Improving Adolescent Reproductive Health in Rural Communities in Nigeria: Evidence to Policy

About CPED Policy Brief

Centre for Population and Environmental Development (CPED) policy brief series is designed to draw attention of stakeholders to key findings and their implication as a research is conducted. The general objective is to contribute to a body of evidence that can influence the development, modification and implementation of policies across various sectors in Nigeria. The primary focus, therefore, is to outline actionable recommendations for policy influence and result utilization by government institutions and other key stakeholders in Nigeria.

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Introduction

Young people in Nigeria suffer disproportionately from negative sexual and reproductive health outcomes, such as early and unwanted pregnancies, unsafe abortion, and sexually transmitted infections. Studies show that most of the adolescents younger than 20 years in Nigeria have had sexual intercourse with different partners without taking any precaution for preventing sexually transmitted infections (STI) or pregnancy. In many cases, the context in which adolescent pregnancy occurs makes it difficult for the adolescent to complete school and leads to adverse socio-economic consequences which prevent adolescents from stepping out of the vicious circle of poverty. The *Nigerian Demographic and Health Surveys, (NDHS)*, in its latest report in 2013 revealed that 23 per cent of Nigerian teenage girls were already mothers or pregnant with their first child. The 2013 report stated that one in six (17 per cent) Nigerian girls between the age of 15 and 19 already have a child with another five per cent pregnant with their first child. One of the findings of the NDHS survey was that young girls in rural areas were more likely to get pregnant than their counterparts in urban areas. The proportion of teenage girls who had begun child bearing in rural areas, according to the report, was 32 per cent as compared to 10 per cent in urban areas. In most parts of Nigeria, early and forced marriage, are still common. Among women ages 20 to 24, 19.8% reported having married by age 15, 39.6% by age 18, and 52.7% by age 20. Among men ages 25 to 29, 15.5% reported having married by age 20. About one-third of women obtaining abortions in Nigeria are adolescents and hospital-based studies showed that up to 80% of Nigerian patients with abortion-related complications were adolescents. Nigeria is characterised by

Background

This policy brief is based on the findings of CPED on-going implementation research on Reproductive Health in Nigeria with special focus on Adolescents. The project is one of the small scale implementation research programmes with support from the *Think Tank Initiative* funded by Canada's *International Development Research Centre (IDRC)*, Ottawa and other donors. The overall goal of the project is to improve the delivery of adolescent reproductive health services in rural Nigeria by successfully engaging policy-makers and various key stakeholders in the generation of new evidence about effective ways to strengthen the provision, uptake, equity and effectiveness of adolescent reproductive health. The policy brief outlines some actions that need to be taken to improve the situation.

different types of harmful practices that impact reproductive rights and gender. The most common includes female genital mutilation (FGM), early marriage and the various taboos which prevent women from controlling their own fertility. Adolescents, in rural Nigeria, move within multiple contexts (family, peers, community etc.). Thus their sexual behaviour is determined by diverse factors that influence attitudes, knowledge, skills and norms. In order to develop effective policies and strategies that aim at improving adolescent reproductive health, it is crucial to identify drivers of adolescents' sexual behaviour. Research in Nigeria show that age, residence, education level, gender norms, socioeconomic status and access to health services are important predictors of adolescents' sexual health in the country.

Although the *National Reproductive Health Policy* and the *Strategic Plan of Action* indicate Nigeria's recognition of the health challenges of its young people, a lack of sufficient political will and resources prevents the policy from being translated into operational plans and programs at the state and local levels. To date, there is little evidence that any of the 36 states and 774 Local Government Councils in the country has formulated specific policies aimed at promoting adolescent reproductive health. The few adolescent health programs in rural areas of the country tend to focus on unidirectional interventions aiming at reducing adolescents' risky behaviours (to prevent unwanted pregnancies and HIV/STI infections), but adoption of healthy reproductive health attitudes and behaviours does not happen in a vacuum. Many adolescents in rural Nigeria underuse sexual and reproductive health (ASRH) services due to barriers such as service costs and distance, lack of awareness about where to get contraceptives and STI treatment, embarrassment, lack of confidentiality and privacy, and negative provider attitudes. Hence a comprehensive community-embedded approach is needed. Adolescents require motivation and ownership to make healthy decisions about their reproductive behaviour. Family and community support are crucial and mobilisation of parents, community leaders and local institutions are essential strategies in ASRH programs in rural Nigeria. It is in this context that this policy brief outlines strategies to improve the delivery of adolescent reproductive health services in rural Nigeria.

Overview of Adolescent reproductive Patterns and Trends in Rural Nigeria

Adolescents in rural communities of Nigeria are growing up in circumstances quite different from those of their parents, with greater access to formal education and more exposure to new ideas through media, telecommunications and other avenues. The environment in which young people are making decisions related to sexual and reproductive health is also rapidly evolving. Rates of sexual initiation during young adulthood are rising. Early marriage and early marital sexual activity present reproductive health risks for young women. Early marriage can lead to pregnancies that put young women at risk for obstetric fistulae and can be a risk factor for HIV infection. The risks for young girls conferred by early marriage may involve older male partners—who have often been sexually active for many years—"bringing" HIV to the marriage. Adolescent sexual activity, within or outside of marriage, can lead to negative reproductive health outcomes. Unprotected sexual activity can expose young women to the risks of unintended pregnancy, unwanted childbearing and abortion, as well as HIV and other STIs. In addition to being a human rights concern, coerced or unwanted sex is associated with these same adverse reproductive health outcomes

Use of modern contraceptives, particularly among married youth in rural Nigeria, is very low—women, who are married, even as adolescents, are expected to have children right away. Women's gender identities and social status are tied to motherhood and childlessness is highly stigmatized. Unmet need for contraception, or non-use of methods despite the desire to limit births or delay them for at least two years, is high among unmarried adolescents in rural Nigeria. Adolescents have unprotected sex for a multitude of reasons. Within or outside of marriage, young women may feel pressure to prove their fertility. Other young people may engage in unprotected sex because they have not considered contraception, fear possible side effects, are misinformed about the risk of pregnancy or STIs posed by unprotected sex or are more concerned with the safety of condoms than the safety of an unintended pregnancy.

A major concern about teenage pregnancy is its impact on the overall health and well-being of the mother and the child. Women of reproductive age, under 18 years of age are considered at high risk for pregnancy related illness and death. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently physically developed to have a safe pregnancy and delivery. The dynamic period of growth associated with poor intakes of all nutrients and vitamins due to improper dietary habits put adolescent girl at high risk for anaemia and nutritional deficiency. The added burden of pregnancy may not only be psychologically traumatic, but also deprive her of nutrition. Nutritional deprivation, increased demand for her growth, excessive menstrual losses and superadded pregnancy, all conspire to aggravate anaemia, and its ill effects. Because rural adolescent mothers belong to a lower socio-economic class they usually suffer from chronic nutritional deprivation once they become pregnant.

Adolescents often report their pregnancies later than adult women. These behaviours are associated with less psychological maturity and fewer coping mechanisms. Furthermore, these high risk adolescents' behaviours have resulted in delayed maternal health services until the very last stage of pregnancy. In some instances attitude and behaviour of the service providers may discourage adolescent girls to seek antenatal and postnatal care which is vital to their reproductive health and the health of new born. A major problem arises from children having children. A young adolescent mother, barely out of childhood herself and certainly not an adult may not have the parenting skills needed to bring up a physically and mentally healthy child. Maternal morbidity rates have also been especially high for the youngest adolescent. Pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early twenties. Since in early adolescent years her pelvis has not reached its full adult size and thus obstructed labour is far more likely to occur. Babies born to young adolescent mothers also face more health risks, including premature delivery, low birth weight and perinatal morality, than the babies of older women.

While reproductive health issues are the major health concern of female adolescents, young girls and boys also face many other health problems which related to their overall well-being.
These problems are, in most cases, largely due to rural poverty and circumstances triggered by their social behaviour. Adolescents are in a major transitional stage in which they are likely to engage in risk-taking behaviour as they separate from their family and eager to achieve independence through risky actions. Major reproductive health problems of adolescents exposed in the rural communities in Nigeria include, use of tobacco, alcohol and psychoactive substances. Young women are much less likely than young men to drink and smoke, but the percentage that do is increasing; furthermore pregnant women who drink and/or smoke run the risk of harming their fetus. Chronic drug users tend to be out of school, alienated from their families and likely to be a major social problem in near future.

Strategies for promoting community-based approach to adolescent reproductive health in rural Nigeria

There is substantial action research evidence to support a community-centred approach when seeking to improve adolescent reproductive health in rural communities in Nigeria, both in terms of encouraging healthy behaviours and improving access to existing services. Based on the prevailing situation in most parts of rural Nigeria, a core set of four activities are articulated to guide the promotion of community-based approach to reproductive health care delivery in rural Nigeria as follows:

(i) *Improved communication on sexual and reproductive health by adolescents:* Open and regular communications about sexual and reproductive health issues between adolescents and their parents are known to have a protective effect. Open communication at the family level can help to encourage adolescents to approach health care providers with questions and concerns related to their sexual and reproductive health as well as encourage healthy sexual behaviour more generally. Research has shown that adolescent girls who communicate easily with their mothers are considerably less likely to become pregnant and that open communication with parents lead to postponed sexual debut and fewer unwanted pregnancies. It is in this

context it is recommended that policies and programmes to improve adolescent reproductive health in rural communities in Nigeria should pay particular attention to improving communication on reproductive health issues between adolescents and their parents or indeed other stakeholders in their communities.

(ii) *Improved quality of, and access to, sexual and reproductive health information*: Sexual education in primary and secondary schools in rural areas of Nigeria is generally poor. Adolescents in rural communities have the impression that the little sexual and reproductive health lessons they receive are negative, heavy on 'scare tactics', moralistic and biologically oriented at the expense of discussions about relationships and communication. The lack of comprehensive sexuality education and easy access to pornography and other negative information sources lead to disinformation, poor knowledge on sexual and reproductive health, false beliefs, myths and negative attitudes towards e.g. contraception use. It is clear that young people in rural communities of Nigeria need both accurate information on sexual and reproductive health, as well as the ability to navigate the overwhelming amount of inaccurate information in order to make healthy and well-informed choices. This is an area where policies and programmes should pay adequate attention.

(iii) *Improved access to existing sexual and reproductive health services:* It is expected that primary health care centres in Nigeria should be easily accessible and available to adolescents in rural communities. However, adolescents in rural areas face multiple barriers when accessing primary health care services. The difficulties faced in accessing sexual and reproductive health services include: 1) difficulty securing an appointment concerns about confidentiality of care; and, 3) concerns regarding communicating with health providers about sexual and reproductive health issues. In addition, adolescents in rural communities are negatively impacted by the following limitations of public health providers: a) limited knowledge and training in the field of adolescent sexual and reproductive health b) lack of knowledge of legal provisions for confidential health services for adolescents (41); and, c) health provider reluctance to discuss sexual and reproductive health issues with adolescents. The policies and programmes to improve adolescent reproductive health in rural communities must address these challenges.

(iv) *Improved healthy and safe sexual behaviours*: Findings of research in rural Nigeria indicate that the percentage of sexually-active unmarried young women (ages 15 to 24) protected by contraception is less than 12 %. This should be addressed in policies and programmes.

Conclusion

When young people are given the information and tools they need to protect themselves, they can and do take charge of their sexual health. Studies have repeatedly found that young people who receive comprehensive sex education programmes put that knowledge to use and delay sex or use contraception. In addition, declines in HIV prevalence around the world can be attributed to a decline in new HIV cases among young people as a result of behaviour change. Yet too many young people, especially those in rural communities of Nigeria, face barriers to their health and well-being, including lack of access to contraception, unintended pregnancy, unsafe abortion, HIV, sexual coercion, and discrimination based on gender, gender identity, and sexual orientation. All governments in Nigeria at federal, state and local governments must take steps to protect young people's reproductive and sexual health and rights and provide them with the information and services they need.

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ABOUT CPED

The Centre for Population and Environmental Development (CPED) is an independent Think Tank organization dedicated to promoting sustainable development and reducing poverty and inequality through policy oriented research and active engagement on development issues. CPED is located in Benin City, Edo State, Nigeria. The Organisation was formally registered in Nigeria by the Corporate Affairs Commission (CAC) in 1999. CPED is a member of different Think Tank Networks including the "West Africa Think Tanks Network (WATTNet)", and also a beneficiary of the Think Tank Initiative (TTI), a multi-donor program of the *International Development Research Centre (IDRC),* Canada. The Centre's Executive Director is ***Professor Emeritus Andrew Godwin Onokerhoraye***, vice chancellor University of Benin (1992-1998).

CPED core programme areas can be broadly categorized into: Action Research; Policy Engagement, Communications and Advocacy; Intervention Programme and Capacity Building for Policy makers, CSOs and Mentees from allied institutions. CPED research agenda covers (1) Climate change with particular reference to the wetland and coaster regions (2) Gender and development (3) Health Systems and Health Care Service Delivery (4) Research on Governance and Development (5) Peace Building and Development in Niger Delta Region (6) Growth, Development and Equity.

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