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Unintended Pregnancies and Decision-Making Among Married Women in South-West Nigeria: what Drives their Choices?

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A B S T R A C T

Background: Unintended pregnancies pose significant risks to women's health, families, and society. In Nigeria, the factors influencing decision-making regarding unintended pregnancies among married women remain largely unexplored. Aim: This study aimed to identify these factors in South-West Local Government Area (IBSWLGA).

Methodology: Using an exploratory, phenomenological design, the study employed qualitative methods. Ten out of twelve wards were selected via balloting for Focus Group Discussions (FGDs), and the remaining two wards for In-depth Interviews (IDIs). One community per ward was randomly chosen for FGDs, conducted with purposively selected women of child-bearing age who had two children in the past five years. Additionally, six IDIs were conducted with women who had experienced unintended pregnancies. Data collection involved FGD guides and IDI schedules addressing decision-making, spousal reactions, induced abortions, and contraceptive use, with thematic analysis of the responses.

Result: The socio-demographic characteristics of the respondents showed that 38.4% were between the ages of 26 and 30, with a mean age of 28.5 ± 4.98 years. Additionally, 47.6% of the participants had three children at the time of the study. Most participants (58.3%) had completed tertiary education, and a significant majority (79.2%) were Yoruba. Nearly half (49.5%) identified as Christians, and a large portion (63.1%) were self-employed. Many FGD participants experienced unintended pregnancies during the nursing period of a previous child. Key factors influencing decisions to continue pregnancies included spousal support, fear of complications, failed induced abortions, and the desire for more children.

Conclusion: Married women often encounter significant challenges when dealing with unintended pregnancies, frequently depending on their spouses for decision-making. The study highlighted a disparity between knowledge and the practical use of contraceptives, resulting in high rates of unintended pregnancies. Asides the intensifying means of public awareness, conducting workshops and seminars for religious leaders, traditional healers and grassroots political leaders can equip them with accurate knowledge about the health risks associated with unsafe abortions, and the critical importance of comprehensive reproductive health education.

INTRODUCTION

The ability of women and couples to control their fertility and access safe maternity care is universally acknowledged as a fundamental human right, endorsed by esteemed global bodies such as the World Health Assembly and the World Health Organization (WHO) [1]. At the heart of this right lies the principle articulated by the International Conference on Population and Development (ICPD) in 1994, affirming individuals' rights to freely determine the number and spacing of their children, supported by comprehensive information and accessible means [2].

Unsafe abortion is a significant contributor to maternal mortality, particularly in low-income countries [3]. In Nigeria, approximately 1.25 million induced abortions occur annually, with the majority being unsafe [4]. The maternal mortality ratio in Nigeria is 545 per 100,000 live births, and unsafe abortions account for 30–40% of these deaths

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[5]. In Sub-Saharan Africa, including Nigeria, induced abortion is illegal, leading women to seek clandestine abortions from unsafe, unhygienic sources [5].

Despite significant strides in improving women's lives worldwide, the persistent prevalence of unintended pregnancies continues to profoundly impact women's and children's health while constraining women's opportunities for personal and socio-economic development [6]. This enduring challenge is underscored by several critical observations:

Firstly, the neglect of family planning within international and national development agendas has perpetuated gaps in addressing reproductive health needs, thereby undermining broader health and development goals. Secondly, societal shifts towards smaller families and evolving norms regarding reproductive decision-making have not been universally supported by accessible and effective contraceptive services, leading to a mismatch between reproductive intentions and outcomes. Thirdly, while effective contraception and, when necessary, safe abortion services exist, their availability and accessibility remain uneven across regions and populations, exacerbating disparities in unintended pregnancy rates. Additionally, challenges persist in accurately collecting and analyzing data on unintended pregnancies, hindering targeted interventions and policy formulation. Lastly, the substantial health benefits of preventing unintended pregnancies extend beyond individual well-being to encompass improved maternal and child health outcomes, reinforcing the intrinsic link between reproductive autonomy and overall family welfare [7].

In the realm of family planning, most couples aspire not only to manage their family size but also to control the timing and spacing of their children's births. A significant majority of married women either have already achieved their desired family size or wish to postpone their next pregnancy for at least two years. Nevertheless, over a quarter of global pregnancies culminate in either abortions or unplanned births, underscoring the far-reaching implications for maternal health, familial well-being, and broader societal development initiatives [8]. In the Nigerian context, despite declining overall fertility rates, unintended pregnancies persist as a critical public health issue with profound implications for women's educational attainment, health status, and economic opportunities. These unintended pregnancies frequently lead to unsafe abortions, contributing significantly to Nigeria's high maternal mortality rates. Robust reproductive health services are imperative not only for mitigating these risks but also for advancing sustainable development goals, ensuring that every child is welcomed into an environment conducive to their health and well-being [9].

Urbanization and increased participation of women in paid employment, along with weakened family support systems for childbearing and rearing, have led to a preference for smaller family sizes in Nigeria. Traditional contraception methods, such as postpartum abstinence and exclusive breastfeeding, are declining, especially among working women. Additionally, many Nigerian women of reproductive age do not use modern contraceptives, contributing to higher rates of unintended pregnancies and induced abortions [10].

Despite a slight increase in the use of modern contraceptive methods among married women from 7% in 2003 to 12% in 2018 hospitalizations due to complications from induced abortions are rising, particularly in areas like Ile-Ife [7]. Research by Oye-Adeniran *et al*., [11] found that married women constituted 30.2% of abortion seekers in southwestern Nigeria. Bankole *et al*, [12] documented that married women often resort to abortion to achieve family planning goals, such as spacing or limiting births.

This indicates that not only adolescents and single women, but also married women, seek abortions for socio-economic and personal reasons. The failure of family planning programs to meet the contraceptive needs of married women likely contributes to high rates of unwanted pregnancies and induced abortions in Nigeria. Although married women significantly contribute to the overall burden of induced abortions, more research is needed to understand the factors leading to unintended pregnancies among them [13].

Nigeria is considered the second most religious country globally, following Afghanistan. According to a report by the Pew Research Center, Nigeria has a high rate of religious observance, with 95% of its population engaged in prayer activities, only slightly behind Afghanistan's 96% prayer rate [14]. This high level of religious engagement highlights the deep spiritual and cultural significance of religion in Nigerian society [14]. In Africa, studies have shown that religion has played a major role in the practice of unsafe abortion among married women. Religious leader often provide counseling on reproductive matters, and when these sources are strongly anti-abortion, they may discourage women from considering safe options and instead push them towards unsafe methods [15,16].

This study aims to understand factors influencing unintended pregnancies among married women in Nigeria's Ibadan South West LGA, focusing on decision-making, spousal communication, help-seeking behaviors, and attitudes towards induced abortion and contraceptives, to better comprehend reproductive health choices and societal perceptions.

MATERIALS AND METHODS

Study Design

This experimental study aimed to assess factors influencing decision-making regarding unintended pregnancy outcomes among married women in the South West Local Government Area, Nigeria.

Study Area

The research was conducted in SWLGA, one of the 33 Local Government Areas in Oyo State. Researchers sought support from community leaders to facilitate smooth data collection. The study employed focus group discussions (FGDs) and in-depth interviews (IDIs). The FGDs were conducted by the researcher and four trained female field workers, while the IDIs were conducted by the researcher with an assistant. Six IDIs were conducted in two communities, and FGDs were held in ten communities where IDIs were not conducted.

Methodology

Participants were informed about the study's purpose and assured of confidentiality. Verbal consent was obtained before participation, and a pre-discussion data form captured their socio-demographic details. Discussions were guided by a pretested and expert-reviewed guide. The researcher moderated sessions in Yoruba, with eight participants per FGD session, each lasting about an hour. Discussions were transcribed within 24 hours, and ten FGDs and four IDIs were conducted in total. All sessions were audio-recorded with participants' consent.

In-Depth Interviews

Six IDIs were conducted with women who had experienced unintended pregnancies, selected through snowball sampling. One participant was experiencing an unintended pregnancy at the time of data collection. Each interview lasted about 70 minutes and was recorded after obtaining consent.

Validity and Reliability

To ensure the validity of the instruments, drafts were reviewed by reproductive health experts, including lecturers and students from the Department of Health Promotion and Education. Instruments were pretested in Local Government Area to refine questions and ensure they effectively gathered relevant data. The guides were translated into Yoruba and back-translated into English to maintain accuracy. Reliability was ensured through supervision during data collection, expert reviews, and pretests in similar demographic areas.

Data Collection Instruments

Qualitative data were collected using pretested FGD and IDI guides. This approach provided in-depth insights into factors influencing decision-making on unintended pregnancies, induced abortions, spousal communication patterns, and family planning perceptions. Local resource persons helped recruit participants, who agreed on discussion venues and times.

Focus Group Discussion Guide

The FGD guide had two sections: Section A introduced the study's objective, and Section B contained 11 probing questions on unintended pregnancy causes, decision-making factors, help-seeking behavior, attitudes toward induced abortion, and family planning effectiveness.

In-Depth Interview Guide

The IDI guide mirrored the FGD guide, comprising 11 main questions and follow-ups on similar themes.

Data Management and Analysis

FGDs and IDIs were audio-taped, transcribed, and analyzed using a thematic approach. Responses were grouped into themes and compared within and between groups.

Ethical Considerations

Community consent was obtained from leaders, and participants were fully informed about the study's nature, objectives, and confidentiality assurances. Verbal consent was obtained, and participants could withdraw at any time. Ethical approval was obtained from Ministry of Health Oyo State

RESULTS

Socio-Demographic Characteristics

The socio-demographic characteristics of the respondents showed that 38.4% were between the ages of 26 and 30, with a mean age of 28.5 ± 4.98 years. Additionally, 47.6% of the participants had three children at the time of the study. Most participants (58.3%) had completed tertiary education, and a significant majority (79.2%) were Yoruba. Nearly half (49.5%) identified as Christians, and a large portion (63.1%) were self-employed.

- **Findings from In-Depth Interviews (IDIs) Occurrence and Causes of Unintended Pregnancy**

IDI participants also confirmed that unintended pregnancies are common among married women, even after deciding to stop having children.

One participant stated, "*I became pregnant after nine years of stopping childbearing. I was on injection but stopped and was using the safe method when I realized I was pregnant.*"

Causes of unintended pregnancy included non-use and discontinuation of contraceptives, misconceptions about exclusive breastfeeding, and failure to abstain from sex shortly after delivery.

Spousal Reactions

All IDI participants reported that their spouses were unhappy with the news of the pregnancy. Some husbands believed the pregnancies were deliberate, leading to misunderstandings and conflicts. One participant shared, *"It led to serious misunderstandings that my husband had to send me out of our matrimonial home for about a year."*

- **Findings from Focus Group Discussion**

Prevalence and Contributing Factors of Unintended Pregnancies

The focus group discussions revealed prevalent experiences and underlying causes of unintended pregnancies among the participants. Many participants confirmed that unintended pregnancies frequently occur among married women, particularly after the birth of their first child. A majority had experienced unintended pregnancies at least once. Contributing factors included contraceptive discontinuation due to method failure, health concerns, discomfort, inconvenience, and improper use.

Participants also cited misconceptions such as exclusive breastfeeding as a contraceptive measure and the inability to abstain from sex after delivery. One participant shared, *"I never realized I could become pregnant just two months after delivery. We were having unprotected sex, even though I was exclusively breastfeeding."*

Another participant shared, "*My husband couldn't abstain from sex shortly after delivery, so I gave in, which resulted in an unintended pregnancy."*

Spousal Communication during Unintended Pregnancy

Focus group discussion participants reported varied reactions from their husbands upon learning about the unintended pregnancies. Most husbands were unhappy, and in some cases, the news led to serious conflicts requiring family intervention.

One participant shared, *"My husband was unhappy with the news because our baby was still very young, but he said we should accept the situation."* Some husbands suggested abortion, while others accepted the situation reluctantly.

- **Factors Influencing Decision-Making on Unintended Pregnancy**

Several factors influenced the decision to carry unintended pregnancies to term. Social support from spouses, parents, friends, and religious figures encouraged women to continue their pregnancies. Fear of complications from abortion and failed abortion attempts also played a role. One participant recounted, *"I used several drugs to terminate the pregnancy, but they didn't work. I had to carry the pregnancy to term."* Spiritual caution from religious houses and the desire for more children were additional factors.

Conversely, lack of spousal support, financial constraints, and achieving the desired number of children with specific sexes influenced decisions to abort. Participants cited concerns over financial burden and perceived maternal risks of subsequent pregnancies. One participant stated, *"I have been warned not to have another baby because I almost lost my life during my last pregnancy."*

Patterns of Help-Seeking Behavior in Cases of Unintended Pregnancy

Most participants reported seeking medical advice upon discovering their pregnancies, although some initially visited traditional healers or local chemists. Many did not start antenatal care early due to a lack of awareness or initial unhappiness with the pregnancy. However, participants acknowledged the importance of antenatal care in preventing complications and ensuring the health of both the mother and baby.

Attitudes toward Induced Abortion

Most participants held negative views on abortion, citing potential health risks and moral concerns. Statements included, *"Abortion is not good; it can lead to sudden death," and "God does not support abortion because it is an act of murder."* Some participants believed abortion is acceptable under specific circumstances, such as to avoid shame or financial hardship.

Perceptions of Contraceptive Effectiveness

Participants were generally aware of family planning methods. About half believed family planning is effective in preventing unintended pregnancies, though many expressed concerns about side effects. Some participants preferred traditional methods over modern contraceptives due to fears of side effects.

Access to Family Planning Services

Participants indicated that family planning services are accessible in their communities, primarily through Primary Health Care Centres. Information about family planning was disseminated during antenatal clinics and through media channels. Despite availability, many participants avoided modern contraceptives due to concerns about side effects. A minority reported using contraceptives. One participant noted, *"The nurses at the health centers usually tell us to come for family planning when we go for antenatal clinic or for immunization."*

DISCUSSION

Most participants were Yoruba and predominantly Muslims, reflecting the demographics of the study location, South-West LGA of Oyo State, Nigeria. The study also found that a significant proportion of women had secondary education, aligning with their understanding of family planning and fertility.

Unintended pregnancies were attributed to various factors including non-use and failure of contraceptives, misconceptions about fertility during breastfeeding, and misjudgments about menopause. These findings align with previous research, such as Furedi [17], who

highlighted the risk of unintended pregnancy postpartum, and Klima [18], who noted contraceptive failure, non-use, and rape as causes. Studies by The Alan Guttmacher *et al*., [19] also support these findings, showing that many women who had abortions were not using contraceptives due to perceived low risk of pregnancy or partner opposition.

The study identified key factors influencing the decision to carry an unintended pregnancy to term, including spousal and social support, fear of abortion complications, failed abortion attempts, desire for more children, and spiritual beliefs. These findings are consistent with Naravage *et al.* [20], who found similar influences in low-income young women in Bangkok. Conversely, decisions to terminate pregnancies were often driven by lack of support, financial burden, and health risks to the mother, as corroborated by AGI [21] and Sumaya [22].

Unintended pregnancies often led to conflicts and depression among couples, initially causing arguments and stress. This agrees with Adhikari [23], who found that unintended pregnancies in Nepal often deteriorated relationships and caused emotional distress. Participants noted that some spouses denied responsibility, leading to further discord.

Contrary to previous studies suggesting that women with unintended pregnancies avoid prenatal care, this study found that most women sought prenatal and postnatal care eventually. This shift occurs as couples accept the pregnancy over time. Those who initially considered abortion often sought antenatal care after deciding to continue the pregnancy. This finding is supported by Yohannes [24].

Many married women in the study viewed abortion within marriage as more acceptable than outside of it. This attitude reflects findings from studies in Ghana, where a significant proportion of women seeking abortions were married [25].

The study highlighted a knowledge-practice gap in contraceptive use among married women. Despite high awareness, actual use was low due to fears of side effects and cultural opposition. This pattern is consistent with findings from Ethiopia and Northern Nigeria, where physical access and awareness did not translate into high contraceptive use [26].

Unintended pregnancy is prevalent among married women, particularly during the nursing period. Spousal support is crucial in decision-making regarding unintended pregnancies, highlighting the need for involving men in reproductive health discussions. Health education should emphasize contraception, using culturally relevant communication methods, and engaging men in venues they frequent. Peer education can also be effective, providing support and accurate information within communities.

Health programs should focus on preventing unintended pregnancies by improving contraceptive use and supporting women through the decision-making process. This involves addressing social and psychological issues and ensuring access to comprehensive counseling and family planning services.

CONCLUSION

Married women face significant challenges when dealing with unintended pregnancies, often relying on their spouses for decision-making. The study revealed a gap between knowledge and practice regarding contraceptives, resulting in high rates of unintended pregnancies. Intervention strategies should focus on improving spousal communication, empowering women, and increasing access to family planning services.

By raising awareness and educating community leaders about the use of contraceptives, we can encourage these influential figures to disseminate accurate and life-saving information to women in their communities. Conducting workshops and seminars for religious leaders can equip them with accurate knowledge about safe abortion practices, the health risks associated with unsafe abortions, and the critical importance of comprehensive reproductive health education. These sessions should feature medical professionals and reproductive health experts who can provide evidence-based information and clarify any misconceptions. Additionally, enhance contraceptive use through proper education and accessibility. Finally, improved community health plays a crucial role in increasing the use of contraceptives. When communities are healthier, there is often better access to healthcare facilities, more comprehensive education on reproductive health, and a stronger emphasis on preventive care. Healthier communities are more likely to have established trust in medical professionals and institutions, which can facilitate open discussions about family planning and contraceptive use.

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