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Perceived Impacts of Abortion and Associated Risks in the Reduction of Maternal Mortality Rates among Women of Reproductive Age at Lth, Ogbomoso

Oyewumi Zaccheus Opeyemi[1], Oyewumi Lydia Omowumi[2], Adedoyin Adeoye Adeyemi[3], Oladotun Nike Oloruntosin[4], Taiwo Diekolola Olajuwon[5]

[1]LAUTECH Open and Distance Learning Centre, Oyo State, Nigeria, [2]General Hospital, Ikoyi-Ile, Oyo State Nigeria, Ago Iwoye, Ogun State, Nigeria, [3]LAUTECH Open and Distance Learning Centre, Oyo State, Nigeria, [4]LAUTECH Open and Distance Learning Centre, Oyo State, Nigeria,, [5]LAUTECH Open and Distance Learning Centre, Oyo State, Nigeria.

ABSTRACT

Background: Abortion is the ending of pregnancy by removing a fetus or embryo before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage. An abortion may be caused purposely and is then called an induced abortion, or less frequently, "induced miscarriage". Grimes, and Stuart, (2010). Although induced abortion is medically safe when done in accordance with recommended guidelines, many women undergo unsafe procedures that put their well-being at risk. Thus understanding the perceived impacts of abortion and its associated risks on reduction of maternal mortality rates is critical for countries like Nigeria with increase maternal mortality rate. **Methodology**: This study was undertaken to determine the impacts of abortion and its associated risks in the reduction of maternal mortality rates among women of reproductive age attending LAUTECH Teaching Hospital, Ogbomoso, Oyo State, Nigeria. A cross-sectional descriptive study was used to generate data among reproductive age women. Simple random sampling technique was used. Quantitative data were collected with the use of a structured, pre-tested and self-structured questionnaire. A p-value of less than or equal to 0.05 was taken to be statistically significant. **Results:** Of all the 200 respondents who participated in the research study, majority of the respondents shows the good knowledge of abortion. 76.0% of them know the meaning of abortion while 24.0% did not. Significant number of the respondents (93.0%) believes that abortion can be procured for therapeutic and elective reasons while 7.0% disagrees. 86.0% affirmed that most abortion performed by unskilled providers is unsafe and 14.0% says contrary. The p value = 0.346 from the calculation is greater than 0.05. Hence, the null hypothesis is accepted meaning there is no significant association between the respondent's knowledge and occurrence of abortion. There is also no significant difference between the age of respondents and the incidence of abortion when the p value is 0.469. **Conclusion:** This study revealed that the majority of the reproductive age women have good knowledge of abortion. Because of the issue with legalization of abortion in Nigeria, many still adopt clandestine means to procure abortion and this had led to a marginal increase in maternal mortality indices in the country. However, effort should be made by the appropriate authority to stem the incessant procurement of unsafe abortion.

Keywords: *Abortion, Reproductive age women, Risk, Impact, Maternal mortality rate.*

INTRODUCTION

Grimes, and Stuart, (2010) defined abortion as the ending of pregnancy by removing a fetus or embryo before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage. An abortion may be caused purposely and is then called an induced abortion, or less frequently, "induced miscarriage". The abortion is often used to mean only induced abortions. Schorge John et al, (2008) submitted that reasons for procuring induced abortions are typically

characterized as either therapeutic or elective. An abortion is medically referred to as a therapeutic abortion when it is performed to save the life of the pregnant woman; prevent harm to the woman's physical or mental health; terminate a pregnancy where indications are that the child will have a significantly increased chance of premature morbidity or mortality or be otherwise disabled; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy. An abortion is referred to as an elective or voluntary abortion when it is performed at request of the woman for non-medical reasons.

According to the report of the Center for Reproductive Rights, (2015), Nigeria's abortion provisions, induced abortion is illegal in Nigeria except when performed to save a woman's life. Both the penal code, which is generally applied in the country's northern states, and the criminal code, which generally applies in the southern states, allows this exception, and both regions specify similar criminal penalties for noncompliance. World Health Organization (WHO, 2009) observed that pregnancy terminations are quite common, and because they are often performed clandestinely or by unskilled providers, most are unsafe. The World Health Organization (WHO), 2007 estimates that worldwide 210 million women become pregnant each year and that about two-thirds of them, or approximately 130 million, deliver live infants. The remaining one-third of pregnancies ends in miscarriage, stillbirth, or induced abortion. Of the estimated 42 million induced abortions each year, nearly 20 million are performed in unsafe conditions and/or by unskilled providers and result in the deaths of an estimated 47,000 girls and women. This represents about 13 percent of all pregnancy-related deaths. Iqbal Shah and Elisabeth Ahman, (2010) admitted that almost all unsafe abortions take place in developing countries, and this is where 98 percent of abortion-related deaths occur.

Akinrinola et al, (2015) inferred that the first national study to examine the incidence of abortion estimated that in 1996, about 610,000 abortions, or 25 per 1,000 women aged 15–44, occurred in Nigeria. A decade later, another study noted that if the abortion rate had not changed since 1996, then 760,000 abortions would have occurred in 2006, given the increase in Nigeria's population during this period. The Government of the Federal Republic of Nigeria, *Nigeria Millennium Development Goals Report 2010, reiterated that since* the release of the 1996 estimates, the Nigerian government and other stakeholders have initiated a number of policies and programs to improve the reproductive health of women in the country. Notable among them are the government's efforts to achieve the United Nations Millennium Development Goals, including Goal 5, to improve maternal health. This goal has two targets: to reduce the maternal mortality ratio by 75% between 1990 and 2015, and to provide universal access to reproductive health by 2015. A 2010 government report concluded that progress toward achieving these targets has been slow, and that the modest progress that has been made in reducing maternal mortality has not been accompanied by improvements in other indicators, such as family planning uptake and the proportion of births attended by skilled health workers.
Akinrinola et al, (2015) in an International Perspectives on Sexual and Reproductive Health further reported that an estimated 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to a rate of 33 abortions per 1,000 women aged 15–49. The estimated unintended pregnancy rate was 59 per 1,000 women aged 15–49. Fifty-six percent of unintended pregnancies were resolved by abortion. About 212,000 women were treated for complications of unsafe abortion, representing a treatment rate of 5.6 per 1,000 women of reproductive age, and an additional 285,000 experienced serious health consequences but did not receive the treatment they needed. As observed by the 2013 NDHS report,

Evidence from national surveys further reiterated that the number of abortions in Nigeria is likely to remain high in the absence of intervention. Nigerian women aged 15–49 had, on average, more children than they wanted. (Sedgh; Singh; Shah; Ahman; Henshaw; and Bankole, (2012) inferred that approximately 205 million pregnancies occur each year worldwide. Over a third is unintended and about fifth end in induced abortion.

According to Sedgh et al report in 2014, during 2010–2014, an estimated 8.3 million induced abortions occurred each year in Africa. This number represents an increase from 4.6 million annually during 1990–1994, mainly because of an increase in the number of women of childbearing age. The annual rate of abortion, estimated at 34 procedures per 1,000 women of childbearing age (i.e., those 15-44 years old), remained more or less constant over the same period. The abortion rate is roughly 26 for married women and 36 for unmarried women. The proportion of pregnancies ending in abortion, estimated at 15% in 2010–2014, also changed little since 1990–1994. The annual rate of abortion varies slightly by region, ranging from 38 per 1,000 women of childbearing age in Northern Africa to 31 per 1,000 in Western Africa. In Eastern, Middle and Southern Africa, rates are close to the regional average of 34 per 1,000. The proportion of pregnancies ending in abortion ranges from 12% in Western Africa to 23% and 24% in Northern and Southern Africa, respectively. It is 13% and 14% in Middle and Eastern Africa, respectively.

As explained by Shah and Say (2007) a maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Globally, the estimated number of maternal deaths worldwide in 2005 was 536,000 up from 529,000 in 2000. According to the WHO Factsheet (2008), 1500 women die from pregnancy or pregnancy-related complications every day. Most of these deaths occur in developing countries, and most are avoidable. Of all the health statistics compiled by the World Health Organization, the largest discrepancy between developed and developing countries occurred in maternal mortality. The maternal mortality ratio in developing countries is 450 maternal deaths per 100,000 live births versus 9 in developed countries. Fifteen countries have maternal mortality ratios of at least 1000 per 100,000 live births, of which all but Afghanistan and India are in sub-Saharan Africa: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Guinea-Bissau, India Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia. Nigeria has one of the highest maternal mortality rates in the world, second only to India whose population is eight times larger than that of Nigeria.

In line with W.H.O, (2007) report, maternal mortality, also known as maternal death, continues to be the major cause of death among women of reproductive age in many countries and remains a serious public health issue especially in developing countries. W.H.O, (2014) further described Nigeria as one of the countries having highest maternal mortality ratios in the world. Although the government has acknowledged the problem and is committed to improving maternal health, evidence suggests that progress has been limited, and unsafe abortion remains a major contributor to maternal morbidity and mortality.

According to Henshaw et al., (2012) a recent study recorded 137 maternal near-miss cases in a six-month period at eight large hospitals across the country, and found that 13 (10%) were due to unsafe abortion. Another study estimated that in the late 1990s, about 3,000 women died annually from unsafe abortion in Nigeria. Because this estimate included only women who had

died in health facilities, and not those who had died from unsafe abortion before reaching a facility, the actual number of deaths was likely higher. In 2012, about 212,000 women were treated in health facilities for complications of induced abortion, suggesting that unsafe abortion remains an important contributor to maternal morbidity and mortality in Nigeria. In addition, an estimated 285,000 women had complications serious enough to require treatment in health facilities, but did not obtain the care they needed.

Bankole et al (2009) observed that the impact of unsafe abortion extends beyond morbidity and mortality; there are also social costs to Nigerian women and their households, including the risks associated with breaking the country's restrictive abortion law and the possibility of strong social sanctions. Furthermore, unsafe abortion imposes a heavy financial burden on both women and Nigeria's fragile health care system. For example, one study estimated that post abortion care cost US$103 per patient in Nigeria in 2005, amounting to US$19 million; the average per-case cost for hospital care was US$132, of which 72% (US$95) was borne by women and their households.

Objectives of the Study

The objective of this research study is:

To determine the knowledge of respondents on abortion

To determine the age of respondents and their knowledge about abortion

To identify the socioeconomic factors responsible for abortion

To determine the educational status of respondents

To determine the impacts of abortion on maternal mortality rates

Research Questions

The research answered the following questions

Do respondents have adequate knowledge on abortion?

What are the socioeconomic factors responsible for abortion among the respondents?

Does the educational status of the respondents influence the procurement of abortion?

Does abortion have any impacts on maternal mortality rates?

Research Hypotheses

The following hypotheses were tested:

There is no significant difference between the knowledge of respondents and occurrence of abortion

There is no significant difference between the age of respondents and the incidence of abortion

There is no significant difference between the socioeconomic status of respondents and occurrence of abortion

MATERIALS & METHODS

A cross-sectional descriptive study was used to generate data among reproductive age women. Simple random sampling technique was used. Quantitative data were collected with the use of a structured, pre-tested and self-structured questionnaire. A p-value of less than or equal to 0.05 was taken to be statistically significant.

Study Setting

The study was carried out in LAUTECH Teaching Hospital, Ogbomoso. LAUTECH Teaching Hospital (LTH) is located in Ogbomoso North Local Government Area, Oyo State, Southwest Nigeria and it is a state owned University Teaching Hospital and a referral centre. Service departments in LTH are Anesthesia, Dental Surgery, Obstetrics & Gynaecology, Ophthalmology, Otorhinolaryngology, Radiology, General Surgery, Community Medicine, Family Medicine, Haematology, Internal medicine, Microbiology, Paediatrics, Psychiatry, Chemical Pathology and Histopathology, Pharmacy, Physiotherapy, Nursing, Records, and Administrative/Finance Departments.

Sample Size Determination

A sample size of 200 respondents was used as derived from Yamane's formula for calculating sample size. $n = N/ 1+N (e)^2$, where n = Sample size, N= 200 which is the population size of women of reproductive

age attending LTH, e= the acceptable sampling error (For this study, 5% is chosen (0.05) at confidence level of 95%. Two hundred respondents will be purposively selected for the study among those that are attending LTH, Ogbomoso.

Sample Technique

Two hundred (200) women of reproductive age in Ladoke Akintola University of Technology Teaching Hospital,Ogbomoso were selected using simple random sampling technique.

Data Analysis

The research questions were analyzed using percentages, frequencies and chi-square tables while the null hypotheses were tested using Spearman Brown Correlation Coefficient with the SPSS 25 version at the 0.05 level of significance.

Psychometric properties of the instruments

Validity

The face validity of the instrument was determined before the researcher's supervisor. Some of the items were assumed to be ambiguous and jettisoned from the initial instrument submitted to the supervisor. The content validity of the instrument was determined by an expert in the field of Maternal and Child Health Nursing.

Reliability

The reliability of the instrument was carried out during the pilot study at Osun State Hospital, Asubiaro, Osogbo amongst 20 pregnant women. The result showed 0.65 on test-re-test reliability, therefore the instrument showed 65% reliability.

Study Population

The study was carried out among women of reproductive age at LAUTECH Teaching Hospital, Ogbomoso.

Inclusion Criteria

All women of reproductive age attending LAUTECH Teaching Hospital, Ogbomoso that agreed to participate in the study.

3.8 Exclusion Criteria

All other patients attending LAUTECH Teaching Hospital, Ogbomoso but are not women of reproductive age are not allowed to participate in the study.

RESULT

Table 1: Socio Demographic Characteristics Of The Respondents

Variable	Frequency N=200	Percentage %
Age group (years)		
20 or less	3	1.5
21 – 25	8	4.0
26 – 30	52	26.0
36 and above	137	68.5
Marital Status		
Single	25	12.5
Married	175	87.5
Religion		
Christianity	171	85.5
Islam	29	14.5
Traditional	0	0.0
Ethnicity		
Yoruba	188	94.0
Hausa	12	6.0
Igbo	0	0.0
Employment		
Full-time	144	72.0
Part-time	7	3.5
Self-employed	46	23.0
Not applicable	3	1.5
Educational background		
Primary	6	3.0
Secondary	16	8.0
Tertiary	178	89.0
No formal education	0	0.0

Table 1 shows the socio demographic characteristics of the respondents. Two hundred respondents were recruited for the study. Most of the respondents were 36 years and above (68.5%) and 87.5% were married. Majority of the subjects were Yoruba (94.0%) and 6.0% were hausas. 85.5% were Christians and 14.5 were muslims. Most of the respondents engaged in full-time work (72.0%), 3.5% and 23.0% were engages in part-time and self-employed work Majority of them 89.0% had tertiary education while 3.0% and 8.0% had primary and secondary education respectively.

Table 2 shows the respondents knowledge of abortion. 76.0% of the respondents knows the meaning of abortion while 24.0% did not, 93.0% believes that abortion can be procure for therapeutic and elective reasons and 7.0% disagrees. 86.0% affirmed that most abortion performed by unskilled providers are unsafe and 14.0% says

contrary. 71.5% of the respondents said most unsafe abortions take place in developing countries and 28.5 disagrees. Larger percentage of respondents concluded that low contraceptive use, poverty, religion and educational qualification are the most imminent factors that contribute to high rate of abortion.

Table 2: Respondents knowledge of abortion

Variables	**Frequency N=200**	**Percentage%**
Abortion is the ending of pregnancy		
Yes	152	76.0
No	48	24
Reasons for procuring induced abortion can be therapeutic or elective		
Yes	186	93.0
No	16	7.0
Most abortion performed by unskilled providers are unsafe		
Yes	172	86.0
No	28	14.0
Most unsafe abortions take place in developing countries		
Yes	143	71.5
No	57	28.5
The incidence of abortion is more among women age 15 to 49 49		
Yes	100	
No	0	0.0
Unsafe abortion remains a major contributor to maternity morbidity and mortality		
Yes	195	97.5
No	5	2.5
Major reason for high rates of unwanted pregnancy in Nigeria is low contraceptive use		
Yes	172	86.0
N0	28	14.0
Poverty contributes to procurement of abortion		
Yes	152	76.0
No	48	24.0
Religious is a factor for obtaining safe abortion in Nigeria		
Yes	143	71.5
No	57	28.5
Educational qualification plays a vital role in determining the safety of abortion		
Yes	142	71.0
No	58	29.0

Table 3: Perceived impacts of abortion on women of reproductive age

Variables	Frequency N= 200	Percentage %
Unsafe abortion imposes heavy financial burden on both women and their family		
Agree	75	37.5
Strongly Agree	50	25.0
Disagree	59	29.5
Strongly Disagree	7	3.5
Undecided	9	4.5
Unsafe abortion imposes a heavy financial burden on Nigeria's fragile health care system		
Agree	55	27.5
Strongly Agree	29	14.5
Disagree	49	24.5
Strongly Disagree	58	29.0
Undecided	9	4.5
Girls and women who have unsafe abortions suffer complications that need medical attention		
Agree	64	32.0
Strongly Agree	97	48.5
Disagree	16	8.0
Strongly Disagree	23	11.5
Induced unsafe abortion is a serious cause of morbidity and mortality among women of childbearing age in Nigeria.		
Agree	90	45.0
Strongly Agree	78	39.0
Disagree	32	16.0
Strongly disagree	0	0.0
Practice of unsafe abortion leads to high fevers, urinary tract infections and genital trauma		
Agree	92	46.0
Strongly Agree	88	44.0
Disagree	12	6.0
Strongly Disagree	8	4.0

Table 3. To be continued...		
Maternal mortality from unsafe abortion is a serious global problem that continues to threaten the lives of many women.		
Agree	142	71.0
Strongly Agree	42	21.0
Disagree	16	8.0
Strongly disagree	0	0.0
The most common complications from unsafe abortion are incomplete abortion, excessive blood loss and infection.		
Agree	84	42.0
Strongly Agree	100	50.0
Disagree	9	4.5
Strongly Disagree	7	3.5
Unsafe abortion can lead to long-lasting health effects.		
Agree	116	58.0
Strongly Agree	84	42.0
Disagree	0	0.0
Strongly Disagree	0	0.0

Table 3 above shows that,

125 (62.5%) agreed that unsafe abortion imposes heavy financial burden on both women and their family while 66 (33.0%) disagreed and 9 (4.5) were undecided.

84 (42.2%) agreed that unsafe abortion imposes a heavy financial burden on Nigeria's fragile health care system while 107 (53.3) disagreed and 9 (4.5%) were undecided.

161 (80.5%) agreed that girls and women who have unsafe abortions suffer complications that need medical attention while 39 (19.5%) disagreed.

168 (84.0%) agreed induced unsafe abortion is a serious cause of morbidity and mortality among women of childbearing age in Nigeria while 32 (16.0%) disagreed.

180 (90.0%) agreed that practice of unsafe abortion leads to high fevers, urinary tract infections and genital trauma while 20 (10.0%) disagreed

184 (92.0%) agreed that maternal mortality from unsafe abortion is a serious global problem that continues to threaten the lives of many women while 16 (8.0%) disagreed

184 (92.0%) agreed that the most common complications from unsafe abortion are incomplete abortion, excessive blood loss and infection while 16 (8.0%) disagreed

All the respondents 200 (100.0%) agreed that Unsafe abortion can lead to long-lasting health effects.

Testing of Hypotheses

Hypothesis 1: There is no significant difference between the knowledge of respondents and occurrence of abortion.

Chi-Square Tests					
	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.887[a]	1	.346		
Continuity Correction[b]	.114	1	.735		
Likelihood Ratio	1.665	1	.197		
Fisher's Exact Test				1.000	.436
Linear-by-Linear Association	.883	1	.347		
N of Valid Cases	200				

X^2 –calculated=0.346, X^2 -tabulated=0.887, df=1, P= 0.05

Inference: Since the table value (0.887) is greater than the calculated value (0.346) at 0.05 level of significant, it implies that; there is no significant difference between the knowledge of respondents and occurrence of abortion; therefore, the null hypothesis is not significant and hence accepted.

Hypothesis 2: There is no significant difference between the age of respondents and the incidence of abortion.

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.535[a]	3	.469
Likelihood Ratio	4.058	3	.255
Linear-by-Linear Association	2.321	1	.128
N of Valid Cases	200		

X^2 –calculated=0.469, X^2 -tabulated=2.535, df=3, P= 0.05

Inference: Since the table value (2.535) is greater than the calculated value (0.469) at 0.05 level of significant, it implies that; there is no significant difference between the age of respondents and the incidence of abortion; therefore, the null hypothesis is not significant and hence accepted.

Hypothesis 3: There is no significant no significant difference between the socioeconomic status of respondents and occurrence of abortion.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.741[a]	1	.000		
Continuity Correction[b]	10.745	1	.001		
Likelihood Ratio	9.633	1	.002		
Fisher's Exact Test				.002	.002
Linear-by-Linear Association	13.673	1	.000		
N of Valid Cases	200				

X^2 –calculated=13.741, X^2 -tabulated=0.000, df=1, P= 0.05

Inference: Since the table value (0.000) is greater than the calculated value (0.469) at 0.05 level of significant, it implies that; there is no significant difference between the socioeconomic status of respondents and occurrence of abortion; therefore, the null hypothesis is not significant and hence accepted.

DISCUSSION

Many regions in Africa are known for their unsafe practices in health care and disease, specifically when it comes to young pregnant women and abortion. Abortion accounts for 40% of maternal deaths in Nigeria, making it the second leading cause of maternal mortality in the country. [Preventing Unsafe Abortion in Nigeria". *African Journal of Reproductive Health, (2012)*]. *In line with the report of Singh et al., (2009).* The present study revealed that most of the respondents were 36 years and above (68.5%) and 87.5% were married. Majority of the subjects were Yoruba (94.0%) and 6.0% were Hausas. 85.5% were Christians and 14.5 were Muslims. Most of the respondents engaged in full-time work (72.0%), 3.5% and 23.0% engages in part-time and self-employed work respectively. Majority of them 89.0% had tertiary education while 3.0% and 8.0% had primary and secondary education respectively. Majority of the respondents shows the good knowledge of abortion. 76.0% of them know the meaning of abortion while 24.0% did not. This research finding gave a good impression that many reproductive age women have a good understanding of abortion and the likelihood of abortion to occur among women of reproductive age is high.

Meanwhile, significant number of the respondents (93.0%) believes that abortion can be procured for therapeutic and elective reasons while 7.0% disagrees. This is in consonance with the position of Schorge John et al., (2008) which affirmed that reasons for procuring induced abortion are typically characterized as either therapeutic or elective. Also 86.0% affirmed that most abortion performed by unskilled providers is unsafe and 14.0% says contrary. This corroborated the finding of World Health Organization, (2007) which observed that of the 40 million induced abortions

each year, nearly 20 million are performed in unsafe conditions and/or by unskilled providers and result in deaths of an estimated 47,000 girls and women. Equally, WHO, (2009) stated that pregnancy terminations are quite common, and because they are often performed clandestinely or by unskilled providers, most are unsafe.

However, of all the 200 respondents who participated in the research study, 71.5% of them said most unsafe abortions take place in developing countries and 28.5 disagrees. This finding supported the position of Akinrionla et al (2015) in his first national study to examine the incidence of abortion, it was estimated that in 1996, about 610,000 abortions, or 25 per 1000 women aged 15 – 44, occurred in Nigeria. A decade later, another study noted that if the abortion rate had not changed since 1996, then 760,000 abortions would have occurred in 2006, given the increase in Nigeria's population during this period. Akinrinola in an International Perspectives on Sexual and Reproductive Health further reported that an estimated 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to a rate of 33 abortions per 1000 women aged 15 – 49. The 2013 National Demographic Health Survey also supported the study finding as it reiterated that the number of abortions in Nigeria is likely to remain high in the absence of intervention. However, larger percentage of respondents concluded that low contraceptive use, poverty, religion and educational qualification are the most imminent factors that contribute to high rate of abortion.

The study results equally deduced that 125 (62.5%) agreed that unsafe abortion imposes heavy financial burden on both women and their family while 66 (33.0%) disagreed and 9 (4.5) were undecided. This significant percentage (62.5%) of the respondents corroborated the claims of Bankole et al (2009) when he observed that the impact of unsafe abortion extends beyond morbidity and mortality; there are also social costs to Nigerian women and their households, including the risks associated with breaking the country's restrictive abortion law and the possibility of strong social sanctions. Furthermore, the higher number of respondents 107 (53.3%) in this present study who disagreed that unsafe abortion imposes a heavy financial burden on Nigeria's fragile health care system negate the report of Bankole et al, (2015) which affirmed that unsafe abortion imposes a heavy financial burden on both women and Nigeria's fragile health care system. For example, one study estimated that post abortion care cost US$103 per patient in Nigeria in 2005, amounting to US$19 million; the average per-case cost for hospital care was US$132, of which 72% (US$95) was borne by women and their households.

Higher number of respondents 168 (84.0%) agreed that induced unsafe abortion is a serious cause of morbidity and mortality among women of childbearing age in Nigeria while 32 (16.0%) disagreed. This goes to support the claim of WHO, (2007) that although the Nigeria government has acknowledged the problem of maternal deaths and is committed to improving maternal health, evidence however suggests that progress has been limited and unsafe abortion remains a major contributor to maternal morbidity and mortality. Also, according to Henshaw et al., (2012), a recent study recorded 137 maternal near-miss cases in a six-month period at eight large hospitals across the country, and found that 13 (10%) were due to unsafe abortion. Another study estimated that in the late 1990s, about 3,000 women died annually from unsafe abortion in Nigeria. Because this estimate included only women who had died in health facilities, and not those who had died from unsafe abortion before reaching a facility, the actual number of deaths was likely higher. In 2012, about 212,000 women were treated in health facilities for complications of induced abortion, suggesting that unsafe abortion remains an important contributor to maternal morbidity and mortality in Nigeria. In addition, an estimated 285,000 women

had complications serious enough to require treatment in health facilities, but did not obtain the care they needed.

There is no significant difference between the knowledge of respondents and occurrence of abortion; therefore, the null hypothesis is not significant and hence accepted since the table value (0.887) is greater than the calculated value (0.346) at 0.05 level of significant. This finding negate the report of Ibrahim et al. (2011) which cited that an educational qualification plays a vital role in determining the safety of abortion. Evidence has shown that educated women always try to access safe abortion services. Being educated gives them the advantage of differentiating between professional health providers and quacks, and to be aware of the possible complications of unsafe abortions. At the same time, they are more likely to discuss the issue with their friends to obtain a good advice of where to secure safe abortion. Moreover, the educated are likely to be working and financially independent. In that regard they can afford to pay for the services in the private hospitals to get safe abortion

There is no significant difference between the age of respondents and the incidence of abortion; therefore, the null hypothesis is not significant and hence accepted since the table value (2.535) is greater than the calculated value (0.469) at 0.05 level of significant, it implies that age does not determine the procurement of abortion. However, this is at variance with the findings of a study conducted at Guttmacher institute in Nigeria by Sedgh et al. 2006; Adebusoye, Singh & Audam 2006 which reveals that 31% of the adolescents 15-19 year old cited being single as the main reason of wanting to procure abortion. While 30% revealed that they are too young to carry the responsibility of child bearing or they are in schools.

Furthermore, Koster (2010); Sedgh et al. (2006); Okonofua et al. (2009) were of the opinion that for the young girls in schools, the fear of expulsion from school is one of the reasons they resort to abortion. In Nigeria once the school finds out that a student is pregnant, she will automatically be expelled from that school. And most of the time there is no provision for her to go back to school to complete her education after delivery. And for the young girls the only guarantee to the future is education especially in southern Nigeria where girl child education is highly valued. Because of this fear and wanting to secure a better future, the young unmarried girl opts for abortion in order to continue with her education

Since the table value (0.000) is less than the calculated value (0.469) at 0.05 level of significant, it implies that; there is significant difference between the socioeconomic status of respondents and occurrence of abortion; therefore, the null hypothesis is significant and hence rejected. This is in agreement with the report of Henshaw et al. (2007); Koster (2010) which opines that one of the reasons why abortion is unsafe is the stigma within the community attached to the termination of the pregnancy. Women because of confidentiality issue don't discuss the pregnancy with anyone for the fear of being exposed. Because of the same fear they delay in seeking healthcare services till the pregnancy is too advanced, and this increases the possibilities of complications. Sometimes they prefer the services of unqualified personnel far from their communities because of stigma in spite the availability of safe procedure in their communities. The idea is that if they go to the qualified personnel, the pregnancy will be known. They further stated that even when a complication arises they remain at home until it becomes worst before they seek health care. All these factors contribute to the reasons why abortions are unsafe. Religion is another obstacle to obtaining safe abortion in Nigeria, it is considered as a sin by most of the religious organizations. Because of all these religious views, women will find it difficult to procure safe abortion freely in Nigeria.

CONCLUSION

The study on the perceived impacts of abortion and associated risks in the reduction of maternal mortality rates among women of reproductive age at Ladoke Akintola University of Technology, Ogbomoso revealed that majority of the reproductive age women have adequate knowledge of abortion and its impacts in the reduction of maternal mortality rates and this has translated to reduced maternal mortality rates in Ogbomoso. Also, it was found out that a good number of reproductive age women procure abortion because of reasons ranging from finance, religion and protection of their future especially among the younger ones. Meanwhile, all the respondents agreed that unsafe abortion can lead to long-lasting health effects and even mortality.

Recommendation

Based on the findings of this study, the following recommendations have been made:

More enlightenment should be given to the women on the causes and implications of abortion

Frantic efforts should be made by the federal government of Nigeria and the handlers of Nigeria health care system to supply required medical equipment in order to reduce the incidence of abortion in the country.

More premiums should be placed on family planning education and services.

Legalization of abortion should be considered by the relevant authorities in the country

Religion institutions should embrace advocacy on reproductive health education in their teachings

Recommendation for further research

Based on the findings of this study, the researcher would recommend the following to those who wish to carry out further research on this most interesting area of abortion and maternal mortality rates.

More research in this area is necessary. While this study has created a platform for dialogue and interests towards the perceived impacts of abortion and associated risks in the reduction of maternal mortality among women of reproductive age, a larger scale research would have a much better impacts in effecting attitudinal changes against wrong perception.

There is need for a country wide survey on abortion procurement in Nigeria and its relationship with maternal mortality rates to ascertain its impacts on families and Nigeria economy.

Further research should also be carried out on the incidence of unsafe abortion and the involvement of untrained persons in the procedure. This will assist policy makers in making comprehensive policies on abortion practice in the country.

REFERENCES

- Akinrinola B, Isaac F. A, Rubina H, Olutosin A, Susheela S, and Joshua O.A., (2015). International Perspectives on Sexual and Reproductive Health, 41(4): 170-181, doi: 10.1363/4117015.
- Bankole, A., Sedgh, G., Okonofua, F., Imarhiagbe, C., Hussain, R. & Wulf, D. (2009). Barrier to safe motherhood in Nigeria. A New York, USA Guttmacher Institute: Pp. 1-27.
- Center for Reproductive Rights, *Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion* (2003).
- Grimes, D.A., & Stuart, G. (2010). Abortion jabberwocky: the need for better terminology. Contraception, 81(2), 93-96. DOI 10.1016/j.contraception.2009.09.005.
- Nigeria Demographic and Health Survey (NDHS). 2013. National Population Commission, Abuja,Nigeria 2013.
- Schorge J., Joseph S., Halvorson L., Hoffman B., Bradshaw K., and Cunningham F. (2008), Williams Gynecology, McGraw-Hill Medical, New York, NY, USA, 23rd edition, 2008.
- Susheela Singh et al.(2009). *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009).
- World Health Organization (WHO), (2007). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe*

Abortion and Associated Mortality in 2003, 5th ed.

- Singh S and Maddow-Zimet I (2012). Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world,: a review of evidence from 26 countries, *BJOG*, 2015, doi:10.1111/1471-0528.13552.
- World Health Organization (WHO), (2009). *Safe Abortion: Technical and Policy Guidance For Health System, 2003 Lancet*, 2016, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30380-4/abstract.
- World Health Organization (WHO) Factsheet, 2008. Maternal mortality. Department of Making Pregnancy Safer.
- World Health Organization (WHO), (2007). *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, 5th ed.
- Iqbal Shah and Elisabeth Ahman (2010). "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35.
- Susheela Singh et al., (2009). *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009).
- Winikoff B and Sheldon W, (2012). Use of medicines changing the face of abortion, *International Perspectives on Sexual and Reproductive Health*, 2012, 38(3):164–166.

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