

Knowledge, Attitude and Practice of Unsafe Abortion among Female Students of Joseph Sarwuan Tarka University (JSTU), Makurdi, Benue State, Nigeria

Akpe Tavershima Thomas, Ph.D.; Vorkyaa Winners Terver

Abstract

This research was carried out to assess the knowledge, attitude and practice of unsafe abortion among female students of Joseph Sarwuan Tarka University Makurdi. Unsafe abortion is entirely preventable. Yet, it remains a significant cause of maternal morbidity and mortality in much of the developing world. Over the past decade, the World Health Organization has developed a systematic approach to estimating the regional and global incidence of unsafe abortion and the mortality associated with it, estimates based on figures for the year 2020 indicates that 19 million unsafe abortions take place each years, this is, approximately one in ten pregnancies end in an unsafe abortion, giving the ratio of one unsafe abortion to about seven live births. Unsafe abortion and its complications are most common among young girls between the ages of 15-25 years especially in developing countries and in Nigeria particularly where restrictive abortion laws are being practiced. Despite the gross under reporting of abortion, unsafe abortion remains one of the five leading causes of maternal mortality (death) in most developing countries.

The major objectives of this study are to determine the level of knowledge, evaluate the attitudes, and assess the practice of unsafe abortion among female students of Joseph Sarwuan Tarka University, Makurdi. A cross-sectional descriptive study was done with two hundred and fifty (250) respondents selected using the multistage sampling technique. Information collected using a structured self-developed and self-administered questionnaire. Data was analyzed using SPSS (version 23.0).

The result shows that most respondents have heard of unsafe abortion and their sources of information were from friends=29.9%, School = 38.4%, Media=27.2% and Church= 13.6%, good attitude toward unsafe abortion (94.0%), and only 8.0% have ever procured abortion.

In conclusion, the majority of the respondents had good knowledge of unsafe abortion (95.0%) and good attitude toward unsafe abortion (94.0%), and only 8.0% have ever procured abortion. The researcher therefore recommended that, the State Ministries of Education and Health services and the department of public health, should improve and sustain the existing knowledge and attitude toward unsafe abortion so as to reduce the practice of procuring unsafe abortion among female students of Joseph Sarwuan Tarka University Makurdi and Benue State at large.

Keywords: Abortion; Unsafe Abortion; Mortality; Morbidity.

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INTRODUCTION

Unsafe abortion is the termination of an unwanted pregnancy caused by a person who does not have the necessary skills and/or in an environment that does not meet the minimum standards (WHO, 2020). Though unsafe abortion are completely preventable, they remain a continuous occurrence and a serious public health challenge globally.

Lisa and Nawal (2009) suggest that even safe abortion in developing countries carries risks that are dependent on health facilities provider skills, and fetal gestational age. For unsafe abortions, the additional risk of maternal morbidity and mortality depends largely on abortion method used, the women's willingness to seek post-abortion care, the quality of facilities and the competence of the service provider.

Often, crude procedures are used for unsafe abortions such as the insertion of sharp objects (sticks, broken glasses or knitting needles) into the vagina or toxic mixtures such as Chili Peppers and chemical such as alum, Lysol, permanganate and many known and unknown herbal concoctions.

Unsupervised abortions may be caused by self-administration of prescriptions or illicitly obtained pharmaceuticals or use of medications not intended for abortion but known to cause miscarriage or uterine contractions (Restergadi, 2019).

Majority of unsafe abortions take place in underdeveloped world, though even in developed regions where there is legal backing for abortion, inadequate access to economical option might restrict the use of acceptable safe procedures. Restrictive regulation, a lack of resources, high costs, stigma, conscientious provider refusal, required waiting periods, forced consultation, false information, third-party authorization, and needless tests that medically delays interventions are obstacles to obtaining safe abortions (WHO, 2020).

Two main determinants of unsafe abortion are delineated thus:

- Individual (proximal) determinants – at the individual level, economics, health status, and family considerations are the determining factors, and
- Systemic determinants – this include the decision making process, political influence, legal restrictions, medical factors, socio-economic and religions factors. Abortion becomes legal depending on whether the act is supported or justified by law. Health care factors are directly related to national politics and policies. These include availability, accessibility, infrastructure setups, quality, cost, delivery of services and impact on safe abortion delivery alongside comprehensive care in specific jurisdiction.

The role and influence of economic factors such as income level/financial resources, employment status, financial aspirations and benefit/support cannot be overemphasized on their bearing on abortions.

Singh., (2009) highlighted measures to reduce unsafe abortion incidences as: increasing women's access to reproductive health, provision of safe abortion services, increased socio-economic empowerment of women and address negative norms to challenge the issues of preventing women from obtaining access of safe abortion. The problem for this study stems from the fact that available statistics and information indicates that approximately 42 million of women globally have unwanted pregnancies which they choose to terminate. (Sedgh, 2016). Half of these abortion are done unsafely leading to the death of about 68,000 women yearly,

thus making it one of the leading causes of maternal mortality and other debilitating complications particularly in underdeveloped societies. Young adolescent women are the most implicated in unsafe abortion because of ignorance, socio-economic and psychological reasons (among others). It is due to high incidence of unsafe abortion among adolescents that called for this study at Joseph Sarwuan Tarka University Makurdi whose female students may be cuprites.

CONCEPTUAL FRAMEWORK

Akin (2021) defined abortion as the loss or expulsion of pregnancy before 28 weeks of gestation. However, the public confuse abortion to mean deliberate and intentional termination or interruption of a pregnancy while miscarriage is an accidental or spontaneous end of pregnancy. WHO (2020) states that unsafe abortions are completely preventable hence it is a procedure performed by unskilled persons and in a poor environment.

According to Singh et al. (2010), a third of the 1.3 billion women in developing countries between 15 and 44 years live in nations where abortions are legalized only to save a woman's life. Despite these stringent law, access for abortion is still severally restricted from these women. Unsafe abortion is recognized as an important factor in mortality and morbidity rates among women of reproductive age (Ganata, Gedts and Rossiers, 2017). Unsafe abortions can endanger a woman's reproductive fitness and may cause serious lifestyles challenges including intense bleeding, persistent inflammatory disease, ectopic gestations, sepsis, secondary infertility and even death. Singh (2009) inform that with regard to the health effects of unsafe abortion, the direct and indirect health effects in terms of mortality are enormous, with an estimated 70,000 women dying each year worldwide- with more than half of these deaths contributed by sub-Sahara Africa. Ganatra, Gerds and Rossiers (2017) have estimated the yearly unwanted pregnancies to be approximately 42 million who would want an abortion and that half of these will be unsafe with its concomitant risks. This view is collaborated by Ibekwe (2007), stating further that in Nigeria, abortion is a crime that carries a penalty of 7-14 years prison term for both the provider and the recipient. Nevertheless, competent and unskilled personnels frequently execute dangerous induced abortion in deplorable settings (Henshaw et al., 1999). Women who live in places where they can have abortions have them at a rate of 34 and 37 abortions per 1000. These rates are however with regional differentiations with Latin American and the Caribbean's having the highest rates while North America and the Oceania have the lowest rate. Africa and Asia have rates that are fairly similar to the global average (WHO, 2020).

Abortion rates have significantly decreased in most nations; this is attributable to the continuous improvement in access to and the usage of modern Contraceptives (Starbird, Norton and Marcus, 2016).

Complications of Unsafe Abortions

According to WHO (2020), complications from unsafe abortions results to the death of a woman in developing world every eight minutes and thought to be responsible for 13% of all maternal fatalities globally.

As abortion in Sub-Saharan Africa are often performed by unskilled providers and in unhygienic and unsafe environment, mortality rates of as high as 20-40% are recorded. This is associated with complications of bleeding, sepsis, uterine rupture pelvic abscesses, endotoxic

shock and renal failure. Other long term morbidities include chronic pelvic ailments, ectopic gestations, cervical incompetence and secondary infertility. These complications have severe costs and the cost- effectiveness of prompt treatment of these includes averting short and long-term morbidity and even mortality from health issues. Infact to save lives and safeguard public health, WHO (2020) advice that every nation has a commitment of providing its public health care system with high-quality post abortion treatment, opening up access to this crucial aspect of reproductive health care, and high-quality contraceptive advice and services must be a part of post abortive care. This is to assist women in avoiding further unwanted pregnancies. Rossier (2003) added that should complications arise, expanding training for care providers and providing prompt medical interventions be applied.

Onyechoa (1990) and Rahel, Deriba and Asrat (2018) advanced reasons provided by women who undertake abortion themselves, some of which are rational. These reasons may include to:

- Continue with their educational pursuits;
- Cover their infidelity
- Limit family stigma;
- Safe their health status; and
- Avoid the birth of unwanted babies.

Abortion conveys a lot of physical, emotional and psychological consequences, some of which are prolonged and grave. The volume of blood lost during abortions may result into fragile and vulnerable to ill-health. Mortality and morbidity becomes high, there is likelihood of abnormal pregnancies, premature births, and even secondary infertility can occur. Besides, abortion can be followed by a feeling of guilt, disturbed sexual relations experience and psychologically induced illness and trauma. Infact termination of pregnancy may bring on a servicing psychoneurotic or even psychotic reactions in the susceptible woman (Confidence et al., 2020; Coneia, Cavalcante and Main, 2009; Bankole, et al., 2015). The psychological and social problems lead adolescents into taking impulsive and desperate actions that results in personal harm like regrets, despair and total melancholy because they ditched professional advice and uptake uninformed peers advices.

Eka et al., (2019), Frank, Jesca and Andrew (2017), Rehel, Deriba and Astrat (2018) and Viengnakhone, Kongmany and Dirk (2020) carried out various studies on knowledge attitude and practice of unsafe abortions in Democratic Republic of the Congo, Indonesia and Tanzania and report good adolescents knowledge of abortions, conservative attitude on abortion and their involvement in the practice of the phenomenon. The Health Action Process Approach (HAPA) basically a theory of health behaviour change which infers replacing unhealthy behaviours with healthy ones.

- The Trans-Theoretical Model (TTM) otherwise known as stages of change. In this model, change is a process involving progress through series of changes with 10 processes of change starting with consciousness and ending with stimulate control.

METHODOLOGY

A cross sectional descriptive study was used for this study with female students who were up to 30years of age among the population of 1889 of Joseph Sarwuan Tarka University, Makurdi.

Inclusion criteria was consenting female students from various departments and levels, while the exclusion criteria was non-consenting female students.

A multistage sampling technique was used:

Stage 1: Selection of faculty using simple random sampling technique.

Stage 2: Selection of departments using simple random sampling technique.

Stage 3: Selection of levels of study was done using simple random sampling technique.

Stage 4: Selection of the sampled students in the various levels with a total sampling frame of one thousand, eight hundred eighty-nine (1889) eligible participants.

Ten percent of sample size questionnaire was pretested in Benue State University, Makurdi. The pre-test was analysed and ascertained its validity using Cronbach Alpha reliability coefficient.

Knowledge was measured by correct definition of unsafe abortion, having undergone unsafe abortion and knowing someone who had unsafe abortion.

Attitude was measured by compliance assessing if unsafe abortion is a good practice by the respondents and reasons for not adopting it.

Practice was measured by the number of the respondents who actually carried out unsafe abortion which was accepted by 8% of the respondents.

Written consent was gotten from each respondent after ethical approval was gotten from research committee of the institution and confidentiality was ensured with anonymity of information recorded and kept securely.

Participants were informed of their right to discontinue with responses at anytime of the research process.

Data Presentation

Variable and data generated were presented in tables.

Table 1: Socio-Demographic Characteristics of Respondents

Variable	Frequency	Percentage (%)
Age		
≤19	46	18.4
20-25	176	70.4
26-30	28	11.2
>30	-	-
<u>Ethnicity</u>		
Tiv	174	69.2

Idoma	60	24.0
Igede	16	6.4
Others (specify)	-	-
<u>Religion</u>		
Christianity	264	98.4
Islam	4	1.6
<u>Marital Status</u>		
Single	244	97.6
Married	6	2.4
Divorced	-	-
Variable	Frequency	Percentage (%)
Heard of Unsafe Abortion		
Yes	238	95.2
No	12	4.8
Total	250	100.0
Source of Information		
Friends	98	29.9
School	96	28.4
Media	68	27.2
Church	34	13.6
Parents	32	12.8
Total	328	100
Variable	Frequency	Percentage (%)
Correct Definition	32	12.8
Wrong Definition	112	44.8
Not Sure	106	42.4
If JSTU students undergo unsafe abortion		
Yes	84	33.6
No	26	10.4
Not Sure	140	56.0
Knowing someone who had unsafe abortion		
Yes	80	32.0
No	146	58.8
Not sure	24	10.0
Variable	Frequency	Percentage (%)
Sickness after Unsafe Abortion		
Yes	62	48.0
No	14	11.0
Don't know	52	41.0
Where to obtain unsafe abortion		
Clinics	86	24.4
Herbal homes	84	23.9
Chemists	82	23.3
Hospital	76	21.5
Don't know	24	6.8
Total*	354	100
Provider of unsafe abortion		
Doctors	130	28.0

Nurses	76	16.4
Herbalist	58	12.5
Self	64	13.8
Don't know	26	11.2
Chemist	110	23.7
Total**	464	100.0
Variable	Frequency	Percentage (%)
Substances used for unsafe abortion		
Drugs	132	53.0
Herbs/Roots	30	12.0
Metal rods/wires	10	4.0
Don't know	78	31.0
Passing instrument through the vaginal		
Yes	102	40.8
No	22	8.8
Not Sure	126	50.4
Examples of such instruments		
Forceps & Scissors	4.0	3.6
Hangers & metals	8.0	7.1
Sticks	2.0	1.8
Drugs insertion	2.0	1.8
Don't know	96.0	85.7
Total*	112	100
Variable	Frequency	Percentage (%)
Complications of unsafe abortion vaginal		
Bleeding		
Yes	230	92.0
No.	20	8.0
Infertility		
Yes	236	94.4
No	14	5.6
Reproductive Tract infection		
Yes	228	91.2
No	22	8.8
Death		
Yes	224	89.6
No	26	10.4

Table 6: Respondents Attitude Inwards Unsafe Abortion

Variable	Frequency	Percentage (%)
Unsafe Abortion A good practice		
Yes	6	2.4
No	236	94.4
Undecided	8	3.2
To abort if pregnant		
Yes	12	2.4
No	208	83.2

Undecided	36	14.4
Reasons for not aborting		
Stigmatization	6	1.4
Death	196	45.8
Infertility	90	21.0
Reproductive tract infection	70	16.4
Illegal	16	3.7
Sin against God	50	10.9
Total*	428	100

Total* 428 because of multiple responses.

Table 7: Pregnancy History among Respondents

Variable	Frequency	Percentage (%)
Previous Pregnancy		
Yes	22	8.8
No	228	91.2
Age at first Pregnancy		
15 – 19	10	45.0
20 – 24	12	55.0
Total*	22	100.0
Number of times pregnant		
Once	14	83.6
Twice	3	23.7
Three times	4	18.1
Five times	1	4.55
Total**	22	100
Planned Pregnancies		
Planned	2.0	9.1
Not planned	20.0	90.9
Total*	22	100

Total* Only 22 respondents have ever been pregnant.

Table 8: History of Unsafe Abortion among Respondents

Variable	Frequency	Percentage (%)
Previous Unsafe Abortion		
Yes	20	8.0
No	2	0.8
Never pregnant	228	91.2
Number of Times		
Once	14.0	70.0
Twice	1.0	5.0
Three Times	4	20.0
Five Times	1	5.0
Total*	20	100
Place of Abortion		
Hospital	5	25.0
Chemist	11	55.0
By self	4	20.0

Post abortion condition		
Illness	8	40.0
No Illness	12	60.0
Post abortion illness		
Bleeding	5	62.5
Reproductive tract infection	3	37.5
Total*	8	100

Total* only 8 became ill following abortion

Table 9: The Distribution by Reasons why the Respondents had unsafe Abortion.

Variable	Frequency	Percentage (%)
Fear of family	2	10.0
To continue education	4	20.0
It was outside marriage	4	20.0
Not ready for motherhood	6	30.0
It was unwanted pregnancy	4	20.0
Total	20	100

Note:

The inconsistencies in the data was due to:

- Multiple response for certain items
- Unawareness of the procedure carried out and the type of instruments used on item.
- Non-response to certain items by the respondents.

DISCUSSION

The study found an unsafe abortion rate of 20 (8%) among the respondents and a post-abortion illness of 40% which included bleeding and reproductive tract infection. As opined by Singh (2010) and Ibekwe (2007), unsafe abortion has put lives of many in more morbidity and, in rare cases, mortality. This is in line with Yeatman and Trinitapoli (2011), though the studies were carried out in different settings. Moseson (2015) whose study was in a low socio-economic setting just like the present study accepts that women in these settings receive poor post-abortion care when they become ill.

Majority of the respondents (95%) had good knowledge of unsafe abortion, just as Frank, Jesca and Andrew (2017), Bright et al. (2020) as well as Ibekwe (2007). Ninety-five percent of the respondents had good knowledge of unsafe abortion. This could be attributed to their level of education as university students and exposure to vast amount unsafe abortion information. Frank, Jesca and Andrew (2017), Bright et al. (2020) as well. As shown, data was analyzed using only descriptive statistics with the presented variables in tables 1 -9. The inferences are as presented in discussion using solely percentages.

Ibekwe (2007) also found their subjects to have had high knowledge of unsafe abortion; though their subjects were secondary school students. However, 21.4% of the respondents had unsafe abortion which is low compared to Abiola, Oke and Balogun (2016) whose study was

conducted in Metropolitan city of Lagos amongst naive secondary school students who may have naive knowledge of unsafe abortion and are much younger.

CONCLUSION

This shows that female students of Joseph Sarwuan Tarka University, Makurdi have good knowledge of unsafe abortion from various sources, though high rate of wrong definition of unsafe abortion, have knowledge of places where and who provides unsafe abortion. Their attitudes to unsafe abortion is 94.4% pessimistic advancing various reasons to support this including stigmatization and even death. By this, 8% accepted having had unsafe abortion.

Recommendations

The following recommendation were made.

1. In order to decrease the menace of unsafe abortions, there should be improvement in the public's understanding of attitudes concerning the phenomenon.
2. There should be legislation on unsafe abortion to deter these involved in it.
3. Massive awareness programmes on unsafe abortion should be carried out by sponsoring mass media information dissemination so that unplanned pregnancies could be avoided.
4. To mitigate complications, post abortion services and care should be strengthened within the health care system.
5. WHO and other health care agencies to develop and strengthen programmes on unsafe abortions.

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