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Knowledge Brief

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ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN NIGERIA

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KEY MESSAGES:

- Early sexual debut and early marriage significantly contribute to teenage pregnancies. The national adolescent fertility rate is 122 births per 1,000 women aged 15-19 years, but with wide regional variations.
- Nigeria's Family Life and HIV Education (FLHE) school program for 10-17 year olds has shown mixed but promising results. Expanding FLHE will be important in improving knowledge of reproductive health among adolescents.
- Focusing on increasing access to youth friendly services that respect adolescents' rights to health services and privacy will be important to ensure that adolescents seek and receive these services.
- Greater clarity and stronger enforcement of the Child Rights Act (2003) will support adolescent well-being through discouraging early marriages, which are strongly linked to early pregnancies.

Introduction

Nigeria is the most populous country in sub-Saharan Africa. It also has a very young population. The majority of the population is below the age of 25 years, with 22 percent of the country's population between the ages of 10-19 years. Data on sexual and reproductive health (SRH) outcomes in Nigeria highlight the importance of focusing on adolescents. At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality (DHS 2013/WHO 2014). Global evidence shows that young girls bear a higher burden of maternal mortality and morbidity. Data show that the average age at sexual debut is roughly 15 years of age among adolescent mothers in Nigeria (DHS 2003, 2008, 2013). The national adolescent fertility rate in Nigeria is 122 births per 1,000 women aged 15–19 years. In the north western states it is as high as 171 births per 1000 women aged 15-19 years.

Investing in the human capital of its youth, including their health, is important for boosting Nigeria's long-term prosperity. This includes a focus on adolescent sexual and reproductive health (ASRH) – choices made at this point in their lives, such as early marriage, pregnancies, or risky sexual behavior, will affect their future.

This note presents the findings of a recent study on Nigeria that examines determinants of adolescent sexual behavior and fertility, with a narrower focus on knowledge, attitudes and behaviors of adolescents aged 10-19 years old in Karu Local Government Authority (LGA), a peri-urban area near the capital city of Abuja.

Study Methods

The study employs mixed methods to examine ASRH outcomes in Nigeria. It uses data from the last three Demographic and Health Surveys (2003, 2008, 2013) and a survey conducted in Karu LGA (n=643) to analyze SRH knowledge, fertility and use of SRH services among adolescents in the country. In Karu LGA, the survey collected data from adolescents aged 10-19 years old. The survey was supported by seven focus group discussions (FGD) with adolescents (split by gender and age groups), parents, teachers, and health service providers to gain further insights into attitudes and behaviors. The choice of Karu LGA was strategic as it presents a melting pot of

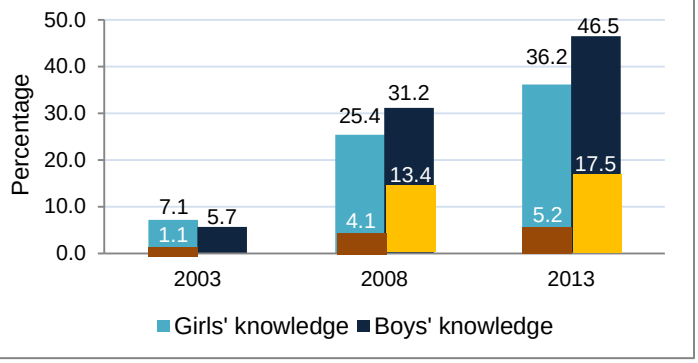
internal migrant populations representing different religious and ethnic groups in the country. The survey and FGD in Karu LGA also helped to capture the 10 to14 year old population. This is complemented with a comprehensive literature review and policy mapping on ASRH.

Study Findings

KNOWLEDGE AND ATTITUDES

Since the 1990s, Nigeria has seen an increase in awareness surrounding SRH, but it is relatively low among adolescents (Figure.1). Less than 2 percent of boys and 6.6 percent of girls, aged 15-19 were able to correctly identify when a female is most likely to get pregnant during the ovulatory cycle, for example.

Figure 1. Knowledge and use of modern contraception, adolescents aged 15-19 years



Source: DHS 2003, 2008, 2013.
Note: (a) weighted proportions; (b) shaded areas ■ and ■ show contraception use by sexually active girls and boys respectively

Data from Karu LGA also show low levels of contraceptive knowledge (roughly 45 percent), with male condoms being the most well-known method (61 percent boys and 55 percent girls).

Table 1. Knowledge of contraception, by type, among adolescents in Karu LGA (percent 15-19 years)

Method	Boys	Girls	Total
Condoms	61.3	55.5	58.5
Injectables	30.9	33.2	32.0
Pills	29.7	24.8	27.4
Female condoms	24.6	20.3	22.5
Emergency contraception	21.3	19.9	20.5
Withdrawal	18.6	13.2	16.0
Rhythm method	14.1	14.8	14.5

Source: World Bank 2014. Karu LGA survey

Interestingly, 75 percent of the respondents considered their school teachers as the most important source of SRH information (80 percent boys and 69.6 percent girls), followed by mothers and peers. This finding may reflect the increased access to information students have through the Family Life and HIV Education (FLHE) program in schools.

While knowledge has increased, use of contraception remains low (Figure 1). Among sexually active adolescents, only 17 percent of boys and 5 percent of girls were using contraceptives. One of the key reasons for this is fear of social stigma. Participants in the Karu LGA study, particularly girls, indicate that they would not ask their partners to use condoms because it may be perceived as a sign of infidelity or promiscuity. Slum dwellers in Ibadan (n=1042) mention shyness, concern about self-image, stigma, and perceived lack of trust by partner as the reason why they do not bring up use of condoms for example (Adedimeji et al. 2007). One study of teen mothers highlights the preference for emergency contraception over condoms because it is more discreet and there is less danger of being discovered by parents (Ilika and Igwegbe 2006).

AGE AT SEXUAL DEBUT AND MARRIAGE

Early sexual debut is a concern in Nigeria, especially among girls. While the median age at sexual debut for women in Nigeria is about 18 years, among adolescent girls, it is lower at 15 years. For boys aged 15-19 years, the median age at first sexual intercourse is slightly higher at 16 years (DHS 2003, 2008, 2013). Study results from Karu LGA show that about 20 percent of adolescents in the sample were sexually active, with the median age at 14.8 (SD=1.8) years for girls and 15.3 (SD=1.6) years for boys. Similar findings are found in the DHS data.

Age at marriage for women has been increasing, but very slowly. Most women still get married in their teenage years. Under the ***Child Rights Act*** of 2003, the legal age for marriage in Nigeria is 18 years. However, under parallel systems – customary and Islamic – that also operate in the country, marriage can take place at earlier ages. Due to this, there is limited enforcement of the law. As a result, there is a persistently high incidence of very early marriage, especially in rural and Muslim areas – nearly 1 in 4 girls are married by age 15 nationally.

FERTILITY AND PREGNANCY

The adolescent fertility rate in Nigeria is 122 births per 1000 women aged 15-19 years. Multivariate regression analysis of adolescent pregnancies using DHS data shows that being in a union is one of the strongest predictors of pregnancies among adolescent girls (Table 2). Knowledge of contraception and use of contraception are also linked to pregnancy (OR=2.2, SE=0.19; and OR=3.5, SE=0.41 respectively) which may be indicative of use of contraception by sexually active females. As expected, secondary education significantly reduces the odds of adolescent pregnancies (OR=0.67, SE=0.09), while the odds increase by poverty - the odds for becoming pregnant as an adolescent in the poorest household are over 2 times higher than for the richest households. While religion or ethnicity by itself does not appear to be significant, the odds of becoming pregnant in adolescence are significantly

higher for Ijaw girls, and may reflect particular social attitudes among this population.

Table 2. Determinants of adolescent pregnancies

Variables	Odds Ratio	Std. Err.	P>|t|	[95% Conf. Interval]	
Region	(Reference Category: South West)				
North Central	1.046	0.219	0.829	0.694	1.578
North East	0.833	0.191	0.425	0.532	1.305
North West	0.704	0.160	0.122	0.451	1.099
South East	1.243	0.415	0.514	0.646	2.394
South South	1.248	0.282	0.328	0.801	1.944
Education	(Reference Category: No Education)				
Primary	1.175	0.133	0.153	0.942	1.466
Secondary	**0.671**	**0.085**	**0.002**	**0.524**	**0.860**
Higher	0.386	0.147	0.013	0.183	0.816
Knowledge of contraceptives	**2.237**	**0.190**	**0.000**	**1.894**	**2.641**
Ever use of contraceptives	**3.462**	**0.406**	**0.000**	**2.752**	**4.356**
In a union	**97.85**	**11.88**	**0.000**	**77.11**	**124.15**
Religion	(Reference Category: Others)				
Christianity	1.606	0.650	0.242	0.727	3.550
Islam	0.920	0.365	0.834	0.423	2.003
Traditionalist	1.014	0.429	0.973	0.443	2.325
Wealth Index	(Reference Category: Richest)				
Poorest	**2.334**	**0.359**	**0.000**	**1.725**	**3.156**
Poor	**2.150**	**0.310**	**0.000**	**1.621**	**2.852**
Middle	**2.141**	**0.291**	**0.000**	**1.641**	**2.795**
Richer	**1.660**	**0.219**	**0.000**	**1.281**	**2.152**
Ethnicity	(Reference Category: Others)				
Hausa	0.877	0.135	0.396	0.648	1.187
Igbo	0.585	0.178	0.079	0.321	1.063
Yoruba	0.899	0.184	0.603	0.601	1.344
Ijaw	**1.793**	**0.360**	**0.004**	**1.209**	**2.659**
Fulani	0.790	0.148	0.209	0.547	1.141
Ibibio	1.812	0.437	0.014	1.128	2.909
Kanuri	0.647	0.176	0.110	0.379	1.104
Tiv	0.401	0.150	0.015	0.192	0.836
_cons	0.012	0.005	0.000	0.005	0.029

Source: DHS 2003, 2008, 2013
Notes: (a) The dependent variable is defined as all adolescents who have given birth, are currently pregnant, or have terminated a pregnancy; (b) logistic regression based on pooled data controlled for survey design, year, and sub-population of women aged 15-19 (n=16245)

The dangers of early pregnancies are well documented in the literature. In Nigeria, several studies also show the negative effects of early pregnancies on maternal mortality and morbidity on girls. Loto et al (2004) compared 104 adolescents (under age 20) with 208 mothers aged 23 to 29 years. The study showed that teenagers experienced significantly higher obstetric complication rates compared to their older counterparts, including anemia in pregnancy, preterm delivery, low birth weight and neonatal admission. Ebeigbe and Gharoro (2007) estimated that the maternal mortality ratio for teenagers was 1835 per 100,000 births – more than double the national maternal mortality ratio.

USE OF SERVICES

One of the major problems in addressing ASRH is that use of services remains low - partly due to social and cultural reasons, and partly due to limited access to these services. Even when services are available, adolescents may not use them. Okekere (2010), for instance, finds that of 836 adolescents sampled in Owerri (Imo State), 73.4 percent confirmed availability of reproductive health center(s) within their neighborhoods, but only 21.5 percent were willing to purchase contraceptives through these centers. In their study, Oye-Adeniran et al. (2005) find that most respondents (19.7 percent) turn to chemists or patent medicine vendors for contraception, but their decision is also guided by their choice of contraception. DHS (2008) data show that adolescent women were less likely than older women to receive ante-natal and post-natal care as well as skilled birth attendance (Suleiman Adamu 2011). Eighty-five percent of women under age 20 years in the North and 56 percent in the South delivered at home. Overall, about 25 percent of women under age 20 used skilled attendance at birth in the country, and about 32 percent received post natal care within 42 days of birth (Rai et al. 2012).

In Karu LGA, data also highlight limited access to SRH services, especially for unmarried girls. Only 10 percent had visited a health facility or doctor for SRH services, with the largest proportion (15 percent) being girls aged 15-19 seeking contraception, abortions, pregnancy, or STI related services. Embarrassment and fear of stigmatization are among the main concerns adolescents express as a reason for not using public health services. Focus group discussants mention turning to private hospitals, traditional healers, patent medical vendors (PMVs), or chemists for reproductive health services, specifically contraception and in cases of unwanted pregnancies, for abortion.

Policy and Programmatic Environment

KEY POLICIES

Two policies have been pivotal in the direction the country has taken on ASRH. The first is the ***National Reproductive Health Policy and Strategy (2001)***, which paved the way for Nigeria's largest SRH education program – the Family Life and HIV Education (FLHE) Program. It was also the first to provide an overarching framework for addressing SRH. The second is the ***National Policy on Health and Development of Adolescents and Young People in Nigeria (2007).*** The policy, which is currently in effect, is the first

comprehensive policy on adolescent health. It emphasizes the importance of access to information and youth friendly services (YFS); and encompasses reproductive health, HIV/AIDS, risky behaviors, and education.

Other important policies include the *National Youth Policy* (2009); *Gender Policy* (2008); and *the National School Health Policy* (2006). The latter provides the framework for implementing the national school health program.

PROGRAMS

The ***Family Life and HIV Education (FLHE)*** program is the central piece of the government's efforts to improve ASRH outcomes in Nigeria. Initiated in 2003, the program targets in-school adolescents, ages 10-17 years. Although being implemented country-wide, recent data suggests that it has reached only 13 percent of in-school adolescents (NACA 2014). While there has been no large scale impact evaluation, evidence of the FLHE's influence has been mixed. A survey conducted in 2006 showed that only 45 percent of teachers sampled (n=1,131) had ever heard of the program (FMoE 2006); while several other studies highlight improvements in knowledge and attitudes among students due to FLHE (for example, Arnold et al. 2012).

While the FLHE reaches in-school adolescents, those who are out-of-school do not have access to the same type of streamlined education. There are a few ongoing efforts to reach these populations including the ***Peer Education Plus (PEP)*** program, implemented by the Society for Family Health, a civil society organization, in partnership with the National Agency for Control of AIDS (NACA). PEP targets high risk populations, ages 15-24 years, through training peer educators, with a focus on HIV/AIDS and reproductive health. The Federal Ministry of Women's Affairs (FMoW) also runs a **mentorship program** for girls who drop out of school due to pregnancy or are single parents to teach them life skills. The program includes SRH education. Association for Reproductive and Family Health, Action Health, and Life Vanguards have also led similar programs. However, these are smaller programs and are not connected to the FLHE (each is run by a different ministry or agency) making it difficult to reach out-of-school adolescent systematically.

Recommendations/Conclusions

The FLHE is a promising program. Its effectiveness can be improved through better funding and coordination between the ministries of education and health and women's affairs to create links between education and access to services. The FLHE will also benefit from more comprehensive curricula and some mechanism to ensure its reinforcement outside of schools. In this regard, parent information sessions may be organized to help them learn techniques for communicating on SRH issues with their children.

Provision of YFS is important in removing some of the barriers to use of services for adolescents. The National Primary Health Care Development Agency has played a facilitating role in developing guidelines and identifying a minimum package of services at the primary level. Nigeria provides some YFS at the secondary and primary level and there is scope for scaling up. These efforts need continued support.

The ambiguity surrounding age at marriage also needs to be addressed. Global evidence indicates that the risk of death from giving birth is much higher for younger adolescents when their bodies are not fully developed. Children whose mothers die at birth also face higher risk of mortality before age 5. Public awareness based on these types of messages may be useful in the longer-term in reducing maternal and child mortality and morbidity in the country.

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