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Adolescents and Utilization of Family Planning Services in Rural Community of Nigeria

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Abstract
Adolescence is a critical stage in human development characterized by peer pressure, confusion, exuberance and experimentation particularly with sex, drugs and alcohol. Hence, adolescent reproductive health is critical due to the gregarious sexual activities, which predispose young people to sexually transmitted diseases, unwanted pregnancies, unsafe abortion, and death. Adolescents in Nigeria constitute about a fifth of the national population, 12% have first childbirth before 15 years, most become parents before 20 years, and suffer from sexually transmitted infections (Federal Ministry of Health, 2003). Objectives of the study were to determine family planning services available, and pattern of utilization among adolescents in a rural community of Akwa Ibom State, Nigeria; identify factors influencing utilization of services; and determine knowledge, and attitude of adolescents to family planning services. Four hundred (400) randomly selected adolescents completed a structured questionnaire, 277(69.75%) said family planning services were available. Sources of services were chemists 125(31.25%), pharmacy 74(18.50%) and hospital/health centre 184(46.00%); and reasons for using a place were low cost 26%, privacy 23.5%, proximity 22.75%, and 19.75% attitude of provider. Sources of information on family planning include radio 33.25%, health facility 24.75%, school 19%, peers 12.75%, church 8.5% and parents 6.5%. Interestingly, 58.25% said family planning was for both sexes, 67.5%, it was not for married people alone, and 91.5% said their religion was not against family planning. Most, 68% were sexually active, 55.25% were not worried about unplanned pregnancy after unprotected sex, and 44.8% were not worried about HIV and sexually transmitted diseases, only 34.5% were using condom, yet 76.50% acknowledged condom could protect a woman from unwanted pregnancy, and 27% did not use any method. Conclusion, family planning services were available but not well-utilized and rather worrisome most adolescents were not worried about unplanned pregnancy and consequences of unprotected sex.

Keywords: Adolescent sexuality; family planning utilization among adolescents, rural adolescents and family planning.

1. Introduction

Nigeria has a young population with about 44% of the population less than 15 years, with median age of 17 years, median age at first marriage for women ages 20 - 49 17.2 years; median age at first sexual intercourse 17.9 years, and median age at first birth for women age 20 –49, 19.6 years. Childbearing begins early with about half of Nigerian women of reproductive age becoming mothers before the age of twenty (Federal Office of Statistics, 2003). Rural areas tend to have higher fertility rates 148 and urban 70 for 15 to 19 year olds. (National Population Commission, 2009). About 250 out of 1000 adolescent pregnancies in Nigeria end in unsafe abortion and of the estimated 600,000 induced abortions annually adolescents contribute 60%. Yet, the level of contraception among sexually active adolescents is low, which results in high teenage pregnancy, unsafe abortions and maternal mortality (Federal Ministry of Health, 2003). Alubo (2000) argues adolescent sexuality and reproductive health are important contemporary concerns especially for reproductive health problems such as unintended pregnancy, maternal mortality and sexually transmitted diseases, including AIDS. Moreover, HIV and AIDS prevalence in rural communities is increasing and persistently high in some rural communities within the study region. Reports of sentinel survey of 36,427 pregnant women 15 to 49 years in 160 sentinel sites in Nigeria show national prevalence of 4.1% and Akwa Ibom 10.9% with rural prevalence of 11.1% (Federal Ministry of Health, 2010). Furthermore, Udiminue and Adindu (2012) in study of 350 respondents in a rural community in Akwa Ibom State reported 168 (48%) had more than one sexual partner, 45.5% males and 32.7% females were not satisfied with one sexual partner, yet many did not like using condom because 62.1% said it was not pleasurable. Despite increasing HIV prevalence

in rural communities and vulnerability of adolescents, people in these areas often have least access to information and services on reproductive health and family planning.

1.1 Objectives

Specific objectives of the study were to: determine family planning services available and pattern of utilization among adolescents; identify factors influencing utilization of services; and determine knowledge, and attitude of adolescents to family planning.

1.2. Methodology

This study was in Eastern Obolo local government of Akwa Ibom State, a rural community within the tropical rainforest, had two clans, 33 communities, and population of about 59, 970 people, 55% males and 45 % females (National Population Commission, 2006). The community had ten primary schools, five secondary schools eight primary health centers, and no hospital nor private clinic. For this study we divided the clans into 2 clusters, ten communities randomly selected from each totaling 20 communities; structured questionnaire administered to 20 randomly selected adolescents 10 to 19 years, one per household, this gave 200 adolescents per cluster, and total of 400 adolescents for the study. Chair, Eastern Obolo local government, community and health facility heads gave approval before entry into the community. Participation was voluntary; each adolescent gave oral consent before involvement in the study, and did not record names on the questionnaire.

2.0 Literature Review

Sub-Saharan Africa has one of the highest levels of teenage pregnancies in the world, largely due to limited education opportunities, sex education and information regarding contraceptives, as well as widespread poverty. The problem of teenage pregnancies should be viewed within the broader socio-economic and socio-cultural environment, where parental guidance on issues of sexuality and sex education is a cultural taboo (Were, 2007). The rapid population growth is due to low contraceptive prevalence rate (CPR) of eight per cent (8%), one of the lowest in the world. Studies show that reproductive health status of adolescents is poor, about 12% have had their first childbirth before 15 years, most became parents before 20 years, suffer from HIV/AIDS and sexually transmitted infections (Federal Ministry of Health, 2003).

2.1 Family Planning

Family planning implies planning size of the family in a manner compatible with physical and socio-economic resources of parents and conducive to health and welfare of members of the family (Gupta, 2005). These practices help individuals or couples to avoid unwanted births; bring about wanted births; regulate the intervals between pregnancies to control time at which births occur in relation to ages of parent; and determine number of children in the family (Park, 2007). Society for Family Health (2006) argues reasons for family planning are economic, demographic and health; economic and demographic rationales are often useful at the national level, however, the health rationale is most acceptable. Family planning services include modern methods, contraceptive pills, intrauterine devices, injections, male condom, female condom, diaphragm, male sterilization and female sterilization; and traditional methods such as breast feeding, rhythm method and withdrawal. National family planning programs and services in developing countries are increasingly associated with increases in contraceptive use and decline in fertility (World Bank, 2003). New initiatives on supply and distribution of commodities and the heightened demand for condoms due to increased awareness on HIV/AIDS have improved availability of some commodities and services, IUCDs and Injectables are high but there is need to create awareness and expand services for implants, permanent contraception and emergency contraceptive pills (Federal Ministry of Health, 2002). Among adolescents and young persons, contraceptive use is very low, resulting in high prevalence of undesired pregnancies, unsafe abortions and hence, high abortion related morbidity and mortality. However, quality of family planning and reproductive health services positively affect the contraceptive use and behavior, and clients deserve to receive safe and quality service with respect and dignity (Ramarao et al., 2003). Contraceptive prevalence rate in Nigeria is still

low but progressively improving, prevalence of 8.2% in 2003 and 2004, 12% in 2007 and 14.6% in 2008 (Federal Government of Nigeria, 2010). Monjok, et. al (2010) argue the rate is very low despite high rate of sexual activity and wide spread knowledge of contraceptive methods, particularly among adolescents leading to unintended pregnancies and illegal abortion.

However, those in the urban areas have greater access and greater chances of utilizing health services than rural counterparts (Akin et al., 2002). This is also affected by the level of education, amount and type of information available, and income that tend to tilt the odds in favor of urban dwellers (Egwu, 2006). Presence of a health insurance significantly increases the utilization of health services (Aslan et al., 2006). This is because the cost of health services, which is a major limiting factor to health service utilization, is largely off patients, hence, low-income earners have greater access to health services.

2.2 Education, Information and Service Utilization

Many sexually active Nigerian adolescents have multiple partners; consequently, the incidence of teenage pregnancy and childbearing is high. A major factor associated with poor adolescent reproductive health status is limited knowledge of relevant reproductive health issues, resulting from limited access to credible sources of information. Most schools do not teach population, family life education and sexuality education, despite inclusion in secondary school curricula. Parents and other stakeholders tend to withhold reproductive health and sexuality information from young people largely due to traditional and socio-cultural beliefs. Young people have limited access to relevant reproductive health services, where available, unfriendly nature of facilities deters utilization (FMOH, 2002). Ensor and Cooper (2004) argue education and information on health service utilization lead to greater tendency to seek and utilize health care services, and capacity for informed decision making on treatment options. Number of teenagers who start childbearing decreases with increase level of education, those with no education are more than twice likely to start childbearing early (NDHS, 2009). Economic autonomy, school enrollment and regular exposure to mass media are less common among poor than among rich adolescents (Rani and Lule, 2004).

Nigerian women with higher education are more likely to plan their families, have fewer children, have better access to health services, and experience less maternal mortality (Federal Office of Statistics, 2003). Furthermore, Onwuzurike and Uzochukwu (2001) argue that despite the high level of knowledge and approval rate of family planning, the socio-cultural influence of men on wives and daughters is impediment to the use of modern family planning methods. There is need for increasing awareness on availability and benefits of family planning on child spacing, family health and ultimately population control and social health (Udigwe et al., 2002). International family planning efforts have integrated male methods, such as condoms and sterilization into various programs, the use of these methods by males was extremely low, partly due to perceived conflict with traditional culture, patriarchal norms, notion of maleness and religion (Seltzer, 2000). Different factors influence utilization of health services in different parts of the world, availability, and affordability of health services; failure or success of the treatment within the popular or folk sectors; the perception of the problem by patients and other people around them (Aslan *et al*., 2006). Additionally, place of settlement (rural or urban), presence of health insurance, age, education and information, indirect consumer costs, household/community preferences, community attitudes and norms, and the price and availability of substitutes (Helman, 2001).

2.3 Government policies on adolescent reproductive health and family planning

Nigerian government in 1989 published the national population policy advocating reduction in birth rate through voluntary fertility regulation. The 2002 National Reproductive Health Policy aims at strengthening reproductive health rights to achieve improvement in the reproductive health status of Nigerians using different strategies. The goal was to create environment for appropriate action and provide guidance to local initiatives in all areas of reproductive health. Five strategic thrusts are advocacy and social mobilization; promotion of healthy reproductive health lifestyle; equitable access to quality reproductive health services; capacity building; and reproductive health research to address emerging issues in reproductive health (FMOH, 2004). The policy recognizes that integrated reproductive health involves a wide range of reproductive health issues beyond the traditional safe motherhood, family planning, and HIV/AIDS/STIs. It addresses adolescent reproductive health, the special needs of the girl-child,

women's empowerment, issues of gender equity and equality, male involvement, needs of vulnerable groups, and integrated and multi-sector approach. The National Strategic Framework and plan for Reproductive Health (2002 – 2006) provides strategic direction for implementation of the National Reproductive Health Policy. Yet, this instrument an important milestone in reproductive health has not received the necessary funding for implementation (FMOH, 2002).

3.0. Data Analysis and Interpretation

3.1 Demographic Characteristics

Results show of the 400 respondents 245 (61.25%) were females and 155 (38.75%) males, 251 (62.75%) were 16-19years, and 149 (37.25%) 10-15years; 287(72.25%) singles, 95(23.75%) married and 16(4.0%) divorced; 63.75% (255) had secondary education, 96 (24.0%) primary and 49 (12.25%) tertiary education. Students were 201(50.25%), self employed 76 (19.00%), civil servants 50 (12.50%), unemployed 33(8.25%), teachers 22 (5.50%) and 18 (4.50%) hawkers; most 349 (87.25%) were Christians, and highest earners had income of ₦1, 500 to ₦5, 000, about ($9.6 to $32) per month (table 1).

3.2 Availability of Family Planning Services and Source of Information on Services

Over half 277 (69.75%) respondents said family planning services were available 166 females (41.5%) and 111males (27.27%), and 123 (30.25%) said services were not available. Services available were counseling 322 (80.50%), and educational program on family planning 303(75.75%); sources of information include media and radio 133(33.25%), health care facilities 99(24.75%), schools 76(19%), peer 51(12.75%), 8.5 % (34) church, 25 (6.50%) parents, and 23(5.75%) newspapers/books (table 2). Places to obtaining services were hospital/health centre 184 (46%), 125 (31.25%) chemist, and 74 (18.50%) pharmacy; and reasons for selecting a service center were privacy 132 (33%), proximity to home/market/office 105(26.25%), short waiting time 84(21%), clean facility 60(15%), and 54(13.50%) low cost (table 3).

Table 1: Demographic variables

Variables	Number of respondents	Per cent
Gender		
Male	155	38.75%
Female	245	61.25%
Total	**400**	**100.0%**
Age		
10-15	149	37.25%
16-19	251	62.75%
Total	**400**	**100.0%**
Marital status		
Single	287	72.25%
Married	97	23.75%
Divorced	16	4.00%
Total	**400**	**100.0%**
Education		
Primary	96	24.00%
Secondary	255	63.75%
Tertiary	49	12.25%
Total	**400**	**100.0%**
Occupation		
Teaching	22	5.50%
Civil servant	50	12.50%
Self employed	76	19.00%
Student	201	50.25%
Unemployed	33	8.25%
Hawkers	18	4.50%
Total	**400**	**100.0%**
Religion		
Christianity	349	87.25%
Islam	26	6.50%
Indigenous worship	25	6.25%
Total	**400**	**100.0%**
Income per Month:		
₦1,500-5,000	108	27.00%
₦6,000-10,000	49	12.25%
₦ 11,000-20,000	13	3.25%
₦ 21,000-above	6	1.50%
Total	**176**	**44.00%**

Table 2 Available services and sources of information on family planning

Available services	Males	Females	Total respondents	Per cent
Family planning services				
Services available	111	166	277	69.75%
Services not available	44	79	123	30.25%
Total	**155**	**245**	**400**	**100.0%**
Counseling				
Counseling available	124	198	322	80.50%
Counseling not available	31	47	78	19.50%
Total	**155**	**245**	**400**	**100.0%**
Educational Program				
Educational program available	138	165	303	75.75%
Educational Program not available	17	80	97	24.25%
Total	**155**	**245**	**400**	**100.0%**
Sources of information*				
Peer	32	19	51	12.75%
Parents	13	13	26	6.50%
Radio	82	51	133	33.25%
Television	32	15	47	11.75%
Newspaper/books	12	11	23	5.75%
Church	14	20	34	8.50%
Health care facility	31	68	99	24.75%
School	43	33	76	19.0%
Others	1	4	5	1.25%

**Multiple responses*

Table 3: Places to obtain services and reasons for using a place

Variables	Males	Females	Total respondents*	Per cent
Where to obtain services				
Chemist	56	69	125	31.25%
Pharmacy	54	20	74	18.50%
Hospital/health centre	72	112	184	46.0%
Others	15	12	27	6.75%
Reasons for selecting service place				
Credit facility	7	8	15	3.75%
Short waiting time	52	32	84	21.0%
Clean facility	15	45	60	15.0%
Offers privacy	60	72	132	33.0%
Low cost	26	28	54	13.50%
Closer home/market/office	21	84	105	26.25%
Others	3	15	18	4.50%
Total				

**Multiple responses*

3.3. Family Planning Methods Available, and Reasons for Adopting a Method

Specific family planning methods available were condoms 228 (57.00%) 101 males and 127 females; injectables 85 (21.25%), 7 males and 78 females; pills 79 (19.75%) 18 males and 61 females; IUCD 21(5.25%), 5 males and 16 females; natural methods 49 (12.25%), 30 males and 19 females; beads 22(5.50%), 3 males and 19 females (figure 1). Reasons for adopting a method were low cost 107 (26.75%) 63 males and 44 females; proximity to home/market/ office 91 (22.75%), 34 males and 57 females; privacy 94 (23.5%) , 47 males and 47 females. Attitude of providers 79(19.75%), 44 males and 35 females; clean facility 51(12.75%), 25 males and 26 females; short waiting time 51 (12.75%) 35 males and 16 females. Reasons for not adopting a family planning method were side effect 101(25.25%), 38 males and 63 females; no information 71(17.75%), 30 males and 41 females; attitude of providers 70(17.50%), 24 males and 46 females; distance from home/market/office 61(15.25%), 16 males and 45 females; not available 56(14%), 13 males and 43 females (Table 4).

Methods in use were condom 138 (34.5%) were using condom, 51 (12.75%) were using injectables, 19 (4.75%) beads and IUCDs, 28 (7%) natural method, 48 (12%) pills, and 108 (27%) were not using any method. Two hundred and twenty-six (56.5%) were satisfied with the method and 174(43.5%) were not satisfied. 146 (36.5%) were pregnant before the study and 254 (63.5%) had not. 75 (18.75%) had live births, 33 (8.25%) abortion, 17 (4.25%) miscarriage , 9 (2.25%) had stillbirth and 12 (3%) were pregnant at time of study (Table 5).

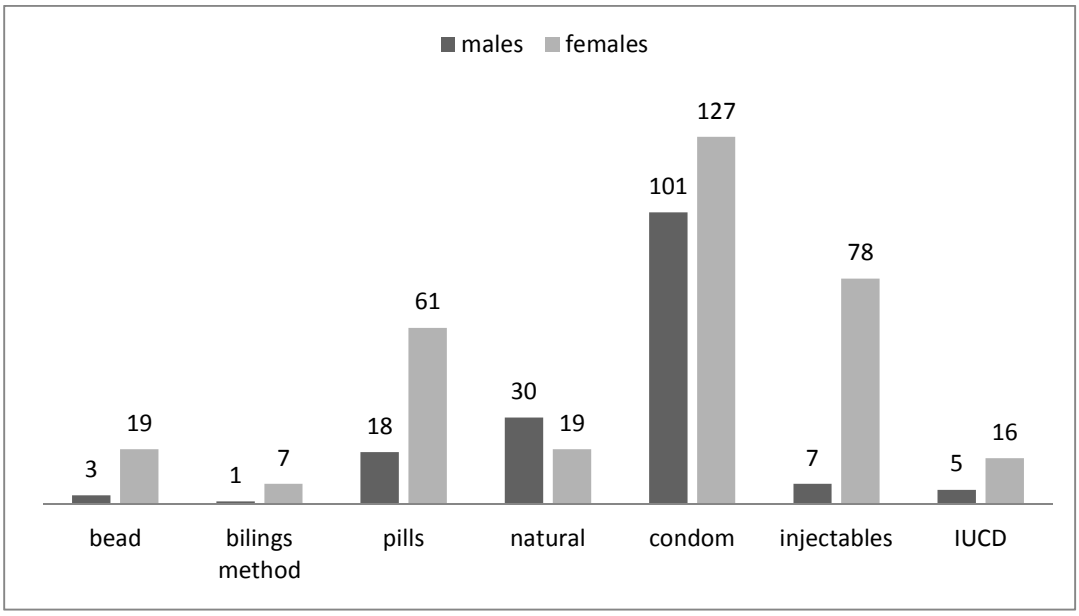

Figure 1: Types of family planning methods available

Table 4: Reasons for Adopting and not Adopting Family Planning Method

Characteristics	Males	Females	Total respondents*	Per cent
Reason for Adopting Family Planning				
Credit facility	6	8	14	3.50%
Short waiting time	35	16	51	12.75%
Clean facility	25	26	51	12.75%
Offers privacy	47	47	94	23.50%
Low cost	63	44	107	26.75%
Closer home/market/office	34	57	91	22.75%
Attitude of the provider	44	35	79	19.75%
Others	11	8	19	4.75%
Reason for not Adopting Family Planning				
Expensive	29	23	52	13.0%
Not available	13	43	56	14.0%
Not accessible	27	21	48	12.0%
Attitude of the provider	24	46	70	17.50%
Distance from home/market/office	16	45	61	15.25%
Side effect	38	63	101	25.25%
No information	30	41	71	17.75%

Table 5: Method in Use, level of Satisfaction and Pregnancy Status

Characteristics	Number of respondents	Per cent
Method in use		
Beads	19	4.75%
Billings method	4	1.0%
Natural	28	7.0%
Pills	48	12.0%
Condoms	138	34.50%
Injectables	51	12.75%
IUCD	19	4.75%
No method	108	27.0%
Satisfied with the method	226	56.50%
Not satisfied with method	174	43.50%
Had been pregnant before the survey	146	36.50%
Had not been pregnant before the survey	254	63.50%
Total	**400**	**100.0%**
Outcome of pregnancy		
Live birth	75	18.75%
Aborted	33	8.25%
Miscarried	17	4.25%
Still birth	9	2.25%
Still pregnant	12	3.00%
Were not pregnant	254	63.50%
Total	**400**	**100.0%**

**Multiple response*

3.4 Attitude and Behavior to Family Planning

Many respondents 282 (70.5%) said family planning was effective, and 118 (29.55 %) it was not, condoms were effective protection against unwanted pregnancy (76.5%); family planning could lead to infertility (39.75%). 167 (41.75%) said family planning was for women only, and 233(58.25%) said it was for men and women; service for married people 130 (32.5%), and not for only married people 270 (67.5%). Most 366(91.5%) said their religion was not against family planning (table 4).

Two hundred and seventy-two (68%) respondents were sexually active and 128 (32%) were not; the sexually active have had sex with boyfriend 115 (28.75%), girlfriend 64 (16%), spouse 57 (14.25%), casual partner 32 (8%), and commercial sex worker 6 (1.5%). Over half (55.25%) were not worried about unplanned pregnancy after intercourse; and 44.75% were worried; 222 (55.5%) were worried about HIV and STIs, and 178(44.5%) were not, 288 (72%) said unsafe abortion could make a woman not have children in future.

Table 6: Perception about family planning

Variables	Number of respondents	Per cent
Effectiveness of family planning		
Was effective	282	70.50%
Was not effective	118	29.50%
Total	**400**	**100.0%**
Condom prevents unwanted pregnancy	306	76.50%
Did not prevent unwanted pregnancy	94	23.50%
Total	**400**	**100.0%**
Effect on fertility		
Could lead to infertility in women	159	39.75%
Does not lead to infertility	241	60.25%
Total	**400**	**100.0%**
Gender and marital status		
Family planning is for women only	167	41.75%
For men and women	233	58.25%
Total	**400**	**100.0%**
It is for the married only	130	32.50%
Not for married only	270	67.50%
Total	**400**	**100.0%**
Position of Religion		
Religion is not against FP	366	91.50%
Religion is against FP	34	8.50%
Total	**400**	**100.0%**

Table 7: Sexual behavior of respondents

Variables	Number of respondents	Per cent
Sexual activity		
Sexually active	272	68.00%
Not sexually active	128	32.00%
Total	**400**	**100.0%**
Sexual partners		
Boyfriend	115	28.75%
Girlfriend	64	16.00%
Spouse	57	14.25%
Casual partner	32	8.00%
Commercial sex worker	6	1.50%
Others	1	0.25%
Total	**275**	**68.75%****
Reaction to pregnancy, HIV/STI and abortion		
Worried about unplanned pregnancy after intercourse	179	44.75%
Not worried	221	55.25%
Total	**400**	**100.0%**
Worried about HIV and STIs after intercourse	222	55.50%
Not worried about HIV and STIs after intercourse	178	44.50%
Total	**400**	**100.0%**
Unsafe abortion could make a woman not have children in future.		
Unsafe abortion does not	288	72.0%
Total	112	28.0%
	400	**100.0%**

** Only the sexually active

4. Conclusion

More than half, 277(69.75%) said family planning services were available, counseling , educational program and methods. Places to obtain services were chemists 125(31.25%), pharmacy 74(18.50%) and hospital/health centre 184(46.00%). Understandably, reasons for using a place were low cost 26%, privacy 23.5%, proximity 22.75%, and 19.75% attitude of provider. Source of information on family planning were radio 33.25%, health facility 24.75%, school 19%, peers 12.75%, church 8.5% and parents 6.5%. Rather encouraging 58.25% said family planning was for both sexes, 67.5% said it was not for the married alone, and 91.5% said religion was not against family planning. However, 68% were sexually active, 55.25% were not worried about unplanned pregnancy after unprotected sex, and 44.8% were not worried about HIV and sexually transmitted diseases, only 34.5% were using condom, yet 76.50% acknowledged condom could protect a woman from unwanted pregnancy, 27% did not use any method. Finally, this study shows that family planning services were available even in rural communities but not well utilized; and worrisome, most adolescents did not care about the consequences of unprotected sexual intercourse.

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