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Unveiling the Hidden Truth": Exploring the Prevalence and Risk Factors Associated with Induced Abortion among Female Undergraduates in Kwara State University Malete

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Abstract

This study delved into the widespread occurrence, unraveled the underlying risk factors, and illuminated the perceptions and depth of knowledge surrounding induced abortion among female undergraduates at Kwara State University. A cross-sectional study was conducted among 350 students to access their socio- demographic characteristics, undertaking of induced abortion, marital status, and experiences related to unintended pregnancies and abortion procedures. The findings reveal a high level of awareness about the risks associated with induced abortion, with 80.0% of respondents possessing good knowledge of the subject. Despite this awareness, a significant portion of students (51.1%) still resort to traditional methods, indicating persistent reliance on culturally ingrained practices. The study also found that 23.4% of respondents had been pregnant, with 61.0% opting for induced abortion primarily due to unpreparedness and unwanted pregnancies. The majority of these abortions were performed by health professionals, with a notable preference for private health facilities to ensure confidentiality. Complications were reported by 82.0% of those who had undergone an abortion, highlighting the health risks involved. The significant association between socio-demographic factors, such as marital status, and the prevalence of induced abortion underscores the influence of social and economic pressures on students' reproductive choices. Challenges are the primary drivers of induced abortion. Fear of parental reaction, societal shame, and financial constraints further exacerbate the situation. The need to continue education and the lack of adequate support systems highlight the pressures faced by students, leading to the decision to terminate pregnancies. This study recommends comprehensive sexual and reproductive health education, improved access to safe abortion services, robust support systems, stigma reduction campaigns, policy advocacy, and ongoing research to address the identified issues and improve reproductive health outcomes for female students.

Keywords: Induced Abortion, Unintended Pregnancy, Female Undergraduates, Risk Factors, Unwanted Pregnancy, Education Continuity.

Introduction

Induced abortion is a public health problem and demands serious attention. The problem is likely to worsen because of increased modernization and urbanization, which tend to sever young people from once previously held tradition of premarital chastity and family organizations and encourage sexual intercourse at an early age without effective practice of contraception. Globally, about 13% of induced abortions are related to low contraceptive usage [1]. In most developing countries including Nigeria, abortion is illegal and highly restricted, hence constraining access to

safe induced abortion services for adolescents and all women [2]. Although preventable, unsafe induced abortion is a leading cause of maternal mortality and morbidities [3]. An estimated 73 million induced abortions take place worldwide annually and 6 out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies, end in induced abortion [4]. About 45% of induced abortions are unsafe, of which 97% occur in developing countries. Of all unsafe abortions, one third were performed under unsafe or unhygienic conditions by untrained and unskilled persons using dangerous and invasive procedures (WHO, 2021).

More than half of all unsafe abortions take place in developing countries, Asia and mostly in south and central Asia. Majority of induced abortions (about 3 out of 4) in Latin America and Africa are unsafe and in Africa, almost half of all abortions occur under the least safe circumstances. The World Health Organization (WHO) report indicated that in developed regions, an estimated 30 women die for every 100,000 unsafe abortions, compared to developing regions, with as high as 220 maternal deaths per 100,000 unsafe abortions (WHO, 2021) The levels of unintended pregnancy and unsafe abortions remain high in Nigeria. Abortion law in the country is highly restrictive and induced abortion is illegal. Abortion is only permitted where it is intended to save a woman‟s life. Despite the restrictive nature of the abortion law, induced abortion is common and often unsafe because it is mostly performed clandestinely by unskilled providers [2]. In 2012, an estimated 1.25 million induced abortions occurred, and the number doubled when compared to an estimated 610,000 induced abortions representing an estimated rate of 25 abortions per 1000 women aged 15–44 in 1996 (Bell, Omoluabi, OlaOlorun, Shankar & Moreau, 2020) [5]. The increased number of abortions was attributed to both population growth and an increase in the rate of abortion.

The estimated abortion rate was 33 per 1,000 women of reproductive age in 2012 [5]. The rates of abortion vary across the geopolitical zones in Nigeria. Evidence showed that in 2012, induced abortion ranged from 27 per 1,000 women of reproductive age in the South west and North central zones; 31 per 1,000 in the North West and South East zones; to 41 and 44 per 1,000 in the North East and South South zones, respectively [5]. Induced abortion especially when unsafe, can endanger a woman‟s reproductive health and can lead to serious, life-threatening complications including, retained products of conception, bleeding, fever, sepsis, injury from instruments, pelvic infections and in the long-term ectopic pregnancy, secondary infertility and even death [6]. The morbidities and mortalities from induced abortion are enormous and thus place a huge burden on the family, the society and women‟s reproductive health generally. Thus, this study intends to assess the prevalence and risk factors associated with induced abortion among female undergraduate students of Kwara State University, Malete.

Methodology

Research Design

The study was descriptive cross-sectional study using quantitative method of data collection.

Target Population

The target population was all the female undergraduate students of Kwara State University, Malete.

Study Area

Kwara State University (KWASU) is situated in Malete, Kwara State, Nigeria, with geographical coordinates approximately 8.4856° N latitude and 4.6325° E longitude. The university, established in 2009, serves a diverse student population of around 10,000 enrolled in various undergraduate and postgraduate programs [7]. This institution is notable for its focus on technological advancement and sustainability, as illustrated by initiatives aimed at achieving a smart city status on campus through infrastructure expansion and effective resource management [7].

Kwara State is often described as a state of harmony due to its multicultural population of over 2.4 million, which supports the university's vibrant academic culture (Sahban & Johari, 2021). The average annual rainfall in the area reaches approximately 1430 mm, indicating significant potential for groundwater resources beneficial for the university's facilities [8]. Furthermore, KWASU emphasizes digital literacy and reading habits among its students, reflecting a commitment to enhancing educational quality through various academic and library services [9].

Sample Size and Participant Recruitment

The sample size was calculated based on a previously reported prevalence of induced abortion in previous study of 28.3% (Nwankwo & Bankole, 2022), at a 95% confidence level and a 5% margin of error. To accommodate possible non-response or incomplete data, a 10% allowance was added, 350 questionnaires was distributed to improve the power of the study A multistage sampling technique was used with a list of departments from the Kwara State University, Malete, Kwara State were obtained and 4 departments were selected by simple random sampling. From each department, a systematic random sampling technique was used to select respondents for the sample study using the total number of students in the departmental nominal roll at the time of the study on each day of data collection as the sampling frame. The first respondent was randomly selected within the sampling interval, while subsequent respondents were selected using the sampling interval until the desired sample size for each department was completed

Method of Data Collection and Data Analysis

A semi – structured interviewer administered questionnaire was used to obtain information about assess prevalence and risk factors associated with induced abortion among female undergraduate students of Kwara State University, Malete. Four research assistants were trained by the researcher to have a clear understanding of the study and well interpretation of the questionnaire on the field for data collection. The training held few days before the day of data collection and a pre- and post-training evaluation of the assistant was done by the researcher to ensure adequate knowledge of the objectives of this study and competence in the collection of required data. Data were entered, cleaned, and analyzed using Statistical Package for the Social Sciences (SPSS) version 26. The data analysis was conducted in line with the analysis structure to achieve the objectives set out at the outset. Descriptive statistics was used to summarize the data on respondent characteristics using; tables, graphs and charts. To test associations between the outcome variable (prevalence of induced abortion) and the independent variables/factors (demographic

characteristics), Chi-square was used. The level of significance for the statistical tests was set at 0.05.

Ethical Considerations

A written permission was obtained prior to study from the Department of Public Health, School of Basic Medical Sciences, Kwara State University, Malete. Ethical approval for this study was obtained from the Ethical review Committee of the Kwara State University, Malete. Verbal informed consent would be obtained from female undergraduate students who agreed to participate in the study. They would be told that participation is voluntary and they would not suffer any consequences if they chose not to participate. Anonymity and confidentiality of all information from respondents was maintained and assured throughout the study process. Information collected was kept confidential and the respondents name will not be asked in the questionnaire.

Results

Table 1: Socio-Demographic Characteristics of Respondents N= 350

Variables	Frequency	Percentage
Age group ≤20	139	39.7
21 – 25	185	52.9
≥26	26	7.4
Mean ± SD	22 ± 2.6	
Religion Christianity	182	52.0
Islam	168	48.0
Tribe Yoruba	296	84.6
Igbo	29	8.3
Hausa	16	4.6
Fulani	9	2.6
College College of basic medical sciences	135	38.6
ICT	62	17.7
Pure and applied	153	43.7
Course of study Biochemistry	19	5.4
Environmental health science	96	27.4
Library and information science	36	10.3
Mass communication	37	10.6
Microbiology	60	17.1
Public health science	102	29.1
Level of study 100	37	10.6
200	83	23.7
300	111	31.7
400	119	34.0
Living status On campus	60	17.1
Off campus	290	82.9

Slightly more than half of the respondents (52.9%) were between the 21-25 years, 39.7% and 7.4% were ≤20 years and ≥26 years respectively with a mean age of 22 ± 2.6 years. More than half of the respondents (52.0%) were Christians while the remaining 48.0% were practicing Islamic religion. Majority of the respondents (84.6%) were Yoruba, 8.3% and 4.6% were Igbo and Hausa respectively. About 34.0% of the respondents were in 400 level while 10.6% of the respondents were in 100 level. Most of the respondents (82.9%) were living off campus while 17.1% were living on campus.

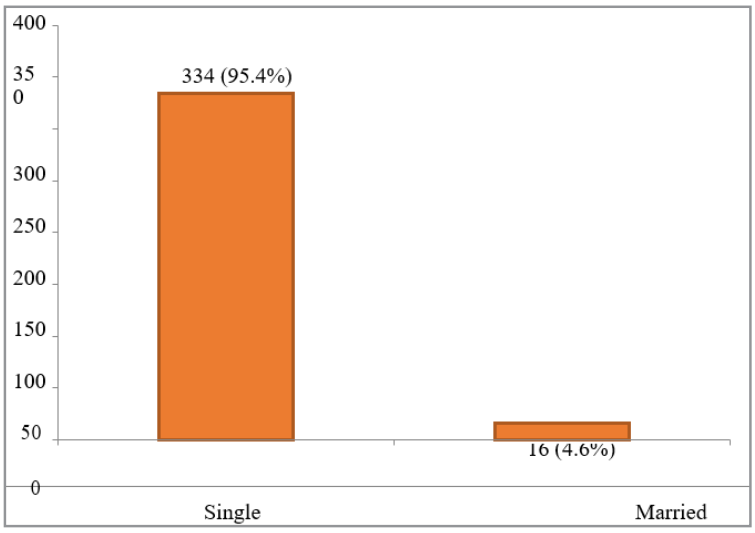

Figure 1: Marital Status Almost all of the respondents (95.4%) were single while 4.6% were married

Table 2: Knowledge on Induced Abortion

Response	Yes (%)	No (%)
Induced abortion is an abortion done by myself	219 (62.6)	131 (37.4)
Induced abortion is an abortion done in the hospital by an untrained person	72 (20.6)	278 (79.4)
Induced abortion is an abortion done by taking local herbs.	179 (51.1)	171 (48.9)
Induced abortion is an abortion done by a trained doctor in his house	79 (22.6)	271 (77.4)
Induced abortion is an abortion done by an elderly woman in the community	77 (22.0)	273 (78.0)
Induced abortion can lead to infection	289 (82.6)	61 (17.4)
Induced abortion can lead to excessive bleeding	330 (94.3)	20 (5.7)
Induced abortion can lead to death	330 (94.3)	20 (5.7)
Induced abortion can be performed through surgical instruments/modern medicines.	314 (89.7)	36 (10.3)
Taking local herbs can induce abortion	263 (75.1)	87 (24.9)

On the knowledge of induced abortion, 89.7% and 62.6% of the respondents noted that induced abortion can be performed through surgical instruments/modern medicines and induced abortion is an abortion done by myself. Also, 94.3% of the respondents agreed that induced abortion can lead to excessive bleeding and death respectively. However, 79.4% an 77.4% of the respondents disagreed that induced abortion is an abortion done in the hospital by an untrained person and done by a trained doctor in his house respectively.

Table 3: Prevalence on induced abortion

Response	Frequency	Percentage
Been pregnant		
Yes	82	23.4
No	268	76.6
Chose to terminate the pregnancy through induced abortion		n = 82
Yes	50	61.0
No	32	39.0
Age at induced abortion		n = 50
≤ 15	2	4.0
≥15	48	96.0
Number of induced abortion done 1	33	66.0
2 or more	17	34.0
Personnel who performed abortion Health professional	50	100.0
Method used		
Medication abortion (pills)	27	54.0

Surgical abortion	22	44.0
Traditional methods	1	2.0

Only 23.4% of the respondents noted to have been pregnant before with 61.0% of them chose to terminate the pregnancy through induced abortion. Among those that had induced abortion, 96.0% of them had the abortion at a age above 15 years and 66.0% of them noted they performed induced abortion just once. About 54.0% and 44.0% of the respondents utilized medication abortion pills and surgical abortion for the induced abortion respectively.

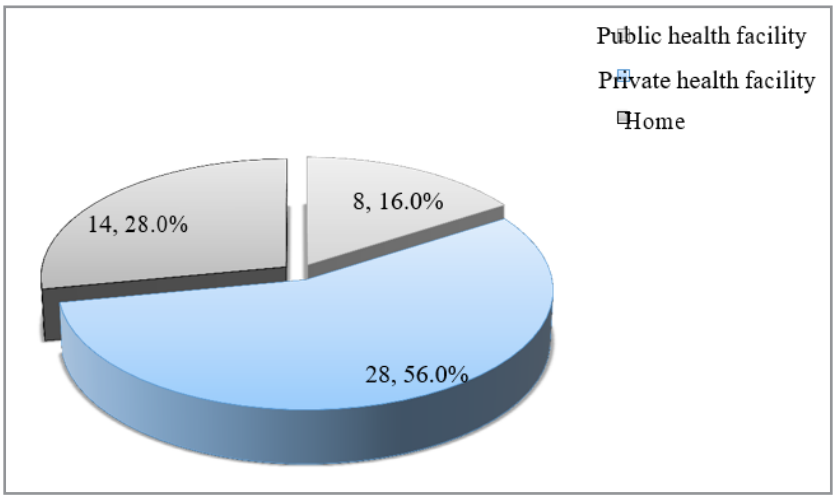

Figure 2: Place of Abortion

On the place where the abortion was conducted, 56.0% noted that they had the abortion in private health facility, 16.0% and 28.0% conducted the abortion in public health facility and home respectively

Table 4: Risk Factors Associated with Induced Abortion

Response	Frequency	Percentage
To finish school	22	6.3
Fear of parents	41	11.7
Lack of money to support the child	13	3.7
Unpreparedness/ unwanted pregnancy	169	48.3
Inadequate social support	3	0.9
Academic challenges	3	0.9
Rejection by partner and family	18	5.1
Shame in society	35	10.0
Pressure from peers	21	6.0

About 48.3% and 11.7% noted that unpreparedness/ unwanted pregnancy and fear of parents are the main risk factors associated with induced abortion respectively. Also, 6.0% and 6.3% of the respondents noted that pressure from peers and be able to finish school as the factors associated with induced abortion respectively.

Table 5: Perception of the Effects of Induced Abortion n = 50

Response	Frequency	Percentage
Experienced complication after induced abortion Yes	41	82.0
No	9	18.0
Type of complication Excessive bleeding	20	40.0
Abdominal pains	14	28.0
Nausea/vomiting	2	4.0
Infection	5	10.0

On the perception of the effect of induced abortion, 82.0% of the respondents noted that they experienced complications after induced abortion with 40.0% and 28.0% noted that they experienced excessive bleeding and abdominal pains respectively.

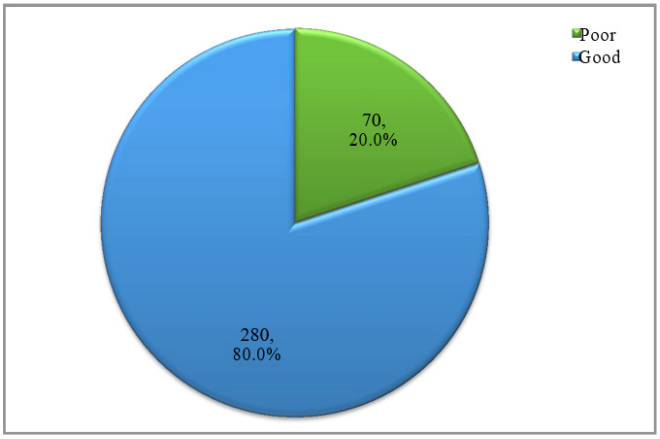

Figure 3: Knowledge of Induced Abortion

Overall, 80.0% of the respondents have good knowledge of induced abortion while 20.0% of the respondents had poor knowledge of induced abortion.

Table 6: Association Between Socio-Demographics and Knowledge of Induced Abortion

Variables	Knowledge o abortion Poor (%)	f induced Good (%)	χ^2	p-value
Age group			0.676	0.713
≤20	30 (21.6)	109 (78.4)		
21 – 25	34 (18.4)	151 (81.6)		
≥26 Marital status	6 (23.1)	20 (76.9)	1.183y	0.277
Single	69 (20.7)	265 (79.3)		
Married	1 (6.3)	15 (93.8)		
Religion			0.011	0.915
Christianity	36 (19.8)	146 (80.2)		
Islam Tribe	34 (20.2)	134 (79.8)	8.044[r]	0.034
Yoruba	54 (18.2)	242 (81.8)		
Igbo	6 (20.7)	23 (79.3)		
Hausa	5 (31.3)	11 (68.8)		
Fulani Level of study	5 (55.6)	4 (44.4)	5.770[f]	0.328
100	8 (21.6)	29 (78.4)		
200	22 (26.5)	61 (73.5)		
300	16 (14.4)	95 (85.6)		
400	24 (20.2)	95 (79.8)		
Living status			0.126	0.723
On campus	11 (18.3)	49 (81.7)		
Off campus	59 (20.3)	231 (79.7)		
[f] – Fisher's exact value	[y] – Yates corrected value			

Association between socio-demographics and knowledge of induced abortion was statistically significant with the tribe of the respondents

Table 7: Association Between Socio-Demographics and Prevalence of Induced Abortion

Variables	Prevalence abortion Yes (%)	of induce No (%)	d χ^2	p-value
Age group			5.684[f]	0.063
≤20	10 (90.9)	1 (9.1)		
21 – 25	32 (59.3)	22 (40.7)		
≥26	8 (47.1)	9 (52.9)		
Marital status			5.898[y]	0.015
Single	46 (67.6)	22 (32.4)		
Married	4 (28.6)	10 (71.4)		
Religion			2.804	0.094
Christianity	25 (71.4)	10 (28.6)		
Islam	25 (53.2)	22 (46.8)		
Tribe			0.013[y]	0.999
Yoruba	50 (61.0)	32 (39.0)		
Level of study			1.503[f]	0.913
100	1 (100.0)	0 (0.0)		
200	4 (57.1)	3 (42.9)		
300	23 (63.0)	16 (37.0)		
400	22 (62.9)	13 (37.1)		
Living status			0.577	0.448
On campus	5 (50.0)	5 (50.0)		
Off campus	45 (62.5)	27 (37.5)		

Association between socio-demographics and prevalence of induced abortion showed significant relationship marital status of the respondents.

Discussion

The age distribution shows that the majority of respondents (52.9%) fall within the 21-25 age group, with a mean age of 22 years (SD = 2.6). This age range is consistent with other studies that have identified young adulthood as a period of heightened reproductive activity and associated risks, including unintended pregnancies and induced abortions [10, 11]. The respondents are almost evenly split between Christianity (52.0%) and Islam (48.0%). Religious beliefs significantly influence attitudes toward abortion, with varying degrees of permissiveness or restriction. Previous research indicates that religious affiliation can impact students' decision-making regarding abortion, with more conservative religious views often associated with lower rates of abortion due to moral and ethical constraints [12, 13]. The predominant tribe among the respondents is Yoruba (84.6%), followed by Igbo (8.3%), Hausa (4.6%), and Fulani (2.6%).

Cultural factors, including tribal affiliation, play a significant role in shaping attitudes toward reproductive health and abortion. Yoruba culture, for instance, has been found to have more liberal views on reproductive health issues compared to other tribes [14]. A majority of the respondents live off-campus (82.9%), which may expose them to different social dynamics and risk factors compared to on- campus residents. Off-campus living has been associated with greater autonomy but also increased exposure to risky behaviors, including unprotected sex, which can lead to unintended pregnancies and consideration of induced abortion [15]. The marital status of the respondents is a significant factor in this context, with a vast majority being single (95.4%) and a small percentage married (4.6%). Marital status plays a crucial role in reproductive health decisions, including the likelihood of seeking an induced abortion. Single women, particularly students, are often more likely to consider abortion due to the social, economic, and educational disruptions that an unplanned pregnancy might cause [16, 15]. The high percentage of single respondents in this study aligns with findings from other studies indicating that single female students face unique challenges that contribute to higher abortion rates.

The knowledge of induced abortion among female undergraduate students at Kwara State University, Malete, reveals significant insights into their understanding of what constitutes induced abortion, the methods used, and the potential risks involved. A significant proportion of respondents (62.6%) correctly identify that induced abortion can be self-administered. However, only 20.6% acknowledge that it can be performed in a hospital by an untrained person, and 22.6% recognize that it can be done by a trained doctor in his house. This suggests that there is some confusion about the professional and unprofessional contexts in which abortions can be performed.

This confusion can lead to risky behavior, as students might opt for unsafe methods due to lack of proper knowledge [16]. Moreover, 51.1% of respondents associate induced abortion with taking local herbs, reflecting a significant reliance on traditional methods. This is consistent with findings from other studies that indicate a high prevalence of herbal- induced abortions in Nigeria due to accessibility and cultural acceptance [15]. However, the use of such methods often leads to complications, given the lack of medical supervision and standardized dosages [17].

The knowledge of the risks associated with induced abortion among respondents is notably high. A vast majority understand that induced abortion can lead to infection (82.6%), excessive bleeding (94.3%), and death (94.3%). This awareness aligns with findings from studies such as those by Sedgh et al, which emphasize the severe health risks associated with unsafe abortions. The high awareness of these risks indicates effective dissemination of information regarding the dangers of unsafe abortion practices, yet it does not necessarily translate to safe practices, as evidenced by the substantial number of students resorting to unsafe methods. A significant proportion of respondents (89.7%) are aware that induced abortion can be performed through surgical instruments or modern medicines.

This suggests a reasonable level of awareness about medical and surgical abortion methods. However, the high percentage (75.1%) of respondents who believe that taking local herbs can induce abortion indicates a persistent reliance on traditional methods. This duality in knowledge suggests that while modern methods are recognized, cultural practices still heavily influence students' choices [13]. Overall, a high level of knowledge about induced abortion among 80.0% of the respondents is encouraging, as it suggests that many students are aware of the methods and potential risks involved in the procedure. This awareness is crucial for making informed decisions about reproductive health. According to Sedgh et al, increased knowledge about safe abortion practices is associated with better health outcomes and lower incidence of complications. The study showed no significant association between age and knowledge of induced abortion ($\chi^2 = 0.676$, $p = 0.713$). This finding aligns with research by Sedgh et al, which suggests that while age can influence reproductive health knowledge, it is often overridden by other factors such as education and access to information. The similar levels of knowledge across different age groups highlight those educational interventions may have been uniformly effective or that peer-to-peer information sharing is prevalent among the students.

The study findings revealed that 23.4% of respondents have been pregnant, with 61.0% of these pregnancies resulting in induced abortions. This high rate of induced abortions among those who have been pregnant underscores the significant role abortion plays in managing unintended pregnancies within this demographic. Oladeji reported similar findings, highlighting those unintended pregnancies among Nigerian university students often lead to induced abortions due to academic, financial, and social pressures. The vast majority (96.0%) of those who had an induced abortion were aged 15 or older at the time of the procedure. This is consistent with findings by Sedgh et al, which indicate that adolescents and young adults are the most likely groups to seek abortions, often due to a lack of preparedness for parenthood and the desire to continue their education without interruption.

Among those who had undergone an induced abortion, 66.0% had the procedure once, while 34.0% had it twice or more. This recurrence suggests that some students may experience multiple unintended pregnancies, pointing to possible gaps in effective contraceptive use and sexual health education. Fawole et al. found that repeat abortions are often linked to inconsistent or incorrect use of contraceptives, highlighting the need for improved sexual education programs. Marital status shows a significant association with the prevalence of induced abortion ($\chi^2 = 5.898$y, $p = 0.015$). Single students have a higher prevalence (67.6%) compared to married students (28.6%). This finding is consistent with research indicating that single women, especially those in educational settings, are more likely to terminate pregnancies to avoid disruptions to their academic and career plans (Nwankwo & Bankole, 2022). Married students may have more social and financial support to continue pregnancies, reducing the need for abortion.

In this study, all reported abortions were performed by health professionals, with 54.0% using medication (pills) and 44.0% opting for surgical methods. Only 2.0% reported using traditional methods, which is notably lower than other studies have found. For instance, Bankole et al. (2022) noted that unsafe methods are often more prevalent in areas with restricted access to professional medical care. The fact that all abortions in this study were performed by health professionals suggests that these students have better access to safe abortion services than the general population, possibly due to their educational status and awareness. The preference for medication abortions over surgical methods may reflect their perceived safety, privacy, and ease of access. Medication abortions can be self-administered, which aligns with the preference for privacy and autonomy reported in other studies [11]. However, the reliance on health professionals indicates that even when self-administered, there is a preference or necessity for professional oversight, which helps mitigate risks associated with the procedure.

The distribution of settings where induced abortions were conducted reveals important aspects of access and choice among the respondents. According to the data, 56.0% of the abortions were performed in private health facilities, 16.0% in public health facilities, and 28.0% at home. The preference for private health facilities (56.0%) suggests that many students prioritize privacy and perceived quality of care. Private facilities often offer more confidentiality and personalized care, which can be crucial for students who fear stigma or wish to keep their abortion private [15]. This trend aligns with the findings of Oladeji, who noted that young women often choose private facilities to avoid the judgment and procedural delays sometimes associated with public health services. Only 16.0% of the abortions were conducted in public health facilities. This lower percentage could reflect several factors, including perceived or actual barriers to accessing public health services, such as bureaucratic delays, lack of privacy, or fear of stigma [10]. Public health facilities may also be less accessible due to location, operational hours, or the requirement for multiple visits, which can be particularly challenging for students managing academic schedules. The fact that 28.0% of the respondents conducted their abortions at home is concerning, as it often implies the use of less safe methods or insufficient medical supervision. Home abortions may involve medication obtained without proper guidance or traditional methods, both of which carry higher risks of complications [15]. This finding is consistent with Ogunbiyi, who highlighted that home abortions are often driven by a lack of access to affordable and confidential medical services, as well as cultural practices that favor traditional methods.

The most common risk factor identified is unpreparedness or an

unwanted pregnancy, accounting for 48.3% of the cases. This aligns with findings from numerous studies that highlight unintended pregnancies as a primary driver of induced abortions among young women [11, 16]. Unpreparedness can stem from inadequate contraceptive use, lack of sexual education, and socio-economic challenges that make pregnancy unmanageable. Fear of parents (11.7%) and societal shame (10.0%) are significant factors influencing the decision to have an abortion. These factors reflect the strong influence of familial and societal expectations on young women's reproductive choices. In many Nigerian communities, premarital pregnancy is heavily stigmatized, leading to fear of parental and societal judgment [13, 14]. This fear often compels young women to seek abortions clandestinely to avoid disgrace and maintain family honor.

Academic challenges (0.9%) and the desire to finish school (6.3%) are also notable risk factors. The pursuit of education is a critical priority for many students, and an unintended pregnancy can pose a significant barrier to academic success [15]. Additionally, lack of financial resources to support a child (3.7%) is a substantial concern, as many students rely on limited financial support and are not economically independent. These findings are consistent with those of Abiodun et al, who found that financial instability is a significant determinant of induced abortion among university students. Rejection by partners and family (5.1%) and inadequate social support (0.9%) further exacerbate the vulnerability of pregnant students.

Without the necessary emotional and financial backing, many feel compelled to terminate their pregnancies. This lack of support highlights the importance of a supportive network for young women facing unintended pregnancies [10]. Pressure from peers (6.0%) also plays a role in the decision to have an abortion. Peer influence can impact decision-making, especially in environments where there is a strong emphasis on maintaining social status and avoiding perceived failures [16]. Peer pressure can lead to decisions that align with group norms and expectations, which may include terminating a pregnancy to avoid disrupting one's social and academic life. The study revealed that 82.0% of the respondents experienced complications following an induced abortion, highlighting a significant health concern. This high rate of complications is consistent with findings from Sedgh et al, which indicated that complications from induced abortions are common, especially when proper medical care is not accessible. The most frequently reported complication was excessive bleeding (40.0%), followed by abdominal pains (28.0%), infection (10.0%), and nausea/vomiting (4.0%). These complications align with common risks associated with both surgical and medication abortions. Excessive bleeding, for instance, can occur due to incomplete abortion or uterine atony, while infections might result from non-sterile procedures or retained products of conception [10].

Conclusion and Recommendations

The study showed that 80.0% of students had good knowledge of induced abortion, including methods and risks, though misconceptions—particularly around traditional methods like local herbs—persisted. Among students who had been pregnant, 61.0% had undergone abortion, with age and marital status being key influencing factors. Younger, single students were more likely to seek abortions, often prioritizing education and facing socio-economic challenges.

Primary drivers included unplanned pregnancies, fear of parental reaction, societal stigma, and financial hardship. A high complication rate (82.0%), mainly due to excessive bleeding, highlighted the dangers of unsafe abortions. While many students preferred private facilities for privacy, a significant number still had abortions at home, raising safety concerns. The study recommended that the government provide confidential, youth-friendly reproductive health services, including safe abortion care and counseling near campuses. Universities should also distribute contraceptives and offer comprehensive education and counseling to prevent unintended pregnancies and ensure access to reliable contraceptive methods.

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