FACTORS INFLUENCING DECISION-MAKING ON THE OUTCOME OF UNINTENDED PREGNANCY AMONG MARRIED WOMEN IN IBADAN SOUTH-WEST LOCAL GOVERNMENT AREA, NIGERIA

BY

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DEDICATION

This work is dedicated to God Almighty, the source of all good gifts who has made the work a reality.

To my parents; Chief and Mrs. J.B. Adeloye, my wonderful spouse; Dr Abiodun Oyeneyin and my children; Oluwatobi, Adedamola and Olamide.

CERTIFICATION

I certify that this work was carried out by **ADELOYE Adenike Olufunmilayo**in the Department of Health promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria, under my supervision.

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ABSTRACT

Unintended pregnancy is a potential risk for women which could adversely affect their health, family and society at large. In Nigeria, information on factors influencing decision-making on unintended pregnancy among married women has not been adequately explored. This study was designed to assess the factors that influence decision making on unintended pregnancy among married women in Ibadan South-West Local Government Area (IBSWLGA), Nigeria.

This study was exploratory and involved the use of qualitative methods. The study is also phenomenological in design. Ten out of the 12 wards in the LGA were selected through balloting for Focus Group Discussions (FGDs) while the remaining two were used for In-depth Interviews (IDIs). One community each was randomly selected from each ward for the FGDs. Ten FGDs were conducted among purposively selected women of child-bearing age who have had two children in the past five years. Four IDIs (2 per ward) were conducted among women who had had unintended pregnancy. FGD guide and IDI schedule containing questions on decision-making, spouses' reaction, induced abortion and use of contraceptives were used to collect data. Responses were transcribed and analysed thematically.

Participants' ages ranged from 19-49 years with a mean age of 30.0 ± 5.63. Majority (81.0%) were Yorubas with 53.6% being Muslims. Those who had secondary education (60.7%) were in the majority, while traders constituted 61.9%. A large proportion (71.2%) had been married for 5-20 years. Many of the FGD discussants had experienced unintended pregnancies during the nursing period of a previous child. Factors identified as influencing the decision to carry unintended pregnancy to term included: spousal support, fear of complications, unsuccessful induced abortion and desire to have more children. Decision to terminate pregnancy was influenced by lack of spousal support, economic implication of caring for another child, fulfilment of the number of children desired with preferred sexes and pregnancy complications. One out of the four IDI participants terminated the pregnancy before term. Majority reported misunderstanding between them and their spouses as a result of unintended pregnancy. Majority stated that they and some of their neighbours who experienced unintended pregnancy visited health centres for antenatal care. The IDI participants were against the procurement of abortion while majority of the FGD discussants

indicated that abortion procurement was common in marriage. Majority were aware of the different types of contraceptives and their effectiveness in the prevention of unintended pregnancy but did not use any for fear of side effects.

Unintended pregnancy and non-utilisation of contraceptives were common among the participants. Intervention focusing on the couple as a unit should be instituted to improve spousal communication and uptake of family planning products thereby reducing the occurrence of unintended pregnancy.

Keywords: Unintended pregnancy, Induced abortion, Contraceptives
Word count: 440

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ACRONYMS

AGI:	Allan Guttmacher Institute
APHRC:	African Population and Health Research Centre
CAUP:	Campaign Against Unwanted Pregnancy
CCP:	Centre for Communication Programs
CDC :	Centre for Diseases Control
CREHPA:	Centre for Research on Environment Health and Population Activities
CRR:	Centre for Reproductive Rights
DHS:	Demographic and Health Survey
FGD:	Focus Group Discussion
FP:	Family Planning
GHC:	Global Health Council
HERFON:	Health Reform Foundation of Nigeria
IBSWLGA	Ibadan South-West Local Government Area
ICPD:	International Conference on Population and Development
IDI:	In-depth Interview
IPPF:	International Planned Parenthood Federation
IUSSP	International Union for the Scientific Study of Population
MDGs:	Millennium Development Goals
MDH:	Minnesota Department of Health
MoH:	Ministry of Health
NIH:	National Institute of Health
NPC:	National Population Census
NSFG:	National Survey Family Growth
PATHS:	Partnership for Transforming Health Systems
PRB:	Population Reference Bureau
RH:	Reproductive Health
SOGON:	Society of Gynaecologists and Obstetricians of Nigeria
STI:	Sexually Transmitted Infection
UNFPA:	United Nations Populations Fund
WHO:	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the study

The ability of women and couples to control their fertility and to have basic, safe maternity care is a fundamental health and human right. This has been endorsed by the World Health Assembly (WHO, 2002), and the World Health Organization (WHO) affirms that "sexual and reproductive health is fundamental to individuals, couples and families, and the social and economic development of communities and nations" (WHO, 2004). As stated by the International Conference on Population and Development (ICPD) in 1994: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so".

Despite significant improvements in the lives of women (Vadnais, Kols and Abderrahim, 2006), high rates of unintended pregnancy continue to detrimentally impact women's and children's health and restrict opportunities for women (Greene and Merrick, 2005). Selection of unintended pregnancy as a focus was based on five main principles:

- Ensuring the ability to choose the number and spacing of children as a means of achieving health and development goals has been neglected as part of key international and national development frameworks (United Kingdom All-Party Parliamentary Group on Population, Development and Reproductive Health, 2006; Blanc and Tsui, 2005; Cleland et.al., 2006; Vogel, 2006; Dixon-Mueller and Germain, 2007; Simelela, 2006; Campbell, et.al., 2007).
- The burden of unintended pregnancy affects a large proportion of society. The growing demand for smaller families, decreasing age at first sex (in some countries) and increasing age of marriage has meant that many women spend much of their adult lives attempting to avoid an unintended pregnancy.
- Safe and highly effective means of primary prevention (contraception) (Centre for Communication Programs and World Health Organization Department of Reproductive Health and Research, 2008) and secondary prevention (termination of pregnancy) (Grimes, et.al., 2006, WHO, 2003) can reduce the burden of unwanted births.

- While reporting of unintended pregnancy raises some methodological concerns, ample data are not available for examination (Dixon-Mueller and Germain, 2007; Gipson, Koenig and Hindin, 2008).
- Assisting women in avoiding unintended pregnancies improves the health of women, children and families, and represents a pledge to the right of all women to control their fertility.

Worldwide, 1.36 billion women are estimated to be of child bearing age (15-49 years) (Population Reference Bureau, 2006). During most of their childbearing years, women are sexually active but do not want to have a child. Usually, the fact that a woman is expecting a baby should be a happy event for women, their partners and their families. Unfortunately, this is not so in all cases in most countries, many women become pregnant every year without planning or wanting to have a child at that time in their lives and majority are usually distressed than joyful under these circumstances.

Out of the estimated 210 million pregnancies that occur annually around the world, nearly four in 10 are unplanned. In the most general terms, unplanned pregnancies occur when couples fail to reconcile their desire for sexual intercourse with their intention or reluctance to conceive a child at a particular time (Allan Guttmacher Institute [AGI], 2010)

Moreover, most couples want to control not only the size of their family, but the timing and spacing of their births as well. Accordingly, the vast majority of married women of childbearing age either have already achieved their desired family size or want to delay their next birth for at least two years. In almost all countries, at least six in 10 women—and in most countries, more than eight in 10want to stop having children or to postpone their next birth (AGI, 2010).

According to Population Reference Bureau [PRB] (2009), women, families, and societies benefit when childbearing is planned. But too often, women become pregnant when they do not wish to have more children or wish to have a child much later. Worldwide, more than a quarter of women who become pregnant have either an abortion or an unwanted birth (AGI, 2010). This is the case in Nigeria, where hundreds of thousands of women every year become pregnant without wanting to, and

where many women with unintended pregnancies decide to end them by abortion (Akinrinlola andGilda, 2006).

Although fertility rates are declining as modernization is increasing, Nigeria is still one of the poorest nations in the world and has the largest population in sub-Saharan Africa (PRB, 2006). Many women are experiencing unintended and mistimed pregnancies, with consequences ranging from interruption of schooling to health risks and economic hardship, all of which hinder efforts to improve their socioeconomic status.

Previous studies have documented various negative health, social, psychological, and economic consequences of unintended pregnancy for men, women, and the community and for a society as whole. These can include unsafe abortions leading to maternal morbidity and mortality, reduced prenatal and postnatal care, infant death and illness, pre-term birth, low birth weight baby, unstable marriages, and the restriction of educational and occupational opportunities leading to poverty and limited roles for women (Sonfield, 2003; Binn-pike et.al., 2002; Senanake, 2001; Cobb et.al., 2001). These studies also documented other socio-psychological consequences such as worries, and poor parent-child interaction, children's education performance. However, very little empirical evidence has been found on the expected consequences compared with real experiences.

Statement of the problem

Unintended pregnancy is a potential hazard for every sexually active woman. It is a worldwide problem that affects women, their families, society and the nation at large. A complex set of social and psychological factor puts women at risk for unintended pregnancy. Abortion is a frequent consequence of unintended pregnancy and, in the developing countries can result in serious long-term negative health effects including infertility and maternal death (Klima, 1998). Many Nigerian married women experience unwanted pregnancies and to prevent associated health problems, it is important to understand the factors related to unintended pregnancy in Nigeria (Sedgh, 2006). Globally, abortion mortality constitutes at least 13% of maternal death (Berer, 2000). Unsafe abortions are taking place all over the world. Worldwide estimates indicate that 19 million unsafe abortions (approximately one in 10

pregnancies) take place each year. Among those, almost all take place in the developing world (AGI, 2003; Ahman and Shah, 2002).

Unintended pregnancy does occur among women of reproductive age from every social, demographic and economic background in Nigeria and quite a number of these women are faced with a situation in which they would have to decide what to do at that point in time. More so, many women faced with an unintended pregnancy feel mixed emotions While each woman's situation is unique, many women share similar mixed feelings about their pregnancies some may feel scared, confused and excited all at the same time and majority are not sure about what decision to make with the pregnancy.

When a married woman is faced with unintended pregnancy, there are usually the following options to consider -Carry the pregnancy to term, or end the pregnancy by induced abortion. A major factor that contributes to induced abortion is unintended pregnancy (Oye-Adeniran, Adewole, Umoh, Iwere and Gbadegesin, 2004). Worldwide, 87 million women become pregnant unintentionally, with an approximately 46 million pregnancies ending in induced abortion (International Planned Parenthood Federation (IPPF), 2006).

Although in Nigeria induced abortion is legal only to save a woman's life, majority of married women each year end unintended pregnancies by abortion, often under unsafe conditions. As a result, unintended pregnancy and consequently unsafe abortion remains a major reproductive health problem in Nigeria that needs to be tackled. A national survey estimated that 610,000 Nigerian women sought abortion annually making abortion rate 25 per 1000 women aged (15-44). Poorly performed abortions are known to contribute to Nigeria's high maternal mortality rate, which is estimated to be 576 per 100,000 live births (22.5- 40%) (NDHS,2013). This is an exceptionally high rate even among developing countries. For years, experts have provided evidence that investing in reproductive health services is integral to meeting all the Millennium Development Goals (MDGs).Good reproductive health care and the exercise of women's reproductive rights can help ensure that every infant is wanted, loved and has a chance to thrive.

Unintended pregnancy may increase especially with the report of low use of modern effective contraceptives. Unsafe abortion has enjoyed wider patronage, perhaps because of the reduced cost, but it may become more expensive when the cost of treatment of complications that may arise is taken into consideration. The cost of death to the family and the country is even more difficult to ascertain. It is therefore important to document the factors relating to unintended pregnancy among married women in the communities in view of the fact that this is needed to yield information for designing an approach geared towards the reduction of unintended pregnancy.

There is a dearth of information regarding the factors relating to unintended pregnancy among married couples in the communities. When women who are sexually active become pregnant at a time they do not wish, what do they do about the pregnancy? What factors make them keep or end the pregnancy? Where do they go for help? Who do they consult or confide in? Issue of communication with spouse, Do these women use contraceptives?

The focus of this study therefore was to determine factors influencing decision making on the outcome of unintended pregnancy among married women in Ibadan South West Local Government Area of Oyo State.

Justification

Roughly 140 million people live in Nigeria (National Population Census [NPC], 2006), making it the most populous country in Sub-Saharan Africa. The country's population growth rate of 2.8% per year means a doubling in size every 25 years (AGI, 2006). Of the 6.8 million pregnancies that occur each year in Nigeria, 63% end in planned births, 10.0% in mistimed or unwanted births, 11.0% in induced abortion and 16 % in miscarriage. That is, roughly one in five pregnancies each year in Nigeria is unintended (AGI, 2006).

The incidence of unintended pregnancy among married women is high in Nigeria and studies have revealed that most women faced with unintended pregnancy consider the abortion option of the outcome more than any other (AGI, 2006). Over the years, concentration has been on the issue of unintended pregnancy among the unmarried hence there is a dearth of information on unintended pregnancy among married women. For any intervention, there is need to determine the factors that influence

decision making as to the outcome of an unintended pregnancy in married women - whether to keep the pregnancy and in keeping the pregnancy, the fate of the baby after delivery and also where, if the decision is to end the pregnancy.

The findings of this study aim to guide reproductive health programme planners and policy makers to understand various factors influencing unintended pregnancy. It will assist in implementation of the reproductive health programme which will decrease unintended pregnancy as well as reduce the risk of maternal and infant morbidity and mortality. Moreover programme planners and policy makers can focus in some particular aspects of the programme and improve the effectiveness of health services in terms of information on contraceptive methods and access to the services.

Policy makers and providers can benefit from the evidence on women's experience of unintended pregnancies, abortion and contraception to formulate policies that can help women and couples have the number of children they want, when they want them, without facing undue risks to their health and also in the case of unintended pregnancy make decisions that would benefit them.

If unintended pregnancy is reduced, then abortion, maternal morbidity and mortality, infant morbidity and mortality will be decreased, and the overall health of the family can be improved with appropriate birth spacing and family size. More so, the study will serve as an eyes opener to the religion sect leaders on the benefits that attached to the use of appropriate family planning methods without only stick to natural billing method that is more common among the Roman Catholic Church.

Broad Objective

The broad objective of this study was to determine and document the factors that influence the outcome of unintended pregnancy among married women in Ibadan South West LGA of Oyo State (IBSWLGA).

Specific Objectives

The specific objectives of the study were to:

1. Examine factors that influence decision making on the outcome of unintended pregnancy in married women in Ibadan South West LGA (IBSWLGA) of Oyo State.

2. Assess the pattern of communication with spouse in situations of unintended pregnancy.
3. Determine the pattern of help seeking behaviour among married women in situations of unintended pregnancies.
4. Assess the attitude of the married women in IBSWLGA towards induced abortion.
5. Examine the attitude of the married women in IBSWLGA towards the use of contraceptives that could result to child spacing.

Research Questions

1. What are the factors that influence decision making to keep or terminate an unintended pregnancy?
2. What is the pattern of spousal communication among married women in situations of unintended pregnancy?
3. How do married women seek help in situations of unintended pregnancy?
4. What is the attitude of married women to induced abortion?
5. What is the attitude of the married women to the use of family planning methods?

CHAPTER TWO
LITERATURE REVIEW

Introduction

In African societies, there is a huge value placed on pregnancy and childbirth; yet, the loss of pregnancies either through spontaneous or induced abortion is not uncommon. In Nigeria, unsafe abortion performed by unskilled persons or under insanitary conditions or both, has been found to contribute 40 percent of maternal deaths in Nigeria (Sai, 2004). In Medical science, there are two categories of maternal deaths: direct and indirect obstetric deaths. The former derives from complications during pregnancy, delivery or postpartum period while the latter, is a factor of medical conditions that are aggravated by pregnancy or delivery (United Nations Populations Fund [UNFPA], 2001). Medical conditions are nonetheless, grossly inadequate in explaining health particularly, women's Reproductive Health (RH) (which includes maternal health), because the major determinants of health are external to biology and medicine. Health, 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation, 2012), is determined by cultural, social, economic, political, psychological, and religious factors among others. This is particularly true of heterogeneous societies and underdeveloped countries. Therefore solution to African women's RH challenges should not be limited to medicine and biology but should also be sought within the social and cultural contexts under which pregnancies occur. Prominent among the socio-cultural factors that influence pregnancies and their outcome in Nigeria are: gender relations, gender roles, social taboos, and traditional beliefs surrounding sexual practices.

Concept of unintended pregnancy

An unintended pregnancy is a pregnancy that is either mistimed (i.e. they occurred earlier than desired) or unwanted (i.e. they occurred when no children, or no more children were desired) at the time of conception (Santelli, Rochat, Hatfield-Timajchy, Gilbert, Curtis., Cabral & Schieve, 2003). It is a complex issue and not just a problem of individual behaviour; it is also a problem of public policy and institutional practices. Around the world, about half a million women die due to pregnancy-related reasons every year, 99% of them are in developing countries (Coeytaux, Bingham and Strauss, 2011; UNICEF, 2008).

Disconcerted problem of unintended pregnancy

Women living in every country irrespective of development status have been facing the problem of unintended pregnancy. Over 100 million acts of sexual intercourse take place each day in the world, resulting into around 1 million conceptions, about 50% of which are unplanned and about 25% are definitely unwanted (Akalework, 2008; WHO, 2007). The World Health Report (WHR, 2005) noted that unwanted, mistimed and unintended pregnancy is the most common cause of maternal mortality in developing countries. In Africa, the very high rate of unintended pregnancy in 1995 which was 92 per 1000 women, declined only slightly by 2008, to 86 per 1, 000 women. The data suggest that approximately 49% of all pregnancies in the United States (Henshaw, 1998), 46% in Yamagata, Japan, 35% in both Iran (Abbasi-shavaji et.al., 2004) and Nepal (Ministry of Health (Nepal), New ERA, and ORC Macro, 2002) are unintended. Almost all have been occurring due to non-use of family planning method or contraception failure.

Therefore, unintended pregnancy is an issue that must not be ignored. Many pregnant women will want or need to end a pregnancy to avoid risks to their lives and health, psychological trauma, and socioeconomic turmoil (Ipas, 2004). Unintended pregnancy is an important public health concern in both developing and developed countries because of its negative association with social and health outcomes for both mothers and children. It often forces women to tackle difficult issues including abortion (Senanake, 2001) the raising of the child without the necessary financial, physical, and emotional support. Unsafe abortions are taking place all over the world, with the exception of countries where abortion is legal, safe and relatively accessible (Ahman and Shah, 2002).

For some, unintended pregnancies result in healthy children in happy families. For others there are negative health effects from late or inadequate prenatal care, low birth weight, fetal exposure to alcohol, tobacco smoke and other toxins, and maternal depression. Unintended pregnancies are also associated with economic hardship, marital dissolution, poor child health and development, spouse abuse, and child abuse and neglect. Almost half of all unintended pregnancies end with an induced abortion (Minnesota Department of Health [MDH], 2011).

The level of unintended pregnancy can be used as an indicator of the state of women's reproductive health and of the degree of autonomy women have in determining whether and when to bear children (Eggleston, 1999). Hence, International Conference on Population and Development (ICPD) held in Cairo in 1994 and Fourth World Conference on Women was held in 1995 in Beijing have emphasized women empowerment as a basic tool for a country's overall development and improving the quality of life of the people (Senanake, 2001).

The concept of unintended pregnancy has been essential to demographers in seeking to understand fertility, to public health practitioners in preventing unwanted childbearing and to both groups in promoting a woman's ability to determine whether and when to have children. Accurate measurement of pregnancy intentions is important in understanding fertility-related behaviours, forecasting fertility, estimating unmet need for contraception, understanding the impact of pregnancy intentions on maternal and child health, designing family planning programs and evaluating their effectiveness, and creating and evaluating community-based programs that prevent unintended pregnancy (Cabral, 2003).

An unintended pregnancy is one defined by the mother as being either unwanted or mistimed at the time of conception (AGI, 2003). The consequences of unintended pregnancy can be serious for the health of the woman and the infant. Women who have unintended pregnancies are less likely to engage in healthy behaviours during pregnancy, such as early antenatal care, good nutrition and avoidance of alcohol, tobacco and other drugs. The parents are less likely to be educationally and vocationally prepared to financially support the child, so there is an increased risk of welfare dependency and poverty (MDH, 2002).

Global burden of unintended pregnancy

The World Health Report (WHR, 2005) noted that unwanted, mistimed and unintended pregnancy is the most common cause of maternal mortality in developing countries. Of all pregnancies worldwide, 40% are unintended. Approximately 20% of pregnancies worldwide are voluntarily terminated. In 2003, an estimated 42 million abortions were induced, 35 million (26 million excluding China) of which occurred in developing countries (Sedgh, Henshaw, Singh, Ahman, &Shah, 2007). Klima also stated in her report that unintended pregnancy is a worldwide problem that affects

women, their families, and society. Unintended pregnancy can result from contraceptive failure, non-use of contraceptive services, and, less commonly, rape. Abortion is a frequent consequence of unintended pregnancy and, in the developing world, can result in serious, long-term negative health effects including infertility and maternal death (Klima, 2011). Unintended pregnancy poses hardships for families and jeopardizes the health of millions of women and children worldwide. It increases the risk of abortion-related morbidity and mortality, especially in countries where abortion is illegal. In fact, unsafe abortion is one of the most common results of unintended pregnancy; from which 80 000 women die each year and over 95% of these deaths occur in developing countries (Islam, 2011). The statistics regarding unintended pregnancy are alarming. Worldwide, it is estimated that approximately 87 million unintended pregnancies occur each year (WHO, 2005).

Unintended pregnancy, in recent times, emerged as a crucial public health issue in developing world because it has extensive adverse health, social and economic effects, not only upsetting for the affected mothers and children (Jaeni,McDonald & Utomo, 2009).

According to Furedi, despite modern methods of family planning, and widespread information about how to use it, unplanned pregnancy is one of the most common medical problems faced by sexually active women under 45. Abortion, the most usual solution to the problem of unplanned pregnancy, is the most common operation among women in the fertile age range.

In many countries, women still have more children than they ideally would like. Large proportions of married women report that in the past five years, they had an unintended birth—one that occurred either sooner than they had wished (a mistimed birth) or at a time when they had wanted no more children ever (an unwanted birth). The proportion of women who describe a recent birth as unplanned is striking everywhere, but it is particularly high in Kenya, the Philippines, Latin American countries and Japan (AGI, 2010).According to Singns in a report released in 2009, the rate of unintended pregnancy in Africa in 2008 is 86 per 1, 000 women.

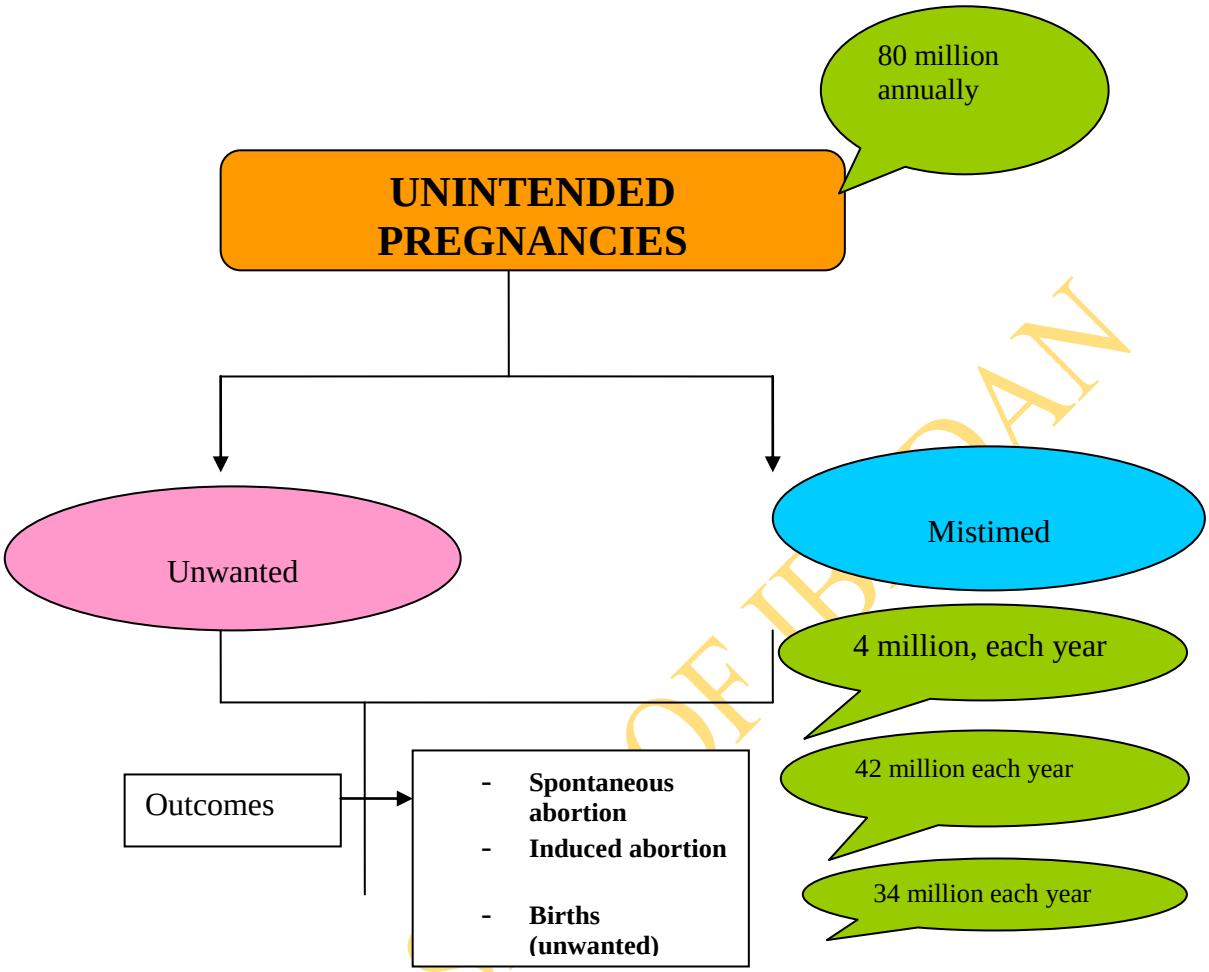

Figure 2.1: Outcome of unintended pregnancies globally

Source: Thapa, 2010

In developing countries where data were available, researchers found that between 14% and 62% of recent births were reported as unintended (Gipson, Koenig and Hindin, 2008). Unintended pregnancy can result from contraceptive failure, non-use of contraceptives, and less commonly, rape and it can create serious health consequences for women, children and family (Adhikari, 2009).

Within countries, the burden of unintended and unwanted pregnancy is not equally distributed. In the United States of America, for example, rates of unintended pregnancy are consistently higher for poor women, ethnic minorities, women aged

18–24 years, women who have not completed high school and unmarried women (Finer and Henshaw, 2006; Jones, Darroch and Henshaw, 2002). The overall rate of unintended pregnancy in the United States has remained constant for almost a decade, with almost half (49%) of all pregnancies reported as unintended (Finer and Henshaw, 2006). Among subpopulations, however, this rate fluctuates. Between 1994 and 2001, the rate of unintended pregnancy declined among adolescents, college graduates and the wealthiest women, but increased among poor and less educated women (Finer and Henshaw, 2006).

Substantially more evidence is available to examine differences in actual births. Demographic and Health Survey data substantiate higher levels of excess fertility among poor women in developing countries. In 41 countries where data were available, poor women from all countries outside Africa and the majority of African countries reported higher levels of unintended births than women from wealthier households (Gillespie et.al., 2007). In other words, poor women are more likely to have larger families than they would prefer in comparison to women from the wealthiest households. It is also of note that women from the wealthiest households are more likely to have fewer children than they would prefer.

In Nepal for instance, the prevalence of unintended pregnancy in the five years preceding a survey conducted in the country was high (35.0%). Among these, more than one in five births (21.0%) was unwanted and one in seven (14.0%) is mistimed (Ministry of Health (Nepal), New ERA, and ORC Macro, 2002). Family planning method failure rate is high. A study found that 20.0% in rural and 16% in urban married women aged 15-49 reported method failure as the reason for their unintended pregnancy (Tamang, et.al., 2002). Similarly, one research study estimated that during the first year of vasectomy, 1.7% women would become pregnant (Nazerali, et.al., 2003), which leads to the higher unintended pregnancies and abortion. A study conducted at 5 major hospitals showed that abortion related admissions account for 20.0% to 48.0% of the total obstetric and gynaecological patients (CREHPA, 2007). Despite the legalisation of abortion laws (After March Ramesh, 2002), lack of awareness about the law and facility centres, many women still seek abortion clandestinely and most often they consult unskilled or unqualified health persons, resulting in high rates of abortion related morbidity and mortality (CREHPA, 2007).

Factors that influence decision making on the outcome of unintended pregnancy

Several factors influence decision making. These factors, including past experience (Juliusson, Karlsson, & Gärling, 2005), cognitive biases (Stanovich & West, 2008), age and individual differences (Bruin, Parker, & Fischoff, 2007), belief in personal relevance (Acevedo, & Krueger, 2004), and an escalation of commitment, influence what choices people make. Understanding the factors that influence decision making process is important to understanding what decisions are made. That is, the factors that influence the process may impact the outcomes. People make decisions about many things. They make political decisions; personal decisions, including medical choices, romantic decisions, and career decisions; and financial decisions, which may also include some of the other kinds of decisions and judgments. Quite often, the decision making process is fairly specific to the decision being made. Some choices are simple and seem straight forward, while others are complex and require a multi-step approach to making the decisions (Dietrich, 2010).

The experience of pregnant adolescents differs from that of older women and is largely defined by marital status (Bearinger, et.al., 2007; WHO, 2004). While the majority of pregnancies among unmarried adolescents are unintended, married adolescents often seek to bear children early as proof of fertility (WHO, 2004). More than 50% of young mothers report an unintended birth in Botswana, Ghana, Kenya, Namibia and Zimbabwe (AGI, 2007). In the United States, a large proportion of married women choose not to continue their pregnancy. In fact, almost four in 10 of the unintended pregnancies that occur to married women end in abortion resulting in 345,000 abortions to married women each year. All in all, 17% of abortions in the United States occur to married women (AGI, 2003).

In a study conducted in Ghana, unintended childbearing in Ghana is estimated to be about 0.7 births per woman, thus contributing to the high total fertility rate of more than 4 births. About one-third of women of reproductive age have an unmet need for family planning and there are strong geographic differences between and within ecological zones. Spatial analysis of risk of unintended pregnancies planning can reveal differences in the provision and usage of contraceptive commodities, thereby providing information of areas where programmes should be strengthened. The study uses data from the 1998 and 2003 Ghana Demographic and Health Surveys to

examine geographical variation in the risk of unintended pregnancies among women in the three ecological zones of Ghana (Savannah, Forest, and Coastal). Approximately 55% of Ghanaian women (married or in union) are at risk of unintended pregnancies and there are differences between urban and rural women, with rural women more likely to have their demand for contraception unmet (Johnson, Amoako, Madise and Nyovani, 2011).

A study conducted on the factors affecting decision making of low-income young women with unintended pregnancies in Bangkok revealed several factors at two levels (individual and family) that showed statistical significance. Of the 15 study variables, 6, (age of the most recent unplanned pregnancies, attitude towards contraception, attitude towards unintended pregnancy, making a decision with- out consultation, relationship with partner, and consulting partner when having a problem) influenced the choices of the young women. The study however noted that, many external factors including society, the community, and most importantly abortion law, which impact upon the choices of young women with unintended pregnancies were not studied. Knowing the influencing factors for the choices of women with unplanned pregnancies allows explaining the women's decisions and their utilization of services with some degree of confidence (Naravage, Vichit-Vadakan, Sakulbumrungsil and Putten, 2009).

Reproductive health and rights are important ends in themselves. They form a foundation for satisfying relationships, harmonious family life and the dream of a better future. Reproductive Health and rights are also keystones to meeting the Millennium Development Goals (MDGs): They offer women and young people greater control over their own destinies and afford them opportunities to overcome poverty. Yet poverty and gender discrimination prevents millions of people around the world from exercising their reproductive rights and safeguarding their reproductive health.

A successful fight against poverty requires a healthy population free of reproductive problems. Though almost entirely preventable, reproductive health problems remain widespread in much of the developing world. These problems include maternal deaths, unintended pregnancies, high fertility, abandoned children, unsafe abortions and AIDS, as well as sexually transmitted infections and the cancers, infertility and

newborn illnesses associated with them (UNFPA, 2005). Although reproductive health was not specifically included as an independent goal or a measurable target in the MDGs, for years experts have provided evidence that investing in reproductive services is integral to meeting them all (Sonfield, 2006).

Besides the personal and familiar hardships that unintended pregnancies cause, a burden is placed on society as well. Women who experience unintended pregnancies tend to be in denial about their pregnancy symptoms, which leads to late initiation of antenatal. Early antenatal care is associated with positive pregnancy outcomes, while unintended pregnancies are more likely to result in low birth weight infants. Low birth weight infants are extremely costly in their first few months of life and mothers of unwanted children are more likely to be depressed and often have lower quality relationships with their children. They are also less likely to breast feed their children which puts them at a disadvantage since breast fed children are sick less often and test significantly higher on IQ tests. Unintended pregnancies put a strain on public sector resources as well (PRB, 2011; Piedrahita, 2000). Published studies showed that unintended pregnancy is associated with late initiation of prenatal care, low birth weight, child abuse and neglect, behavioural problems in children, increased risk for exposure to tobacco or illicit drugs, missed opportunity to use folic acid supplementation, pregnancy-related problems, depression in pregnancy and high prevalence of postpartum depression. In fact, when women with unintended pregnancy do not receive proper care during pregnancy, the possibility of obstetric complications that cause maternal and child deaths increases(Yanikkerem, Ay and Piro, 2013).

From a societal perspective, unintended conceptions carry a high cost. About one-half of unintended pregnancies among women 15 to 34 years old are terminated by abortion. For older women, the proportion ending in abortion increases to almost 60 percent. This reflects the higher proportion of unwanted conceptions among the unintended pregnancies of older women. Married women terminate more than one-fourth of their unintended conceptions.

Influence of socio-demographic characteristic on unintended pregnancy

Of those who believed that there are social consequences, most of them mentioned the economic impact on the family and the society due to too many unwanted children. Similar to the findings of in-depth interviews, a large proportion of respondents thought that unintended pregnancies may create misunderstandings between husband and wife and also with family members that may result in frequent quarrels in the family. Over one-third of men and women considered social shame is one of the social consequences.

Fecundity rate

A community based survey carried out in Nigeria by The Alan Guttmacher Institute (AGI) and Campaign Against Unwanted Pregnancy (CAUP) between 2002 and 2003 showed that almost one-third (28%) of women of childbearing age say they have had an unintended pregnancy. The proportion is higher in the North than in the South, but higher among rural women than among their urban counterparts (30% versus 24%). The proportion is also higher among women with at least four children than among their childless counterparts (29% versus 23%). This difference reflects that women with more children are generally older, which means that they have been exposed to the risk of unintended pregnancy for a longer time. Unwanted pregnancy is less prevalent among women with no education than among those who have had some or great deal of schooling (22% versus 30-31%). The survey also found that unintended pregnancy is more common among women not currently using a modern contraceptive method than among those using (49% versus 24%).

Although Nigerian women and men still want large or medium size families, almost a third (28%) of women of childbearing age have had an unintended pregnancy at one time or the other (Sedgh et al, 2009; Bankole, 2004). Unintended pregnancy reflects the broader context of the Nigerian society and women's lives. Sexual activity outside of marriage has increased as women stay in School longer and marry later thus giving rise to increase in out-of-wedlock pregnancies many of which are unintended. Growing urbanization, the increasing participation of women in the paid labour force and the diminishing ability of families to support many children (due to the economic situation in the country) all lead to a desire for somewhat smaller families and in the

absence of contraception, the fewer children couples plan to have, the higher the proportion of pregnancies that are unintended.

Age at first sexual intercourse

Another study carried out to identify the characteristics and factors influencing unintended pregnancy among unmarried young women in a rural community in south-east Nigeria showed that over 75% of the girls had their first sexual intercourse by 19 years, and over 69% had multiple partners. Over 95% had sex for economic reasons and exchanged sex for money or gifts. Only 13.5% ever used condoms. Ninety seven per cent suffered violence such as beating and verbal abuse from family members because of the pregnancy. Most of the adolescents or young women experienced major stressors, most importantly school and job termination, partner's negative attitude, religious sanction, discrimination and stigmatization as a result of the unintended pregnancy. Over 27% of the girls attributed misleading information as contributing to their getting pregnant. Such misleading information is often obtained from uninformed peers and medical quacks. Confusing and misleading information on safe period, painful menses, puberty maturational problems and emergency contraception were mentioned by the girls as major problems (Amobi and Igwegbe, 2004).

World-wide Statistics

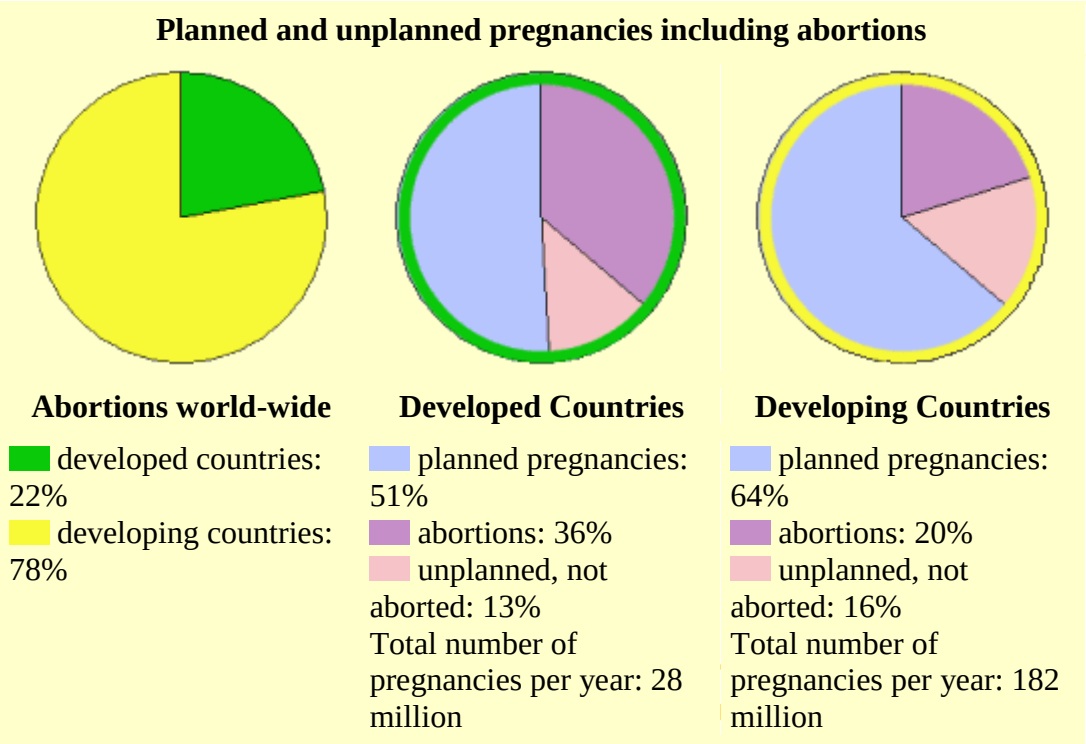

Figure 2.2: Worldwide Pregnancies and estimated outcome

Sources: Center for Bioethical Reform, Alan Guttmacher Institute, (2000)

Those considered at risk of unintended pregnancy are sexually active fertile women who are not pregnant intentionally or trying to get pregnant (AGI, 2000). Within the at-risk for unintended pregnancy population, women living in poverty have a greater risk of unintended pregnancy and poor birth outcomes (Henshaw, 1998). The findings from a survey conducted in Nepal in 2003 on consequences of unintended pregnancy suggest that conflicts with spouses and family members, depression, worries or mental tension, loss of education and employment opportunities were the major anticipated socio-psychological consequences of unintended pregnancies. Reduced prenatal and postnatal care, unsafe abortions, post-abortion complications, and maternal deaths were the major expected outcomes of an unintended pregnancy.

In general, the perceived opinions on socio-psychological consequences corroborated with real experiences. However, there are some differences between the perceived opinions and real experiences when it comes to the health consequences.

A PRB survey carried out in the Middle East in 2009 revealed that, pregnant women with higher numbers of children tend to report their pregnancy as unintended at a

higher rate. The percentage of women who said that they did not want to have their pregnancy at all increases as the number of children they have increases. In Morocco, for example, 33 percent of pregnant married women who already had three or four children said they did not want the pregnancy at all, compared with 6 percent of those who had one or two children. In Yemen, one in 10 married women who had given birth to at least five children were pregnant, and three quarters of them said they did not want that pregnancy; with nearly half of them saying that they did not want it at all (PRB, 2010).

Socio-economic influence

Globally, each year, nearly 70 million women have unintended pregnancies (Global Health Council, 2002)**.**The impact of these pregnancies will vary immensely depending on such factors as a woman's health, family relationships, economic resources, and the availability of medical care. These and other factors will influence her decision to either carry a pregnancy to term or seek an abortion. Given the complexity of this decision, the only person equipped to make it is the pregnant woman herself. Unsafe abortion can have devastating effects on women's health. Where death does not result from unsafe abortion, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain or pelvic inflammatory disease (Centre for Reproductive Rights, 2004).

The consequences of unintended pregnancies are serious. When a pregnancy is begun without planning and intent, there is less opportunity to prepare for an optimal outcome.

Unintended pregnancy in marriage

Marriage is associated with more predictable and more frequent sexual intercourse (AGI, 2003).The statistics "*show that marriage is not, in and of itself, a solution to the problems women have in controlling their fertility: In fact, poor women who are married have unintended pregnancy rates more than twice as high as those of higher-income women who are unmarried or cohabiting*," (Roan, 2011).

United State annual report revealed that, each year, of the 3.5 million pregnancies among married women in the US, more than one-quarter are unplanned. Married women still account for nearly one million unplanned pregnancies each year.Although

most married women experiencing an unintended pregnancy carry their pregnancies to term, 27% of unintended pregnancies that occur to married women end in abortion (The National Campaign, 2008). Women of all racial and ethnic backgrounds deal with the issue of unintended pregnancy, whether they are teens, single women or married women (Indianapolis Women Magazine, 2009).

A study conducted in Iran, also revealed that unintended pregnancy among married women is high in Iran, despite the widespread use of contraceptives. In an analysis of data from the 2000 Iran Demographic and Health Survey, 35% of 5,427 currently married women who were pregnant classified their pregnancy as either mistimed or unwanted. Two-thirds of women with unintended pregnancies had been using a method at the time the current pregnancy occurred (72% of urban women and 63% of rural women), of whom 48% were relying on the pill, 11% on the condom, 30% on withdrawal and 12% on another method (Abbasi- shavazi et al, 2004).

In Ethiopia, many women are experiencing unintended pregnancy. For example, Ethiopian Demographic and Health Survey of 2005 reported that 35% pregnancies among women in reproductive age were unintended (CSA and ORC Macro, 2006). As a result, significant proportion of married women turned to induced abortion to avoid unintended birth. According to Ministry of Health 2006 report, approximately half a million pregnancies annually end in induced abortion among 3.7 million pregnancies, which is a reflection of the high rate of unintended pregnancy (Geda and Lako, 2011).

According to a research on unintended pregnancy and associated factors among married women carried out in Nigeria in 2006, unintended pregnancy poses significant public health risks. One consequence of unwanted pregnancy is induced abortion. In the mid-1990s, the abortion rate in Nigeria was estimated at 25 per 1,000 women. At this rate, approximately 760,000 abortions will occur in 2006. Since abortion is illegal in Nigeria except to save a woman's life, many procedures are conducted under unsafe conditions and carry a substantial risk of maternal morbidity and mortality. It is estimated that about 25% of women who have abortions in Nigeria experience complications. Nigerian women often turn to abortion to avoid unwanted births. The provision of family planning counseling and information could substantially reduce the incidence of unwanted pregnancy and induced abortion in Nigeria (Sedgh, et.al, 2006).

Consequences of unintended pregnancy

Unsafe abortion

Women with an unwanted pregnancy are faced with a difficult decision. Deciding whether to terminate an unwanted pregnancy or have an unwanted child is influenced by many factors, including the availability and accessibility of induced abortion services, the social acceptability of childbearing and induced abortion, and support from social structures. Either choice has social, financial and health consequences that are not equally experienced among women.

Abortion is defined by World Health Organization (WHO) as a pregnancy that ends before 28th week of gestation. Abortions are divided into two groups as: (1) induced abortion and (2) spontaneous abortion. The spontaneous abortion rate increases when the maternal and natal care is insufficient. Induced abortions occur at the desire of the couple and an increase in induced abortion rate is a good indicator of insufficient family planning services. The aim of the family planning services is the prevention of unwanted pregnancies. Inadequate access to contraceptive methods, method failure caused by misuse of the methods and non-use of effective methods are the reasons of unwanted pregnancies, which lead women to induced abortion

Induced abortion in Married women

Unintended Pregnancy is the underlying cause of induced abortion. It has been observed that most women of reproductive (aged 15 – 49 years) regardless of their status/and level of education face difficulties in regulating their fertility and as a result, still find themselves victims of unintended pregnancies. The reasons for not wanting a pregnancy vary from being too young and single to not desiring more children or the wish to delay the next birth in the case of married women (AGI and CAUP, 2003). This is because large families need care and meeting those needs reduces the mother's opportunity to work and earn money to support the family. So, high levels of unintended pregnancy are at the very heart of why large numbers of women seek induced abortion each year. About one–third of all unintended pregnancies in Africa end in abortion (Singns et.al., 2009; WHO, 2007).

Induced abortions have been used as a family planning method for many years and become an important problem in women's health especially in developing countries (Akin, 2002). It is one of the main causes of death of women of reproductive age.

Induced abortions have many health disadvantages especially when performed in unsafe conditions. In a study, it has been found out that abortion may be a risk factor for subsequent depression for a period of 8 years after pregnancy occurs. In another study, the mortality rate for induced abortion was found to be 5.3% and this accounted for 21.1% of the total maternal deaths for this period. As it is seen from these studies, induced abortions have many health disadvantages for women and thus induced abortions should not be used as a family planning method.

Several procedures are currently available to assist women with safe termination of pregnancy. Expansion of safe induced abortion services into remote and rural areas is possible largely as a result of advances in medical technologies, which have reduced cost and simplified procedures (AGI, 2008; Grimes, 2006; WHO, Warriner et.al., 2006). Complication rates for these procedures are extremely low, with almost all abortion-attributable morbidity and mortality resulting from untrained providers, use of harmful procedures or failure to use appropriate infection prevention procedures (Ahman and Shah, 2002). "Unsafe abortion" is defined as a procedure for terminating pregnancy carried out by attendants without appropriate skills, or in an environment that does not meet minimum standards for the procedure, or both (WHO, 2003). Unsafe abortion is a major cause of maternal mortality, accounting for an estimated 13% of maternal deaths worldwide (Grimes,et.al., 2006). The highest estimated rate of unsafe abortion is in Latin America and the Caribbean, where there are 33 unsafe abortions per 100 live births, followed by Africa (17 per 100 live births) and Asia (13 per 100 live births) (Sedgh, 2007).

In 2005, an estimated 5 million women were hospitalized for treatment of complications from unsafe abortion (Singh, 2006). Rates of unsafe abortion are highest among young women (Shah and Ahman, 2004), with almost 60% of unsafe abortions in Africa occurring among women under age 25 (Shah and Ahman, 2004). A number of studies have documented higher complication rates and mortality resulting from unsafe abortion among women of low socioeconomic status (Chowdhury et.al., 2007; Korejo, Noorani and Bhutta, 2003).

A 1991 study of women who had procured abortion in selected hospitals in Shangai, China showed that married women aged 25-29 years represented the largest proportion of abortion seekers, followed by women aged 30-34 years. The two age

groups represented 61 percent of the women in the sample. Majority (80.8%) of the women had completed junior and senior middle school while only ten percent had finished primary school or less. The women who had the highest proportion of induced abortion were transport workers; the second highest were technicians; and the third highest were service workers. The study also noted that married urban women had higher abortion rates than unmarried women (Shi-xun, 1991).

In Nigeria, it is estimated that about 40% of maternal deaths are from abortion and its complications. Although abortion is only legal in Nigeria only to save the life of the woman but thousands of women resort to it each year. Illegal and unsafe abortions have been identified as an important challenge associated with women's reproductive health in Nigeria by several researchers over the decades. In Nigeria, roughly one in five pregnancies each year are unplanned; of these unplanned pregnancies, slightly more than half end in abortion (AGI, 2006). Abortion has also been found to be prevalent among all classes of women in Nigeria. This is evident in various studies that have been conducted in time past. For example, some studies have shown that a high proportion of those who sought abortion were unmarried, nulliparous and unemployed, and were either students or traders (Oye-Adeniran *et.al.*,, 2004; Ikechebelu andOkoli, 2003). Others have revealed that abortion is also prevalent among married women as well as adolescents (Shah andAhman, 2004; Adewole, Oye-Adeniran, Iwere, Oladokun, Gbadegesin and Babarinsa, 2002). One in seven Nigerian women of reproductive age has attempted to end an unwanted pregnancy at some point in their lives. This is a minimum estimate, given women's frequent reluctance to report that they have had an abortion (Okonofua, 2005).

Induced abortion currently accounts for 20,000 of the estimated 50,000 maternal deaths that occur in Nigeria each year. It is thus the single largest contributor to maternal mortality. Induced abortions occur amongst young adolescents, married women, commercial sex workers, widows, divorcees etc regardless of their status or location. More often, induced abortions are usually obtained clandestinely and are frequently unsafe. Unsafe abortions are often the end result of an unwanted pregnancy which in turn is often the result of lack of contraceptive use. The practice of abortion is by no means a new phenomenon in Nigeria, although the main reasons women seek abortions is their desire to avoid premarital births and to control family size while de-

emphasizing more traditional reasons such as spacing births to protect infant health and appearing to adhere to the social norm that they should abstain from intercourse when breastfeeding (Bankole, 2006).

Irrespective of the Nigerian law which make it a crime to perform or to obtain an abortion except to save a women's life and with the penalties for any person who performs an abortion , as well as for any woman who seeks an abortion or who attempts to cause her own miscarriage, women in Nigerian obtain abortions mainly from physicians providing the service in private clinics and hospitals but majority of these women still terminate their pregnancies through unsafe means resulting in severe health consequences for the women. There are no measures of the nationwide incidence of induced abortion in Nigeria. Yet the incidence of abortion is an important indicator of the availability and use of contraceptive service and measuring the extent of abortion–related care is essential to quantifying and comparing the social and health implications of induced abortion relative to other health or service needs.

Complications of abortion

Despite the penalties attached to the termination of unwanted pregnancy in the country, abortion is still carried out daily both by trained and untrained personnel, albeit with the utmost secrecy; except when it becomes complicated. A national survey indicated that about 610,000 pregnancy terminations occur in Nigeria yearly, and about 141,000 patients were treated for complications of pregnancy termination. The majority of induced abortion seekers end up with quacks at a very high risk to their health, as frequently these become complicated (Adewole, 2002).

Despite the controversies surrounding termination of unwanted pregnancies, many medical doctors, specialists and non specialists as well as non- medical personnel still provide services for pregnancy termination. Some doctors and nurses performing D&C procedures despite their medical qualifications likely lack experience, proper training and appropriate equipment (Adewole, 2002). As earlier pointed out, abortion in Nigeria is illegal except to save a woman's life. Of the estimated 6.8 million pregnancies that occur annually in Nigeria, one in five is unplanned and half of these end in an induced abortion. (Guttmacher Institute, 2008) Abortion is therefore common in Nigeria and most procedures are performed under unsafe, clandestine conditions. In 1996, an estimated 610,000 abortions occurred (25 per 1000 women of

childbearing age), of which 142,000 resulted in complications severe enough to require hospitalization. The number of abortions is estimated to have risen to 760,000 in 2006 *(*Bankole,et.al., 2006). Unsafe abortions are a major reason Nigeria's maternal mortality ratio – 1,100 deaths per 100,000 live births- is one of the highest in the world (WHO, 2007). According to conservative estimates, more than 3,000 women die annually in Nigeria as a result of unsafe abortion *(*Henshaw, et.al., 2008)

In Nigeria, the situation is still gloomy. Complications of induced abortion are being treated daily in our health institutions. Several efforts have been made to quantify, the financial cause of treating these complications based on the type of complication (Konje, 1992) the need for surgical or medical care, and the blood transfusion and hospitalization. As a matter of fact, that 60% of terminations in Nigeria are still being done by unskilled providers using unsafe methods like dilatation and curettage, a range of often harmful and ineffective drugs and insertion of solid or sharp objects into the cervix to perform abortion suggests a high post abortion complication rate (Oye-Adeniran, 2004).

Prevalence of maternal death through abortion

World Health Organisation (WHO) estimates that one in five of the 210 million women who become pregnant each year worldwide resort to abortion (UNFPA, 2007). Out of the estimated 46 million abortions carried out globally every year, 19 to 20 million are unsafe. Five million and three hundred thousand women (5.3 million) are also estimated to suffer disabilities as a result of unsafe abortion globally while 13 percent or one in every eight of all maternal deaths that occur every year is related to unsafe abortion (UNFPA, 2007). Nigeria accounts for 20 percent of the global estimates of abortion-related deaths (Health Reform Foundation of Nigeria [HERFON], 2006). Furthermore, unsafe abortion has been found to increase the risk of ectopic pregnancy, preterm delivery and miscarriage. The overwhelming burden of death and disabilities due to unsafe abortions carried out in developing countries fall especially on poor women (UNFPA, 2007). Up until almost a decade and half ago, approximately 610,000 abortions, a rate of 25 abortions per 1,000 women aged 15-44 was carried out in Nigeria annually (Orisaremi, 2012). While current figure is not immediately available, the Society of Gynaecologists and Obstetricians of Nigeria (SOGON) estimates that about 20,000 Nigerian women die from unsafe abortions

each year and that adolescents constitute about half of this figure. This death rate from unsafe abortion is one of the highest in Africa (Raufu, 2002). Rather than being spontaneous, much of this is induced and the illegality that characterizes induced abortion in Nigeria renders the practice clandestine and perilous for many women.

Lack of existing laws that support or approve a woman's choice to procure abortion has often been blamed for the high rate of unsafe abortion in Nigeria (Raufu, 2002). Thus, intervention strategies designed to reduce unsafe abortion in Nigeria pay very little attention to the non-medical or socio-cultural factors that expose women to carrying unwanted/unplanned pregnancies that may eventually bring about the quest for induced abortion whether safe or unsafe.

Moreover, literature on non-medical conditions that influence induced abortion are also health facility related as they often point to factors like universal access to RH education and family planning (FP) services; availability of and access to modern health facilities; women's health seeking behaviour; etc. Not much attention is given to understanding and documenting the critical role of social and cultural factors in unintended pregnancy and abortion.

Control over fertility and access to safe maternity care are fundamental to health and human rights and are strongly influenced by social determinants. Reproductive health problems are the leading cause of women's ill health and death worldwide. When both women and men are taken into account, reproductive health conditions are the second largest cause of ill health globally, after communicable diseases (UNFPA, 2005).

Gender role

Gender role that is a set of socially significant activities associated with being male or female is variable and changes from time-to- time, culture-to-culture and even from family-to-family within the same society. Internationally, young peoples' reproductive health has been a major concern for sometimes now both because of an urgent need to reduce the high levels of unintended pregnancy and sexually transmitted infections, and because of a desire to improve less tangible aspects of health including psychological well-being. Youth (15-24 years) who largely define the socio-economic and political future of a population comprise of nearly 20 percent

of India's population (United Nations, 2011). However, social vulnerabilities persist and transitions to adulthood are often marked by abrupt and premature exit from school, entry into the labour force/marriage and strongly held gender norms (Jejeebhoy and Sebastian, 2004). Further, the fact is that these young people are at a very vulnerable, yet crucial phase of their lives coupled with lack of and/or poor knowledge on matters related to sexuality, reproductive health and their inability, inaccessibility and/or unwillingness to use family planning and health services puts them at a significant risk of experiencing negative consequences (Pradhan and Ram, 2007; Verma and Lhungdim, 2004; Jejeebhoy and Sebastian, 2003; Collumbien, et.al., 2001). Moreover, societies that dictate different attitudes towards males and females with respect to youth sexuality and where talking about sex with young people continues to be a stigma, may further contribute to the risk taking behaviour and unwanted health outcomes (Hardee ,et.al., 2004 and Miller and Whitaker, 2001).

Gender disparities and double standards have a considerable influence on the sexual and reproductive health and lives of young people (Tangmunkongvorakul et.al., 2005). In many parts of the world marriage is interpreted as granting men the right to unconditional sexual access to their wives and power to enforce this access through force if necessary. Inequalities in power often make women vulnerable to men's risky sexual behaviour and irresponsible decisions.

Unintended pregnancy, which includes both unwanted and mistimed pregnancies (Santelli, et.al., 2003) is undoubtedly an important indicator of the state of reproductive health, as almost all women are at risk of unintended pregnancy throughout the reproductive years (Forrest, 1994) and it occurs in all socio-economic strata of the society (Moos, 2003). In India, almost 75 percent of the conceptions are unplanned; more adolescent girls aged 15-19 years die from pregnancy related causes than from any other cause and almost 90 percent of the induced abortions are performed by unqualified persons subjecting women to the risk of mortality as well as morbidity (Puri, 2005). Langer (2002) opines that the desire to have small family, unmet need for family planning and the ineffectiveness of family planning methods besides the unwanted sexual relations have found to be the important reasons for classifying a pregnancy unwanted. Besides this, other factors associated with unwanted pregnancies are younger age (Sedgh et.al., 2006 and Islam et.al., 2004),

marital duration and number of sons (Khan et.al.,2006), higher parity (Islam et.al., 2004), low socio-economic status (PRC, 2001), unmet need of contraception (Senanayake, 2001), level of dependability and support from partner (Kroelinger and Oths, 2000), barriers in accessing contraception (Islam et.al.,2004), behavioural problems in the offspring (Moos, 2003) besides contraceptive failure and rape (Klima, 1998). Another study by Ram (2001) among the tribal and Muslim women in India has revealed son preference, accessibility to RCH services, exposure to mass media and decision-making power of the women besides education of the couple as important determinants of unwanted pregnancy/birth.

Studies by Islam, et.al., (2004) and Ram (2001) has found the lack of association between contraceptive knowledge and pregnancy intention, which means awareness does not always show an ability to obtain the methods or to use them correctly.. Women who experience unwanted pregnancy are at greater risk of complicated pregnancy outcomes and their children are more likely to experience physical or psychological problems in infancy than those women with wanted pregnancies (Kroelinger and Oths, 2000).

Influence of male partners

Involving men in reproductive health has been found to have a positive impact on women's health in a number of ways, including improving maternal health care utilization, preventing or reducing the transmission of sexually transmitted infections (STIs), including HIV/AIDS, and improving contraceptive use—effectiveness and continuation. One study in Egypt found that husbands who received counselling at the time of their wives' abortions were more likely to be supportive during the recovery period. However, despite the surge of interest in this area, there is a lack of consensus about what it means to involve men in reproductive health programs and uncertainty about how such involvement will affect women's health and status. The extent of male involvement in abortion decision-making remains uncharted, yet it is important from a policy standpoint. This is because existing gender inequalities between women and men have a significant influence on sexual health, male partners can play an important role in determining women's ability to access safe abortion services, from both a social and economic standpoint (CREHPA/PATH, 2007).

Certain researches have shown some evidence that fathers' pregnancy intentions matter. Specifically, a child whose conception was intended by her mother generally appears to do better if the pregnancy was also intended by her father. However, there was no evidence that a child whose conception was not intended by his mother does better if the pregnancy was intended by his father. This pattern of results suggests a new classification of unintended pregnancy: conceptions intended by both parents and those not intended by one or both parents. Children born following an unintended pregnancy so defined are at elevated risk of having a mother who delayed prenatal care, did not breastfeed and, possibly, smoked heavily during pregnancy (Ted, 2002)
Attitudes and behaviours of male partners may influence women's intentions, sexual behaviour, contraceptive use and parenting. A study carried out in Indianapolis in 1941 interviewed couples, but later surveys have interviewed only women. (The National Survey Family Growth (NSFG) included men for the first time in 2002) Current surveys often ask women to indicate their male partner's intentions, but relevant data are not usually collected directly from men, and discordance in intentions between partners is common. In the 1988 NSFG, women reported different intentions for themselves and their husbands for 30% of births. Zabin and colleagues have argued that changing marriage and partnership patterns may influence pregnancy intentions, and that women's desire for children may be more strongly tied to meeting the needs of a particular partner than to abstract notions about ideal family size. Partners' disagreement about pregnancy intentions is associated with instability in women's reported pregnancy intentions and with the likelihood that a pregnant woman will engage in behaviours that may have adverse effects on her infant (Santelli et al, 2003).

Unintended pregnancy and HIV/AIDS related issues

Although AIDS-related deaths among U.S. women have decreased, the number of HIV-positive women has increased, and more than half of infections are among black, non-Hispanic women. Given that the majority of HIV-positive women are of reproductive age (13-44 years) (Centers for Disease Control and Prevention (CDC), it is necessary to understand the interaction between HIV and family planning, especially as antiretroviral medications allow HIV-positive women to live longer, healthier lives (Kirshenbaum, Hirky, Correale, Goldstein, Johnson, Rotheram-Borus and Ehrhardt, 2004).

Pregnancy decision-making is complicated for HIV-positive women. They must contend with unpredictable symptoms and prognoses, the potential for vertical (mother- to-infant) transmission and often problematic life contexts such as poverty, substance abuse and stigma that may compromise parenting abilities. Few differences have been found between the reproductive beliefs, attitudes and behaviours of HIV-negative and HIV-positive women (Wilson, et.al., 2003). Infected women are no less likely than other women to become pregnant (Kirshenbaum, et.al., 2004) and are no more likely to terminate a pregnancy (Kirshenbaum, et.al., 2004). The HIV Cost and Services Utilization Study (HCSUS), which examined fertility desires of a large sample of HIV-positive men and women in the United States, revealed that 12% of all infected women and 26% of those younger than 30 conceived after diagnosis. An additional 10% (15% of those younger than 30) had their infection diagnosed during a pregnancy and carried to term (Schuster, et.al., 2000).

Women who become pregnant after diagnosis may be younger, be less educated, have been living with HIV longer and have had more previous pregnancies, miscarriages and abortions than women who do not become pregnant. HIV-positive women in poor health may be as likely to become pregnant as their healthier counterparts, but less likely to continue a pregnancy to term (Kirshenbaum, et.al., 2004; Kline, Strickler and Kempf, 1995). In a small convenience sample of rural and urban U.S. women, the serostatus of children born to HIV-infected women was associated with women's future pregnancies. Data from the HCSUS found that while 29% of HIV-positive women acknowledged a desire for children, 31% of those women did not intend to have children. Women who intended to have children had had fewer previous births than others (Chen, et.al., 2001).

Vertical transmission risk may be an important factor in women's pregnancy decision-making. While the majority of HIV-positive women know their HIV status prior to delivery, a substantial proportion of women and their health care providers do not. Taking prophylactic medication during pregnancy can dramatically reduce, but not eliminate, the risk of vertical transmission. The reported rates of mother-to-child transmission are less than 2% for women who begin treatment early in pregnancy; 12-13% among women who do not initiate treatment until labor, delivery or after birth; and 25% among women who do not receive any preventive treatment (CDC, 2002).

The perceived risk of bearing an HIV-infected child, rather than a woman's HIV status alone, is often associated with reproductive decision-making (Sowell, et.al., 2002). However, women's knowledge and perception of vertical transmission risk varies widely (Kirshenbaum, et.al., 2004). Some women distrust health care providers, believing they may overestimate vertical transmission risk. Although knowledge of available treatments to reduce vertical transmission may lead women to consider pregnancy, other factors may play an important role in pregnancy decisions (Kirshenbaum, et.al., 2004).

Having or wanting children is generally accepted as the norm for women in the United States, regardless of HIV serostatus (Kirshenbaum, et.al., 2004). Some circumstances may affect whether or not a woman conforms to this norm, including serious medical conditions, such as HIV, or lack of adequate parenting resources. However, even in the presence of such circumstances, not having a child is often viewed as a norm violation (Kirshenbaum, et.al., 2004). HIV-positive women may be in a sociocultural double bind, in which their desire for children violates beliefs about "acceptable mothering." Such beliefs may be based on concern regarding the challenges and constraints that some HIV-positive women face, the potential impact on children or the stigma associated with childbearing among infected women (Ingram and Hutchinson, 2000). Stigma associated with poverty, ethnic minority status, public assistance, substance abuse and single motherhood may further complicate the dilemma of HIV-positive women contemplating motherhood. Attitudes of peers, partners and family members, as well as religious beliefs, have also been associated with the decision-making of HIV-positive women (Kirshenbaum, et.al., 2004).

Women's Autonomy

Women autonomy refers to a woman's ability to make and execute decisions regarding personal matters of importance to her based on power over others, access to information, control over material resources, freedom from violence by husband or other men (Jejeebhoy, 2004). It also involves an individual's ability to act independently of the authority of others (IUSSP, 1997). Autonomy implies freedom, such as the ability to leave the house without asking anyone's permission or to make personal decisions regarding contraceptive use. Autonomy indicates the ability

(technical, social and psychological) to obtain information and to use it as the basis for making decisions about one's private concerns and those of one's intimate. It is typically defined as the ability of women to make choices/decisions within the household relative to their husbands.

The low status of women in many countries restricts their ability to make decisions within the household. One way that Demographic and Health Surveys capture this dynamic is by asking women if they are able to decide for themselves to seek health care. In the 30 countries where data were available, an average of only 37% of women report they are able to seek their own care. In 26 of 30 countries, a smaller proportion of women in the poorest households were able to seek care. The rich–poor gap ranges from less than 1 percentage point in Bangladesh (2004) to 32 percentage points in Peru (2000) (Gwatkins, 2007).

Beyond seeking health care, obtaining contraception also frequently requires out-of-pocket expenditure. Women with the autonomy to make decisions about how money is spent are substantially more likely to use contraception than women in couples where the husband makes all such decisions (WHO, 2010).

Sexual violence

A growing body of evidence indicates that sexual violence is part of many women's lives. The WHO Multi-country Study on Women's Health and Domestic Violence against Women documented prevalence rates of forced sex from 15 countries. Lifetime experience of intimate partner sexual violence against women over 15 years old varied from 6% in Japan to 59% in Ethiopia. These figures underestimate the prevalence of sexual violence and coercion as they do not include experience with "unwanted sex" unless it was "forced", and do not include sexual child abuse. In 10 of the 15 settings, over 5% of women reported their first sexual experience as forced, with more than 14% reporting forced first sex in Bangladesh, Ethiopia, Peru and the United Republic of Tanzania (Garcia-Moreno et.al., 2006). Beyond the potential consequences of sexually transmitted infection and unwanted pregnancy, evidence suggests that sexual coercion negatively affects victims' general activity without full and informed consent. These often affect their mental and physical well-being. Sexual violence is also associated with risky behaviours such as early sexual debut and multiple partners (Bott, 2010; Garcia-Morenoet.al., 2005; Watson, Taft and Lee,

2007). Key factors associated with higher levels of sexual violence and coercion includes armed conflict and legal systems that fail to prosecute sexual violence or protect women's civil rights (Bott, 2010).

Pregnancy outcome

Women living in every country, irrespective of its development status, have been facing the problem of unintended pregnancy. Unintended pregnancy is an important public health issue in both developing and developed countries because of its negative association with the social and health outcomes for both mothers and children (Adhikari, 2008). Unintended pregnancy is a key factor for adverse pregnancy and maternal outcomes, including mortality morbidity and unsafe induced abortion (African Population and Health Research Centre (APHRC), 2011).

A study carried out in the United States revealed that unintended pregnancy is also associated with an array of negative outcomes for the women and children involved. For example, relative to women who become pregnant intentionally, women who experience unintended pregnancies have a higher incidence of mental-health problems, have less stable romantic relationships, experience higher rates of physical abuse, and are more likely to have abortions or to delay the initiation of prenatal care. Children whose conception was unintentional are also at greater risk than children who were conceived intentionally of experiencing negative physical- and mental-health outcomes and are more likely to drop out of high school and to engage in delinquent behaviour during their teenage years (Thomas and Monea, 2011).

Pattern of communication with spouse in situations of unintended pregnancy

Inter-spousal communication is an effective means which enables couple to know each other's ideas and attitudes in all areas including the desire about when and how many number of children they want or contraceptive method choice. It can play a vital role in the process of decision making in regard contraceptive practices. Therefore several studies have shown the relation between spousal discussion and the contraceptive use, which affect intention of pregnancy (Adhikari, 2005).

Couple, or spousal, communication can be a crucial step toward increasing men's participation in reproductive health. Since men, as well as women, play key roles in reproductive health, communication is necessary for making responsible, healthy

decisions. Communication enables husbands and wives to know each other's attitudes toward family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues, such as worries about undesired pregnancies or STDs.Communication also can encourage shared decision-making and more equitable gender roles.

In a study conducted among married couples in Nepal in 2004, case studies revealed that the relationships between spouses and family members deteriorate as a result of unintended pregnancy. Fourteen out of 30 respondents (4 men and 10 women) reported that their relationship either with their spouses or other family members were unpleasant when they experienced unintended pregnancy. Both women and men recalled their experiences of misunderstandings between their spouses and with their family members. Most women confirmed that they were looked upon as inferior, and did not get support from the family members. They were even told that they were the "bad books" of the family when they couldn't help in the household works during the time of pregnancy. One woman narrates her personal experience as follows:

> "…*I am not in the good books of my husband's family. I couldn't work, I was tensed on one hand and the family members didn't understand. I think that if that pregnancy not occurred I would have good relationship with the family members"*.

Partners may also influence contraceptive behaviour. Partner influence varies according to the type of contraceptive decision being made and the specific method of contraception. For example, partner support can facilitate consistent use of condoms for pregnancy prevention. Additionally, an examination of DHS data suggests that considering male partners' intentions greatly reduces national estimates of unmet need for contraception. The "second demographic transition"--marked by higher divorce and cohabitation rates, and increases in sexual intercourse and childbearing occurring outside committed unions--may weaken the ability of couples to plan pregnancies. Poor, young and never-married women are the least able to plan pregnancies successfully and jointly with their partner (Gilbert, 2003). This is also consistent with PRB findings in 2009 stating that men can play a large role in addressing social pressure and stigma that impede widespread family planning. Misperceptions by women of their husband's views on contraception and lack of spousal communication about family planning are obstacles that can be overcome. While some husbands

oppose contraception, others support family planning or may be encouraged to support it through programs that involve men in couples counselling, and programs that promote the health benefits of child spacing for mothers and infants. According to a recent WHO review of reproductive health programs involving men, the evidence is significant that even a single individual or couple counselling session with men can lead to increased support for contraceptive use.

Help seeking behaviour among married women in situations of unintended pregnancies

Help-seeking can be viewed as a multi-dimensional information behaviour which often overlaps with both information seeking and searching (Collen 2012). The concept 'help-seeking behaviour' has gained popularity in recent years as an important vehicle for exploring and understanding patient delay and prompt action across a variety of health conditions. The term is used interchangeably with health seeking and is described as part of both illness behaviour and health behaviour (Cornally et al, 2011).

The benefits of maternal health care to maternal and neonatal health outcomes have been well documented. Antenatal Care (ANC) attendance, institutional delivery and skilled attendance at delivery all help to improve maternal and neonatal health (Yohannes, 2013).

Good care during pregnancy is important for the health of the mother and the development of the unborn baby. Pregnancy is a crucial time to promote healthy behaviours and parenting skills. Good ANC links the woman and her family with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle. Inadequate care during this time breaks a critical link in the continuum of care, and affects both women and babies:

In a study conducted to assess the incidence, pattern of presentation and management of complications resulting from unsafe abortion as well as the associated demographic variables at the Lagos Island Maternity Hospital which involved a cross sectional survey of all cases with complicated induced abortion. The study revealed that majority of the patients was young 21.7% were teenagers between 14 and 19 years while 32.6% were in the 20-24 year age group. The majority (64.0%) were single

while 30.9% were married, 1.7% were divorced, while 3.4% were separated. 81.2% of the patients knew about modern methods of contraception but only 34.5% had ever used contraception and only 8.6% were using contraception when they became pregnant. Medical doctors were the abortionists in 46.9% of the cases, followed by nurses (17.7%) and traditional practitioners. Retained products of conception was the commonest complication (77.1%) followed by anaemia (48.6%) and sepsis (44.6%). Evacuation of the uterus was the commonest surgical procedure done. There were 16 maternal deaths giving a case fatality rate of 9.14%. Sepsis was the commonest cause of death (Rabiu,et.al., 2009).

Family planning and use of contraceptives

Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods. Contraception is the science of preventing pregnancy with the aim of spacing children or limiting family size. Oxford Dictionary defines it is as an effective way of preventing unwanted pregnancy and induced abortion. Contraception can also be defined as the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. This means that something (or some behaviour) becomes a contraceptive if its purpose is to prevent a woman from becoming pregnant. There are several types of contraceptives that have been officially labelled as such because they have shown reliability in preventing conception from occurring (Dawn, 2009).

Contraceptive Methods

There are two contraceptive methods

1. Modern Methods
2. Traditional Methods

The modern methods are available in different forms – Oral Contraceptive Pills injectables, foaming tablets, intra-uterine devices (IUDs), cream jelly, implants and barriers in the form of condoms for females and males. The traditional methods include ring, hamlets, etc.

Between 1992 and 1993, an information, education and communications campaign was launched to change Nigerians' attitudes toward family planning, and to thereby

increase their contraceptive use. The campaign was based on evidence that family planning messages relayed through the mass media can influence contraceptive behaviour. For example, in Nigeria, one-quarter of new clients attending a family planning clinic identified a television campaign as their source of referral. Similarly, a mass media effort in the Philippines promoting sexual responsibility substantially increased requests for contraceptive information among adolescents. Other studies have shown that exposure to a mass media family planning campaign increases contraceptive use (Odimegwu, 1999).

Several studies have reported changes in Nigerians' knowledge of and attitudes toward family planning. These studies, however, did not examine the association between attitudes toward contraception and its use. In the 1981-1982 Nigerian Fertility Survey, only 34% of all women reported that they had heard of any family planning method. By 1990, when the Nigerian Demographic and Health Survey was conducted, the proportion of women who knew of any contraceptive methods had increased by about one third, to 46%, and the proportion of women who knew of specific methods also had grown. Furthermore, 41% of married women who knew of a contraceptive method had discussed family planning with their husbands. Although the majority of them had discussed the topic with their husbands only once or twice, a substantial proportion had done so more often. Seventy-one percent of married women who knew a family planning method said that their husbands also approved of family planning (Odimegwu, 1999).

Contraceptive use is still low in Nigeria, particularly among married women. According to the Nigeria Demographic and Health Survey 2003, only 7% of married women aged 15-49 years were using an effective modern method of contraception, unintended pregnancy is inevitable. Although a majority of married Nigerian women either do not want any more children or do not want a child soon, most of them are not using modern methods of contraception to prevent further pregnancies.At present, 15% of currently married women in Nigeria are using a contraceptive method indicating only a two percentage point increase from the 2003 NDHS. The majority of contraceptive users rely on a modern method (10 percent of currently married women), and 5 percent use traditional methods. Among the modern methods, injectables (3 percent), male condoms (2 percent), and the pill (2 percent) are the most

common methods being used. The practice of all other modern methods is far less under 1 percent). Interestingly, 3 percent use withdrawal as a method of contraception (NDHS, 2013; NDHS, 2008, NDHS 2003,AGI, 2005).

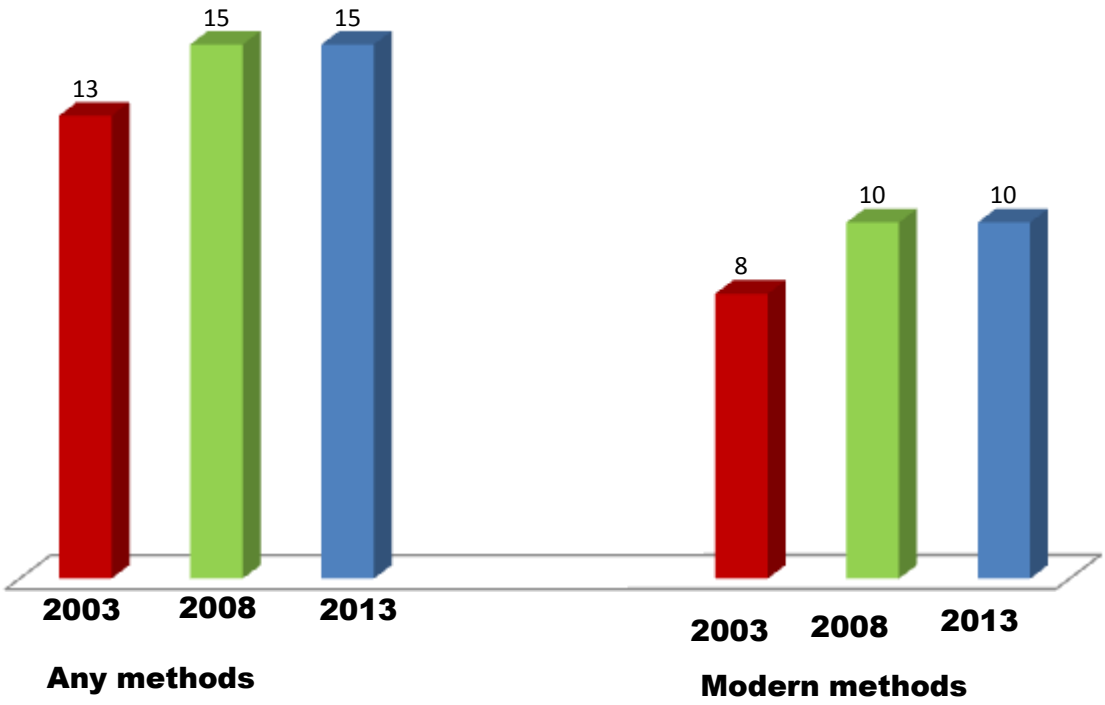

Figure 2.3: Prevalence of contraceptive use among married women in Nigeria
Source: Nigeria Demographic and Health Survey (NDHS), 2013

According to national surveys, Nigerian women and couples want fewer children than they once did: Between 1990 and 2003, the mean desired number of children declined from 5.8 to 5.3. Even so, levels of contraceptive use remain low. In 2003, only 7% of married women used a modern contraceptive method and another 6% relied on a traditional or folk method. The combination of low contraceptive use and smaller desired family size implies high levels of unmet need for family planning in Nigeria. Indeed, among married women of reproductive age, 32% do not want to have a child in the near future but are not using a modern contraceptive method, and are therefore at risk of an unwanted pregnancy (Sedgh, Bankole, Oye-Adeniran, Adewole, Singh and Hussain, 2006).

According to AGI Report 2005, the typical Nigerian woman now has fewer children than she did in the past. In 1978-1982, Nigeria's total fertility rate was 6.4 children per woman. (3) By 1990, it had dropped to 6.0, and by 2003 to 5.7. Rural women have about one child more than their urban counterparts and women in the less developed northern regions also have more children than women in the south (6.7-7.0 in the North West and North East vs. 4.1 in the South West and South East). Yet women in the South-South and South East regions have the largest gaps between their wanted and actual fertility rates, while women in the North West are nearly matching their fertility goals. Overall, women living in both rural and urban areas have more children than they want.

As women become more educated and as Nigeria continues to modernize/develop. Two trends that foster a desire for smaller families – levels of unintended pregnancy may actually rise if the increasing desire for fewer children is not matched by increased contraceptive use. The rate of induced abortion to end unintended pregnancies may also increase (Okpani, 2000). Because the laws against induced abortion are restrictive, more Nigerian women resort to unsafe procedures and continue to suffer the adverse health consequences- already a contributor to high maternal mortality in the Country (WHO, 2004). As a result, increase levels of effective contraceptive use would go a long way towards reducing unintended pregnancy in Nigeria. However, health planners should consider what contraceptive methods are appropriate for women living in widely differing circumstances (Bankole, 2006).

Research on reasons for family planning non-use in Nigeria generally points to women's perceived lack of need for contraception, fear of side effects and opposition to contraception on personal or religious grounds. Less is known about the circumstances surrounding women's unwanted pregnancies and their reasons for seeking to terminate some of these pregnancies. The limited evidence available from small studies in various parts of Nigeria generally points to such reasons as a wish to space births, economic constraints, the desire to remain in school and not being married.

Providing better and more accessible contraceptive service, while important will be insufficient to reduce the incidence of unintended pregnancy and unsafe abortion in

Nigeria. Many other obstacles constrain women's ability to space births and limit their numbers of children. These include a wide spread lack of knowledge about contraceptive methods and where to obtain them, disapproval of family planning by married men and women, women's erroneous perceptions about the side effects associated with modern contraceptive methods, and stigma that restricts women's access to contraceptive service in some parts of the country particularly in rural areas, these barriers to family planning are wide spread.

Family planning is essential to the well-being of families. Health promotion related to family planning means that families will have the knowledge and access to opportunities to plan and space their children in order to achieve personal goals, independence and to prevent costly health and social risks associated with unintended pregnancy.

Contraception's role in unintended pregnancy

Contraceptive use is critical to couples' ability to reconcile their sexual lives and their childbearing goals. However, effective contraceptive use presents significant challenges for women and men all over the world. If a couple wants to have between two and four children, they must practice birth control successfully for 16-20 years. Yet women in many developing countries do not have access to the contraceptive supplies or family planning services they need, because contraceptives are too expensive, supplies are erratic, services are difficult or impossible to obtain, or the quality of care is poor (AGI, 2010).

The typical Nigerian woman has intercourse for the first time at age 17 and reaches menopause at age 51. If she wants only two children, she will have to spend three decades being sexually active but trying to avoid unintended pregnancy. This is not an easy goal for an individual woman to meet.

A large part of many women's reproductive lives, from menarche to menopause, may be spent trying not to become pregnant. Effective contraception is important for women who wish to avoid pregnancy at certain times during their lives. However, recent research noted that 50% of all unintended pregnancies were among women who did not use contraception, and that the overall rate of unintended pregnancy

could be cut in half if these women were to use highly effective contraception (Forest, 1993).

Between the ages of 20 and 44, a fertile, sexually active woman is potentially capable of giving birth about 12 times, even if she breastfeeds each baby for one year. So if the average woman is to have a small family and avoid unintended pregnancies, she will have to practice contraception effectively for many years (AGI, 1999).

There are 123 million women around the world, mostly in developing countries, who are not using contraception in spite of having expressed a desire to space or limit the numbers of their births. About 38% of all pregnancies worldwide every year are unintended, and around six out of ten such unplanned pregnancies result in an abortion. By helping women to exercise their reproductive rights, family planning programs can improve the social and economic circumstances of women and their families.

Whether couples are successful in preventing unplanned pregnancies depends not only on their having reliable access to family planning services but also on how effectively they practice contraception. However, all contraceptive methods have drawbacks. Some have inherently high failure rates, while others are difficult for women (or their partners) to use on a consistent basis (AGI, 2010).

Often contraception is available only in family planning clinics and hospitals, where it is given by trained providers; however, worldwide supplies of contraceptives are available from diverse places. Studies have suggested that conventional family planning clinics might discourage some groups, such as younger people, from using their facilities, an observation backed by findings that report high awareness of contraception in some communities but low usage. But other barriers to contraceptive use include cultural issues, religion, cost, husband/partner's refusal, availability, accessibility, and fear of side effects.

Unmet need for contraception

The "typical" woman with unmet need for modern contraception is 25 years or older, is married, has one or more children and lives in a rural area; about four in 10 are poor. If the woman lives in Sub-Saharan Africa, she likely wants more children after a delay of two or more years; however, if she lives in South Central or Southeast Asia, she probably has already had all the children she wants (Cohen, 2011).

CONCEPTUAL FRAMEWORK

The conceptual framework relevant to the study selected for review is the Ecological model. A conceptual framework describes the relationship of a problem to some concepts. The Ecological model was used in highlighting the linkages among a set of concepts believed to be related to problem under investigation in this study.

Contemporary health promotion involves more than simply educating individuals about healthy practices. It includes efforts to change organizational behaviour, as well as the physical and social environment of communities. It is also about developing and advocating for policies that support health, such as economic incentives. Health promotion programmes that seek to address health problems across this spectrum employ a range of strategies; and operate at multiple levels (National Institute of Health [NIH], 2005).

The Ecological Model

The ecological model emphasizes the interaction between, and interdependence of, factors within and across all levels of a health problem. It highlights people's interactions with their physical and socio-cultural environments. Two key concepts of the ecological model help to identify intervention points for promoting health. The first is that behaviour both affects, and is affected by, multiple levels of influence while the second is that individual behaviour both shapes, and is shaped by, the social environment (reciprocal causation).

McLeroy and associates developed the ecological model for health promotion that links health promotion strategies that target individual behaviours and environmental influences. The ecological model consists of five levels of analysis related to health behaviours and potential interventions. The intrapersonal level of the ecological

model includes an individual's knowledge, attitudes, values, skills, behaviour, self-concept and beliefs. The interpersonal level encompasses social networks, social supports, families, peers and neighbours. The institutional level includes rules regulations and informal structures that may influence behaviour. The community level is comprised of community resources, neighbourhood organisations, and social and health services. The public policy level constitutes relevant legislation, policies and regulatory agencies.

An ecological perspective shows the advantages of multilevel interventions that combine behavioural and environmental components. Clearly, the ecological model stresses a holistic approach to problem identification resolution. The Figure highlights the key concepts of the model while the ecological model as adapted to facilitate the study of factors influencing decision making in unintended pregnancy by married women is presented in figure 2.5

For example, psychological factors (e.g. attitudes, risk taking) that are independent of the situation have been purported to account for unplanned/unintended pregnancy. In addition, situation-specific factors such as the role of lifestyle have also been purported to affect levels of unintended pregnancies. The social dimension is crucial to understanding sexual behaviour. This is evidenced in the contextual and relationship levels, where partner, peers, parents and people in general, play a critical role in determining what individuals think and do and how they attach meanings to behaviour. Therefore, relationship factors associated with the nature and type of sexual partner involved are important when trying to understand sexual behaviour and contraceptive decisions, as are contextual factors (e.g. Spousal influences parental influences, social and gender norms). Finally, service level and policy factors have also been found to be relevant when trying to understand aspects of the wider context and its influence on sexual behaviour.

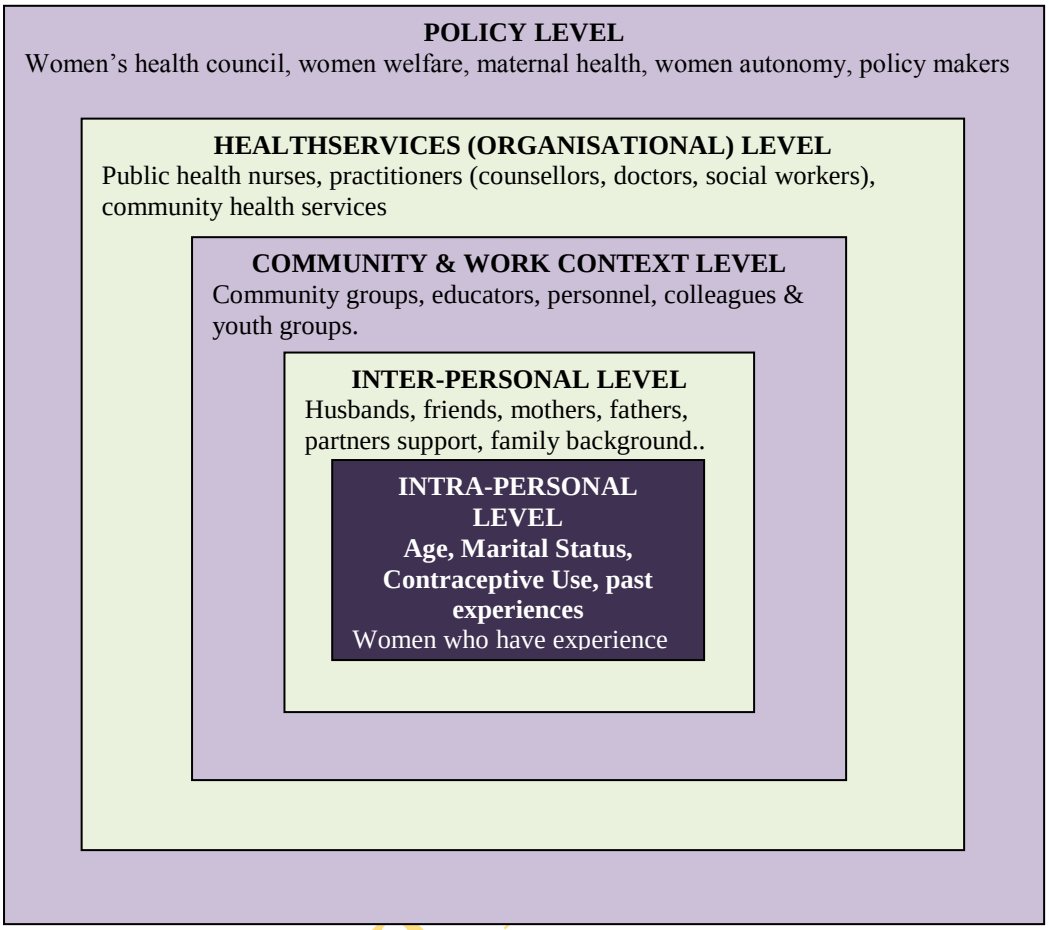

Figure 2.5: Levels of analysis of factors affecting unintended pregnancy

It is important to recognise that the factors relating to unintended pregnancy, described above, are not mutually exclusive. They all relate to, and affect each other in different ways and to different degrees, depending on the circumstances. For example, policy level factors, such as how social, personal and health education, is structured and resourced, have a direct effect on service-level factors (quality of education and who teaches it). This in turn may affect how a young person learns about what to expect to happen to them, physically and emotionally, when they are growing up.

Psychological factors

Psychological factors, specific to the individual, have been found in many studies to differentiate between an individual's use of contraception and pregnancy outcome. For example, an individual's attitude towards using contraception and their knowledge of how to use contraception affects actual use and efficacy of

contraceptives. Age, gender and socioeconomic status (SES) have been found to differentiate between some psychological variables and will be referred to where evident. It is important to bear in mind that psychological factors cannot be considered in isolation. The interaction between the following factors and other levels of analysis will become clearer as the document progresses.

It is well documented that knowledge is an important factor in safe sexual practices. However, research has demonstrated that high knowledge levels do not reduce risk-taking behaviour. Knowledge is but one important factor in explaining sexual behaviour and risk of pregnancy. The following points aim to summarise some of the research findings, which examine the relationship between knowledge and unsafe sex and unintended pregnancy.

Relationship factors

It has been found that variations in women's contraceptive behaviour can be related to the nature and type of relationship they are in. Many of the factors described previously interact with the type of relationship or partner involved to affect contraceptive practice.

Situational factors and service level factors

Various situational influencers have been purported to explain differences in contraceptive use. Situational factors include alcohol and substance abuse and general failures with method e.g. condoms that leak, antibiotics reducing pill effectiveness. Some of these can be attributed to lack of knowledge of how to use contraception safely and effectively. Situational factors also overlap with service level factors such as a lack of access to contraception due to cost, clients' age, confidentiality issues or location.

These factors are listed below:

Situational and service level factors associated with contraceptive behaviour

Alcohol or drug influencers

Spontaneity of sex

Fear of side effects

Technical failure e.g. burst condom or failed pill

Service level: Lack of access to contraception e.g. ability to access, cost

CHAPTER THREE

METHODOLOGY

Study Design

The study was an exploratory one designed to assess factors influencing decision making on the outcome of unintended pregnancy among married women in Ibadan South West Local Government Area of Oyo State.

Study Area

This study was carried out in Ibadan South West Local Government Area (IBSWLGA) which is one of the 33 Local Government Areas in Oyo State and one of the five in Ibadan metropolis. Ibadan, the capital city of Oyo State is regarded as the largest city in West Africa. The metropolis can be divided into inner core, transitory and peripheral areas based on settlement patterns. Ibadan South West LGA was created on the 27th of August 1991 (from the old Ibadan Municipal Government), by the then Federal Military Government. The Administrative headquarters is Aleshinloye. It is about 150 km from Lagos and 659 km from Abuja. It has a land mass of 244.55 km square, one of the largest local government in Oyo State. Its boundaries are Ibadan North and Ibadan North West Local Government Areas to the North; Ido Local Government Area to the West; Oluyole Local Government Area to the South and Ibadan North and South East Local Government Areas to the East.

Ibadan South West local government area has a population of 282, 929 people. The male accounted for 139,519 while the female population was 143,410 (National Population Commission (NPC), 2006). The LGA comprises of 12 wards (see table 3.1)

Table 3.1 Political wards in Ibadan South West LGA

WARDS	COMMUNITIES
Ward 1	Oritamerin, Gege, Oniseniya
Ward 2	Isale Osi, Ojaoba, Aladorin
Ward 3	Ita Aregbeimo
Ward 4	Agbeni, Ode
Ward 5	Agbeni; Ologode, Gege, Akuro
Ward 6	Foko; Itamoya, Agbeni
Ward 7	Agbokojo; Amunigun, Foko, Amule
Ward 8	Oke-Bola Gbagi, Anfani
Ward 9	Molete, Ososami, Agbeja, Anfani
Ward 10	Oke-Ado, Joyce B, Liberty road
Ward 11	Ring road, Oluyole Estate, Challenge, Elewura
Ward 12	Apata, Alesinloye, Molete Petrol station and Idi-Ishin.

Source: Information Unit, Ibadan South West Local Government Council Secretariat (2011)

Most of the inhabitants are Yorubas though it also houses people from other parts of the country especially the Hausas and Ibos. The LGA also has a high population of civil servants as well as those in private business other occupation include trading, and farming. The people are a mix of Christians, Muslims and indigenous religion practitioners.

Study Population

The study population comprised of married women in Ibadan Southwest LGA. The inclusion criterion was women who have had at least two pregnancies (whether intended or unintended) in the last 5 years preceding the survey residing in the community.

Sampling Procedure

The multistage sampling technique was used in selecting the participants. The stages involved are described below.

Stage 1: All the 12 political wards in Ibadan South West LGA were purposively selected.

Stage 2: One community was selected from the list of communities under each of the wards by balloting to have 12 communities in all.

Stage 3: From the 12 communities selected, 10 communities were further selected for FGD while the remaining 2 were used for the IDI.

Stage 4: Out of the households, snowball sampling was used to further select 80 women who participated in FGDs and 4 women in IDIs based on the inclusion criterion stated above.

Data collection process

Visits were paid to leaders in the chosen community for the study to solicit for their support and for smooth running of the process of data collection. The focus group discussions were conducted by the researcher and two trained female field workers (i.e. one for note taking and one for logistic as well as standing as an observer). The in-depth interview was carried out by the researcher and one assistant (assisted in recording the session by using tape recorder). Four IDIs were conducted in two communities while FGDs were carried out in 10 communities where IDIs were not done.

At the commencement of discussions, discussants were told about the purpose of the study and were assured of confidentiality of the information provided. They were also informed that information obtained from the study was purely for research purposes. Verbal consent was obtained before enrolling them for the activity. A pre-discussion data form was also filled by the participants to get some of their socio-demographic description. A guide which had been reviewed by experts and pretested was used to facilitate the discussions. Two female research assistants (a note taker and recorder) were recruited and trained on the objectives of the study and content of the FGD guide. The researcher moderated the sessions in the local language (Yoruba). Eight participants were recruited for each FGD session which lasted for about fifty-five minutes on the average. Each session was transcribed within 24 hours of the discussion. Altogether, Ten FGDs and 4 IDI sessions were conducted. All focus groups and IDIs were audio recorded, and consent to use audio taped was obtained during the initial consent process with each participant. Study participants were advised not to use names or other identifying information during the discussion.

Verbatim quotations were included in the results which are the recorded explanation of the informants preserving the language used.

Four in-depth interviews were conducted with women who have experienced unintended pregnancy selected through snowball sampling method. One of the participants was currently experiencing an unintended pregnancy at the time the data was collected. Each interview session lasted for about 70 minutes. The interview took place in the respective homes of interviewees and each session was recorded on audio tape after consent was obtained.

Validity of instrument

Validity describes the ability of an instrument to measure what it is expected to measure. Several measures were taken to ensure the content validity of the instrument. The draft guide was also reviewed by experienced experts in the field of reproductive health including lecturers and students from the Department of Health Promotion and Education.

Copies of the instrument were critically examined by the various experts within and outside of the Department of Health Promotion and Education. The objective opinions of supervisor and experts in the Department of Health Promotion and Education were sought to ascertain the face and content validity of the developed instruments. The instruments (FGD guide) were pre-tested in Ibadan North Local Government Area to determine how effective the developed instrument would be in collecting appropriate data relevant to the research objectives. Since all of the interviewees spoke Yoruba language, the IDI and FGD guides were translated into Yoruba Language and back-translated into English to ensure that appropriate questions were asked.

Reliability

Reliability describes the accuracy or precision of a research-measuring instrumentSpecial care was taken to monitor the quality of data collected through supervision during collection of data. The Focus Group Discussion Guide was thoroughly reviewed by experts to ensure quality and consistency.

The FGD/IDI guide, were pre-tested in Ibadan North Local Government Area of Oyo State which had similar characteristics with the population of the study area. Two

FGD sessions were conducted. The findings of the pre-test were used to make necessary changes for the main study. The changes included removing questions that were ambiguous and gave different interpretations and those that had no direct bearing to the research questions.

Objective opinions of supervisors and experts in the Department of Health Promotion and Education were also sought towards ascertaining the validity of the instruments. Translation and back translation of the tool was done to ensure reliability of results that will be obtained from the data collection processes.

Instruments for data collection

This study employed qualitative method of data collection using pretested Focus Group Discussion (FGD) and In-depth Interview guides. This qualitative approach was chosen to provide rich information with regards to factors influencing decision making on unintended pregnancy, induced abortion, pattern of spousal communication in situations of unintended pregnancy and family planning among the study participants. These methods are very useful for documenting people's perceptions and to explore the depth of the issue. Local resource persons who were well known by women in the communities assisted in recruiting the discussants. The discussants agreed upon the venues and time for the discussions.

Focus Group Discussion Guide

The FGD guide comprised two sections. Section A introduces the objective of the study and Section B contained 11 questions with more of probing leading questions that focused on the causes of unintended pregnancy, factors influencing decision making on unintended pregnancy, pattern of help seeking behaviour in situations of unintended pregnancy, attitude to induced abortion and perception on the effectiveness of family planning respectively.

In-Depth Interview Guide

The IDI guide used for this study was designed along with cogent theme expressed in FGD guide and it consist of 11 main questions and their follow up questions that focused on the causes of unintended pregnancy, factors influencing decision making on unintended pregnancy, pattern of help seeking behaviour in situations of

unintended pregnancy, attitude to induced abortion and perception on the effectiveness of family planning.

Data management and analysis

The Focus Group Discussions (FGD) were recorded on audio-tapes, transcribed and analyzed using the thematic approach. Audio recordings of the IDI sessions were also transcribed and then analyzed for recurring themes. The responses from the sessions were grouped into themes and compared within and between groups.

Ethical consideration

Community consent was obtained from the community leaders in communities participating in this study. In addition, participants involved were fully informed about the nature of the study, research objectives and confidentiality of the data.Participants' full verbal consent was obtained regarding their participation in the study. As such, names, addresses and other tracers were not required from the participants. Participants were given the choice to withdraw their consent freely whenever they feel the need to discontinue the study and are free not to answer to any of the questions if they do not feel like doing so. To maintain confidentiality of participants during and after the collection of data, data were kept in a secured place where public access to it was denied.

The audio-tapes were carefully stored in a safe place where unauthorized persons would not have access to them. Reference to personally identifying information was deleted when audio tapes were transcribed. Upon completion of the research project, all audiotapes will be destroyed.

Limitation to the study

Due to the fact that unintended pregnancy is a very sensitive and personal issue, some eligible respondents would not participate in the study. Also among those who participated, some biases (e.g. information, recall) came up as a result of their attitude towards the topic. To minimize this bias, meetings were held with key persons and leaders in the community to solicit their support for the study. The participants were also reassured of confidentiality of any information provided by them and made aware of the importance of carrying out the study. The research team was also trained so as to prepare them properly for the study.

Ascertaining the authenticity of response provided by the study respondents is a daunting challenge in any research. This study however is no exception. It will be assumed that since participation is voluntary, and necessary ethical issues are given consideration, then all the responses provided which form the basis of the findings of this study would then be honestly made. The same guide was used for the Focus Group Discussions and In-depth Interview.

CHAPTER FOUR

RESULTS

This chapter presents the result of the study. It consists of the following sub-sections: the socio- demographic characteristics of the study participants; causes of unintended pregnancy; spousal communication/reaction in situations of unintended pregnancy; pattern of help seeking behaviour in situations of unintended pregnancy; factors influencing decision making in situations of unintended pregnancy; attitude to induced abortion; perception of the effectiveness of contraceptives. A total of 10 Focus Group Discussions (FGDs) were carried out with married women in the communities selected from the list of the wards Ibadan South West Local Government Area (LGA). A pre-discussion questionnaire was given to the participants at the beginning of the sessions to get their socio demographic data.

The themes are discussed in more detail below and enhanced by direct quotes of focus group and IDI participants.

Socio-demographic characteristics

The socio-demographic characteristics of the respondents. More (40.5%) of the participants were in the 31-35 years age bracket with mean age of 30.0 ± 5.63. in the same vein, 45.2% of the participants had had two children prior to the time of the study. Many (60.7%) had a secondary school education and majority 81.0% of the participants were Yorubas. Slightly above half (53.6%) were Muslims. Many (61.9%) of the participants were petty traders.

Findings from FGDs

Occurrence and causes of unintended pregnancy

This part contains findings on the participants' experience and causes of unintended pregnancy. It revealed some of the reasons why pregnancies were termed unintended at the time of conception. It was generally affirmed across all the groups that unintended pregnancy is common among married women especially after the first child is born. Majority of the discussants in all the groups have experienced unintended pregnancy at least once in their years of marriage. Most of the participants who have personally experienced unintended pregnancy were willing to share their experiences.

"*I was shocked when I discovered I was pregnant. My baby was just few months old and I was not happy at all especially at the initial stage" (Petty trader woman).*

The result also showed that pregnancies preceded by a contraceptive discontinuation due to reasons such as method failure, health concerns, discomfort, inconvenience, and misuse were significantly more likely to be reported as mistimed or unwanted than other pregnancies.

> *I did not expect that such a thing could happen to me because I've stopped child bearing and even did family planning when I discovered I was pregnant"(IDI respondent)*

The causes of unintended pregnancy include perception that exclusive breast feedingcan protect from becoming pregnant, non-use of contraceptives, failure of a contraceptive method, and inability of the couple to abstain after delivery. One of the participants said

"I never knew I could become pregnant 2 months after delivery, we were having unprotected sex though I was breast feeding exclusively" (FGD participant)

Another woman said

"My husband could not abstain from sex shortly after delivery he said he could not wait after been denied of sex in the last months of pregnancy therefore I gave in and the result was an unintended pregnancy"(FGD Participant)

Another participant said

"I was ignorant of any preventive measure after intercourse, I hate condom and my husband also dislike it because there is no pleasure derived from using it. In a nut shell, I was not able to abstain after delivery that was why it happened to me"

Another participant said

"I *thought I had reached menopause therefore I could not get pregnant again but alas I became pregnant" (FGD Participant).*

Most of the participants also stated that unintended pregnancy is common shortly after a planned birth. This may be because women at this time are occupied with taking care of their infants and have not thought of any contraceptive regimen.

Findings from IDIs

The participants in the IDIs also affirmed that unintended pregnancy is common among married women especially after the birth of the first child and even after having stopped child bearing. One of them responded saying:

"I became pregnant after nine years of stopping child bearing. I was on injection but stopped after a while and was using safe method when I realised I was pregnant."

Another participant said

"In *my own case I never imagined I could get pregnant because I was still breast feeding and I thought I was completely safe because it worked for me when I had my first child. I breast fed my first child for two years and I did not take in until when I wanted to , but while nursing my second child I became pregnant in fact it was not a pleasant experience at all because we had made up our mind we were going to have just two children"*

Another participant said

"I became pregnant because the contraceptive I was using failed. I was not aware the copper T has shifted, I was shocked when I realised I was pregnant.

The major causes of unintended pregnancy from the discussions included non-use of contraceptive, discontinuation of contraceptive, perception that exclusive breastfeeding can prevent pregnancy, inability to abstain from sex shortly after delivery, other said they just thought they could not get pregnant. The pregnancies were tagged an unintended pregnancy because some of the women said they have stopped child bearing, other said they actually wanted to space their next birth while some very few said though they would have wanted more children but because of financial constraints they could not cope with another child.

Spousal communication in situations of unintended pregnancy

Focus Group Discussion participants were asked about their husbands' reaction on hearing the news of the pregnancy. Most of the respondents said their husbands were not happy with the news of the pregnancy.

One of the participants in the FGD said

"My husband told me point blank that he is not ready to father another child he is satisfied with the ones God has given him already"

Some even disclosed that it lead to serious wrangles which their relatives had to intervene. Most of the women confessed that their husband blamed them for the pregnancy and told them they should have done what their friends do to prevent pregnancy instead of being careless and allow it to happen, some even doubted the paternity. The following were some of the statements made by the women.

> *"When I informed my husband that I cannot see my monthly period he told me I should go and look for it by all means and knowing the kind of husband that I have he can turn it into something else if care is not take. I decided to go and abort the pregnancy without delay"*

Another woman said

My husband was not happy with the news because our baby was too small, in fact it really pained him, but since he is not interested in abortion, he said I should not make any attempt to abort it that we should accept it that way. We just agreed I should stop breast feeding our baby."

Another participant said:

> *"My husband was very angry and it took a lot of efforts to convince him that he was the one responsible for the pregnancy even family members had to intervene"*

Some of the participants said their husbands asked them to go and abort the pregnancy.

> *"When I informed my husband, he said I should go and abort the pregnancy but all efforts to do this proved abortive".*

A trader in one of the FGD groups recounted her experience as follows:

> *"We argued regularly when I conceived. My husband wanted me to abort the pregnancy but I did not agree to it, but since I had more say in the matter, he gave up. This actually affected our relationship for some time because he was not pleased with my decision not to terminate the pregnancy"*

For some, their spouses took the news like any other and accepted the situation

"My husband said we should accept it that it is the will of God"

For some very few ones their husband did not get to know about the pregnancy because they actually took the sole decision to abort without consulting their spouses. Stating some of their responses,

"*When I discovered I was pregnant, I did not even bother to inform my husband because I don't even want to be convinced to keep the pregnancy as I don't want another child therefore I just decided to have an abortion.*

Findings from the IDIs

All the participants in the IDI also affirmed that their spouses were not happy with the news of the pregnancy. One of them stated that the husband thought she became pregnant deliberately. Stating her response

"*My husband actually believed I intentionally became pregnant because we have both agreed that we were just going to have two children. It took a while to really convince him that it was not deliberate at all. It affected our relationship for a while."*

For the other three the situation led to serious quarrel and their husbands were not pleased. One narrated her experience as follows:

> *"It led to serious misunderstandings that my husband had to send me out of our matrimonial home for about a year. The excuse he gave was how can I get pregnant when I'm still breast feeding and have not started seeing my menstruation. In fact it took a lot of intervention from our extended families to convince him that he is responsible for the pregnancy. Though he later came back to beg for forgiveness and to the Glory of God the child looks exactly like him. I believe that was what God used to vindicate me."*

Some of the women who stated that their spouses were not happy with the news of the pregnancy especially those who have planned to have particular number of children said it took them awhile to eventually build back the trust in their relationships.

Factor influencing decision making on unintended pregnancy

When asked about the factors that influenced their decisions, majority of the women who carried their pregnancy to term said it was mainly as a result of;

Social support from their spouses and other significant others like parents, friends, pastors etc. This support encouraged them to carry their pregnancy to term.

"*My husband supported me all through the pregnancy and assured me everything will be alright and he also allowed my mother to take over the care of the baby I was nursing at that time" (FGD Participant).*

Another participant said

"My parents and my husband were there for me all through the period. This really encouraged me "(IDI participant)

Another factor that made some of the participants to carry their pregnancy to term was fear of complications from abortion. Stating some of their responses:

"I was afraid of the various complications from abortion and I don't want to die from the procedure therefore I decided to keep the pregnancy"

Another factor was failure of attempt to abort the pregnancy. One of the women that was interviewed narrated her personal experience as follows:

"When I discovered I was pregnant we agreed to abort the pregnancy.We visited a Patent Medicine Vendor where I was given some drugs meant for abortion; however, the drugs did not work. Afterward, I used so many other things to get rid of the pregnancy but all to no avail afterwards we did not seek any other alternative sources hence I don't have any choice than to carry the pregnancy to term".

Another participant recounted thus:

"I used several drug to terminate the pregnancy but the drugs did not work, I realised I had to carry the pregnancy to term but I was afraid the drugs I've used might affect my baby. Indeed the waiting period was a trying period for me"

One other factor was spiritual caution from religious houses one of the participants said

"We were warned spiritually to leave the pregnancy and I don't want to die prematurely that was the reason why we decided I should carry it to term"

Another factor is the desire for more children. When a couple is yet to achieve the desired number of children they desire to have, even though the pregnancy might be mistimed, they may decide to keep the pregnancy. A participant at the FGD said:

"We still desire to have more children though not at that time but since it has happened we accepted it that way"

For those that aborted the unintended pregnancy the following influenced their decisions

Lack of spousal support and that of significant others. Most of the participants that did not receive support from spouse and other key members of their families aborted their pregnancy. One of the respondents said

"My husband made me realise that he is not willing to father another child therefore he asked me to abort the pregnancy"

One of the IDI participants said:

It was not a pleasant experience at all…..my husband was very furious at the news and he asked me to abort the pregnancy without any delay"

Financial burden to raise and care for an additional child. Most couples that have probably achieved their desired number of children and obviously do not have the financial capability to care for additional children decided to abort the pregnancy. Stating some of their responses

"We don't have money to raise another child even the one we have we are still begging God to help us raise them"

Another woman from the FGD group said:

"My husband said he does not have the means to cater for another child"

Another factor is the fulfilment of the number of children with desired sexes

"We have both boys and girls so what else do we want"

Another reason given for pregnancy termination is perceived maternal risk of subsequent pregnancy. Some have been advised never to be pregnant again because of the threat involved for them and the baby.

Quoting some of their responses:

"I have been warned not to have another baby because I almost lost my life during my last pregnancy because age was not on my side, therefore the doctor said I should not have another baby so I decided to abort the pregnancy when I discovered I was pregnant again"

Pattern of help seeking behaviour in situations of unintended pregnancy

Most of the participants in all the groups reported going to the hospital when they discovered they were pregnant. Some visited traditionalists to seek help at the initial period. A few reported going to the chemist for drugs. Some said the doctors advised them to keep the pregnancy while for others it was vice versa.

Almost all the participants that experienced unintended pregnancy and eventually carried it to term mentioned that they did not start antenatal clinic early either because they were not aware of the pregnancy early enough or they were not happy with the pregnancy at the initial stage. But majority of the women in the FGD and all the women who participated in the IDI affirmed the importance of health care in pregnancy stating that antenatal care is vital when a woman decides to keep a pregnancy. The majority are of the opinion that antenatal care is to prevent or identify and treat conditions that may threaten the health of the baby and/or the mother, and to help a woman approach pregnancy and birth as positive experiences.

One woman explaining reasons for going for ANC check-ups said:

> *"When we decided to keep the pregnancy, I started going for antenatal because I believe health care is very important when one is pregnant"*

Other participants in the FGDs and IDIs said:

> *"To a large extent antenatal care (ANC) can contribute greatly to help provide a good start for the baby and the mother as well so for this reason, I went to the hospital and gave my baby to my mother to nurse".*

> *I stopped breastfeeding my baby and I was advised to put the baby I was nursing below my stomach while having my bath so that the baby will not become sick I also visited the clinic for advice from medical personnel because I know the importance of seeking assistance from medical personnel"*

> *"This pregnancy came 9 years after I've stopped child bearing it was like a dream when I discovered I was pregnant. I have made up my mind that I was going to terminate it but when I got my doctor, he convinced me to carry it to term. I am also aware that antenatal care can help detect any problems or*

complications in pregnancy before it becomes serious therefore I started going for antenatal when I decided to keep the baby" (A woman currently experiencing an unintended pregnancy among the IDI participants).

"Based on the advice of my friend, I soaked St Morris cigarette in water and drank it but it did not work afterwards I used some drugs which I procured from the chemist to abort the pregnancy but this attempt also failed therefore I went to a private clinic to terminate the pregnancy"

"I went to the hospital to abort the pregnancy since we cannot afford to have another child at that time"

If I do not go for ANC checkups then either the baby in my womb or myself as the mother will be affected. If I do not care for my health, one might have problem when the time to deliver comes. Neglecting an unintended pregnancy will harm the health of the woman and she will have difficulty delivering the child .Therefore, I used to go for checkups and eat good food. The only thing is that I was worried for untimely pregnancy in the beginning.

Although, some very few participants were of the opinion that one does not need any antenatal care if the mother and baby are healthy all through the pregnancy and they would rather deliver with the help of a Traditional Birth Attendant (TBA) because their charges are cheaper than that of the clinics and health centres.

Stating some of their responses

"As for me, I don't usually have any problem during my pregnancies and all I do is eat and sleep therefore I don't see any reason why I should be going to the clinic when there is nothing wrong with me. When the time to deliver comes I just go to the TBA close to my house. She was the one who delivered all my babies".

I believe in my church, because the spiritual aspect of everything is important so as a result, I usually deliver in my church"

Attitude to induced abortion

Most of the participants in the groups are of the opinion that abortion is not good

Quoting their statement

"Abortion is not good, it can lead to sudden death therefore it should be avoided"

"God does not support abortion because it is an act of murder"

"Abortion is very dangerous I have a friend who aborted several times when she was young in fact she nearly lost her life when she aborted the last one. She's married now but she has not been able to conceive because her womb has been perforated".

"Induced abortion can result into death, infertility, infection and other things. It is a sin to commit abortion".

Some said abortion is allowed in marriage to get rid of unintended pregnancy. For example some of the participants said:

"*Though abortion is not good at all, but the pregnancy that can bring shame can be aborted"*

"From my own perspective, abortion is very good because it has helped many marriages if not, many people would have died of hunger. Abortion is not a sin. Though it leads to death if not done in a perfect way or handled by an expert. If some women have unintended pregnancy they would go to a chemist where they would be given pills that can damage their uterus, some will go to the local herb sellers where a lot of concoction will be given and it might lead to death. But if the abortion is done by qualified medical personnel there will not be any complication."

"Abortion is permitted if one has an unintended pregnancy it is better than bringing a child into the world and not be able to cater for it".

Majority of the participants in all the FGDs were also of the view that abortion can lead to death. Also in all the groups, many discussants said that abortion can lead to the damage of the womb or infertility. In one group, a participant said that abortion can lead to miscarriages in later pregnancies. But quite a number choose abortion to resolve their unintended pregnancies.

Participants in the IDIs were also against the procurement of abortion. Most of them affirmed that there is no condition under which a woman should consider abortion except if her life is in danger. They emphasized that abortion is against God's law.

Stating some of their responses

"*Abortion is a sin; one should just accept the pregnancy and trust in God".*

"Abortion can damage the womb if not performed properly and can even lead to death, so why would one endanger one's life though abortion can be done if the life of the mother is in danger"

Perception on the effectiveness Contraceptives

All the participants knew what family planning is and they are all aware of most of the common methods including the traditional methods.

Almost about half of the respondents were of the opinion that family planning is very effective in preventing unintended pregnancy. Some others said family planning though effective has too many side effects which can result into another problem afterwards.

Quoting some of their responses

"*Family planning is very good especially for nursing mothers who want to enjoy good health and rest after the delivery of a child"*

"Family planning help couples to enjoy sexual intercourse without fear of unintended pregnancy"

Family planning is very effective though some people have been complaining that it usually fails but my own has never failed and it will not fail (IDI Participant)"

Others are of the opinion that family planning is meant for people that have stopped child bearing this is because it can result into various side effects which can result into infertility. Most of the women said they and their partners don't like using condom. Some of the women also said their spouses do not support the use of contraceptives.

Stating some of their responses

"Family planning is good for women that have stopped child bearing because I've seen some women that could not conceive again after doing the family planning"

"Family planning has a lot of side effects I don't like it and I can't do it. If I become pregnant I will abort the baby".

My husband does not like condom and I don't like it either, I am scared of all the other methods of modern contraceptives I've heard of I prefer the traditional methods"

In my years of marriage, anytime I suspect conception will likely take place or I experience delay in seeing my period, I use dry gin locally called " pepper soup" and within 24 hours I'll see my period that is my own method of family planning"

Access to family planning services

All the participants in the FGDs said family planning services are readily available in their communities usually at the Primary Health Care Centres. They are usually sensitized on family planning issues during antenatal clinics. They also get information from the radio, television and posters. Majority also affirmed that they were not using any form of modern contraceptives because of the side effects associated with most of the methods. Very few women in both the FGD and IDI said they were on any method of contraceptives. Stating some their responses:

"The *nurses at the health centres usually tell us to come for family planning when we go for antenatal clinic or for immunization"*

"We hear about family planning on the radio, television etc. Some people usually come to give us health talks in the community. These people distribute condoms at times."

CHAPTER FIVE
DISCUSSION

Socio-demographic characteristics of the participants

The majority of the participants were Yorubas and more of Muslims.This was so because the study location is in the southwest of Nigeria where the Yorubas are the most dominant ethnic group. Apart from this, residents in the study site (Ibadan South-West LGA of Oyo State) are predominantly Muslims. This current study finding that showed a large proportion of the women having secondary education was in consonant with their level of understanding of family planning and uncontrollable fecundity.

Causes of unintended pregnancy

The causes of unintended pregnancy among the study participants included non-use and failure of contraceptive methods, belief that one cannot conceive when breast feeding exclusively, having unprotected sex, thought that one cannot get pregnant, perception that menopause has been achieved therefore pregnancy cannot occur. These findings agree with other researches that have been carried out in the past on the causes of unintended pregnancy such as Furedi, (1998) who found out that women are at particular risk of unintended pregnancy shortly after the birth of a planned child, when they may be preoccupied with mothering and not yet settled into a new contraceptive regime. Fertility can return within a few months of childbirth, particularly if the new mother is not breastfeeding. Klima, (2011) in another study also reported that unintended pregnancy can result from contraceptive failure, non-use of contraceptive services, and, less commonly, rape. The findings of this study is also in line with a survey of women who had abortions, conducted by researchers at The Alan Guttmacher Institute, which stated that almost half (44%) of married women who had had an abortion in 2000-2001 were not using a contraceptive method in the month they became pregnant, although most had used a method in the recent past. Women cited various reasons for not using a method even though they were at risk of unintended pregnancy and did not want to become pregnant. Three in 10 perceived that they were unlikely to become pregnant, perhaps because they had just had a baby or because they had assumed that they were infertile, and almost half reported that they had had concerns or felt ambivalent about contraceptive methods. Other women

reported that they had either had unexpected or unwanted sex, they had had difficulty obtaining contraception or that their partner preferred that they do not use contraception. Less than one in 10 said that they had felt ambivalent about becoming pregnant (Dailard, 2003).

Factors influencing decision making on unintended pregnancy

This study provides an understanding on the factors that influence decision making on unintended pregnancy amongst married women in Ibadan South West Local Government Area. The study revealed that unintended pregnancy is common among married women and it mostly occurred when nursing a previous child. This might be so because marriage is associated with more predictable and more frequent sexual intercourse (AGI, 2003). A study conducted in Ghana revealed that approximately 55% of Ghanian women (married or in union) are at risk of unintended pregnancies.. Since perceptions are very important part of decision making process, major factors which influenced decision making to carry an unintended pregnancy to term included support from their spouses and other significant others like parents, friends, spiritual leaders, etc, fear of complications from abortion, failure of attempt to abort the pregnancy, desire for more children and spiritual caution. Some of these findings are in agreement with that of a study conducted on the factors affecting decision making of low-income young women with unintended pregnancies in Bangkok which revealed several factors at two levels (individual and family) that showed statistical significance. Of the 15 study variables, 6, (age of the most recent unplanned pregnancies, attitude towards contraception, attitude towards unintended pregnancy, making a decision without consultation, relationship with partner, and consulting partner when having a problem) influenced the choices of the young women. (Naravage, Wanapa, and Rungpetch, 2009)

Major factors that influenced decision to terminate an unintended pregnancy included lack of support from spouse and significant others, fulfilment of the number of children with desired sexes, financial burden to raise and care for an additional child and risk of subsequent pregnancy to the mother. These findings generally coincide with previous research findings like the AGI's report on reasons why women seek abortion which stated that worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing. The second most

common reason—socioeconomic concerns—includes disruption of education or employment; lack of support from the father; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children. In addition, relationship problems with a husband or partner and a woman's perception that she is too young constitute other important categories of reasons. Women's characteristics are associated with their reasons for having an abortion. With few exceptions, older women and married women are the most likely to identify limiting childbearing as their main reason for procuring an abortion (Sumaya, 2007; Akinrinlola,et.al.,2006).

Communication with spouse in situations of unintended pregnancy

The data revealed that conflicts with spouses and family members, depression, worries in situations of unintended pregnancies occur amongst the study group. The situation usually results into quarrels and arguments between couples especially at the initial stage. This is in agreement with a study carried out among married women in Nepal in which case studies revealed that the relationships between spouses and family members deteriorate as a result of unintended pregnancy. The study also revealed that there are some differences between the perceived opinions and real experiences when it comes to the health consequences of unintended pregnancy. The study also revealed that the issue of unintended pregnancy usually results into wrangles between couples at the initial stage and most of the victims are usually depressed than happy at such times and some of the women also transfer aggression to their partners. Some even confessed that it led to quarrels and other members of the extended families had to intervene before it can be settled (Adhikari, 2005)

Some of the women also revealed that their spouses claimed that they were not responsible for the pregnancy stating “it is not possible for you to get pregnant when you have not even started menstruating after delivery”.

Help seeking behaviour of women in situations of unintended pregnancy

Most previous studies have shown that women with unintended pregnancy are less likely to go for prenatal or postnatal check-ups; however, this study showed that this was not completely true. The study revealed that most women visited health centres for prenatal or postnatal care despite their pregnancy being unintended. It is largely explained by the fact that most couples who reported unintended pregnancy wanted to

postpone their pregnancy, so in the beginning they are worried and get upset. Therefore, they did not take immediate action for prenatal care, but subsequently the unintended pregnancies are usually accepted by the parents once they have taken some time to adjust to them.

For others who consider the abortion option, when these women were not successful for abortion or decided to keep the pregnancy for other reasons then they go to health centres' for antenatal care. For those who successfully aborted the pregnancy, it was affirmed that the procedure was carried out in the clinics though some stated that they tried other crude methods of obtaining abortion Overall, a clear difference was noticed between the perceived opinion and the actual behaviour regarding prenatal and postnatal care in the case of unintended pregnancy. Most of the participants that carried the pregnancy to term said they eventually accepted the pregnancy after a while and accepted the child like the other children.

Despite a pregnancy being unintended at the initial stage, most women reported that they had gone for prenatal or postnatal checkups. They reported that after some months of pregnancy they felt like going for ANC as well as PNC despite the unintended pregnancy. This suggests that prenatal or postnatal cares are not depending on the pregnancy intention (Yohannes, 2013).

Though some very few were of the opinion that one does not need any antenatal care if the mother and baby are healthy all through the pregnancy and they would rather deliver with the help of a Traditional Birth Attendant (TBA) because their charges are cheaper than that of the clinics and health centres coupled with the fact that they are closer to the people in the communities (Kagiri, 2010, The Nigerian Voice (TNV), 2012).

Attitude to Induced Abortion

An attitude is "a relatively enduring organization of beliefs, feelings, and behavioural tendencies towards socially significant objects, groups, events or symbols" (Hogg & Vaughan, 2005).

Cases of unintended pregnancies and abortions are not peculiar to young unmarried adolescents alone, many of the married women also engage in abortions for diverse

reasons. For instance in Ghana, studies revealed that out of 900 women seeking an induced abortion or reporting complications from induced abortion, more than half (about 55%) were married and one-fourth were adolescents (WHO, 1994). Most of the participants in the FGDs are of the opinion that abortion can be tolerated in marriage than outside marriage.

Attitude to the use of contraceptives

The findings are in agreement with some other studies conducted among married women. In a study conducted in Ethiopia showed that the high knowledge on contraceptives did not match with the contraceptive practice in the study area. The study demonstrates that mere physical access (proximity to clinics for family planning) and awareness of contraceptives are not sufficient to ensure that contraceptive needs are met (Tilahun, Coene, Luchters, Kassahun, Leye, 2013). Contraceptive use and fertility rates vary substantially among developing countries. In some sub-Saharan African countries, fewer than 10% of married women use contraception. Despite all efforts by governments to ensure availability of the products, prevalence has remained low. A community-based study that was conducted to examine contraceptive knowledge, attitude and practice of family planning among married women in Samaru, Zaria, Nigeria also revealed that contraceptive prevalence was 12.5% and respondents had a positive attitude towards family planning. Thirty years after Alma Ata of which one of the components is to ensure maternal and child health (MCH) and family planning, contraceptive use in most of the communities in Northern Nigeria is low. In another study on the awareness and use of family planning methods among 1188 married women aged 15-40 years, attending antenatal clinic in four different locations, conducted in Ibadan, Nigeria between May to December 1995 reported that most respondents (94.3%) were aware of the use of family planning but only 12.0% had ever visited a family planning clinic. Awareness of specific methods was 82.6% for condoms, 75.7% for oral contraceptives, 75.5% for injectable contraceptives and 65.3% for intrauterine device. Current use of family planning methods was low with 10.0% using withdrawal, 8.1% oral contraceptives, 5.2% using intrauterine devices and 4.7% using condoms. Perceived constraints to the use of family planning methods included husband's opposition, fear of complications and perceived insufficient knowledge about family planning methods. It is concluded that there is a knowledge-practice gap in the use of family planning methods among

married women in Ibadan, Nigeria. Improved education strategies and better access to services are needed to solve these problems. There is urgent need to step-up public awareness campaigns on family planning to ensure wide spread acceptability and utilization among women within reproductive age group(Akinrinlola et al, 2006).

Implications of the Findings for Health Promotion and Education

Unintended pregnancy affects individual, families and communities and it is common among married women especially during the nursing period of another child. The issue of spousal support amongst others has been found to be vital in the decision making on the outcome of unintended pregnancy in married women.Hence it is important to take couples as a unit in reproductive health matters.

Therefore there is need to recognise that men's attitude and behaviour can either undermine or promote sexual and reproductive health. Most reproductive-health services offered around the world in service deliverysettings such as clinics or health posts are geared almost exclusively to women.Men are generally the forgotten reproductive-healthcare clients, and theirinvolvement often stops at the clinic door. When they accompany their partnerto a facility, men may find no programmes encouraging or allowing them toparticipate in reproductive-health decision making with their partner, or toaddress their own reproductive and sexual healthcare needs (Mehta et al. 2004)

The results presented in this study highlight the fact that women who are married are also a key demographic that need to be considered for prevention of unintended pregnancy.

Health talks have been and still remain the most common way to share health knowledge and facts (WHO, 2002). Since it is better to prevent unintended pregnancy before it occurs, health education geared towards promoting contraception to broaden women's knowledge of the health and social benefits ofusing culturally relevant and acceptable method of contraception using the appropriate medium of communication is very important. The most natural way of communicating with people is to talk with them in small groups or with many people together. An effective way of passing the message on contraception in the communities is through the use of the local language.

Men should be reached where they are, instead of seeking or creating new arenas in which to engage men,programmesshould utilize the existing key venues where men congregate or can bereached.These include sports and religious events,workplaces,and sociallocations such as bars or cafés.All of these are important places whereinformation and discussion on a variety of issues can be shared with men.Scaling-up a programme is also easier when working through existinginstitutions that can reach large numbers of men,such as unions,the military,and industries such as mining or transportation,where men predominate.

Peer education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. Peer education is the teaching or sharing of health information, values and behaviour in educating others who may share similar social backgrounds or life experiences. Peer education is a flexible social strategy within a prevention and early intervention delivery system. It usually focuses on children and youth, but it is increasingly utilized in workplace settings and has long been used successfully to reach high-risk populations. It is a process in which trained supervisors develop and support a group of suitable people to educate, strengthen and support their peers to contend with the health threats and decisions they face. Peer educators create a safe place for candid and genuine examination of attitudes, choices and situations. And through their role as educators they become informal influences, helpers, and advocates for systemic change (Harvard 2009). This health education approach can be used to reach men. More so, research suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures.

Therefore, communicating this problem to the public, increasing community and individual understanding about prevention and improving access to necessary services should be an essential component of reproductive health programmes. A comprehensive counseling service that aimed to address worries and mental tension of couples, and enable young couples and their families to make responsible choices and timely decisions are required. Health service providers should be equipped to deal with all the social-psychological issues related to unintended pregnancy among couples. Programmes that focus to identify couples, families and individuals at risk of

unintended pregnancies, integrating contraceptive and family planning issues into pre-marital counseling is important. Couples intending marriage should be adequately informedto plan the number of children they want to have and the timing and encouraged to take necessary actions required to achieve this.

Support groupscan also be created in health facilities for women experiencing unintended pregnancies. This will enable them to share their experiences with one another and also encourage one another.Health workers should also be trained to address social-psychological issues related to unintended pregnancy among couples.

Conclusion

Without any doubt, married women are faced with difficulties in making decisions when they experience unintended pregnancies. This study revealed several characteristics of the decision making process that a sample of married women had to go through when confronted with unintended pregnancy. Most of the participants required the assistance of others especially their spouses to make their final decisions. This implies that partners influence plays a major role in final decision and outcome.

Majority stated that they and some of their neighbours who experienced unintended pregnancy visited health centres for antenatal care. The IDI participants were against the procurement of abortion while majority of the FGD discussants indicated that abortion procurement was common in marriage. Majority were aware of the different types of contraceptives and their effectiveness in the prevention of unintended pregnancy but did not use any for fear of side effects.

Unintended pregnancy and non-utilisation of contraceptives were common among the participants. Intervention focusing on the couple as a unit should be instituted to improve spousal communication and uptake of family planning products thereby reducing the occurrence of unintended pregnancy.

There is also an urgent need to address the gaps in knowledge among women in the communities with regards to effective pregnancy prevention and safe practices within the context of safe motherhood. There is also need to design health education programs that focus on the importance of avoiding unintended pregnancies.

Recommendations

The recommendations based on the research findings are as follows:

1. Unintended pregnancy should be prevented before it occurs. This can be achieved through the proper use of contraceptives. This is because the success of any contraceptive method depends on the effectiveness of the method in itself and the ability of women to use it properly.
2. Programme managers or implementers should do as much as possible to support the decision-making process in women faced with unintended pregnancy in order to provide better information and services to reduce the impact of the selected choice.
3. Africa is characterized by deep-rooted patriarchal culture; therefore programs should emphasize the importance of male involvement in family planning, So that misconception of husband towards family planning methods can be changed. This is because spousal communication has positive effect on unintended pregnancy
4. Improving inter-spousal communication as well as women empowerment to persuade the husband to use FP method and small family norm could be another strategy to influence unintended pregnancy. Furthermore, in all family planning activities both wives' and husbands' participation should be considered.
5. Interventions are needed to reduce unintended pregnancy. Moreover, improving access to maternal health services and understanding women's pregnancy intention at the time of first antenatal care visit is important to encourage women with unintended pregnancies to complete antenatal care.
6. There is a need for policy guidelines that focus on increasing access to contraceptive services and information for women. This is expected to reduce the incidence of unintended pregnancy, unsafe abortion and the related complications significantly.
7. Comprehensive contraceptive and family planning issues should be integrated into premarital counseling.
8. Traditional Birth Attendants (TBAs) should be trained and included in community education and mobilisation efforts.
9. Further researches (both quantitative and qualitative) are needed on the impact of unintended conceptions in relation to antenatal and postnatal care seeking

behaviours, birth outcomes, family formation, and parent-child interactions. This study has shown the positive effect of spousal communication on unintended pregnancy. Further researches are also needed to determine the exact nature and pattern of this relationship.

10. The influence of the husband should also be considered. It is important to also determine the reasons for usage and non-usage of contraceptives so as to prevent and reduce the incidence of unintended pregnancy and unsafe abortion.

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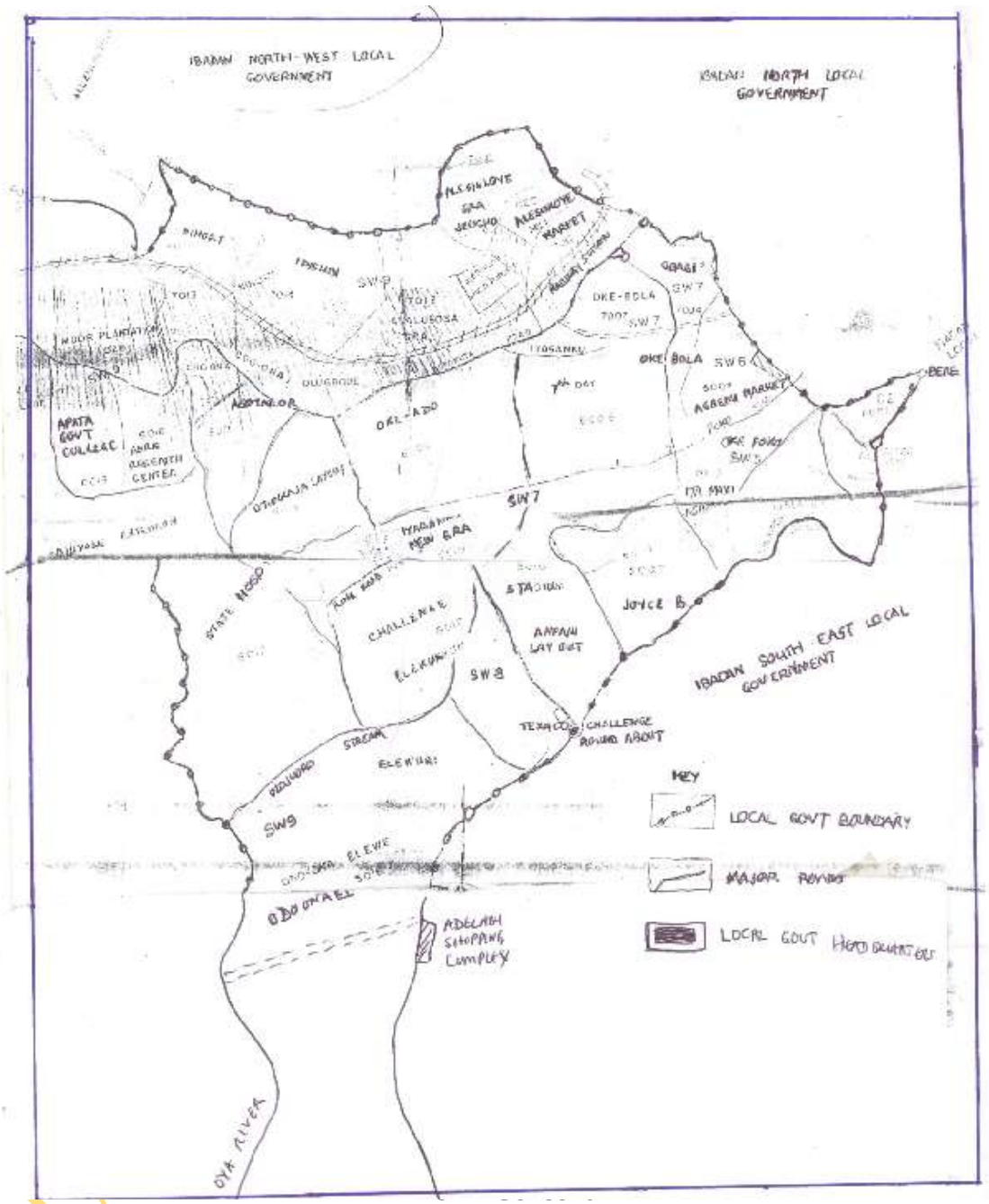
Appendix I:

Map of Ibadan South-West Local Government Area



APPENDIX II

INFORMED CONSENT FORM

I am Adeloye Adenike O, a student of the Department of Health Promotion and Education, College of Medicine, University of Ibadan, Ibadan. I am carrying out a study on **Factors influencing decision-making on the outcome of unintended pregnancy among married women in Ibadan South-West LGA of Oyo State**. I am having some questions for you about this subject.

As a married woman, you are requested to kindly answer these few questions I have here for this research work. Please note that your responses will be kept very confidential. Your name is not required in this interview so you cannot be traced with the instrument that is going to be used to get the information from you. The information you and others give me will be used for purely academic reasons, though it may also be used by the Government, concerned Agencies/NGOs to help find solution(s) to problems relating to the issue.

During the discussion, you are assured that no harm on injury is attached to the exercise now or later.

Your honest answers to the questions will help us to identify different problems with regards to the reproductive health of women, issues of unintended pregnancy, factors that influenced choice of decision on unintended pregnancy, family planning services and strategies towards prevention unintended pregnancy. This will help agencies concerned to plan adequate intervention/training programme.

You are free to refuse to take part in this study and you have right to withdraw at any given time if you choose to. I will be very grateful if you help to honestly respond and take part in this study.

Consent: Now that the study has been well explained to me and I fully understand the content of the study process, l am willing to take part in the programme.

…… ……

Signature of the participant & Date ***Signature of the interviewer & Date***

Appendix III

Pre-Discussion Data Form

INSTRUCTION: TICK (✓) IN THE APPROPRIATE BOX FOR YOUR RESPONSE

Section A: demographic Data

1 Age: _____in year (as at last birthday)

2 Religion: (1) Christianity ☐ (2) Islam ☐ (3) Traditionalist ☐

3 Tribe: (1) Yoruba ☐ (2) Igbo ☐ (3)Hausa ☐ (4) Others _____

4 Occupation: _____

5 Educational background: 1. No formal education ☐ 2. Primary education ☐

3. Secondary education ☐ Post-secondary education but not Bachelor degree ☐

5. Bachelor Degree ☐ 5. Others (specify) _____

6. Number of children: _____

Appendix IV

Focus Group Discussion (FGD) Interview Guide

FACTORS INFLUENCING DECISION-MAKING ON THE OUTCOME OF UNINTENDED PREGNANCY AMONG MARRIED WOMEN IN IBADAN SOUTH WEST LGA OF OYO STATE

A: INTRODUCTION

I am Adeloye Adenike O. and my colleagues are ……..

We are students from the College of Medicine, University of Ibadan.

This discussion will focus on health of women in this community, most especially on unintended pregnancy. The result of this research will be useful for designing health programmes that can meet the health needs of women in this community.

In this discussion, your view will be respected and will not be used against anyone. No response will be judged right or wrong. We also seek your permission to use a tape recorder so that we can adequately capture all the views that will be expressed by you all.

This discussion will last between 40 minutes to one hour. We assure you that all that will be discussed here will be confidential.

B: FGD QUESTIONS

Q/N	MAIN QUESTION	FOLLOWUP QUESTION
1	How is life generally in this LGA Good things of life. Problems.	How is life with the women? What is the socio economic status of women in this community?
2a	What problems do you all face with regards to the reproductive health of women	Which are the most common ones among the problems? Which of these problems you have just mentioned are the most serious?
2b	Let us discuss the issue of unintended pregnancy.	Have you or anyone close to you ever experienced unintended pregnancy? How many times can you recall you or any one close to you have had unintended pregnancy? Why is it unintended?
3	How did you feel as a woman when you discovered you were pregnant and you are not prepared for it?	What do you think was responsible for the unintended pregnancy?
4.	What did you do you do in this situation?	How did you inform your spouse? What was his reaction? What other people did you inform about the

		pregnancy?
5.	What was your action afterwards?	How did you seek help? Where did you go for help? Who influenced your choice of help seeking?
6.	What are the factors that influenced your choice of decision?	What are the things you considered? Did you regret the decision made afterwards?
7.	What do you think about induced abortion?	Probe for: The prevalence of induced abortion in the community The group among which abortion is common Where abortion is usually procured
8.	What is family planning?	Do you believe in family planning? Does your husband support family planning? How do you plan your family?
9	Are family planning services available readily in the community?	Where do women in the community procure their family planning services? How do they get information with regards to family planning? Are men involved in family planning issues?
10	How can we prevent unintended pregnancy?	Did it re occur

We have come to the end of our discussion. I THANK you all for agreeing to participate in the discussion.

Any questions from anyone?

Appendix V

Ede Yoruba

Itoni fun iforowanilenuwo oni Ijiroro to se san

(Focus Group Discussion (FGD) Interview Guide)

AWON OKUNFA IGBESE LORI OYUN AIROTELE LARIN AWON OBINRIN ABILEKO NI IJOBA IBILE GUUSU IWO ORUN IBADAN, NI IPINLE OYO

IpaA: Ifaara

Oruko mi ni Adeloye Adenike O. ati awon elegbe mi ..... ti aje akeko lati Ile-eko isegun oyinbo, yunifasiti Ibadan.

Iforowero yi daleri ilera awon obinrin ni agbegbe yi, pataki lori oyun airotele. Abo iwadi yi yo jelilo lati le pese eto ilera fun awon obinrin ni agbegbe yi.

Afi dayinloju wipe ako ni lo esi yin fi tako enikeni tabi tabuku oludahun. Be si ni afe gba ase yin lati lo ero agbounsile lati le gba esiyin lekunrere.

Iforowero yi koleju ogoji iseju si wakati kan lo. Afiun dayin loju wipe iforowero awa pelu yin, yo je ounti odo batide ti kole rita (owa larin awa pelu yin).

B: IBERE FGD

Q/N	MAIN QUESTION	FOLLOWUP QUESTION
1	Bawoni igbaye-gbadun awon eniyan ni Ijoba ibile yii? Kinni adun ti e n ri nipase igbaye-gbadun Awon ewu to n tara re yoo?	Bawo ni n kan ti seri pelu awon obinrin? Kinni ipa eto isuna awon obinrin ni agbegbe yi?
2a	Awon idojukowo ni gbogbo yin koju lori itoju fun ibimo awon obinrin?	Ewo lo woopo ninu awon ewu won yii?
2b	Eje ki soro lori bi liloyun airotele.	Ewo lo lagbara ju ninu awon ewu ti eso yi? Nje eyin tabi eni too sunmo yin ti loyun airotele ri? Otito bi igba melo ti oyun airotele yi tisele siyin tabi eni tio sunmo yin ri? Bawo loseje airotele?
3	Gegebi obinrin, bawo ni ose ri ni ara yin nigba ti e ri apere wipe e loyun lasiko ti e ko reti?	Kinni elero wipe ole je okunfa oyun airotele yi?

4.	Kinwa ni ese ni igba na?	Bawo ni ese so fun oko yin? Kinni esi oko yin? Awon wo ni e tun sofun leyin oko yin?
5.	Igbese wo legbe leyin eleyi?	Bawo nii e se gbiyanju lati wa itoju sii? Nibo le lo lati wa iranlowo? Tani e o je olupinnu ibi ti e wa itoju lo?
6.	Awon kinni oje okunfa igbese yin?	Awon kinni ero? Nje e kabamo lori igbese yin?
7.	Kinni ero yin nipa oyun sise?	Wadi siwaju sii: Iwopo oyun ti agbani nimoran lati se in awujo yii. Elegbe-jegbe ti siseyun ti wopo ju? Ibo ni won ti ma n se oyun?
8.	Kinni ifeto-somo-bibi?	Se eni igbagbo ninu ifeto-somo-bibi? Se oko yin fi aramo ifeto-somo-bibi? Bawo ni e se n seto ebi yin?
9	Se ibi igbani nimoran lori ifeto-somo-bibi wani arowoto ni agbegbe yii?	Ni ibo ni awon obinrin ma n lo fun igba imoran lori ifetosomo bibi lagbegbe yi? Bawoni won sele mo nipa ifeto si omo bibi? Se awon okunrin maun fi owo sowopo lori ifeto si omo bibi?
10	Ona wo ni alefi deena liloyun airotele?	Se otun maa un sele?

Ati pari iforowero yii.

APPENDIX VI

In-depth Interview Guide (IDI)

FACTORS INFLUENCING DECISION-MAKING ON THE OUTCOME OF UNINTENDED PREGNANCY AMONG MARRIED WOMEN IN IBADAN SOUTH-WEST LGA OF OYO STATE

A: INTRODUCTION

I am Adeloye Adenike O. and my colleagues are …….....

We are students from the College of Medicine, University of Ibadan.

This discussion will focus on health of women in this community, most especially on unintended pregnancy. The result of this research will be useful for designing health programmes that can meet the health needs of women in this community.

In this discussion, your view will be respected and will not be used against anyone. No response will be judged right or wrong. We also seek your permission to use a tape recorder so that we can adequately capture all the views that will be expressed by you all.

This discussion will last between 40 minutes to one hour. We assure you that all that will be discussed here will be confidential.

B: IDI QUESTIONS

Q/N	MAIN QUESTION	FOLLOW-UP QUESTION
1	How is life generally in this LGA Good things of life. Problems.	How is life with the women? How is life with you as a woman? What is the socio economic status of women in this community?
2a	What problems do you face with regards to your reproductive?	Which are the most common ones among the problems? Which of these problems you have just mentioned are the most serious?
2b	Let us discuss the issue of unintended pregnancy.	How many times can you recall you have had unintended pregnancy? Why is it unintended?
3	How did you feel as a woman when you discovered you were pregnant and you are not prepared for it?	What do you think was responsible for the unintended pregnancy?
4.	What did you do you do in this situation?	How did you inform your spouse? What was his reaction? What other people did you inform about the pregnancy?
5.	What was your action afterwards?	How did you seek help? Where did you go for help? Who influenced your choice of help

		seeking?
6.	What are the factors that influenced your choice of decision?	What are the things you considered? Did you regret the decision made afterwards?
7.	What do you think about induced abortion?	Probe for: The prevalence of induced abortion in the community The group among which abortion is common Where abortion is usually procured
8.	What is family planning?	Do you believe in family planning? Does your husband support family planning? How do you plan your family?
9	Are family planning services available readily in the community?	Where do women in the community procure their family planning services? How do they get information with regards to family planning? Are men involved in family planning issues?
10	How can we prevent unintended pregnancy?	Did it re occur

We have come to the end of our discussion. I THANK you all for agreeing to participate in the discussion.

Any questions from anyone?

Appendix VII

Ethical Approval

TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to

the Honorable Commissioner quoting

Our Ref. No. AD 13/ 479/389 15th April, 2013

The Principal Investigator,
Department of Health Promotion and Education,
College of Medicine,
University of Ibadan,
Nigeria.

Attention: Adeloye Adenike. O.

Ethical Approval for the Implementation of your Research Proposal in Oyo State

This acknowledges the receipt of the corrected version of your Research Proposal titled: "Factor influencing Decision making on the Outcome of Unintended Pregnancy among Married men in Ibadan South West Local Government Area."

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
Signature & Date

Sola Akande (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee