 46 | 6.1 |
| Adherence to the Bible | 26 | 3.5 |
| Parental Care | 31 | 4.1 |
| Others | 209 | 27.8 |
| No response | 67 | 8.9 |
| TOTAL | 752 | 100 |



## RESULTS OF BIVARIATE ANALYSES

In order to determine the effects of selected socio-demographic variables on adolescents' use of contraceptives, sexual activity, experiences of premarital pregnancy, induced abortion and their attitudes toward legalization of abortion, bivariate analyses were carried out through cross-tabulations.

## 4.14: DETERMINANTS OF CONTRACEPTIVE USE

Table 4.14 presents the percentages of respondents who reported having used contraceptives and those who have not used by selected sociodemographic characteristics.

As shown in the table, there is a tendency toward increasing prevalence of contraceptive use with increasing age of adolescents. Adolescents who are less than 16 years are the least to use contraceptives, followed by those in age group 16-19. Contraceptive use increased among those aged 20 years and above. This is perhaps because, as the adolescents advance in age, they become more experienced and exposed to use contraceptives.

As regards religion, adolescents who have no religion are more likely to use contraceptives (25.7%) than catholics, muslims, protestants, traditional religionists and those in other religious groups. The Muslims are more likely to use contraceptives than christians. This is a rather unexpected finding, which may be related to small size of the Muslim population in the sample. The use of contraceptives is higher among catholics than protestants, an indication that the catholics are becoming more liberal in their use of family planning methods since their doctrine approves only the use of natural family planning.

Education has direct influence on adolescents' use of contraceptives. Contraceptive use is higher among adolescents with tertiary education (30.6%)

than those with secondary education (21.1%), followed by those who are currently in school. As the level of education increases, the use of contraceptives increases also. However, the high use of contraceptives among adolescents with no formal education is an exception. This could be because, some of the adolescents may engage in casual commercial sex to earn a living and as such, it becomes necessary for them to use contraceptives, more.

Concerning occupation, fashion designers are more likely to use contraceptives, than adolescents who engaged in trading. Students are the least in the use of contraceptives; it could be that they do not have access to them or that they lack contraceptive knowledge.

Adolescents with low socio-economic status are less likely to use contraceptives than those with medium socio-economic status. This may be because, they cannot afford them. The least to use are those from high socio-economic families and this could be because they are more exposed and well informed about sexual matters, hence they can do without contraceptives.



4.14: **DISTRIBUTION OF FEMALE ADOLESCENTS BY CONTRACEPTIVE USE BY SELECTED CHARACTERISTICS**

| Characteristics | Ever Used Contraceptive | | Never used contraceptive | | Total | |
|---|---|---|---|---|---|---|
| Current age | % | No | % | No | % | No |
| <16 | 4.7 | 6 | 95.3 | 121 | 100 | 127 |
| 16-19 | 9.2 | 29 | 90.8 | 287 | 100 | 316 |
| 20+ | 37.2 | 55 | 62.8 | 93 | 100 | 148 |

Table 4.14 continued

| | | | | | | |
|---|---|---|---|---|---|---|
| Religion | | | | | | |
| No Religion | 25.7 | 9 | 74.3 | 26 | 100 | 35 |
| Catholic | 17.2 | 35 | 82.8 | 168 | 100 | 203 |
| Protestant | 13.4 | 32 | 86.6 | 207 | 100 | 239 |
| Muslim | 10.0 | 2 | 90.0 | 18 | 100 | 20 |
| Traditional | 15.8 | 3 | 84.2 | 16 | 100 | 19 |
| Others | 12.5 | 6 | 87.5 | 42 | 100 | 48 |
| TOTAL | | | | | | |
| Level of Education | | | | | | |
| Secondary Education | 21.1 | 30 | 78.9 | 112 | 100 | 142 |
| Tertiary Education | 30.6 | 15 | 69.4 | 34 | 100 | 49 |
| Currently in school | 11.5 | 46 | 88.5 | 335 | 100 | 381 |
| Occupation: | | | | | | |
| Student | 12.4 | 59 | 87.6 | 415 | 100 | 474 |
| Trading | 33.3 | 14 | 66.7 | 28 | 100 | 42 |
| Fashion designer | 37.5 | 6 | 62.5 | 10 | 100 | 16 |
| Family | | | | | | |
| Socioeconomic Status | 14.3 | 9 | 85.7 | 54 | 100 | 63 |
| Low | 19.9 | 34 | 80.1 | 137 | 100 | 171 |
| Medium | 13.4 | 46 | 86.6 | 298 | 100 | 344 |
| High | | | | | | |



## 4.15: DETERMINANTS OF SEXUAL ACTIVITY

Table 4.15 shows the percentage of respondents who are sexually active by selected socio-demographic characteristics. As shown in the table, adolescents who are less than 16 years are the least sexually active. Sexual activity increases among those aged 16-19 years and even higher among adolescents in age group 20 years and above. As age increases, sexual activity also increases. This is

probably because adolescents are more sexually active at mid and late-teens than at early teens. Moreso, between 15-24 years, most of them are in the secondary schools and tertiary institutions where there is more freedom and easy contact with the opposite sex. Under this condition where family control and supervision wane, the acceptable pattern of sexual behaviour is bound to change.

**Table 4.15: DISTRIBUTION OF FEMALE ADOLESCENTS BY SEXUAL ACTIVITY BY SELECTED CHARACTERISTICS**

| Characteristics | Sexually active | | Not Sexually Active | | Total | |
|---|---|---|---|---|---|---|
| Current age: | % | No | % | No | % | No |
| <16 | 32.3 | 41 | 67.7 | 86 | 100 | 127 |
| 16-19 | 38.3 | 121 | 61.7 | 195 | 100 | 316 |
| 20+ | 70.9 | 105 | 29.1 | 43 | 100 | 148 |
| Religion | | | | | | |
| No religion | 54.3 | 19 | 45.7 | 16 | 100 | 35 |
| Catholic | 47.8 | 97 | 52.2 | 106 | 100 | 203 |
| Protestant | 40.6 | 97 | 59.4 | 142 | 100 | 239 |
| Muslim | 40.0 | 8 | 60.0 | 12 | 100 | 20 |
| Traditional | 47.4 | 9 | 52.6 | 10 | 100 | 19 |
| Others | 54.2 | 26 | 45.8 | 22 | 100 | 48 |
| Level of Education | | | | | | |
| Secondary education | 53.5 | 76 | 46.5 | 66 | 100 | 142 |
| Tertiary education | 73.5 | 36 | 26.5 | 13 | 100 | 49 |
| Currently in school | 38.7 | 155 | 61.3 | 246 | 100 | 401 |
| Occupation | | | | | | |
| Student | 40.1 | 191 | 59.9 | 284 | 100 | 474 |
| Trading | 69.0 | 29 | 31.0 | 13 | 100 | 42 |
| Fashion designer | 75.0 | 12 | 25.0 | 4 | 100 | 16 |

Table 4.15 continued

| | | | | | | |
|---|---|---|---|---|---|---|
| Family Socioeconomic Status | | | | | | |
| Low | 38.1 | 24 | 61.9 | 39 | 100 | 63 |
| Medium | 48.5 | 83 | 51.5 | 88 | 100 | 171 |
| High | 43.9 | 151 | 56.1 | 193 | 100 | 344 |

As shown in table 4.15 also, adolescents with no religion are more sexually active than those in other religious groups. However, the percentage of christians (88.4%) who indulge in sexual activity is very high, despite the fact that Christianity has continued to preach against and condemn illicit sex. This implies that most of the young people do not adhere to Christian doctrines. Even though they engage in religious activities, they do not actually practise what they are taught.

Education has direct influence on adolescents' sexuality. The rate of sexual activity is higher among adolescents with tertiary education (73.5%, followed by those with secondary education and then those who are currently students. This indicates that as the level of education increases, the rate of sexual activity increases also. As the adolescents become more educated, they become more exposed to westernized lifestyles which present sex as glamorous, exciting and risk free. Hence, many young people regard sex as a'hobby' without any serious socio-economic repercussions (Liskin 1995).

Also, as educational level of adolescents increases, they tend to look down on tradition and series of props such as religious doctrines, moral codes and family organisation channelled towards discouraging sexual relations among never-married adolescents. According to Orubuloye et.al, (1991), many Nigerian youths now view it as anti-social to refuse sex, especially with a boyfriend, who may, through the act, propose marriage.

As regards occupation, fashion designers are more likely to be sexually active than adolescents who engage in trading. Students are the least sexually active. Fashion designers engaged more in sexual activity than those who are trading probably because they have more leisure time for pleasure. The reason for students not being very sexually active could be fear of premarital pregnancy since most of them are too young and too poor to take care of a baby. Adolescents with medium and high socio-economic status are more sexually active than those with low socio-economic status. This is perhaps because they are more exposed and well informed.



## 4.16 DETERMINANTS OF PREMARITAL PREGNANCY

Table 4.16 presents the percentage of respondents who have had premarital pregnancy by selected socio-demographic characteristics. There is a tendency toward increasing prevalence of premarital pregnancy with increasing age of

female adolescents. The rate of pregnancy is highest among girls aged 20 years and above. This could be probably because at this age, most of the teenage girls are mature enough to take care of a baby and with the support of their partners, they might attempt to become pregnant. As regards religion, muslims are more likely to be pregnant than Christians, although the small size.

Education exerts some influence on the rate of premarital pregnancy. As shown in the table, adolescent girls with tertiary and secondary education are more likely to have been pregnant than those who are currently students. This is probably because among some men, the proof of fertility has become pre-condition for marriage and as such, some girls attempt to become pregnant in order to impress their boyfriends with the hope of getting married to them. Also, since pregnancy is not condoned in Nigerian secondary schools, it is likely that the girls who are currently in school will do everything to prevent pregnancy. Hence, most of those who become pregnant resort to illegal induced abortion so as to enable them remain in school. Another reason why students are less likely to be pregnant could be the avoidance of family disgrace since premarital pregnancy in some cultures implies that a girl is not well brought up.

**Table 4.16: DISTRIBUTION OF FEMALE ADOLESCENTS BY PREMARITAL PREGNANCY BY SELECTED CHARACTERISTICS**

| Characteristics | Ever been pregnant | | No pregnancy experience | | Total | |
|---|---|---|---|---|---|---|
| Current Age | % | No | % | No | % | No |
| <16 | 7.9 | 10 | 92.1 | 116 | 100 | 126 |
| 16-19 | 11.1 | 35 | 88.9 | 279 | 100 | 314 |
| 20+ | 38.1 | 56 | 61.9 | 91 | 100 | 147 |
| Religion | | | | | | |
| No Religion | 20.6 | 7 | 79.4 | 27 | 100 | 34 |
| Catholic | 17.9 | 36 | 82.1 | 165 | 100 | 201 |
| Protestant | 13.9 | 33 | 86.1 | 205 | 100 | 238 |
| Muslim | 20.0 | 4 | 80.0 | 16 | 100 | 20 |
| Traditional | 21.1 | 4 | 78.9 | 15 | 100 | 19 |
| Others | 25.0 | 12 | 75.0 | 36 | 100 | 48 |
| Level of Education | | | | | | |
| Secondary education | 24.3 | 34 | 75.7 | 106 | 100 | 140 |
| Tertiary education | 25.0 | 12 | 75.0 | 36 | 100 | 48 |
| Currently in School | 13.8 | 55 | 86.2 | 345 | 100 | 400 |
| Occupation | | | | | | |
| Student | 14.0 | 66 | 86.0 | 404 | 100 | 470 |
| Trading | 35.7 | 15 | 64.3 | 27 | 100 | 42 |
| Fashion Designer | 56.3 | 9 | 43.7 | 7 | 100 | 16 |
| Family Socioeconomic Status | | | | | | |
| Low | 17.7 | 11 | 82.3 | 51 | 100 | 62 |
| Medium | 20.5 | 35 | 79.5 | 132 | 100 | 167 |
| High | 15.2 | 52 | 84.8 | 289 | 100 | 341 |



The rate of pregnancy is higher among fashion designers and adolescents who are trading than students. This could be because they are independent and tend to maintain more liberal and permissive lifestyles. To many, having a baby

for a man may be a sure means of more capital in their business or an assurance of marriage.

The table also shows that adolescents from medium socio-economic families are more likely to have premarital pregnancy, followed by those with low socio-economic status. This is perhaps due to lack of exposure and proper knowledge of reproductive health matters. Those from high socioeconomic background are the least to have premarital pregnancy probably because they have more knowledge of contraceptives and can afford them.



## 4.17: DETERMINANTS OF PREGNANCY OUTCOME

As shown in table 4.17, the rate of abortion among the different age groups is very high. However, it is highest among adolescent girls who are less than 16 years (90.0%) followed by those aged 16-19 years.

### 4.17: DISTRIBUTION OF FEMALE ADOLESCENTS BY PREGNANCY OUTCOME BY SELECTED CHARACTERISTICS

| Characteristics | Had a Baby | | Failed in abortion bid | | Successful abortion | | Total | |
|---|---|---|---|---|---|---|---|---|
| Current Age | % | No | % | No | % | No | % | No |
| <16 | 10.0 | 1 | - | | 90.0 | 9 | 100 | 10 |
| 16-19 | 2.6 | 1 | 7.9 | 3 | 89.5 | 34 | 100 | 38 |
| 20+ | 5.6 | 3 | 9.3 | 5 | 85.1 | 46 | 100 | 54 |

Table 4.17 Continued

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Religion | | | | | | | | |
| No religion | - | | 25.0 | 2 | 75.0 | 6 | 100 | 8 |
| Catholic | 8.6 | 3 | 5.7 | 2 | 85.7 | 30 | 100 | 35 |
| Protestant | 8.5 | 3 | 8.5 | 3 | 83.0 | 29 | 100 | 35 |
| Muslim | - | | - | | - | - | - | - |
| Traditional | - | | 25.0 | 1 | 75.0 | 3 | 100 | 4 |
| Others | - | | - | - | - | - | - | - |
| Level of Education | | | | | | | | |
| Secondary education | 8.8 | 3 | 11.8 | 4 | 79.4 | 27 | 100 | 34 |
| Tertiary education | - | - | 8.3 | 1 | 91.7 | 11 | 100 | 12 |
| Currently in school | 3.6 | 2 | 3.6 | 2 | 92.8 | 51 | 100 | 55 |
| Occupation: | | | | | | | | |
| Student | 5.9 | 4 | 8.8 | 6 | 85.3 | 58 | 100 | 68 |
| Trading | 6.7 | 1 | 6.7 | 1 | 86.6 | 13 | 100 | 15 |
| Fashion designer | - | - | 100 | 9 | - | | 100 | 9 |
| Family Socio-economic Status | | | | | | | | |
| Low | | | | | | | | |
| Medium | - | - | 10.0 | 1 | 90.0 | 9 | 100 | 9 |
| High | 114 | 4 | 2.9 | 1 | 85.7 | 30 | 100 | 10 |
| | 1.9 | 1 | 11.1 | 6 | 87.0 | 47 | 100 | 54 |



In all, about 90% of all the girls who get pregnant out of wedlock in Port Harcourt City resort to illegal abortion. This could be because most of these girls are too young, too poor, and too inexperienced to care for a child. Some of these adolescent girls come from poor families and lack reasonable means of livelihood. Their situation is worsened by the Structural Adjustment Programme (SAP) which

is the major cause of unemployment in Nigeria. Since most of them are jobless, it becomes difficult to take care of an extra mouth and rather than carry the pregnancy to term, they resort to abortion. Some of the teenage girls are abandoned by their partners and therefore are not able to raise a child alone. In most parts of Nigeria, illegitimate children are not socially acceptable and they are regarded as 'bastards'. To avoid the embarrassment of having an illegitimate child, some female adolescents resort to induced abortion to save face.

The table also shows that adolescent girls who are traditional religionists are most likely to engage in illegal abortion. This is followed by Christians and those with no religion. No Muslim adolescent has attempted abortion probably because of early marriage and their religious beliefs. Also, this could be because the proportion of Muslims in the sample population is small. However, the high rate of abortion among Catholics (85.7%) could be related to their use of natural family planning which has a high failure rate. It could also be an indication that they are becoming more liberal in their attitudes toward abortion practices. Furthermore, the Catholics are more likely to have a baby out of wedlock than protestants.

As shown in the table, 92.7% of adolescent girls who are currently students had successfully terminated pregnancy. The rate of abortion is a little higher among girls who are still in school than those with tertiary and secondary education. This is consistent with the report that abortion is school girls' problem in Nigeria - Durojaiye (1996). This high rate of abortion among female students could be as a result of desire to remain in school, ignorance and lack of access to contraceptives.

As regards occupation, pregnancy termination is higher among adolescent girls who are trading than students. This could be because, they can afford the bill whereas, the students are dependent upon their parents.

Concerning socio-economic status, adolescent girls from low socio-economic background are more likely to have had abortion than those from high and medium socio-economic families. The reason could be because, they are poor and may not be able to take care of a child.



## 4.18: ATTITUDES TOWARD LEGALIZATION OF ABORTION

Table 4.18 presents the proportion of respondents who favour legalization of abortion by selected socio-demographic characteristics.

Table 4.18: **DISTRIBUTION OF FEMALE ADOLESCENTS BY ATTITUDE TO LEGALIZATION OF ABORTION BY SELECTED CHARACTERISTICS**

| Characteristics | Agree with Legalization of Abortion | | Do not agree with Legalization of Abortion | | Total | |
|---|---|---|---|---|---|---|
| Current Age | % | No | % | No | % | No |
| <16 | 15.9 | 20 | 84.1 | 106 | 100 | 126 |
| 16-19 | 21.2 | 67 | 78.8 | 249 | 100 | 316 |
| 20+ | 28.4 | 42 | 71.6 | 106 | 100 | 148 |
| Religion | | | | | | |
| No religion | 40.0 | 14 | 60.0 | 21 | 100 | 35 |
| Catholic | 24.3 | 49 | 75.7 | 153 | 100 | 202 |
| Protestant | 19.2 | 46 | 80.8 | 193 | 100 | 239 |
| Muslim | 25.0 | 5 | 75.0 | 15 | 100 | 20 |
| Traditional | 26.3 | 5 | 73.7 | 14 | 100 | 19 |
| Others | 12.5 | 6 | 87.5 | 42 | 100 | 48 |
| Level of Education | | | | | | |
| Secondary education | 26.1 | 37 | 73.9 | 105 | 100 | 142 |
| Tertiary education | 31.2 | 15 | 68.8 | 33 | 100 | 48 |
| Currently in school | 19.2 | 77 | 80.8 | 324 | 100 | 401 |
| Occupation | | | | | | |
| Student | 20.0 | 95 | 80.0 | 379 | 100 | 474 |
| Trading | 23.8 | 10 | 76.2 | 32 | 100 | 42 |
| Fashion designer | 25.0 | 4 | 75.0 | 12 | 100 | 16 |
| Family Socioeconomic Status | | | | | | |
| Low | 16.1 | 10 | 83.9 | 56 | 100 | 66 |
| Medium | 19.9 | 34 | 80.1 | 137 | 100 | 171 |
| High | 24.4 | 84 | 75.6 | 280 | 100 | 364 |

As shown in the table, as age increases, the tendency to support legalization of abortion also increases. As the adolescents advance in age, they become more knowledgeable about the restrictive nature of abortion law in Nigeria hence their support for the legalization of abortion.

Religion also influences the attitudes of adolescents toward legalization of abortion. Christians tend to support the legalization of abortion more than Muslims. This could be either because of their religious beliefs or small sample size of the Muslims in the study. However, the proportion of Catholics that supported legalization of abortion is a little higher than protestants. This liberal attitude of Catholics towards legalization of abortion could be because most of them are becoming sexually active and since their doctrine is against the use of modern contraceptives, the abortion rate is high.

From the table also, it is clear that, the more educated the adolescents, the higher their likelihood of supporting legalization of abortion. Those with tertiary education were more likely to support legalization of abortion than those with secondary education, followed by those who are currently students. The more educated the adolescents, the more their understanding of the high morbidity and maternal mortality experienced by female adolescents due to illegal induced abortion. Apart from the approval of abortion when a woman's health is in danger which is the only condition acceptable under the existing abortion law in Nigeria,

there are other reasons such as when pregnancy occurs from rape and when an unmarried schoolgirl becomes pregnant. Based on their knowledge of these reasons, the adolescents tend to support legalization of abortion. Fashion designers are more likely to approve of legalization of abortion than those engaged in trading and students. This could be due to small sample size of fashion designers in the study. The table also shows that those from high socioeconomic families are more likely to support legalization of abortion, than those from medium socioeconomic background. The least to support legalization of abortion are those from low socioeconomic families. The reasons for this could be because adolescents with high socioeconomic status can afford the cash, to get rid of pregnancy when it occurs.

## 4.19: IMPACT OF COMMUNICATION ON ADOLESCENTS' SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH

Table 4.19 shows the percentages of sexually active female adolescents who have discussed sex education with their parents, teacher and friends and those who have not had discussion on the issue with anyone by sexual activity and experience of abortion. As shown in the table, adolescents who have had discussion on sexual matters with their parents and teacher are less likely to have sexual intercourse and induced abortion than those who did not have any discussion at all. This shows the importance of communication between parents and their girls. Girls who discuss sexual matters with their parents and teachers

are more disciplined and less promiscuous. This is because, through discussion, they become more enlightened as regards their reproductive health. They also become aware of the dangers of illicit sex and illegal abortion.

**Table 4.19: DISTRIBUTION OF SEXUALLY ACTIVE FEMALE ADOLESCENTS BY COMMUNICATION WITH PARENTS, TEACHERS AND FRIENDS BY SEXUAL ACTIVITY AND INDUCED ABORTION**

| Sexual activity | Discussed | | Not Discussed | | Total | |
|---|---|---|---|---|---|---|
| Mother | 35.7 | (124) | 64.3 | (223) | 100 | 347 |
| Father | 17.9 | (62) | 82.1 | (285) | 100 | 347 |
| School Teacher | 26.2 | (91) | 73.8 | (256) | 100 | 347 |
| Friends | 53.6 | (186) | 46.4 | (161) | 100 | 347 |
| Induced abortion | | | | | | |
| Mother | 35.2 | (31) | 64.8 | (57) | 100 | 88 |
| Father | 9.1 | (8) | 90.9 | (80) | 100 | 88 |
| School Teacher | 29.5 | (26) | 70.5 | (62) | 100 | 88 |
| Friends | 56.8 | (50) | 43.2 | (38) | 100 | 88 |



From the table also, adolescents who had discussion with their mother are more likely to be sexually active and to have abortion than those who discussed sexual matters with their fathers. This could be because fathers are more strict hence, discussion with mothers is taken for granted since girls are naturally closer to their mother than their father. It could also be that few of the girls had discussion on sexual matters with their father, hence the small proportion. The

result could also imply that the discussion with mother perhaps took place after pregnancy must have taken place.

It is also observed that the rate of sexual activity and induced abortion is higher among adolescents who had discussion with their friends than among those who did not have. This could imply that the information they get through discussion with their friends are wrong, incomplete and misleading. From the foregoing, it is clear that communication with parents and teachers on sexual matters, yield more positive results as regards the reproductive health of adolescents than not having any discussion at all.

## RESULTS OF MULTIVARIATE ANALYSES AND TEST OF HYPOTHESES

To measure the simultaneous effects of some selected background variables on the likelihood of adolescents using contraceptives, approving legalization of abortion, being sexually active and having premarital pregnancy and induced abortion, multivariate logistic regression analyses are carried out for the females in the sample population.

## 4.20: CHARACTERISTICS PREDICTING SEXUAL ACTIVITY

From table 4.20, age proves to be an important predictor of adolescent premarital sexual relations. Teenagers less than 16 years are less likely to indulge in premarital affairs than those 20 years and above. Those who are in age category 16-19 years are 33 per cent less likely to have sexual relations. The result shows that adolescents become more exposed and experiment with sex with time.

Education presents a positive association with sexual activity. The higher the adolescents level of education, the higher the probability of engaging in premarital relations. Those with some secondary and tertiary education are more likely to have sexual intercourse relative to those who are currently in school. The probability of having premarital relations is higher for those with some secondary education and highest for those with tertiary education. The reason for this could be because, they are more educated and exposed. Because of their exposure, most of them do not regard premarital affairs as immoral hence they view it as anti-social to refuse sex. Also, they are inclined to indulge in illicit sex primarily for material returns, since many of them are unemployed. Hence, Isiugo-Abanihe (1993:12) in his study confirmed that this category of adolescents included many unemployed young women, and some students of secondary and tertiary

institutions who usually hang out at popular spots to solicit for sex in return for money.

**Table 4.20: LOGISTIC REGRESSION FOR SEXUAL ACTIVITY AMONG FEMALE ADOLESCENTS**

| Variable/Category | Coefficient | Odds Ratio |
|---|---|---|
| Current age: | | |
| <16 | -1.374 | .253*** |
| 16-19 | -1.125 | .325*** |
| 20+ | (RC) | 1.00 |
| Educational Level | | |
| Some secondary | .395 | 1.484** |
| Some tertiary | .881 | 2.412*** |
| In School | (RC) | 1.00 |
| Religiousity | | |
| High | -343 | .709* |
| Other | (RC) | 1.00 |
| Family Socioeconomic Status | | |
| High | .369 | 1.446* |
| Medium | .472 | 1.603 |
| Low | (RC) | 1.00 |
| Constant | .4837 | |
| -2 Log likelihood | 755.436 | |
| Chi square | 63.549 | |
| Number of cases | 595 | |

***P<.001 **P<.05 *P<.10

As also indicated in the table, adolescents who are highly religious are 71 per cent less likely to indulge in premarital sexual relations compared to those in the reference category. This reflects the importance of religion in the lifestyle of

adolescents, indicating that highly religious adolescents follow strictly the Biblical doctrine which condemns fornication.

As regards family socioeconomic status, adolescents with high and medium socioeconomic background are respectively 1.5 times and 1.6 times more likely to engage in sexual activity relative to those with low socioeconomic status. The relationship is statistically significant at a low level (.10). However, those with medium socioeconomic family background are slightly more sexually active than those with high socioeconomic status. This result could be because since they are well informed about contraceptives, they tend to experiment more with sex. Also, since composite household durables such as radio and television are among our crude measure of socioeconomic status, it is most likely that those with high and medium socioeconomic background own and regularly use these media whose westernized programmes report and present sex as exciting and risk-free.

Table 4.20 indicates that sexual activity is significantly related to age, thus confirming hypothesis one. In this case, we accept the substantive hypothesis and reject the null hypothesis.

## 4.21: CHARACTERISTICS PREDICTING CONTRACEPTIVE USE

Table 4.21 shows that the odds of adolescent girls using contraceptives vary by age. Adolescent girls in the early and mid teens are less likely to use

contraceptives than those aged 20 years and above. The relationship is statistically significant at .001 level. Girls aged 16-19 years are more likely to use contraceptives than those in their early teens (<16 years). This means that adolescents experiment with contraceptives with time. The older they become, the more exposed they are and the higher the likelihood of contracepting.

Adolescents with some secondary and tertiary education are respectively 1.4 times and 1.3 times as likely to use contraceptives relative to those currently in school. However, the relationship is significant only at .10 level. The reason for this result could be because; adolescents with higher education are more knowledgeable and they also have more access to contraceptives and freedom to use them.



**TABLE 4.21: LOGISTIC REGRESSION FOR CONTRACEPTIVE USE AMONG ADOLESCENTS IN PORT HARCOURT CITY**

| Variable/Category | Co-efficient | Odds Ratio |
|---|---|---|
| Current Age | | |
| <16 | -2.457 | .085*** |
| 16-19 | -1.718 | .179*** |
| 20+ (RC) | | 1.00 |
| Educational Level | | |
| Some secondary | .319 | 1.375* |
| Some tertiary | .255 | 1.291* |
| Currently in school (RC) | | 1.00 |
| Religiousity | | |
| High | -1.064 | .345*** |
| Others (RC) | | 1.000 |

Table 4.21 continued

| Variable/Category Co-efficient | | Odds Ratio |
|---|---|---|
| Family Socio-economic Status | | |
| High | .897 | 2.452** |
| Middle | .932 | 2.538** |
| Low (RC) | | 1.00 |
| Constant | | -.593 |
| -2 Log likelihood | | 428.818 |
| Chisquare | | 80.234 |
| Number of Cases | | 595 |

***P<.001 **P<.05 *P<.10

As shown in the table also, religiosity has a very strong statistically significant effect on the use of contraceptives. Adolescents who are highly religious are less likely to use contraceptives compared to others. This implies that those who are very religious hardly indulge in sexual activity hence they do not experiment with contraceptives.

Family socio-economic status of adolescents, which is derived as a composite of modern household durables such as radio, television, refrigerator, and car, exerts statistically significant effect on the use of contraceptives. Adolescents from families with high and middle socio-economic status are more likely to use contraceptives relative to those from low socio-economic background. The relationship is statistically significant at .05 level. This finding is in the expected direction and it means that those who are well informed about contraceptives are more likely to use them. In addition, they are more conversant with contraceptive advertisements through the radio and television.

From the results, it is clear that age of adolescents influences their use of contraceptives. Since the relationship is significant, we reject the null hypothesis and accept the substantive hypothesis thus confirming hypothesis two.

## 4.22: CHARACTERISTICS PREDICTING PREMARITAL PREGNANCY

As table 4.22 suggests, the odds of having premarital pregnancy vary by age. Adolescents aged less than 16 years and those aged 16-19 years are significantly less likely to be pregnant relative to those aged 20 years and above. This is perhaps because, those in the early teens are too young and inexperienced to have a baby. From the finding of this study also, they are less likely to engage in sexual relations.

Adolescents with some secondary education are significantly more likely to be pregnant than those with tertiary education as well as those currently in school. The odds of being pregnant is lowest for girls with tertiary education though the relationship is insignificant. The higher likelihood of premarital pregnancy among adolescents with some secondary school education relative to those in school may result from the fact that the latter may do everything to prevent premarital pregnancy so as to avoid expulsion from school, while the

former who have left school are more likely to be experienced and knowledgeable in reproductive health matters.

Religiousity exerts a significant negative effect on the likelihood of having premarital pregnancy. The probability of being pregnant is lower among the highly religious relative to those in the reference category who are not very religious. The relationship is highly statistically significant. The probability of having premarital pregnancy is higher for those with high and medium socioeconomic status relative to adolescents with low socioeconomic background. Those from high socioeconomic families are 1.9 times more likely to have premarital pregnancy, and those with medium socioeconomic status are 2.9 times more likely. This is probably because they can afford to take care of an extra mouth.

From the table, the relationship between religiousity and premarital pregnancy is significant confirming hypothesis three. Therefore we reject the null hypothesis and accept the initial hypothesis.



**TABLE 4.22: LOGISTIC REGRESSION SHOWING ODDS RATIO FOR THE CHARACTERISTICS PREDICTING PREMARITAL PREGNANCY**

| Variable/Category | Coefficient | Odds Ratio |
|---|---|---|

Table 4.22 continued.

| | | |
|---|---|---|
| Current Age: | | |
| <16 | -1.930 | .145*** |
| 16-19 | -1.502 | .210*** |
| 20+ | (RC) | 1.00 |
| Educational Level | | |
| Some secondary | .376 | 1.457* |
| Some Tertiary | -.180 | .835 |
| In school | (RC) | 1.00 |
| Religiousity | | |
| High | -.817 | .442*** |
| Other | (RC) | 1.00 |
| Family Socioeconomic Status | | |
| High | .628 | 1.874* |
| Medium | 1.051 | 2.861** |
| Low | (RC) | 1.00 |

| | |
|---|---|
| Constant | -.541 |
| -2 log likelihood | 476.173 |
| Chisquare | 64.362 |
| No. of cases | 591 |

***P<.001 **P<.05 *P<.10



## 4.23: CHARACTERISTICS PREDICTING INDUCED ABORTION

Logistic regression was carried out as shown in table 4.23 to determine the likelihood of ever having abortion. The odds of adolescents having abortion vary by age but the relationship is not statistically significant.

This table also shows that education has a substantial effect on abortion. Adolescents with some secondary and tertiary education are less likely to have induced abortion relative to those in school. Those in school have the highest

probability of having an induced abortion because they lack access to contraceptives. They are also more exploratory and highly sexually active. This sexual activity without adequate knowledge and use of contraceptives results in premarital pregnancy. In order to remain in school, they resort to abortion.

**Table 4.23: LOGISTIC REGRESSION FOR THE LIKELIHOOD OF HAVING INDUCED ABORTION**

| Variable/Category | Coefficient | Odds Ratio |
|---|---|---|
| Current age | | |
| <16 | -.515 | .974 |
| 16-19 | .270 | 1.309 |
| 20+ | (RC) | 1.00 |
| Educational Level | | |
| Some secondary | -1.385 | .250** |
| Some Tertiary | -.223 | .800 |
| In School | (RC) | 1.00 |
| Religiousity | | |
| High | -1.235 | .291* |
| Other | (RC) | 1.00 |
| Family Socioeconomic Status | | |
| High | -6.785 | .001*** |
| Medium | -.5332 | .005*** |
| Low | RC | 1.00 |
| Constant | 10.038 | |
| -2 log likelihood | 71.327 | |
| Chisquare | 10.262 | |
| Number of Cases | 102 | |

***P<.001 **P<.05 *P<.10

As indicated in the table, religiousity is significantly related to abortion inversely. Adolescents who are highly religious are less likely to have had abortion compared to others who are not. This could be in obedience to the Bible injunction, thou shalt not kill.

Those from high and medium socio-economic families are less likely to have had induced abortion relative to those from low socio-economic families. This result could be that those from low socioeconomic families lack adequate means of livelihood or are too poor to take care of an extra mouth, hence many of them resort to unsafe induced abortion. It could also be that they lack proper information about contraception. This result also is a confirmation of hypothesis four. The relationship is significant at .001 and as such we reject the null hypothesis and accept the substantive hypothesis.

From table 4.20, the in-school adolescents are less likely to indulge in sexual relations, but more likely to have had abortion relative to those out-of-school. (Table 4.23). This could be because of lack of exposure and the desire to remain in school. Also, table 4.22 shows that the in-school adolescents are somewhat less likely to have premarital pregnancy but more likely to have had induced abortion compared to those out-of-school. This result is perhaps due to the fact that they are less sexually active and since they lack adequate knowledge of and access to contraceptives, they are bound to experience induced abortion

more. These results confirm hypothesis five and the relationships are significant. Therefore, we reject the null hypothesis and accept the initial hypothesis.

## 4.24: CHARACTERISTICS PREDICTING LEGALIZATION OF ABORTION

As shown in table 4.24, the odds of adolescents supporting legalization of abortion vary by age. Those in their early teens (<16 years) are less likely to support legalization of abortion relative to those in the mid teens (16-19 years) and the reference category (20 years and above). The relationship is statistically significant at .05 level. Those aged 16-19 years are more likely to support legalization of abortion relative to those aged less than 16 years, but the relationship is not statistically significant. This result could be because, the younger they are, the more inexperienced about reproductive health matters.

**4.24: LOGISTIC REGRESSION SHOWING ODDS RATIO FOR CHARACTERISTICS PREDICTING THE LEGALIZATION OF ABORTION**

| Variable/Category | Coefficient | Odds Ratio |
|---|---|---|
| Current Age | | |
| <16 | -.617 | .540** |
| 16-19 | -.253 | .777 |
| 20+ | (RC) | |
| Educational Level | | |
| Some secondary | .293 | 1.340* |
| Some tertiary | .438 | 1.550* |
| In school | (RC) | 1.00 |
| Religiousity | | |
| High | -.646 | 0.524** |
| Other | (RC) | 1.00 |
| Family Socioeconomic Status | | |
| High | 1.085 | 2.958*** |
| Medium | .934 | 2.579** |
| Low | (RC) | 1.00 |
| Constant | -1573 | |
| -2 Log likelihood | 603 | |
| Chisquare | 18.613 | |
| Number of Cases | 594 | |
| ***P<.001 **P<.05 | *P<.10 | |



As also shown in the table, education significantly affects the approval of legalization of abortion. Adolescents with some secondary and tertiary education are respectively 1.3 times and 1.6 times as likely to support the legalization of abortion relative to those currently in school. Those with tertiary education have a higher probability of supporting legalization of abortion than those with some secondary education. However, the relationship is significant but at a low level

(.10). This result could be because, adolescents with some tertiary education are more enlightened and exposed.

As regards religiousity, adolescents who are highly religious are 52.% less likely to support legalization of abortion than those in the reference category (those who are not very religious). The relationship is statistically significant. This suggests that those who adhere to Bible teachings are less likely to indulge in immoral acts hence they are inclined to disapprove of legalization of abortion.

Socioeconomic background of the adolescents also has significant effect on their likelihood of supporting legalization of abortion. Those from families with high socioeconomic status have a significantly higher probability of supporting legalization of abortion compared to those with medium and low socioeconomic background. Those with high socioeconomic background are more likely to support legalization of abortion than those from families with medium socioeconomic status. The relationship is highly statistically significant. This is perhaps because, they can afford the high bills charged by professional abortionists. Also, since premarital pregnancy or having a baby out of wedlock may place a social stigma on the family, they tend to support legalization of abortion so as to avoid family disgrace.

As shown in table 4.24, level of education is a very important predictor of approval of legalization of abortion. This confirms hypothesis six and as such, we reject the null hypothesis and accept the initial hypothesis.

# CHAPTER FIVE

## SUMMARY AND POLICY IMPLICATIONS

This chapter summarizes the work, providing a synopsis of the main research findings from which some recommendations were made.

### 5.1 SUMMARY OF WORK

World concern over the high rate of premarital sexuality, pregnancy and induced abortion especially in sub-Saharan African countries is the principal motivation behind this work. Available evidence shows that there is increasing movement towards sexual permissiveness, premarital pregnancy and induced abortion in Nigeria. This is largely attributable to the rapidly changing socio-economic environment, more education (especially for women), massive rural-urban migration and consequent urbanization, modernization or westernization.

As a result of this concern over the high rate of induced abortion in Nigeria, several studies have been carried out to determine the prevalence of abortion in the country. However, most of these studies have tended to concentrate on South-western part of the country, and this does not allow for a broad based data with which categorical deductions can be made. Therefore, it becomes necessary to carry out this study in the eastern part of the country for more accurate information on the magnitude of the incidence of abortion among adolescents in Nigeria. Port Harcourt City which is a cosmopolitan city with a high concentration of young people was selected as a case study.

To yield quantitative results, research strategy was employed. The major sampling procedure adopted in the study was probability sampling in order to ensure that each member of the study population (i.e. adolescents aged 13-24 years) had a fair chance of being selected. A total of seven hundred and fifty-two (752) adolescents formed the sample population, and data was collected through the use of a structured questionnaire. Data collected were displayed through appropriate tabular presentation technique. Bivariate analyses were carried out through cross-tabulation and hypothesised relationships were analysed by using logistic regression.

## 5.2 SUMMARY OF FINDINGS

The ultimate objective of this study was to examine adolescents' knowledge of, attitudes toward and practice of induced abortion as well as their sexual activity and use of contraceptives in Port Harcourt City. However, some of the findings are consistent with past studies while some are not.

From the results of the study, the rate of sexual activity among adolescents in Port Harcourt City is high. About 46 per cent of the sample population have had sex. By age 17, a majority of them have had sex at least once. The mean age at first intercourse is 15.1 years. Coital frequency is high and there is also a high rate of sexual networking among the adolescents. About 27.7% of them engaged

in casual sex and 22.4% admitted having had three partners in the past four weeks. As regards their relationship with their partners, it was found that 44.1 per cent of the adolescents do not have permanent relationship with their partners. Apart from high rate of sexual networking, this result also reflects the spread of sexually transmitted diseases.

Bivariate analyses results show that education is an important factor influencing sexual activity. The rate of sexual activity is high among adolescents who are currently in school, higher for those with secondary education and highest for those with tertiary education. This implies that those with higher education perhaps look down on tradition and moral codes which discourage sexual relations and uphold chastity among never-married adolescent girls. The results also show that catholics are more sexually active than protestant girls. Generally, Christians are more sexually active than Muslims. This may reflect non-adherence to Christian teachings which condemns fornication. It could also be due to small sample size of Muslims in the study. In addition, the odds of engaging in sexual activity vary by age. Teenage girls aged less than 16 years are less likely to indulge in sexual relations compared to those aged 16-19 years and 20 years and above. This indicates that adolescents experiment more with sex as they grow older. Also, girls from high and medium socio-economic background are more sexually active than those from families with low socio-economic status.

This could mean that they are more exposed to westernized programmes through the mass media which presents sex as "glamorous".

Despite the high rate of sexual activity, we found that contraceptive use among the adolescents is very low. This is consistent with past studies. Though about half of the sample population admitted that they know about modern contraceptives, only 12.8% of them are currently using. Among the modern contraceptives known and used, condoms and pills are the most common. The traditional methods used include alcohol, potash, white quinine, Andrews liver salt (a laxative), stout, hot drinks (kai kai), herbs and lime. Results indicate that pharmacist shops are the major source of contraceptive methods. This could be due to easy accessibility. Age and religion are found to be important determinants of contraceptive use. Those in their early and mid teens are less likely to use contraceptives than those aged 20 years and above. This may be due to lack of exposure and access since most of them are in school. Catholics are more likely to use contraceptives than protestants. This is a rather an unexpected finding which indicates that Catholics are becoming more liberal in their use of family planning methods. Low socio-economic status or family background reduced the odd for using contraceptives.

Since the majority of the girls are not contracepting, we found that some of them have had premarital pregnancy. About 16.9 per cent admitted ever being

pregnant. Among the reasons given for not wanting the pregnancy, desire to remain in school is the most common. We found that education has a significant influence on the rate of premarital pregnancy. Adolescents with tertiary and secondary education are more likely to have been pregnant than those who are currently in school. This could be because pregnancy is not tolerated in Nigerian schools. From results of logistic regression model, age reduces the likelihood of having premarital pregnancy. The younger girls are less likely to have been pregnant relative to those aged 20 years and above.

On the issue of abortion, we found that more than half (68.1%) of the adolescents have heard about induced abortion, while 55 per cent admitted that they know places where abortion services can be obtained. These results indicate that a majority of the adolescents in Port Harcourt City are well informed about abortion and places where abortion services can be obtained. Among the places mentioned, private hospitals are the major sources of abortion services. This is probably because it provides privacy.

As regards adolescents attitudes toward abortion and its legalization in Nigeria, results indicate that the majority of the adolescents did not favour legalization of abortion. About 93.6 per cent admitted that it is wrong and the main reason given is that abortion is an act of murder. Only a few admitted that it is right based on high cost of child rearing. We also found that education

significantly influences attitudes toward legalization of abortion. Those with high level of education tend to support legalization of abortion more than those who are currently in school. Family socio-economic status is an important predictor of legalization of abortion. Results show that high socio-economic status increased the odds for supporting legalization of abortion. Also, religion has significant influence on attitudes toward legalization of abortion. Catholics are more likely to favour legalization of abortion than protestants. This may reflect lack of adherence to Catholic doctrines.

A major finding of this study is that abortion practice is common among adolescent girls in Port Harcourt City. About 7.8 per cent of those sexually experienced have attempted abortion but failed while 86.3% had successful abortion. Among those who have had abortion, 30.4 per cent have had over four abortions. The estimated rate of abortion in this study is 15%. However, given the high rate of non response encountered, there could have been under-reporting of induced abortion by the girls. We found that age, religion and education are important determinants of abortion. The rate of abortion is higher among those who are less than 20 years than among adolescent girls aged 20 years and above. Abortion is slightly higher for Catholic girls (85.7%) than for protestants (83.0%). This may reflect the use of natural family planning by Catholics which has a high failure rate. The in-school adolescents are more likely to have abortion

than out-of-school adolescents. Another important finding is that adolescents from low socio-economic background are more likely to have induced abortion relative to those with high socio-economic status. In all, about 90% of all the girls who get pregnant out of wedlock in Port Harcourt City resort to illegal abortion. Among the reasons given for pregnancy termination, avoidance of family disgrace and desire to remain in school are the most prominent. This is consistent with the report by Durojaiye (1996) that abortion is schoolgirls' problem.

Our data show that out of all the adolescent girls who have had abortion 83.4% had complications and other health problems which include bleeding, stomachache, fever, headache and menstrual pains.

On the issue of post-abortal counselling, a majority of the girls admitted that they received advice after abortion, but 42.4% of them were counselled by their friends. Only 16.4% and 10.9% received counselling from doctor and mother respectively. The main content of the advice is how to prevent pregnancy and use of contraceptives. Of a remarkable interest is our finding concerning the impact of communication on adolescents sexual behaviour and reproductive health. Adolescents who had discussion on sexual matters with their parents and teacher are less likely to have sexual intercourse and induced abortion than those who did not have any discussion at all. On the basis of this, we assume that girls who discuss sexual matters with parents are more disciplined and tend to be less

promiscious. On the question of how to reduce the incidence of premarital pregnancy and induced abortion, the most popular suggestion is sex education.

## 5.3: POLICY IMPLICATIONS

Based on the findings of this study, some recommendations are warranted.

* It is clear from the study that there is a high rate of sexual activity and induced abortion among adolescent girls in Port Harcourt City. Therefore, it is necessary that the government begins to develop realistic programmes which will address the unmet needs of adolescents. There is need for sex and reproductive health education among the youths who are in school and out-of-school. For the in-school adolescents, it should be a part of the secondary school education curriculum and for those out-of-school, counselling centres, should be established where they can receive teachings on reproductive health matters. The major emphases of this reproductive health education should be on the effective use of contraceptives, sexuality, how to seek appropriate care for post-abortion complications and to develop confident, healthy and rational attitudes toward issues that affect adolescents' reproductive health.

* There is need for intervention programmes, especially counselling programmes for adolescents who have premarital pregnancy and those who have had induced abortion. From the study, we found that most of the adolescents who

have had induced abortion received post-abortal counselling from friends. However, they are less likely to give proper advice on reproductive health matters, hence the need for the establishment of effective counselling units. These units should be run by experts on adolescent reproductive health so as to ensure quality counselling.

* The restrictive nature of abortion law in Nigeria needs to be re-examined. It should adopt a more flexible approach, so as to allow abortion when pregnancy occurs from rape. Also, it should allow adolescents access to contraceptives since this study found that low use of contraceptives was responsible for a substantial proportion of premarital pregnancies and induced abortions.

* The results of this study show that private hospitals and pharmacist shops are the major sources of abortion and contraceptive services. It is likely that some of the services may be provided by non-professional abortionists since 83.4 per cent of the girls who have had abortion reported significant health problems in association with the abortions. In view of this, we recommended that private hospitals which provide abortion services should be controlled or outlawed if necessary. In addition, government should ensure that qualitative services for the management of post-abortion complications are provided in both private and public hospitals. This will help reduce the number of maternal morbidity and mortality caused by abortion complications.

* We found that adolescents with tertiary education engaged more in sexual relations and those with low socioeconomic background had a high rate of induced abortion. This implies that they lack adequate means of livelihood and most of them engage in illicit sex for material gains. Since they are poor and dependent, and cannot take care of a child, they resort to illegal abortion. Based on this, we recommend that the government should provide employment opportunities for out-of-school adolescents. It should also design programmes which will make them creative. For instance, the National Directorate of Employment (NDE) programme should be re-designed and made more efficient to meet the needs of unemployed adolescents.

* To reduce the rate of premarital sexuality and induced abortion, discussion on sexual matters between parents and adolescents should be made more effective. Therefore, there is need for awareness programmes for parents so as to enlighten them on the need for sex education at home, since some of them regard it as a 'taboo' to discuss sexual matters with their children.

* As indicated by the study, being religious, decreased the likelihood of having premarital sexual relations, pregnancy and induced abortion. Therefore, we suggest that moral instruction programme should be made part of secondary school education curriculum. It should include sound Biblical teachings on the dangers of premarital sex and induced abortion.

These recommendations may not be all embarrassing, but it is hoped that if they are seriously considered and implemented, the practice of induced abortion by adolescents will be highly reduced in Nigeria, for the preservation of our youths and the future of this country.

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"APPENDIX"

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Dear Respondent,

This research is a partial fulfilment of the requirement for the award of M.Sc. degree. It is therefore purely an academic exercise. Though some of the questions are somewhat personal in nature, all information you provide will be kept strictly confidential. Your responses to the question will help the government to improve reproductive health education for the adolescents. I would therefore like you to give truthful answers to the questions. You don't need to write your name on the questionnaire.

Thank you.



SECTION A: DEMOGRAPHIC CHARACTERISTICS

1. How old are you?_____ (years)

2. What is your religion? (Tick as appropriate)

   1. No religion ( ) 2. Catholic ( ) 3. Muslim ( )

   4. Protestant ( ) 5. Traditional ( )

   6. Others (Specify) _____

3. How many times do you attend to your Church's programme/services every week?

   1. Once ( ) 2. Twice ( ) 3. Three times ( )

   Other (State) _____

4. How often do you do the following (Tick the correct option):

   Daily, Rarely, Often, Occasionally.

   1. Pray
   2. Read Bible
   3. Go to Church

5. Religion in your daily life is considered:

   1. Very important ( ) 2. Moderately important ( )
   3. Less important ( ) 4. Unimportant ( )

6. What is your highest level of education?

   1. No formal education ( ) 2. Primary education ( )
   2. Secondary education ( ) 4. Higher Education ( )
   5. Currently student (all levels) ( )

7. What is your marital status?

   1. Married ( ) 2. Divorced ( ) 3. Separated ( )
   4. Cohabiting with a man ( ) 5. Never Married

8. What is your current occupation?_____

9a. Who gives you the money you spend for your personal upkeep?

_____

b. Are there other sources? 1. Yes ( ) No. ( )

c. If Yes, specify _____

10. Can you roughly estimate the monthly income of your parents?

1. Less than N2,000 ( ) 2. 2,000 - 3,000 ( )

3. N3,500 - 5,000 ( ) 4. Above N5,000 ( )

11. Do you have any of the following items in your home? (Tick as appropriate).

1. Running water (in your flat) Yes ( ) No ( )
2. Radio
3. Television
4. Electricity
5. Refrigerator
6. Flushing toilets
7. Motorcycle
8. Car

**SECTION B: KNOWLEDGE OF ABORTION/CONTRACEPTIVE USE**

12. Have you heard about induced abortion?

1. Yes ( ) No ( )

13. Do you know where people can obtain abortion services?

1. Yes ( ) No ( )

14. If Yes, where?

1. Government Hospitals ( ) 2. Private Hospital ( )

3. Self medication ( ) 4. Non professionals (quacks) ( )

5. Pharmacists ( ) 6. Traditional healers ( )

7. Nurses ( ) 8. Other (specify) ( )

15. Do you know any modern contraceptive methods used by adolescents? List all that you know

_____

_____

16. How do they get the contraceptives?

1. Provided by Government hospitals ( )

2. Buy from the pharmacist shops ( )

3. Get them from private hospitals at high prices ( )

4. From friends ( ) 5. Other (specify) _____

17. Have you ever used modern contraceptive methods?

Yes ( ) No ( )

18. If yes, what methods have you ever used? List all: _____

_____

19. What method are you using now? _____

20. How long have you been using this method? _____

21. Are you satisfied with the method? Yes ( ) No ( )

## SECTION C: ATTITUDE TOWARDS INDUCED ABORTION

22. From what you know, can you say that abortion is a legal (lawful) procedure in Nigeria? Yes ( ) No ( )

23a. In your opinion, do you think that abortion should be legalized in Nigeria? Yes ( ) No. ( )

b. If Yes, give reasons: _____

c. If no, what is your reason: _____

24. What are your views toward adolescents and young women seeking abortion? _____

_____

25. Are the abortion services available for adolescents and young women safe? Do you consider the abortion procedures safe based on medical standards?

1. Yes ( ) 2. No ( )

26. Under what circumstances would you approve of abortion officially in Nigeria? (Enter the correct number in the box):

1. It should not be allowed at all ( )

2. When a woman's health is in danger ( )

3. When pregnancy occurs from rape ( )

4. When an unmarried school girl becomes pregnant ( )

5. It should be allowed all the time ( )

27. Is it easy or difficult to obtain abortion services in Port Harcourt City?

_____

28. In your opinion, is abortion right or wrong? _____

State reasons for your answer: _____

_____

29. What do you think are the factors that motivate adolescents to seek induced abortion? (Enter the correct number in the box).

1. Avoidance of family disgrace? ( )

2. The desire to remain in school ( )

3. The inability to raise a child alone ( )

4. Lack of reasonable means of livelihood ( )

5. Other reasons (State) _____

## SECTION D: SEXUAL ACTIVITY/NETWORKING

30a. Have you ever had sexual intercourse? Yes ( ) No ( )

b. If yes, at what age did you have your first sexual intercourse?

_____ (years old)

31. How often do you have sexual intercourse?

1. Daily ( ) 2. 3-4 times a week ( )

3. 2 times a week 4. Once a week ( ) 5. Monthly ( )

6. Once a while ( ) 7. Other (State) _____

32a. Have you had more than one partner in the past 4 weeks?

1. Yes ( ) 2. No ( )

b. If yes, how many? _____ and what is his/their occupation(s)

_____

33. Who was your partner in your last sexual act? _____

33a. What type of relationship do you have with your partner?

1. Permanent ( ) 2. Not permanent ( )

3. Occasional ( ) 4. No relationship ( )

b. What is the duration of the relationship?

1. 1 year ( ) 2. 1-3 years ( ) 3. 3 to 5 yrs Occasional ( )

4. 5 to 8 years ( ) 5. Other (state) _____

34. Have you ever discussed the following topics with the following people?

| | Sex Education | Dating | Pregnancy | Abortion | Marriage |
|---|---|---|---|---|---|
| Mother | _____ | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ | _____ |
| School Counsellor/ Teacher | _____ | _____ | _____ | _____ | _____ |
| Friends | _____ | _____ | _____ | _____ | _____ |
| Relation | _____ | _____ | _____ | _____ | _____ |

35. When you had your first sexual intercourse, did you discuss it with 1. Your mother ( ) 2. Friends ( ) 3. Your teacher () Your father ( ) 5. Religious leader ( ) 6. Other (specify)

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## SECTION E: PREGNANCY AND ABORTION PRACTICE

36. Have you ever been pregnant even for only a short while (for instance a few moths)? 1. Yes ( ) 2. ( ) 3. May be ( )

b. If yes, who did you inform about the pregnancy? _____

37. In the past, have you ever been pregnant when you did not want to be? 1. Yes ( ) 2. No. ( )

38. If yes, why did you not want the pregnancy? 1. No reason ( )

2. Still schooling ( ) 3. High cost of children ( ) 4. Abandoned by partner ( ) 5. Socially unacceptable ( )

6. Premarital pregnancy ( ) 7. Other (specify) _____

39. If yes to question 37, what did you do about this unwanted pregnancy? Nothing, kept the pregnancy ( ) 2. Attempted to abort, but did not succeed ( ) 3. Attempted to abort the pregnancy and succeeded ( ) 4. Other (State) ----------

40. If yes to question 37 still, did you become pregnant while using a contraceptive 1. Yes ( ) 2. No ( )

41. How many times have you aborted a pregnancy? _____ times.

42. How many months old was the pregnancy (cies) before the abortion took place? 1. One month ( ) 2. 6 months ( )

3. 3 months ( ) 4. Don't know ( )

43. Where was the abortion carried out? 1. Self ( ) 2. Traditional Healer 3. Private Doctor ( ) 4. Government hospital ( ) 5. Chemist shop ( ) 5. Other (specify) _____

44. Did you experience any health problems? 1. Yes ( ) No ( )

45. If yes to question 44, did you receive treatment from:

1. Traditional healers ( ) 2. Private Doctor ( )

3. Government hospital 4. Self treatment ( )

5. Pharmacist ( ) 6. Other (state) _____

46. Did you inform your partner about the abortion?

1. Yes ( ) 2. No ( )

47. Who paid for the fee? _____

48. Have you received advice from anyone after the abortion took place? 1. Yes ( ) 2. No ( )

b. If yes, from whom? _____

49. If yes to question 48(a), what was the advice about?

1. How to prevent unwanted pregnancy ( )
2. Use of contraceptives ( )
3. Where to seek abortion ( )
4. Other (specify) _____

50. Do you have any friend or neighbour who had an induced abortion recently or in the past? 1. Yes ( ) 2. No ( )

51a. If yes, why did she abort the pregnancy? _____

_____

b. and where did it take place?

1. At home ( ) 2. Traditional healer ( )
3. Private hospital ( ) 4. Public Hospital ( )
5. Pharmacist ( ) 6. Other (specify) _____

52. From your own observation, is abortion practice common in this city? 1. Yes ( ) 2. No ( ) 3. Don't know ( )

4. Can't be estimated ( ) 5. Other (specify) _____

53. What do you think can be done to reduce the incidence of unwanted pregnancy and induced abortion in Nigeria? _____

_____

_____