KNOWLEDGE AND USE OF CONTRACEPTIVES AMONG ADOLESCENT MOTHERS IN OGBERE COMMUNITY, EGBEDA LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA.

BY

CHRISTIAN CHUKWUEMEKA ONYEJEKWE

B. Sc, Hons (Nursing Education), Ibadan.

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH (HEALTH EDUCATION) OF THE UNIVERSITY OF IBADAN,

DEPARTMENT OF HEALTH PROMOTION AND EDUCATION

FACULTY OF CLINICAL SCIENCES AND DENTISTRY

COLLEGE OF MEDICINE

UNIVERSITY OF IBADAN

AUGUST 2001

DEDICATION

To God is the glory for the inspiration and guidance in completing this endeavor. This work is dedicated to my wife Catherine, son Solomon and my parents, Mr. Sunday and Mrs. Mercy Onyejekwe. They have all been the fuel of life for me and made sacrifices for this worthy course.

ABSTRACT

The reproductive health of adolescents and young people has continued to receive attention in many countries, including Nigeria. Previous studies in the country show that many young people engage in early sexual activities with multiple partners. Unfortunately, most of these sexual activities are unplanned or unprotected, resulting in unwanted pregnancies and associated complications. Many of the studies focused on use of contraceptives among young people who are not married and are in school. However, little attention has been paid to adolescents who are mothers and are out-of-school. Hence, the objectives of this study were to assess knowledge and use of contraceptives among adolescent mothers in Ogbere community, Egbeda Local Government Area, Oyo State.

This study was descriptive in design. Data were collected through face-to-face interview using a pre-tested questionnaire. The questions covered socio-demographic characteristics, reproductive history, and outcome of pregnancy, knowledge and use of contraceptives and reproductive health rights. A cluster sampling procedure was used to select 7 (50%) clusters/ villages from a sample frame of 14 clusters, followed by a systematic random sampling of 703 households, from which a total of 316 eligible respondents were selected.

The age of respondents ranged from 17 to 20 years with a mean of 18 years. Two hundred and forty-three (76.9%) were married, 65 (20.6%) cohabited, 3 (2.8%) were separated, 1 (0.3%) was divorced and 4 (1.3%) were

single. The highest level of education attained by most respondents 230 (72.3%) was primary. One hundred and eighty-seven (59.2%) were petty traders, while 67 (21.1%) were artisans. The range of pregnancies that occurred since menarche was between 1 and 3, with a mean of 1.28.

On knowledge of contraceptives, majority 207 (65.5%) knew at least four of the ten listed contraceptive methods. The most commonly known contraceptives were condoms 87 (27.5%), oral contraceptive pills 81 (25.8%), injectables 72 (22.8%), and spermicides (foaming tablets) 35 (11.0%). There was no association found between level of educational attainment and knowledge of contraceptives ($p>0.05$). The sources of information for contraceptives were mainly health workers 84 (40.6%), radio 78 (37.7%) and television 20 (9.7%). Ninety-two (29.1%) had ever used any form of contraceptives, 224 (70.9%) had not. Eighty-one mothers (25.6%) were currently using contraceptives. The most commonly used methods were condoms 36 (44.4%) and pills 13 (16.1%). The main reasons adduced for non-use of contraceptives were 'Need for children' 58 (24.8%), 'Don't believe in contraceptives' 36 (15.3%), 'Lack of knowledge' 13 (5.5%) and 'No reasons' 105 (44.7%). Neither the marital status nor parity of the respondents had any significant effect on current use of contraceptives ($p<0.05$). The adolescent mothers scored an average of 0.97 on the 6 points STDs knowledge scale that was constructed.

In conclusion, majority of the adolescent mothers showed fair knowledge and poor utilization of contraceptives. This may predispose them to high parity and related social consequences. This also underscores the need for community based health education to promote contraceptive use among adolescent mothers.

ACKNOWLEDGEMENT

This work has been made possible through the invaluable assistance of a number of people and organizations.

I wish therefore to express my deep appreciation to Dr. I. O. Olaseha for his interest, patience and guidance in this work to its present form. Mr. A. J. Ajuwon is acknowledged for his critical reviews. I am grateful to other faculty members of the Sub-Department of Health Promotion and Education for their scholarly support, namely, Professor J. D. Adeniyi, Dr. O. Oladepo, Dr. W. R. Brieger and Mr. Fred Oshiname. I must also mention the secretarial and administrative assistance provided by Mrs. Taiwo Kunle Ajagbe, Mrs. F. O. Ogunsina, Mr. Kekere Asaname and Mr. Sam Adedapo.

I express my thanks to Mr. and Mrs. Gbola Omotosho for their personal interest and support during the fieldwork in Ogbere Community. The Youth Associates of Family Health and Population Action Committee (FAHPAC) were enthusiastic and are specially acknowledged for their active involvement in data collection.

I recognize the dedication and brilliance of Mr. Olatunde Aderoju in translating the data collection tools into Yoruba language. The staff of FOLRAM Health Research and Data Management Centre was painstaking in data analysis, typesetting and production of the completed work.

Finally, to all others who contributed in other ways to the success of this program, I wish you all God's blessing.

Chris Onyejekwe

CERTIFICATION

I certify that this work was carried out by MR. CHRISTIAN CHUKWUEMEKA ONYEJEKWE, in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

SUPERVISOR

Oladimeji Oladepo, B.Sc., M.P.H., PhD (Ibadan)

Professor of Health Education,

Department of Health Promotion and Education

Faculty of Public Health

College of Medicine

University of Ibadan

Ibadan, Nigeria

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

Background to Research Problems

One in every five people in the world is an adolescent (WHO, 1998). According to the World Health Organisation (WHO) an adolescent is any one aged between 10 and 19 years (WHO, 1986). Adolescence is traditionally a time of growth and development when young men and women experience great and rapid changes in their bodies, their concerns, their relationships and their roles in the society (AIDS Action, 1992). It is also a period when young people seek to stretch beyond the protective shelter of the family and begin to create an independent vision and life.

Worldwide, adolescents are thought to be healthier than other groups in the society. They have survived the diseases of early childhood and are decades away from the infections associated with aging (WHO, 1998; Blum and Rinehart, undated). Yet, many adolescents are afflicted by several health problems. According to WHO (1998) every year, an estimated one million male and female adolescents lose their lives mostly through accidents, suicide, violence, pregnancy-related complications and other illnesses that are preventable or treatable. Threats to the health of the adolescents stem primarily from their behaviour.

One of such behaviours relates to sexual activity. Experimentation with sex is one of the typical features of adolescence and pre-marital sex is a common practice in this population in all regions of the world (McCauley and Salters, 1995). Although

sexual feelings may be expressed in many ways not in themselves harmful to health, unfortunately, many adolescents participate in risky sexual behaviours. These are early age at sexual debut (Aral, 1992), sex with multiple partners (McCauley and Salters, 1995; Jinadu and Odesanmi, 1993) and low utilisation of contraceptives (Amazigbo, Silva, Kaufman and Obikeze, 1998; Nichols, Ladipo, Paxman and Otolorin, 1986).

One important negative consequence of these risky behaviours is pregnancy. Pregnancy in a female adolescent is ill timed because her reproductive organs are not fully developed to cope with the rigours of delivery. Despite the complications associated with it, the incidence of pregnancy among adolescents is high in many developing countries. In Nigeria, for example, the Demographic Health Survey (DHS) of 1991 show that more than a quarter of Nigerian adolescents aged 15-19 years were pregnant or had had children and that 43 percent of the pregnancies were unintended (DHS, 1992). Okonofua (1992) also found that 80 percent of pregnancies by a sample of unmarried girls in some rural areas were not planned for compared to 6 percent of married girls with unplanned pregnancies.

Delivery always carries certain risks, and complications from childbearing may occur regardless of the age of the female. However, the risk of having serious complications during pregnancy or childbirth is much higher for female adolescents than for women aged 20-24 years or older (Arkutu, 1995). Girls aged less than 18 years are more likely than women in their twenties to suffer from pregnancy-related

complications and to die in childbirth (Okonofua, Onwudiegwu and Odunsi, 1992). The risk of death is estimated to be two to four times higher, depending on the woman's health and socio-economic status (McCauley and Salters, 1995). The life threatening complications young pregnant girls face are numerous including, pregnancy-induced high blood pressure, anaemia and haemorrhage.

In Nigeria, many of the studies on young persons documented the use of contraceptives among never married adolescents who are in school. Little attention has been paid to female adolescents who are already mothers and are not enrolled in school. This study was designed to fill this gap. It explores the reproductive health knowledge and use of contraceptive among adolescent mothers living in the Ogbere community in Egbeda Local Government Area (LGA), Oyo State, Nigeria.

Significance of the Study

It is significant that adolescent pregnancy and motherhood are common causes of school drop out among school age girls. The effect of this event is far-reaching and largely determines the life-long experience of these adolescents. These effects include lack of vocational or professional skills for any meaningful employment, lack of economic, social and political power within the family and community settings to escape the burden of poverty. These adolescent mothers are constrained in making independent decisions on their health, child-rearing and subsequent childbearing. This situation underlines the dependency status and subsistence of most adolescent mothers.

Most previous studies have had to focus on teenagers in schools and depended on contact tracing to identify youths. To a large extent, this left a substantial gap on information related to pregnant adolescent mothers and out-of-school youths.

This study is therefore significant for various reasons, which are outlined below as follow.

It determines some of the factors contributing to the contraceptive behaviour of adolescent mothers.

It contributes to the increasing body of information, data and research reports on the contraceptive behaviour of adolescent mothers in a sub-urban community.

The obtained data illuminates the concerns and expectations of adolescent mothers towards existing contraceptive services. It also supports the formulation of a responsive community-based intervention increase access to contraceptive education and services by adolescent mothers in the suburban areas.

This study obtained the views of adolescents for reviewing and shaping the legal and health issues in the laws for improving the health and social conditions of teenagers and young persons in Nigeria.

This study has its basis on the adolescent health programme. The lessons of this study suggest health education strategies to promote the awareness and action among young women to take control of their sexuality for responsible reproductive health decision making and improving their overall health status.

Scope of the Study

The study is exploratory and descriptive, using quantitative data to measure the contraceptive behaviour of adolescent mothers in Ogbere community of Egbeda Local Government Area (LGA). This area of Egbeda LGA has been submerged in suburban periphery of the ever-expanding Ibadan metropolis. The study focussed on health related behaviour of adolescent mothers towards the utilization of contraceptives. This study is also confined to assessing the factors that may hinder the adolescent mother from utilizing contraceptive services since the promulgation of the National Population Policy. It is a community-based study that proposes to meet the respondents in their natural settings. The study further documented information that can be used in promoting contraceptive use among adolescent mothers and young adults, to prevent unwanted pregnancies and sexually transmitted diseases.

Organization of the Text

The preceding introduction to the research problem constitutes the first chapter of this text. The report continues with Chapter two, which reviews the literature on contraception among adolescents and women of reproductive age. The emphasis is on utilization of contraceptives to prevent unwanted pregnancies and sexually transmitted diseases. Chapter three describes the study area, material development, while methods used are discussed. Chapter four presents the results of the study. Chapter five focuses on discussion of results and the implications of the findings.

Finally, conclusions and recommendations are made for improved contraceptive education and services in the suburban areas

CHAPTER TWO

LITERATURE REVIEW

In this chapter, the nature and extent of the problem affecting adolescent reproductive health is described. It also reviewed the theoretical framework that underlies behaviour in contraceptive utilization by adolescent mothers. In concluding, this chapter reviewed contraceptive technology, its effectiveness and safety.

The Reproductive Health concerns/problems of female Adolescents

The sexuality associated with puberty is often seen as the starting point for the transition from childhood to adulthood. This period is laced with the awakening of the sexual response system, which although not new to the adolescent, may lead to pregnancy and other complications.

According to James (1973), throughout history, most societies have dealt with the problem of pre-marital sex and illegitimacy by strictly supervising young girls so that sexual activity does not begin until marriage. This ensures that young girls marry at onset of puberty. Physical violence or ostracism may be visited on unmarried pregnant girls and mothers to serve as punishment to the culprits and deterrent to others. In some parts of the world, especially in the rural areas, there is often considerable pressure on young women to bear children immediately after marriage. A young woman also often does not have any status in the society until she bears a son. In some instances, a girl may be required to prove that she is fertile for the desired marriage to take place, or once married, in order to avoid being abandoned

and left destitute. Therefore, most primary societies have social and cultural factors that put a high premium on early fertility.

Sexual Activities

Today, young people become physically mature at a considerably early age than previous generations. Makinwa-Adebusoye (1991) confirmed that young persons are becoming biologically mature at young ages and are doing so in an urban milieu that permits them a great degree of freedom from adult supervision. As part of the achievement of complete sexual identity, most teenagers engage in heterosexual experience and experimentation. This starts with early dating and attainment of psychological readiness for sexual intercourse and in fact engages in it prior to marriage. Lambert (1972) amply demonstrated that adolescents make early debut with sexual intercourse which is mainly unplanned and unprotected, thus increasing the chances of teenage pregnancy.

In the same vein, it could be observed in a more permissive society in which there is early dating, childhood betrothal and early marriage in some areas, and a deluge of mass media influence in sexual arousal through pornographic materials. Against this backdrop of disintegrating traditional controls due to modernization, urban and rural development, the adolescent view sexual intercourse as a means of obtaining adult status. Arising therefore, are increasing evidence, which suggest a high sexual activity, rising unintended pregnancy, practice of unsafe abortion, use of alcohol and tobacco. According to Oladepo and Bawa (1994), the increase in sexual

activities is due to weakening traditional value system, rapid urbanization, rural to urban migration, deluge of sex messages and pressure through the media. He also found out that the lack of in-school Family Life Education (FLE) programme and negative teachers' attitude towards FLE contributed to the trend among the study group.

The sexually active adolescent, whether married or unmarried, desirous of controlling her fertility, must have access to contraceptives. All available evidence in Nigeria shows limited use of contraceptives among women generally and among adolescents. For instance, less than 15 percent of Nigerian women have ever used family planning methods and 9 percent ever used a modern contraceptive (NDHS, 1991). As in most contraceptive prevalence studies, the ever use data on adolescents is lower to other women of reproductive age.

In his work, Anyan (1978) reported that several elements appear to exert particular influence on the adolescent decision to use or not to use contraception. First, the attainment of sexual maturity and procreative ability are among the most important aspects of adolescence. The use of contraceptives means temporarily putting aside any concrete display of fertility and the internal forces against such action can be formidable. Second, the interference with normal physiologic function that attends steroid contraception and intrusiveness of intra-uterine devices frequently places obstacles on the part of contraceptive. A third important element is the degree of resentment felt by the contraceptor on having to assume or accept the responsibility

for using contraception. This includes being able to plan use and availability well in advance of its possible need. Finally, unlike most medical conditions that require treatments, the decision about contraceptive use is subject to the actual or expected responses of others who are important to the adolescent (parents and peers).

Sexually Transmitted Diseases/Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (STD/HIV/AIDS)

A major concern arising from pre-marital sexual activities among adolescents is the possibility of contracting sexually transmitted infections (STI) including human Immuno-deficiency Virus (HIV) and pregnancy (WHO, 1995). This is in view of complex network of social relationship developed with peers and adults outside the home (Anyan, 1978).

According to the World Health Organisation (1995), STI is endemic in many parts of the world because the therapies and prophylaxis have not curbed the emerging resistant strains of pathogens. The adolescents are at higher risk due to the peculiar development phase, which they are passing through. Their increased vulnerability come from various sources the vagina of the teenager is not well lined with protective cells compared with that of matured women and their cervix may be more easily eroded, most adolescents are likely to experiment sexual intercourse with multiple partners including much older men who are infected with STD/HIV, young women generally have weak economic power and negotiating skills on protective

devices e.g. condoms; and adolescents lack of information on their own bodies, mechanisms of STD/HIV transmission and their level of risk in unprotected sex.

In a study of 2111 Ethiopian women, Duncan et al (1990) established that early sexual activity was associated with an increase in prevalence rates of STD and Pelvic Inflammatory Disease (PID); possible etiological factors include physical and immunological immaturity of female genital tract and number of sexual partners.

The 1998/99 sero-prevalence reports on STD/HIV/AIDS in Nigeria had estimated HIV prevalence at 5.4 percent of the population, with the most vulnerable groups as young people aged 18-29 years. This shows that a reasonable number were infected much earlier in their teenage years.

In addition, the general legal and medical requirements in the control and prevention of STI require the clients to undergo treatment and partner disclosure. This leads to some degree of personal embarrassment, which affects use of the orthodox health facilities by adolescents. Hence, there is under-presentation and under-reporting of STD/HIV cases in the formal health system.

Pregnancy and Related Complications

As noted earlier, pregnancy is another effect of teenage sexual activities. Pregnancy at this stage, particularly in the younger age group is associated with greater mortality and morbidity among both mothers and offspring. Young people's mortality is compounded with less access to ante-natal care than older women are. Child bearing at any age involves some risk. Young women who have not reached

full physical and physiological maturity are almost three times as likely to die from complications of childbirth as older women. Data from several countries consistently show a higher risk of maternal death among teenage girls compared to women between 20 and 30 years. The risk for every young teenager (10-14 years) is much greater than older teenagers, 15-19 years (WHO, 1986).

According to Federal Office Statistics/International Research Department-FOS/IRD (1990) report, pregnant teens of 15-19 years run a greater risk, sometimes, twice as high, of dying from pregnancy related causes than pregnant women in their twenties and early thirties. Some of the complications include hypertensive disorders, eclampsia, obstructed labour, death of mother and baby. Furthermore, vesico-vaginal and recto-vaginal fistulae may follow obstructed labour. Also, most women in Nigeria suffering from fistula are adolescents, 33 percent younger than 16 years.

The adverse effects of early child bearing on the mother are matched by disadvantage for her baby. Babies of adolescent mothers have lower chances of survival. In Nigeria, there is 36 percent of Low birth weights babies born to 15-19 years age group, while peri-natal and infant mortality rates are consistently higher where mothers are under 20 years (NDHS, 1991).

The NDHS (1991) report, showed that child mortality is 115 per 1000 births, infant mortality 87 per 1000 live births and neonatal mortality is 62 percent of deaths. These figure are indicative of poor health status and seriously underlining the inefficient health system, health screening and reproductive health services in Nigeria.

Specifically, the high neonatal mortality of babies may be attributable to complications, which require medical attention at birth. Some of these complications include low birth weights of babies born to teenagers, aged below 20 years.

It is incontrovertible that adolescents who do not abstain from sexual intercourse and/or not use contraceptives become pregnant, hence, a major concern of adolescent, is accessibility to and utilization of contraceptives to prevent unwanted pregnancies. A number of reasons have been proffered for the unsuccessful avoidance of unwanted pregnancies among adolescents as sexuality is a taboo subject in most societies and young adolescents frequently have little knowledge about contraception or basic facts of contraceptives; they are naturally impulsive about sexual intercourse; in many countries and societies, it is illegal to advice or counsel any unmarried youth on contraception, the fear of hostile reception from family planning staff, who disapprove of pre-marital sexual activities, and young people tend not to use contraceptives or use less effective methods (Lambert et al 1972; NDHS, 1991).

The outcome of unwanted pregnancy may be termination of pregnancy, perinatal death or becoming a teenage/adolescent mother. The proportion of adolescents who seek abortion rather than continuing with unwanted pregnancy has been increasing. At the moment in Nigeria, abortion is illegal, but abortion on young women accounts for over 10 percent of abortion rate. Illicit abortion involves major health risks such as pelvic infection, haemorrhage, uterine perforation and tetanus. If

left untreated, most of these complications can result to sterility, structural damages to the reproductive organs or death. In Nigeria, 16 percent of all maternal deaths are due to adolescent abortion, while teenagers account for 80 percent of unsafe abortion complications (FOS/IRD, 1990). There is evidence that abortion among adolescents (23.7%) is on the increase, even though illegal, except as medically approved for adults (Achibong, 1992; Campaign Against Unplanned Pregnancy-CAUP 1996; Henshaw, 1998).

In a study conducted in a rural community of South-Eastern Nigeria (Kegbara Dere in Rivers State), Brabin et al (1995) found that almost half (43.6%) of the adolescents less than 17 years reported themselves to be sexually active and have had at least one abortion (22%). In addition, STI among teenagers was 25.6 percent and the facilities for treatment were virtually non-existent.

In a related development, poor parenting has been identified with adolescent mothers, which is given expression in the weak or absent parent child communication (Campion, 1995). Unlike older women, teenage mothers are more likely to come from poor background and have low educational attainment. This situation is compounded with the likelihood of being single, and depriving the child of a father. These adolescents are not economically self-reliant and lack affordable childcare for their babies. The lack of competence at parenting (shown in negligence, less responsiveness and communication, and authoritarian attitude) spells long term disaster for the child. The problems of adjustment to parenthood infer negative long-

term outcomes on the care of the child, especially at the infancy period. It is therefore, obvious that most teenagers are unfit for parenting (Campion, 1995).

Whether or not a woman is married, having a child at a young age severely limits her education and employment prospects. In Nigeria, pregnancy in the unmarried female may lead to an economically depressed future as a single parent or to forced marriage before her partner is ready, with greater likelihood of divorce. According to Campion (1995), in most countries, unmarried adolescent mother face social and legal sanctions because they are single.

Too early child bearing continues to be a major impediment to improving the status of women in the developing world. Accordingly, James (1973) reported that worldwide, 15 million teenage mothers give birth every year, and more than 80 percent of these are in the developing countries. While birth rates of women of all ages are declining in most parts of the developing world, births to adolescents comprise a growing percentage of all births. On the African scene, of the population of female teenagers aged 15-19 years, about 30% become pregnant, while a total 25 percent have successfully carried unwanted pregnancy to full term and become mothers (IRD/macro report, 1992).

This situation reflects on the persisting large family size and early childbearing culture of the relatively large population of young people in Nigeria. According to Nkoyo (1997), current estimates of the total young people in Nigeria is 56 percent while a projected 29 percent will be teenagers, 10-17 years. In the same

vein, NDHS (1991), proffered that one half of Women of Reproductive Age (WRA) become mothers before the age of 20, of which 10-20 percent give birth before age 15 and 28 percent give birth before age 17. This analysis shows that about 28 percent of teenagers have already begun childbearing (have already given birth, or are pregnant with their first child), while 6.2% would have given birth to two children. By giving birth early and presumably with short birth intervals, these young women are at a higher risk of dying.

It is known that young women, who bear their first child during adolescent, are likely to get pregnant again sooner than older women. Hence, the early onset of childbearing is associated with high fertility. This has implications for population growth. Yet, in Nigeria, one target of the National Population Policy-NPP (1990) is to reduce the pregnancy occurring to mothers below 18 years and above 35 years of age by 50 percent and 90 percent respectively by the year 2000. The policy also aims at dissuading families from giving away their daughters in marriage before the age of 18 years.

As was established earlier, less than 15% of Nigerian women have ever used family planning methods and about 9% ever used a modern contraceptive. This ever-used data also demonstrate low figures among the youngest age groups (adolescents). Variation is evident between urban and rural users, as well as in educational level and parity. Young people generally favoured pills and condoms as their contraceptive choice, while the most cited sources of contraceptives were private outlets, such as

private pharmacies and private medical practitioners (NDHS, 1991). This implies that adolescents who depend on pills and condoms could have access to contraception if the enabling environment and demand are created. In another study, Oladepo and Bawa (1994) found that low socio-economic status of parents (15%), poor knowledge of sexuality (65%), poor knowledge (58%) and use (8%) of contraceptive were responsible for unintended pregnancy among female teenagers in Minna, Niger state of Nigeria. Also Dada, Olaseha and Ajuwon (1997/8) concluded that most (74.7%) of the sexually experienced respondents did not use any contraceptives to prevent STDS or pregnancy during their first sexual encounter.

Implication of the Situation

Given that young people aged 18 years and under comprise a little over half the population of Nigeria and other developing countries, this means that a growing number of young people will be at risk of early child-bearing every year. In an age of globalisation, it stands to reason, that so far as the absolute number of births to adolescents in Nigeria and other developing countries continues to increase, the problem has global dimensions. There is, therefore, the need to support a global effort to reduce adolescent fertility rate and the associated problems of teenage motherhood.

It has been established from literature that the increasing teenage births have dramatic implication for both the young mothers and their children. Women under 20

years are at greater risk of pregnancy-related complications and are more likely to die during child-birth than older women. Pregnancy-related complications are the leading causes of death among teenagers while babies born to them have high morbidity (health complications) and higher mortality rates than children born to older women. The social consequences of teen births include compromised future education and employment.

In addition to adolescent pregnancy and teenage motherhood, the issue of sexually transmitted infections, particularly HIV, adds increased urgency to addressing adolescent reproductive health issues. Available records show that the incidence of AIDS among teenage girls is most evident between ages 19 and 29 years, which aptly demonstrate early infection with HIV. Low level of contraceptive use (specifically condoms) and relatively poor knowledge about AIDS and other STI leave the teenagers with the increased risk of infection (FMOH/NASCP, 1996).

The challenge of the 1980s and early 1990s on adolescent health issues prompted the enactment of conventions, charters and policies at international, regional and national levels to redress the existing problems. These include United Nations (UN) convention on the rights of the child, Rio Declaration on Environment and Development June 1992, Vienna Declaration and Program of Action, June 1993, Program of Action of the ICPD, September 1994, Copenhagen Declaration on Social Development, March 1995, Platform for Action of the 4th World Conference on Women, September 1995. On the Nigerian scene, the following policies exist, National Policy on Population for Development, Unity Progress and Self-reliance in 1988, National Youth Policy for

Nigeria, 1989, and the Draft National Policy on Adolescent Health in Nigeria (unpublished 1995). The importance of these declarations, platforms, conventions and policies is to create an environment to increase awareness and generate services to serve young people (especially adolescents/teenagers), reducing morbidity, mortality. In addition, there will be increased information empowerment, youth programmes, redressing of gender gaps and ensuring a stable social security for the future and guaranteeing the fundamental human rights of children and young people.

Contraceptive Knowledge and Use among Adolescent Girls

The indications from a number of studies amply demonstrate huge gap between knowledge and use of contraceptives among adolescent girls.

Oladepo and Bawa (1994) concluded that over 57 percent of Secondary School teenagers in urban northern communities have not heard of family planning and only about 8 percent use contraception. As a result, the authors found that after two years of the study, most of the teenagers were already mothers. The situation was attributed to poor knowledge of ovulation and lack of exposure to sex education, knowledge and use of family planning methods.

In an earlier report, WHO (1993) showed that fewer than 30 percent of married women aged 15 – 19 years in the developing countries use family planning. Married or unmarried, young people in developing countries tend not to use contraception or to use ineffective methods.

The 1999 NDHS report on contraceptive methods showed that only about 38 percent of married women aged 15 – 19 years knew any method of contraception. On ever use of contraceptive, the lowest reported rate was among the married 15 – 19 years group with 7 percent. Interestingly, current use of contraceptives among this age group is about 4 percent. The most commonly used methods were periodic abstinence (5%), pills, injectables and the IUCD, which is used by 2 percent of married women each.

The report further indicated that level of educational attainment and number of living children with the women influenced use of contraceptives. Contraceptive use rises from 6 percent for women with no education to 34 with higher education. As expected, contraceptive use increased from 3 percent for married women with no children to 21 percent for women with four or more.

In a comparative review of four studies on adolescent reproductive health in Nigeria, the Association for Reproductive Health (ARFH, 1996), found that knowledge of various modern contraceptive methods was high among young people with in-school (approximate 5%) and out-of-school (approximate 81%). Most of the respondents mentioned abstinence, withdrawal method, alcohol drinking, antibiotics, concoctions and abortion as known methods of contraception. The review also showed that contraceptive use was about 23 percent for in-school youths and 37 percent for out-of-school youths.

The report concluded that while many of the respondents were sexually active, few had ever used and currently are not using any methods to prevent pregnancy. Comparing in-school and out-of-school youths, the review speculated that the reported higher usage among out-of-school youth was due to the perceived high maturity among the group.

Contraceptive Effectiveness and Safety among Adolescents

It is commonly believed that adolescents and young persons are skeptical about the use of contraceptives. Their disposition borders on the questions "will it work?" and "will it hurt me?" (Hatcher, 1997).

The concerns of adolescents on effectiveness of contraceptives cannot be answered with certainty because of the difficulty of quantifying efficacy. The closest to efficacy of contraceptives are the reported failure rates. Both contraceptive providers and clients attest to the fact that many factors influence efficacy, namely:

a. the inherent effectiveness of the method when used correctly and consistently and the technical attributes of the methods.
b. characteristics of the user and
c. competence and honesty of the investigator in planning, executing and reporting the results (Hatcher , 1989).

For some methods, such as sterilization, implants and injectables, the inherent efficacy is so high and consistent use so nearly guaranteed by their attributes, that extremely low failure rates are found in all studies. For other methods, such as the pills,

and IUD, the inherent efficacy is high, but there is still room for potential misuse, so that this factor contributed to a wider range of reported rates (Hatcher, 1989). The World Health study of the ovulation method of periodic abstinence was 14 percent, whereas failure rates among those who sometimes had difficulty with abstinence was 25 percent (WHO, 1987). A summary of reported effectiveness of contraceptives is presented below in Figure Table 1.

Based on the available efficacy and failure rates, there is an indication towards greater effectiveness of a method when the technology is advanced in perfection and less limited human control.

Table I

Contraceptive Method Effectiveness

Method	Effectiveness Common use 1st year	FM=Female M=Male Used correctly & Consistently 1st year
Low-Dose Combined oral pills	6-8 pregnancies/100 FM	0.1 pregnancies/100 FM
Progestin-only oral pills	1 pregnancy/100FM	0.5 pregnancies/100 FM
DMPA Injectables	-	0.3 pregnancies/100 FM
Norplant Inplants	-	0.1 pregnancies/100 FM
Female Sterilization	-	0.5 pregnancies/100 FM
Vasectomy	-	0.15 pregnancy/100 FM
Condoms	14 pregnancies/100 FM	3 pregnancies/100 FM
IUDS	0.8 Pregnancies/100FM	0.6 pregnancy/100 FM
Vaginal Methods:		
-Specimicides	25 pregnancies/100 FM	6 pregnancies/100 FM
-Diaphram	20 pregnancies/100 FM	6 pregnancies/100 FM
-Cervical Cap	20 pregnancies/100 FM	9 pregnancies/100 FM
Fertility-Awareness-based methods:		
-Abstinence	20 pregnancies/100 FM	-
-Cervical Secretin	-	3 pregnancies/100 FM
-Basal Body Temperature	-	1 pregnancies/100 FM
-Calendar	-	9 pregnancies/100 FM
Lactational Amenorrhea Method	2 pregnancies/100 FM	0.5 pregnancies/100 FM

Adapted from the Essentials of Contraceptive Technology: A handbook for clinic staff.

Contraceptive users including adolescents are concerned about safety. This singular issue is at the heart of contraceptive use. Safety is often perceived by users as something other than the simple absence of potential adverse effect. In fact the concern is about how a contraceptive method affects overall health, including interest in sex, physical vitality and emotional well-being, which are aspects of health that may not easily be measured in a clinical trial. Adolescents accept that all contraceptives pose

some risk, but are more concerned about the effect of contraceptives on their future reproductive capacity and the potential impact of failed method on developing baby. Beyond these are issues of the potential risk of death, also risks in terms of inconvenience, does the method make sexual intercourse less pleasant or even unpleasant? Is their great expense? Loss of time from work? Or partner embarrassment associated with a method? (Hatcher, 1989)

To determine contraceptive safety, most trials or researches have been largely carried out in the developed world. Overall, many of the studies have shown contraceptives to be safe among women generally and adolescents in particular. The frameless intra-uterine inplant system (fixed, frameless and completely flexible) has been studied since 1985 in women between 14 and 50 years of age. The results in multi-gravid (many pregnancies) women confirm its very high effectiveness (cumulative pregnancy rate at 36 months 14%), its low expulsion rate (cumulative rate at 36 months: 0.9%) and its optimal tolerance (cumulative removal for medical reasons at 36 months 2.4%), resulting in high acceptance of the inplant and a high continued use". (Wildemeersh, 1997)

In another study, noriplant acceptors tend to be adolescents and adult women who have experienced contraceptive failures or dissatisfaction with other methods (Cullins and Garcia, 1997). In yet another study, in the United States of America, the risk of death from thrombo-embolism is very small for teenagers using low dose OCPs (ACOG, 1992). An evaluation of the Copper T 380 IUD's safety and efficacy was conducted at

three African centres, namely Cameroon, Egypt, and Nigeria from 1986 to 1989. According to the report on that evaluation, the 12-month unintended pregnancy rates were low for all three centres, ranging from none to 1.6 per 100 women. The 12-month discontinuation rates for all reasons ranged 8.8 to 26.9 per 100 women. The performance of TCU 380A IUDs was considered satisfactory (Farr, 1996).

On the Nigerian scene, most of the contraceptives available for use have been subjected to trials for effectiveness and efficacy. The efficacy, acceptability and side effects of a contraceptive pill administered by oral and vaginal routes were compared in another multi-centre clinical trials (including Ibadan, Nigeria). Although, there was no statistically significant differences in the discontinuation rates between the two groups for any reason except 'desire for pregnancy', the complaints recorded throughout the study do suggest that subjects using the pills orally tended to experience more headaches, nausea, and gastric complaints than those using the pills by vaginal route (Coutinho et al, 1993). In another study on Profiles of users of long term and permanent contraceptive methods, Landry (1992) showed that the primary reasons for discontinuation of norplant was bleeding side effects, followed by desire for pregnancy. The reasons for discontinuation among IUCD users were the opposite. The majority stopped because of desire for pregnancy, followed by side effects (bleeding and pelvic infection). Other studies also show favourable results of contraceptive effect and safety. For example, in a study, which aimed to evaluate the safety, efficacy and overall acceptability of the implants in Nigerian population, Ladipo (1993) found a total of 36.4

percent of the respondents' cited menstrual changes as the least-liked aspect of norplant use. However nearly 98 percent of the respondents said that they would recommend the method to another friend or relative. The findings presented in that report suggest that Norplant system is an effective, safe and acceptable method among Nigerian women.

The concern for safety of contraceptives is not only an instinctive fear but may be aggravated by rumours and ill-informed health workers. According to Population Reports (1987 edition) rumours about family planning methods flourish around the world. Oral contraceptives (OCs) and intrauterine devices (IUDs) especially are often the subject of exaggerated or wholly fanciful accounts that circulate informally wherever people -particularly women- gather. A common fear shared by some health workers, is that reversible Family Planning (FP) methods OCPs and IUDs will make women permanently infertile. Such rumours may discourage couples from using any contraceptive at all. More recently Akande (1999) in a paper delivered at the National Conference on Adolescent reproductive health Abuja pointed out that many women are anxious and fearful about contraceptive side-effects and reactions of their partners and families to contraceptive use. While they may discuss their worries with other women, they have limited access to complete technical information or professional counselling.

Educational and Behavioural Issues in Contraception

Health education is any intentional activity that is designed to achieve health or illness related learning i.e. some relatively permanent change in an individual's capability or disposition. Effective health education may, thus produce changes in knowledge and

understanding or ways of thinking; it may influence or clarify values; it may bring about some shift in belief or attitude; it may facilitate the acquisition of skills, it may even effect changes in behaviour or life styles (Tones and Tilford, 1994). From the above understanding, behaviour is the outcome of effective health education. Yet, behaviour has some content, which include knowledge, attitude and practice. These behavioural variables are the real targets of health education.

To fully understand the educational and behavioural issues in contraception, it is necessary to apply relevant conceptual framework or model. This will establish causal linkages and illuminate the various factors at interplay for positive or negative contraceptive behaviour among the group of interest in this study. According to Lawrence (1980), the precede/proceed framework is a psychosocial analytical assessment model of individual behaviour as function of cultural and policy antecedents. Its diagnostic and predictive function has five phases namely, social (quality of life), epidemiological (health status), behavioural/environmental (behavioural life style and social learning), educational/organisational (predisposing, enabling and reinforcing factors, and administrative/ policy diagnosis (institutional regulation and policies).

This framework takes its root from the health education principles that every behaviour is caused and has effect on health. The antecedents of contraceptive behaviour include predisposing factors (knowledge, attitude and skills of individuals towards contraception), the enabling factors (the resources that make it possible to

access contraceptive), and the reinforcing factors (identifies influence of significant others in adopting contraception).

The institutional environment of policy and regulation directly moderates these antecedents. The prevalent behaviour has effect on the health status of the individual and corporate health of the society (Earp and Earnest, 1991). The precede model is a strategic problem analysis tool which enables the researcher set goals of health education to promote the health of individuals and the community. (Please see figure 1)

FIGURE 1

Precede Framework/Model

5

Policy and Administration Diagnosis

- Restricted Services
- Ambivalence about policy
- Attitude of Health Workers

4
Educational Diagnosis

3
Behavioural Diagnosis

2
Epidemiological Diagnosis

1
Social Diagnosis

Predisposing Factors
-Knowledge of Contraception
-Belief in the efficiency of Contraception
-Misconceptions about Contraception
-Knowledge of reproductive health and rights

-Finds available for Contraception
-Availability of Contraceptives
-Ability to access Contraceptive information and services.

Use of Contraceptiv

-Incidence of
-Teenage Pregnancy
-Prevalence of teenage Motherhood
-Incidence/ prevalence of STD/HIV/AIDS

-School drop out rate
-Population growth rate
-Promiscuity level
-Child Survival rate
-Mobidity rates
-Mortality rates
-Lack of skills Employment level
-Poverty

Reinforcing Factors
-Attitude of Gate-Keepers' (parents, teachers, health workers)
-Information from Peers
-Partner neglect
-Peer users of contraceptive

Environment
-Media advers
-Social values for Health
-Cultural 'Loading'
-Reproductive Health
-Rights and Laws

CHAPTER THREE

METHODOLOGY

Description of the Study Area

Ogbere, the site for the study is situated in Egbeda Local Government Area (LGA). Egbeda LGA itself was created in 1985 out of the old Ibadan Metropolitan city council. Ogbere community is a relatively new settler area, which is situated on the left side along Oremeji/Ajia/Gbaremu road, which forms its southern boundary. The area also extends to old Ife Road which forms its Northern boarder, while the Eastern and Western boarders are occupied by Akinfenwa/Hope road linking to Ife road and Ogbere stream/Oremeji communities, respectively (please see Appendix 3).

According to 1991 census, Ogbere community had a population of 19,828 in 1997 (NPC, 1997). The majority of the inhabitants are Yoruba ethnic group who bought and developed the land from the indigenous Ibadan people. Their mission was to escape from the congestion in the Ibadan inner core areas. Historically, the indigenous Ibadan people formed these communities from setting up their own farms and hunting lands about a century ago. As the settlers erected modern buildings, and given the relative low cost of residential accommodation in the area, the influx of urban migrants has been on the increase. The present inhabitants are mainly low-income workers, businessmen and women, petty traders, casual workers and farmers. Over time and given the influx of people seeking residential accommodation, over half the area has transformed into

slums. Stratification of the inhabitants along religious orientation shows Muslims (58%), Christians (41%) and traditionalists (1%) (Egbeda L.G.A Brochure, 1997).

Concerning leadership structure, each community unit is headed by a "Baale' or local traditional head who is appointed by the Olubadan (Oba of Ibadan land) to oversee traditional administrative responsibilities. Each community is delineated with the assistance of town planners. Within each unit, there are discrete residential buildings, made up of households. There are no public sector health facilities but the few private hospitals, clinic and maternity homes are unevenly distributed in the area.

According to the local folklore confirmed by the local traditional heads, high premium is placed on female chastity before marriage. Young women are betrothed to suitors or married out during teenage years or delayed depending on the economic status and orientation of the families. Teenage pregnancy outside marriage is tabooed and stigmatised. Families of victims are viewed as weak in control and rearing of children. In consequence, the unmarried pregnant adolescent or adolescent mothers are viewed with disdain or ostracized from their families. Many are deprived of family support to pursue their educational and vocational careers; some of the unlucky ones are ejected from parent homes. All these actions serve as punishment to the victims and deterrent to other adolescents. Experience has shown that mothers and grandmothers of these adolescents readily come to their rescue especially if the male friend or 'sugar daddy' refuses marriage proposal. These women have the burden of providing accommodation, nutritional support, and funds for health and upkeep of the baby and adolescent mother.

Objectives of the Study

The general objective of the study was to determine the reproductive health knowledge and contraceptive attitude and behaviour of adolescent mothers in Ogbere community.

Specific objectives

1. Determine the contraceptive knowledge of adolescent mothers in a suburban setting.
2. Document attitudes towards the use of contraceptives among adolescent mothers.
3. Document the patterns of contraceptive use among adolescent mothers.
4. Identify sources of contraceptive information and service to the adolescent mothers.
5. Identify factors influencing the use of contraceptives among the adolescent mothers.
6. Document other reproductive health needs of the adolescent mothers.
7. Discuss the implications of these findings for improvement of the reproductive health of adolescent mothers.

Hypothesis

The following hypothesis were formulated to guide implementation of the study objectives:

1. There is no significant relationship between knowledge possessed by adolescent mothers regarding contraceptives and their use.

2. The attitude of adolescent mothers will not significantly affect use of contraceptives.

3. The source of information to the adolescent mothers will not significantly affect use of contraceptives.

4. The source of contraceptive services available to adolescent mothers will not significantly affect use of contraceptives.

5. The types of contraceptive methods available to the adolescent mother will not significantly affect use of contraceptives.

6. The marital status of adolescent mothers will not significantly affect use of contraceptives.

7. The knowledge of reproductive health right/laws will not significantly affect use of contraceptives.

Operational Definitions

1. Contraceptive Behaviour: This is the sustained action or inaction towards contraceptive use by adolescent mothers.

2. Contraceptive Attitude: This reflects the likes and dislikes (believes and values) that adolescent mothers have towards use of contraception.

3. Adolescent mothers: This is a young female aged between 10 and 20 years and who had been pregnant at least once in her lifetime.

4. 'Gate-Keepers': These are persons respected, feared or influential in the life of the adolescent mother whose comments, advice or directives will be accepted in respect of contraceptive decision-making e.g. parents, teachers, health workers, peers etc.

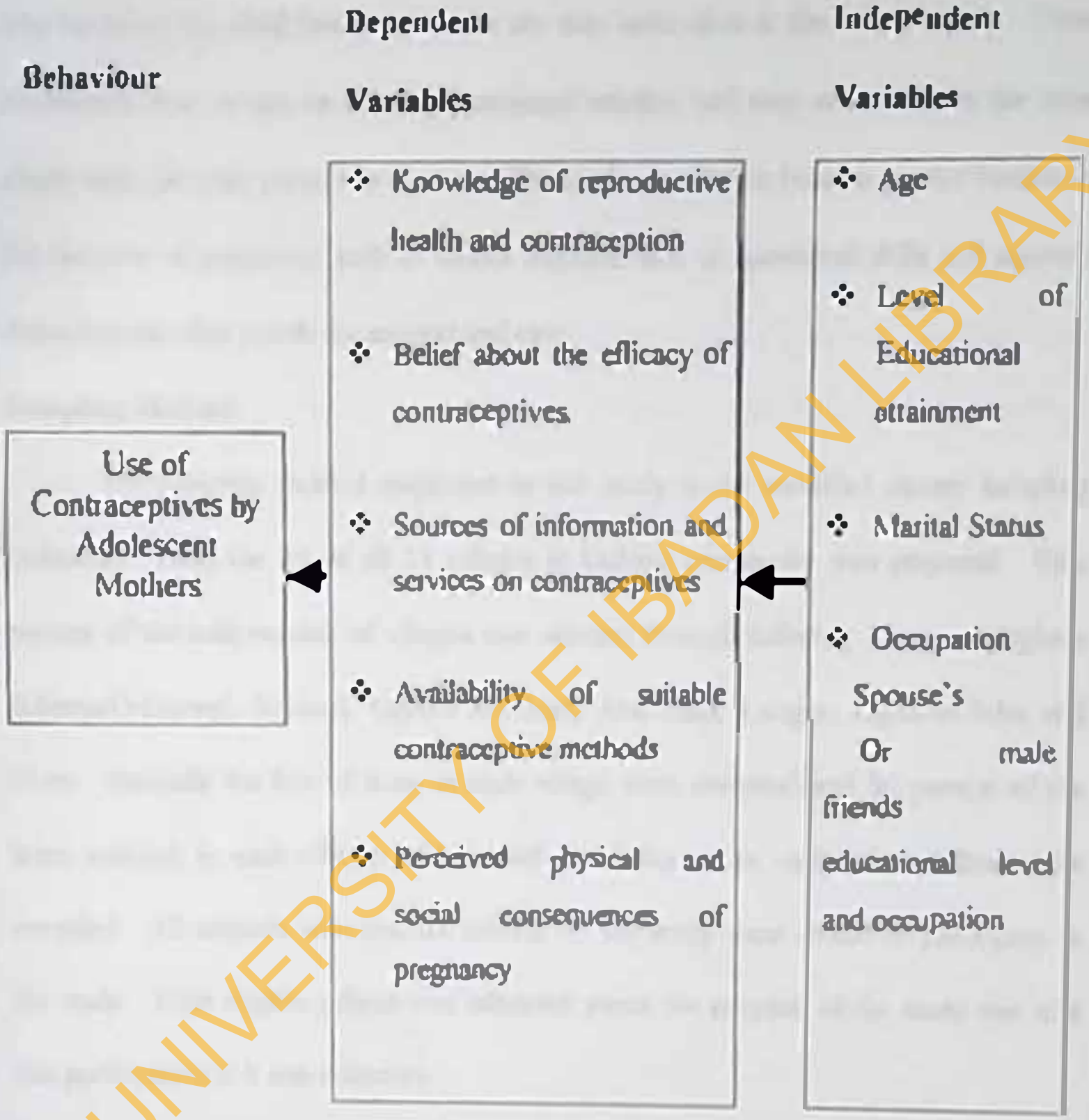
5. Household: The occupants of a home regarded as a unit which includes the father, wife (ves), child (ren) and other dependants.

Research Design

This study is descriptive in design. A survey was conducted to measure the knowledge and contraceptive behaviour of teenage mothers in Ogbere community of Egbeda LGA. The first variables (independent) explored were demographic information e.g. age, level of educational attainment, marital status, occupation, previous exposure to contraceptive education and counselling and spouse's or male friends education or occupation. The second set of variables (dependent) is knowledge of reproductive health and availability of contraceptive methods (see figure 4). The relationships between the variables were explored to determine their effect on use of contraceptives by adolescent mothers.

Figure 2

Relationship of the Study Variables



Study Population

The target population covered in this study was adolescents' aged 10-20 years who have had live child (ren) whether or not they were alive at the time of study. These adolescents may or not be in a legal conjugal relation and may not reside in the same abode with the male partner or spouse. The study population bears a greater burden of the outcome of pregnancy such as school dropout, lack of vocational skills and squarely dependent on other people for support and care.

Sampling Method

The sampling method employed in this study is the modified cluster sampling technique. First, the list of all 14 villages in Ogbere community was prepared. Fifty percent of the total number of villages was selected through balloting. These are Ogbere Babanla/Oritayangi, Sawmill, Ogbere Idi-Osan, Aba Efun, Laogun, Ogbere-Oloba and Mato. Secondly the lists of lanes in each village were compiled and 50 percent of the lanes selected in each village. The numbers of houses in each selected lane were compiled. All subjects who met the criteria for the study were invited to participate in the study. Each eligible subject was informed about the purpose of the study and told that participation in it was voluntary.

The calculated sample size was three hundred and nine (309) adolescent mothers and distributed at the rate of forty-four in each of the seven villages. However, the investigator covered a total of three hundred and sixteen (316) respondents who were distributed in the clusters as follows: Ogbere Babanla/Oritayangi 50, Sawmill 46,

Ogbere Idiosan 48; Laogun 43; Ogbere Oloba 42; Mato 43; and Aba Efun 44. Overall, a total of 703 households were covered in the process of interviewing the required number of subjects.

Prior to commencing field-work in the Ogbere community, the investigator visited the LGA headquarters to inform the health department about the study and to solicit their assistance in mobilisation of community leaders. Thereafter, consultative meetings were held with Ogbere community leaders who pledged their co-operation in passing information on the study to community members. Based on this groundwork in Ogbere community, the households allowed access to the target respondents for interviewing.

Method of Data Collection

Interview

The main tool for data collection was by face-to-face interview using a questionnaire (see Appendices 1A and 1B). The interviews were conducted in the mornings (between 10.00am and 2.00pm) and in the evenings (between 4.00pm and 7.00pm). This time schedule included all respondents met upon first visit and rescheduled visits.

The questionnaire sought information about personal characteristics, reproductive history, consequences of pregnancy, contraceptive knowledge and attitude, sexually transmitted diseases (including HIV/AIDS) and reproductive health rights of the adolescent mothers.

Recruitment and Training of Research Assistants

To conduct the interviews, six youths, all female, school certificate level and aged 16-20 years, and two professional nurse/midwives were recruited and trained. The nurse/midwives were to serve as supervisors of the interviewers and assist in gaining entry into the households. Each individual interview was conducted under full privacy and assurance of confidentiality.

The author developed an interview guide and translated the questionnaire into Yoruba, the language widely spoken in the study area. With these, the research assistants (interviewers and supervisors) were trained on how to administer and record responses. In addition, there instructed on where to administer the questionnaires. The training lasted 2 days using discussion, demonstration/return demonstration, post review and lectures. The issues covered during training included interpersonal relationship with the respondents and gaining consent, securing voluntarism for the interview, verification and documentation of interview, booking appointments or re-scheduling interviews and others.

Pre-testing

Prior to its administration, 96 copies of the questionnaires were pre-tested at Muslim Area of Ona-Ara Local Government Area (LGA) of Oyo State, which is off the expressway, about three kilometers from Ogbere community. The two communities share similar socio-economic characteristics and are contiguous. The research assistants

conducted the pre-testing after their training. This provided opportunity to test their competence and disposition to participate in subsequent fieldwork on the research.

At the end of the pre-test, changes were made in the questionnaire. First, additional questions were inserted as 6a (state of origin) and 34a (what contraceptive method are currently being used?). Secondly, question 34 was modified to read 'for the contraceptive you used, where did you get it'? Thirdly, the skip question pattern was corrected e.g. on question 12, if respondent is pregnant for the first time, go to question 21 instead of 20. Fourthly, appropriate response checklist was developed for some questions e.g. questions 35 and 54. On the whole, the total number of questions increased from 53 to 56 as a result of the changes made.

Validity and Reliability

In order to certify that the study instrument measured what it was intended to (test of reliability), an expert translated the questionnaire originally written in English to Yoruba. As required another expert translated the Yoruba version into English. This was necessary to ensure that the same understanding was gained from both the English and Yoruba versions. During pre-testing, the research assistants used it to interview the respondents under observation by the female nurse/midwives who served as supervisors. During the daily review meetings, errors were detected and corrected and the same interviewers re-tested these.

As planned, some of the respondents agreed to be interviewed twice by two-research assistant on different dates during the pre-testing period. The investigator and supervisors compared the consistency of responses on the two questionnaires for validity. In addition, the investigator and supervisors reviewed the completed questionnaire and held discussions with the interviewers to discuss issues and problems during interviews. The experiences were shared and mutual support engendered. The lessons learned from the pre-testing exercise were used to plan for and conduct the training for data collection in the study area.

The interviews were conducted privately with full assurance of confidentiality. The interviewers were teenagers and carried out the interviews in the interviewees' residence, which enhances their confidence and openness.

Data Analysis

The completed questionnaire forms were manually collated sorted, edited, coded and entered into a computer for analysis. Database was created in Epi info in the computer while frequency tables, cross tabulation, means (averages) and percentages (proportions) were compiled for descriptive, analysis. Statistical tests of significance and association were carried out to draw inferences.

Limitations of the study

The design of this study was to obtain information from respondents on their knowledge and contraceptive behaviour using a questionnaire. The information requested was personal and viewed by most people as an intrusion into their privacy

Secondly, there was no means of immediate verification of some information given by the respondents. Hence, the study relied on the four-pronged strategy to minimise bias namely, reliable questionnaire criteria (question item), respondents' voluntarism, and legitimacy of the interviews within the household of the respondents and assurance of privacy and confidentiality.

This study was conducted in a suburban setting, which has developed as a result of the rapidly expanding Ibadan metropolis. While it might be argued that the inhabitants may share some demographic and behavioural characteristics similar to certain urban areas, the findings may be limited in generalization to urban and rural areas. However, this inquiry is supportive of previous studies that looked at the reproductive health knowledge of adolescent mothers in a typical suburban area using community survey.

Another limitation was the study size. Due to limited resources of money, time and personnel, the study covered a relatively small area and only 50% of the target population in the sampled clusters. The investigator's practical experience in the field showed that many adolescent mothers turned down the request for interview while cases of failed interview were recorded due to perceived intrusion into respondents' privacy and frustration of helplessness in their situation.

CHAPTER FOUR

RESULTS

In this chapter, data collected from the study were analysed and presented in five major sections, namely: socio-demographic characteristics; respondents' reproductive history; outcome of pregnancy, contraceptive knowledge and practice and some reproductive health issues

Socio-demographic Characteristics

A total of three hundred and sixteen adolescent mothers were interviewed in the study area. The clusters from which they were selected are presented in Table 2. Ogbere Babanla had the highest number of subjects (15.8%), followed by Idi-osun 15.2%), Sawmill (14.65%), Ogbere Efun (13.9%), Laogun (13.6%), Mato (13.6%) and Ogbere Oloba (13.3%).

Age, Marital Status and Educational Achievements

The ages of the subjects ranged from 17 to 20 years with a mean age of 18.78 years. About half, 147(46.5%) were aged 19 years, 29.4% were 18 years old (see Table 3). Conveniently, the adolescent mothers are categorized into younger (17 - 18 years) and older (19 - 20 years). On marital status (Table 4), a large majority of the subjects were married (76.9%), (20.6%) co-habiting, separated (0.9%), widowed (0.3%) and single (1.3%). The level of educational attainment of the subjects showed that (72.8%) had primary, secondary (15.5%), Non-formal education (10.8%), and post-secondary level (0.9%), see Table 5.

Table 2

Area of Residence

Villages	f	%
Ogbere Babanla	50	15.8
Saw Mill	46	14.6
Ogbere Idi-osan	48	15.2
Laogun	43	13.6
Ogbere Oloba	42	13.3
Mato	43	13.6
Efun	44	13.9
Total	316	100.0

Table 3

Respondents' Age

Age (Years)	F	%
17	18	5.7
18	93	29.4
19	147	46.5
20	58	18.4
Total	316	100.0

Table 4

Respondents' Marital Status

Marital Status	f	%
Single	4	1.3
Married	243	76.9
Cohabiting	65	20.6
Separated	3	0.9
Widowed	1	0.3
Total	316	100.0

Table 5

Respondents' Educational Attainment

Educational Attainment	f	%
Non-formal	34	10.8
Primary	230	72.8
Secondary	49	15.5
Post-secondary	3	0.9
Total	316	100.0

Religion, Occupation and Current Residence

More than half (55.7%) of the subjects belonged to Islam, followed by Christianity (43.5%), while traditional religious practitioners were (2.8%) see figure 3. Figure 4 shows that the predominant occupation of the subjects was petty trading (59.2%), others were artisans (21.1%), house wives (13.9%) casual workers (0.3%) and (5.5%) had no work.

Virtually all (90.8%) lived in husbands' apartment, (2.2%) staying with friends, parents-in-law (3.8%), and parents' home (2.2%). See Table 6.

The ethnic composition of the respondents showed that they are mainly Yoruba 314 (99.4%) while a few were Ibo 2 (0.6%).

Figure 3

RESPONDENTS' RELIGION

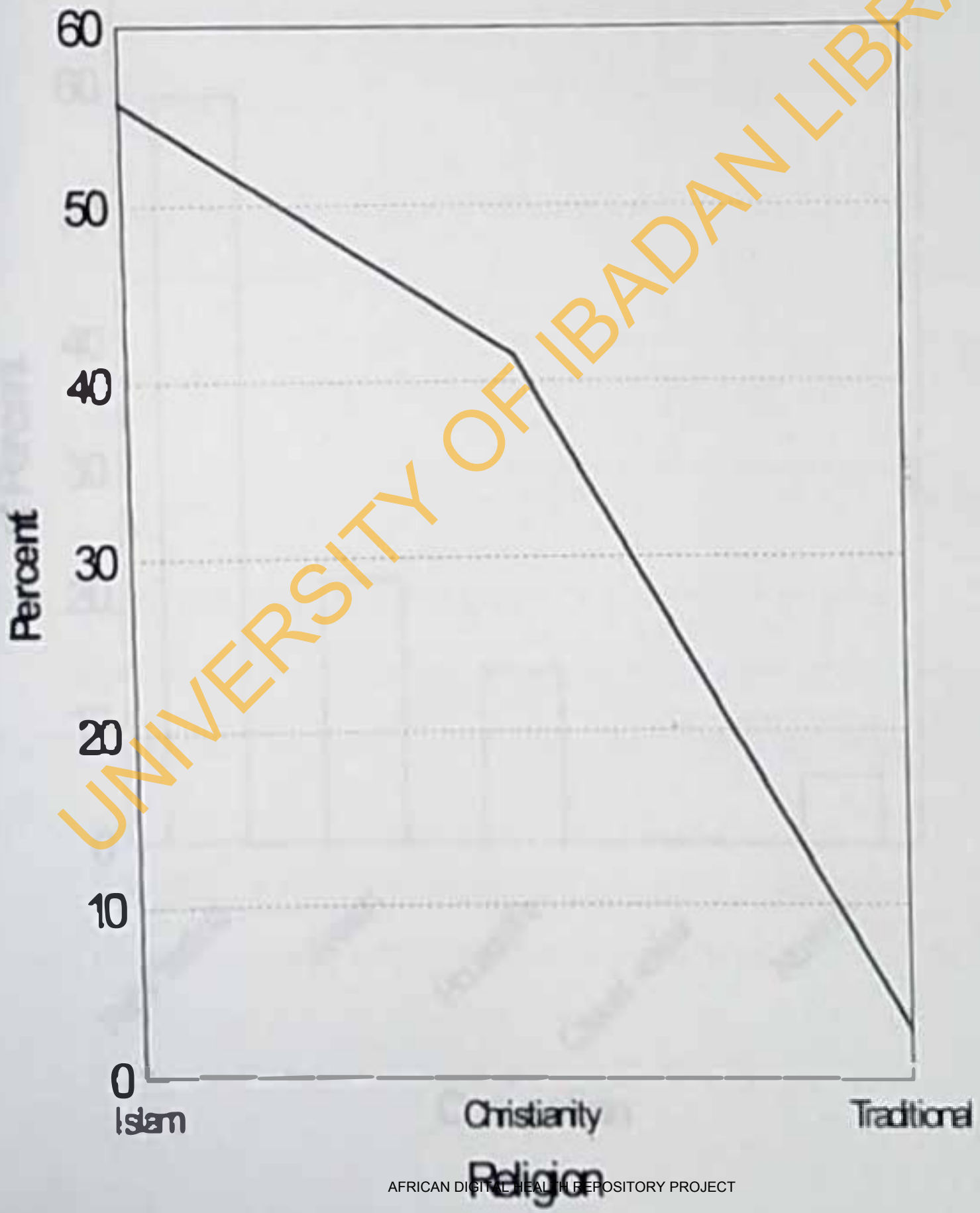


Figure4

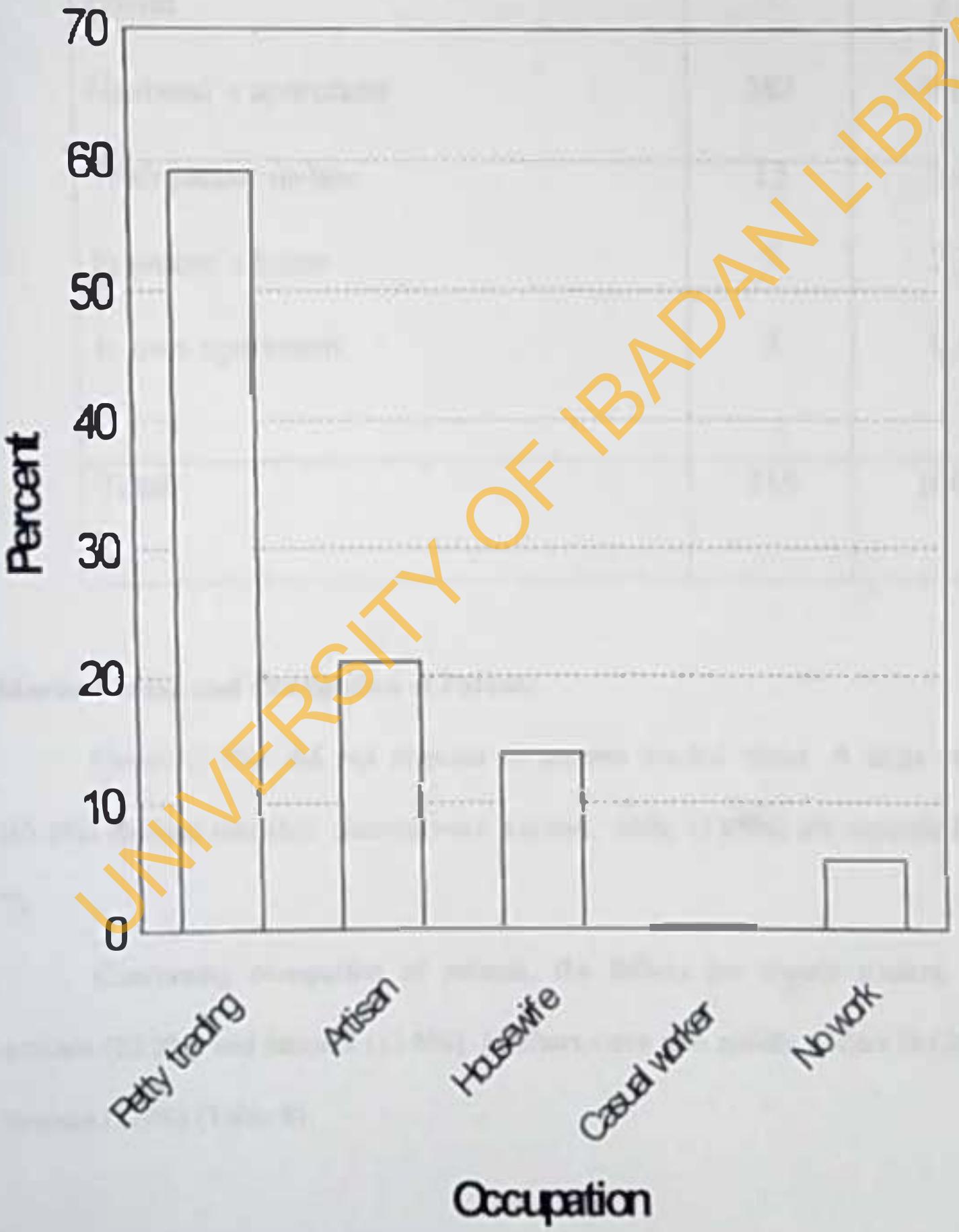


Table 6

Current Place of Residence

Current Place Of Residence	f	%
Friend	7	2.2
Husband's apartment	287	90.8
With parent-in-law	12	3.8
In parent's home	7	2.2
In own apartment	3	0.9
Total	316	100.0

Marital Status and Occupation of Parents

Eleven (3.5%) did not respond to parents marital status. A large majority, (65.5%) claimed that their parents were married, while, (15.5%) are separated (Table 7)

Concerning occupation of parents, the fathers are mostly traders (17%), artisans (22.2%) and farmers (13.6%). Mothers were also mainly traders (64.2%) and farmers (3.5%) (Table 8)

Table 7

Parents Marital Status

Marital Status	f	%
Married	207	65.5
Separated	49	15.5
Divorced	7	2.3
Dead	42	13.3
No response	11	3.4
Total	316	100.0

Table 8

Parents Occupation

Occupation	Parents	
	Father	Mother
Farming	43 (13.6%)	11 (3.5%)
House wife	-	20 (6.3%)
Driving	24 (7.6%)	-
Trading/business	54 (17.0%)	203 (64.2)
Artisan	70 (22.2%)	-
Apprenticeship	-	21 (6.7%)
Government work	27 (8.5%)	9 (2.8%)
Pastor(res)/Alfa	8 (2.5%)	3 (1.0%)
Native doctor	4 (1.3%)	-
No response	86 (27.2%)	49 (15.5%)
Total	316 (100.0%)	316 (100.0%)

Reproductive History

The subjects were asked how many times they had ever been pregnant. The frequency of their pregnancies ranged from 1-3 with a mean of 1.28. A large majority, 233(73.7%) said they had one pregnancy, 77(24.4%) had had 2 pregnancies and 6(1.9%) one pregnancy.

The number of previous pregnancies was compared with respondents' age. The older mothers have had more pregnancy (64.9%) than younger mothers (35.1%). The difference is significant ($P< 0.05$) as shown on table 9.

Table 9

Relationship between Age and Pregnancy Occurrence

Age	Pregnancy Occurrence			Total
	1st	2nd	3rd	
17-18 years (Younger Adolescent Mothers)	100	10	1	111
19-20 years. (Older Adolescent Mothers)	133	67	5	205
Total	233	77	6	316

$X^2 = 23.67$ df = 2 $P < 0.0001$

The number of children currently living with the adolescent mothers is presented on table 7. Most of the mothers said they lived with one child 128 (40.5%), 69 (21.8%) two children, while 4(1.3%) lived with three children. Some of the mothers claimed they had no child living with them 115 (36.4%)

Table 10

Children Living with Adolescent Mothers

No. Of Children	f	%
One Child	128	40.8
Two Children	69	21.8
Three Children	4	1.3
None	115	36.4
Total	316	100.0

The subjects were asked how many pregnancies they had carried to term. Only 14(4.4%) said they had lost some pregnancies. Out of this number, 7 (50.0%) did not respond to the reasons for the loss of the pregnancy. Of those who responded, 3(42.9%) induced an abortion, 1(14.2%) had a miscarriage, while 3(42.9) had still birth. Two of these pregnancies were aborted mainly in patent medicine stores, while one was terminated in a hospital.

The boyfriend made the decision to terminate two of the pregnancies while the subjects decided to terminate one herself. Two of these pregnancies were aborted because the subject was not ready to be a parent while one was terminated because parents said it should be done.

About half 150(47.4%) of the subjects said they did not encounter problems during last pregnancy, while 166(52.6%) said they did. The problems encountered

were ill-health 142(85.5%), rejection by parents or boy friends 15 (9.1%) and school dropout 9(5.4%).

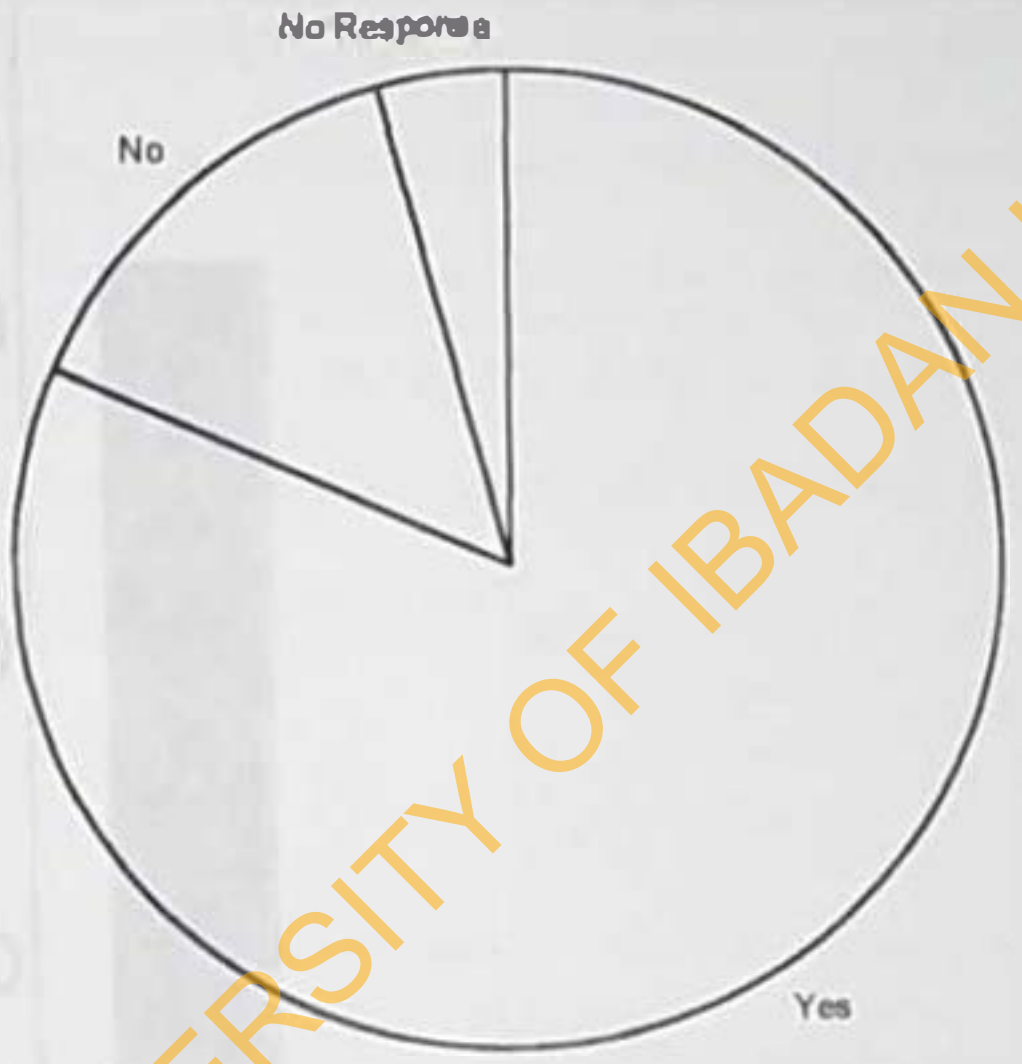
Consequences of Pregnancy

The subjects were asked whether they wanted their last pregnancies. Their responses show a large majority 258 (81.7%) desired it, 45(14.2%) did not, while 13(4.1%) did not answer the question. See Figure 5.

Figure 6 shows the sources of support to the adolescent mothers during last pregnancy. Husbands 254 (83.6%) provide the bulk of the support, followed by parents 43 (14.1%) and significant others, mainly grand mothers, mother in-law, siblings and co-wife. The types of support provided were accommodation, feeding, clothing, medicine and money.

Figure 5

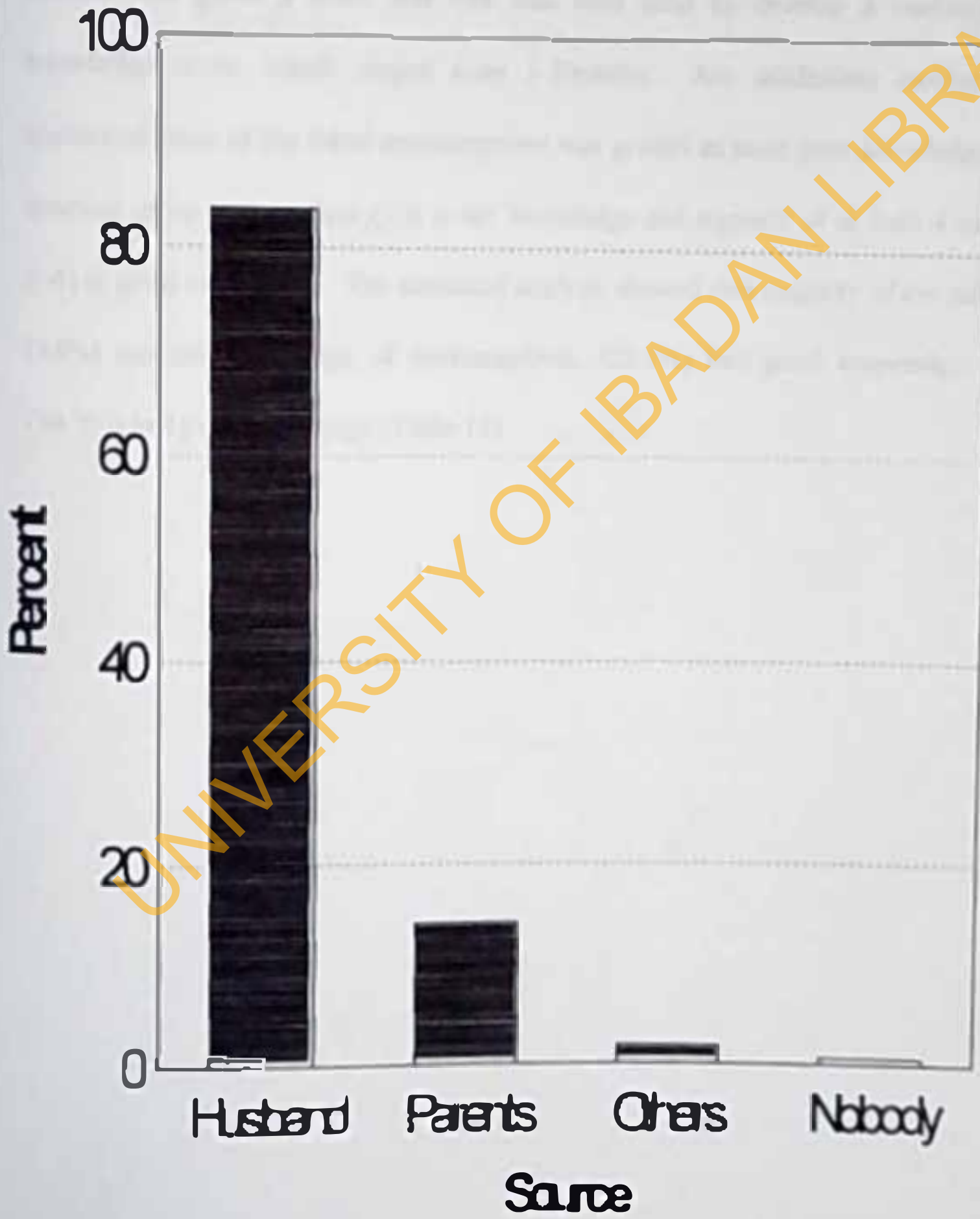
Desirability of last Pregnancy



- Yes
- No
- No Response

Figure6

SOURCE OF SUPPORT DURING LAST PREGNANCY



Contraceptive Knowledge and Practice

Knowledge of Contraceptive

To determine knowledge of contraceptives, ten contraceptives were listed and subjects were requested to identify those they heard about. Each correctly listed method was given a score and this was then used to develop a contraceptive knowledge score, which ranged from 1-10marks. Any adolescent mother who mentioned none of the listed contraceptives was graded as have poor knowledge, any mention of up to 3 method (≤3) is fair knowledge and mention of at least 4 method (≥4) is good knowledge. The statistical analysis showed that majority of the subjects (43%) had fair knowledge of contraceptives, (22.5%) had good knowledge while (34.5%) had poor knowledge (Table 11)

Table 11

Knowledge of Contraceptive Methods

Knowledge	f	%
Poor knowledge	109	34.5
Fair knowledge	136	43.0
Gold knowledge	71	22.5
Total	316	100.0

The most commonly known methods by the subjects was the pill (45.9%), followed by condoms (45.1%) and spermicides (vaginal foaming tablets) (19.6%). Table 12 shows that the contraceptives were arranged according to the order they are known, while the calculation of each method was independent of the others.

Table 12

Knowledge of Specific Contraceptive Methods

Types	f	%
Pills (OCPs)	145	45.9
Condoms	155	45.1
Foaming Tablets	62	19.6
Injectables	128	40.5
IUCDs	37	11.7
Implant	4	1.3
Rhythm	2	0.6
Withdrawal	8	2.6
Abstinence	11	3.5
Traditional	4	1.3

The knowledge of contraceptive was compared with age. Older mothers (21.9%) had good knowledge of contraceptives than younger mother (21.6%). Older mothers (44.4%) had fair knowledge of contraceptives than younger mothers (40.6%). As shown in Table 13, the difference is significant (P< 0.05).

Table 13

Comparing Contraceptive Knowledge and Age

Age	Contraceptive Knowledge			Total
	Poor	Fair	Good	
Young adolescent (17-18 years)	42 (37.8%)	45 (40.6%)	24 (21.6%)	111 (35.1%)
Older adolescent (19-20 years)	67 (32.7%)	91 (44.4%)	47 (22.9%)	205 (64.9%)
Total	109 (70.5%)	136 (85%)	71 (44.5%)	316 (100%)

X^2 = 25.20 df = 6 P = 0.0003

Attitude towards Contraception

The attitude towards contraception was analyzed using Likert's scale On the scale, questions were proposed and analyzed with minimum and maximum scores as 0 and 40 respectively However, the actual respondents scores range were between 2 and 33 The calculated mean was 23.47 and the standard deviation (SD) 5.83 Based on the mean score, attitudes of respondents were graded as negative if below the mean score and as positive, if above the mean score Hence, the adolescent mothers' attitude to contraceptives were negative 138 (44.5%) and positive 172 (55.5%) respectively See Table 14

The attitude to contraception was compared with respondents' educational status showed that a large majority of the subjects who attained primary school level and above had positive attitude (56.6%) than the those with no formal education (48.5%), with significant effects ($P < 0.05$).

Table 14

Attitude to Contraception

Attitude	f	%
Negative	138	44.5
Positive	172	55.5
Total	310	100.0

$\bar{X}$ = 23.47 SD = 5.83 Range 2-33

Use of Contraceptives

A large majority (70.9%) reported that they had never used any contraceptive, (29.1%) had not done so. Of those who had done so, only (56.7%) specified the method used. On Table 15, the most commonly used contraceptives were pills 24 (44.4%), injectables 13 (24.1%) and IUCDs 8 (14.8%).

Table 15

Ever Use Contraceptives by Methods

Method Ever Use	F	%
Pills (OCPs)	24	44.4
Condom	0	0.0
Foaming tablets	8	0.0
Injectables	13	24.1
IUCDS	8	14.8
Norplant	0	0.0
Rhythm	0	0.0
Withdrawal	2	3.7
Periodic abstinence	5	9.5
Traditional	2	3.7
Total	54	100.0

The sources of information for contraceptives ever used were calculated independently and recognised the number of responses on each. Figure 7 shows health workers (90.6%), radio (37.7%), Television (9.7%), Peers/Relatives (4.3%), churches (1.4%), health workers/Radio (2.9%).

The contraceptives were obtained mainly from government hospitals (21.7%), medicine stores (34.8%) and private hospitals (33.7%) and private maternity homes (8.7%) See Table 16.

Figure 7

Source of Information on Contraceptives Ever Use by Respondents

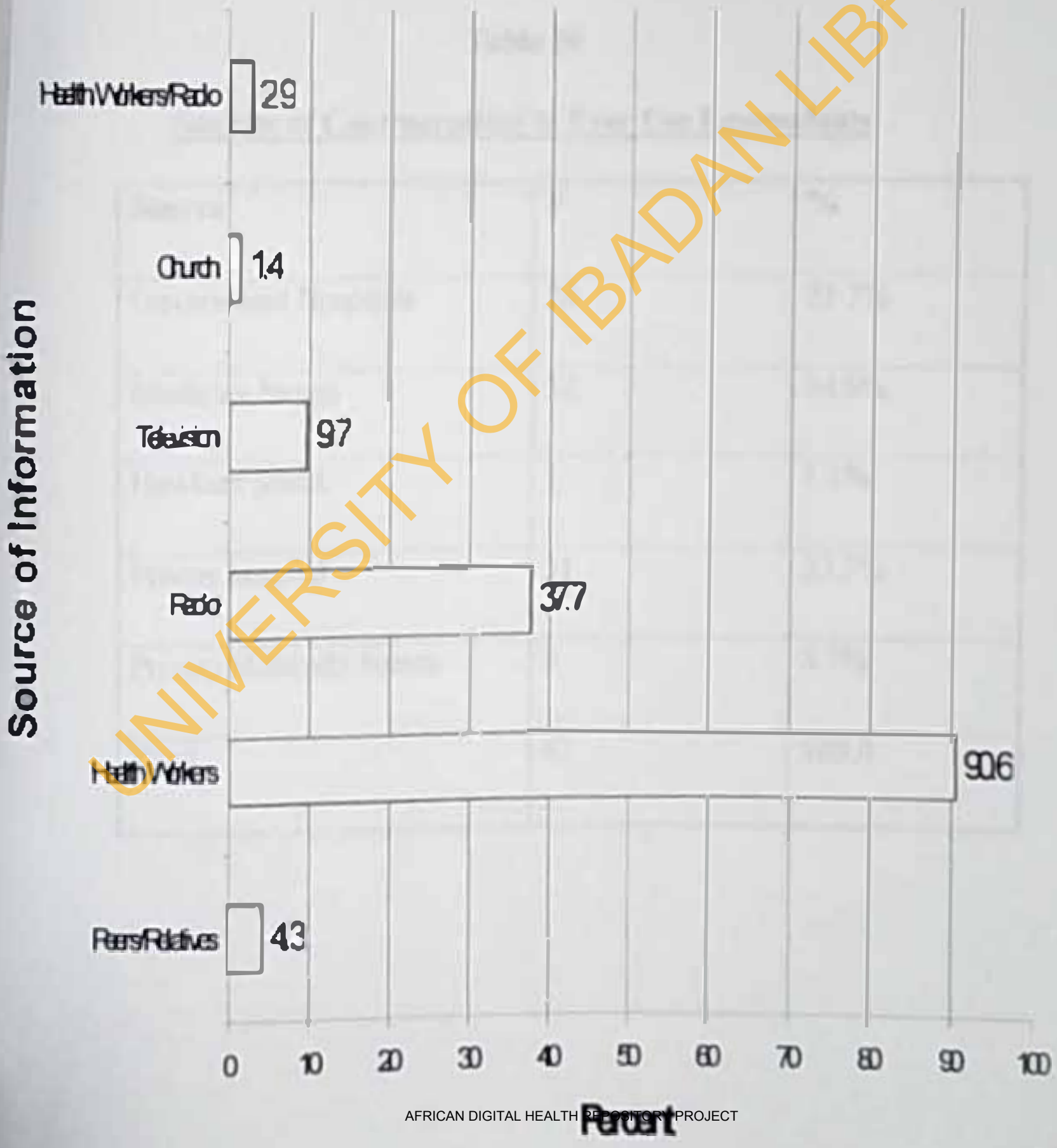


Table 16

Sources of Contraceptives to Ever Use Respondents

Source	F	%
Government Hospitals	20	21.7%
Medicine Stores	32	34.8%
Hawkers Stand	1	1.1%
Private hospital	31	33.7%
Private Maternity homes	8	8.7%
Total	92	100.0

A large number of adolescent mothers (70.9%) who have not used any contraceptive gave reasons for not doing so, while 15.2%) did not. Of those who did, majority (60.1%) gave reasons. The reasons include 'not ready/want more children' (32.1%), 'Do not believe/dislike contraceptives' (36.6%), 'Lack knowledge of contraceptive' 33 (17.4%) and 'Breast/Feeding/Afraid' 11 (5.8%), other reasons were 'married' 2 (1.1%) and 'husband's refusal' 1 (0.5%) see table 17.

Table 17

Reasons why contraceptives was never used

Reasons	F	%
Lack knowledge	33	17.4
Married	2	1.1
Breast feeding	11	5.8
Husbands Refusal	1	0.5
Dislike Contraceptives	82	36.6
Not ready want children	61	32.1
Total	190	100.0

Among the 92 respondents that 'ever use' contraceptives, only 8(8.7%) experienced difficulties in obtaining contraceptives. The difficulties were high cost (12.5%), partner's dislike for contraceptives (25.0%) and peer disapproval (62.5%).

Current use of Contraceptives

Only 81(25.6%) of those who have ever used a contraceptive were using them at the time of survey. The methods used are presented on table 18. The most used methods are condoms (44.4%), pills (16.1%) and periodic abstinence (13.6%).

Relationship between current use of contraceptives and some demographic variables were explored. In addition, the relationship of current use with sources of contraceptive information and supplies, and attitude were also tested.

Table 18

Current use of contraceptives among Adolescent mothers

Contraceptives	f	%
Pills	13	16.1
Condoms	36	44.4
Vaginal Foaming tablets	4	4.9
Injectables	8	9.9
IUCDs	7	8.6
Periodic Abstinence	11	13.6
Traditional	2	2.5
Total	81	100.0

Table 19 showed that all the current users (100%) and those who have never used any contraceptives (96.9%) were married, however, the difference was not significant (P> 0.05). Although fewer Christians (44.3%) than Moslems (55.7%) are current users of contraceptives, the difference between the two groups was not significant (P> 0.05) on Table 20. Older adolescents (80.2%) were current users of contraceptives than the younger ones (19.8%). The difference is significant (P< 0.05) as shown in Table 21.

There are more users among adolescent mothers with one child (72.2%) than those with two (25.9%) or three children (1.9%). However, the difference was not significant (P> 0.05) as shown in Table 22. Table 23 shows that the sources of information on contraceptives were mainly Radio/Television (58.5%) and health workers (33.8%). This distribution significantly affected current contraceptive use among adolescent mothers (P< 0.05).

Table 24 explored the relationship between sources of contraceptives and current use of contraceptives. More of the current user of contraceptives obtained them from medicine stores (33.7%) and at the hospitals (58.8%) than non-users. The difference was significant (P< 0.05).

In table 25, both current users (98.8%) and non-users (998.1%) of contraceptive had good knowledge of reproductive health rights P > 0.05

Table 19

Relationship between current use and marital status

Contraceptive Use	Marital Status		Total
	Unmarried	Married	
current user	0 (0.0%)	8 (100.0%)	81 (33.3%)
Non-user	5 (3.1%)	157 (96.9%)	162 (66.7%)
Total	5	165	243

$X^2 = 1.25$ df=1 P= 0.2634

Table 20

Relationship between current user and Religion

Contraceptive Use	Religion		Total
	Christianity	Islam	
current-user	35 (44.3%)	44 (55.7%)	79 (33.5%)
Nor-user	70 (44.6%)	87 (55.4%)	157 (66.5%)
Total	105	131	236
	$X^2 = 0.009$	df=1	P=0.9222

Table 21

Relationship between current use and Age

Contraceptive use	Age		Total
	17-18yrs	19-20yrs	
Current User	16 (19.8%)	65 (80.2%)	81 (33.3%)
Non-User	68 (42.0%)	94 (58.0%)	162 (66.7%)
Total	84	159	243

X^2=10.83 df=1 P=0.0001

Table 22

Relationship between current Use and Number of children living with Respondents

Contraceptive Use	Children Living With Mother			Total
	1	2	3	
Current user	39 (72.2%)	14 (25.9%)	1 (1.9%)	54 (34.6%)
Non-user	66 (64.7%)	35 (34.4%)	1 (1.0%)	102 (65.4%)
Total	105	49	2	156

X^2 1.29 df=2 P=0.523

Table 23

Relationship Between Current Use And Source Of Information On Contraceptives

Contraceptive Use	Sources of Contraceptive Information								Total
	Peers/ Relations	Health worker	radio	TV	Church	M	H/R	Other	
Current User	3 (3.9%)	21 (27.3%)	31 (40.3%)	14 (18.2%)	2 (2.6%)	1 (1.3%)	5 (6.5%)	0 (0.0%)	77 (35.5%)
Non User	3 (2.1%)	69 (49.3%)	62 (44.3%)	5 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.7%)	140 (64.5%)
Total	6	90	93	19	2	1	5	1	217

$X^2 = 33.76$ df = 7 P = 0.05

Table 24

Relationship Between Current Use and Sources of Contraceptives To Respondents

Contraceptive Use	Source Of Contraceptives						Total
	General Hospital	Medicine Store	Hawker Stand	Private Hospital	P/Mat.	Others	
Current User	17 (25.0%)	27 (39.7%)	0 (0.0%)	16 (23.5%)	7 (103%)	1 (1.5%)	68 (72.3%)
Non-User	2 (7.7%)	6 (23.1%)	1 (3.8%)	13 (50.0%)	0 (0.0%)	4 (15.4%)	26 (27.7%)
Total	19	33	1	29	7	5	94

$X^2 = 20.67$ df = 5 P = 0.0009

Table 25

Relationship Between Knowledge of Reproductive Health Rights and Current Contraceptive Use

Knowledge of Reproductive Health Rights	Current Contraceptive Use		Total
	Current Use	None Use	
Poor	1 (100.0%)	0 (0.0%)	1 (0.4%)
Fair	0 (0.0%)	3 (100.0%)	3 (1.2%)
Good	80 (33.5%)	159 (66.5%)	239 (98.4%)
Total	81	162	243

$X^2 = 3.50$ df = 2 p = 0.1

Knowledge about Reproductive Health

Knowledge of Sexually Transmitted Diseases (STD)

In order to determine the subjects' awareness of STDs, they were requested to mention six common STDs that they have heard. For the purpose of analysis, the awareness was stratified into three categories: poor (zero = 0), fair knowledge (<2) good knowledge (>3). Results showed that the range was between 0 (zero) and 5, with a mean of 0.97 and standard deviation of 0.04. A large majority (94.7%) fell under fair while only few (5.3%) scored good, see Table 26.

Table 27 shows the STDS mentioned by the adolescent mothers, which was determined through the number of responses on each independently. The most commonly mentioned ones are gonorrhoea (26.8%) and HIV/AIDS (67.5%).

Table 26

Awareness of STDS

STD Awareness	f	%
Poor	54	22.2
Fair	179	73.7
Good	10	4.1
Total	243	100.0

Range = 0 – 5 SD = 0.04 X = 0.97

Table 27

STDS Known by Adolescent Mothers

Type Of STDs	f	%
Gonorrhoea	65	20.5
Syphilis	11	3.5
Chanchroid	1	0.3
Herpes	2	0.6
HIV/AIDS	164	52.0
No Response	73	23.1

Awareness and knowledge of HIV/AIDS

A large majority (93.4%) had heard about AIDS, (6.6%) had not. The respondents were requested to identify all the routes by which HIV is transmitted More than half (53.9%) did not know of any route of transmission. The most frequently mentioned route of transmission sexual intercourse (67.9%), followed by contaminated instruments 20 (8.8%).

The respondents' knowledge of the prevention of HIV was also assessed. About half (49.1%) were not aware of the preventive measures, (50.9%) knew of at least one method of prevention.

Knowledge of Reproductive health Rights

The respondents' were able to give an indication of their knowledge on specific reproductive health rights in Table 29. This included awareness of five laws and policies on sexual offences against adolescents in Nigeria. A large majority (98.9%) were not aware while only (1.1%) was aware of the RIIR. Among the respondents that knew about RIIR. only (66.7%) knew of unlawful canal knowledge and (33.3%) knew of Rape.

Table 30 presents suggestions from the respondents to assist in formulating adolescent health policies and laws in Nigeria. Although there were no responses from 217 (68.7%) adolescent mothers, 99 (31.3%) responded. The main suggestions

were that violators of children's rights should be prosecuted 71 (71.7%) and that the economy should be improved 9 (9.1%).

Table 28

Knowledge of Specific Reproductive Health Rights

N = 316

Reproductive Health Rights	Yes	No
Adequate growth and development	305 (96.5%)	11 (3.5%)
Rejection of Bethrodal/ before Marriage before 18 years	301 (95.3%)	15 (4.7%)
Report sexual assault and indecent Sexual advances	299 (94.6%)	17 (5.4 %)
Basic education and skills acquisition	300 (94.6%)	16 (5.1%)
Use of contraceptives	212 (67.1%)	104 (32.9%)
Good health	278 (88.0%)	38 (12.0%)

Table 29

Suggestions towards formulation of Adolescent Reproductive Health Policies/Laws

Suggestions	No	%
Jail offenders	71	71.7
Improve Awareness on Existing' Laws/Policies	5	5.1
Improve Economy	9	9.1
Increase Health Facilities	8	8.1
Provide Free Medicine	1	1.0
'Kill Offenders'	3	3.0
'Encourage Contraceptive Among Adolescents'	2	2.0
Total	99	100.0

CHAPTER FIVE

DISCUSSION OF RESULTS

The discussion of results and their implications are presented in this chapter. As in presentation of findings, the discussion is grouped under socio-demographic characteristics, reproductive history, and outcome of pregnancy, contraceptive knowledge and practice. Conclusions are drawn and recommendations are proposed.

Socio-Demographic Characteristics

The age of the respondents ranged from 17 to 20 years. This implies that many of the mothers had commenced sexual activities before 17 years. There are many problems associated with precocious sex. Young people who have sex before age 18 years are more likely than woman in their twenties to suffer from pregnancy-related complications and to die in child-birth (Okonofua, Onwudiegwu and Oduna, 1992). The risk of death is estimated to be two to four times higher depending on the woman's health and socio-economic status (McCauley and Salter, 1995). The life threatening complications that young girls face includes pregnancy-induced high blood pressure, anaemia and haemorrhage (Harrison, 1985). Apart from pregnancy, the problems associated with precocious sex include exposure to multiple sexual partners, sexually transmitted diseases (including HIV) and cancer.

Most of the adolescent mothers were married or co-habiting with a male partner. Although this suggests that pregnancy and childbirth were achieved within a relatively stable relationship, it is not clear whether marriage preceded pregnancy or

vice visa. Given the findings from previous studies (McCauley and Salters, 1995) pregnancy is likely to be a cause of marriage for these subjects.

The subjects' levels of educational attainment were generally low. This limited education has several implications for their social and economic development. First, limited education undermines their opportunity for employment in the formal sector. Lack of employment in turn limits their future social and economic development and those of their offspring. This is exemplified in the fact that majority of the adolescent mothers were petty traders, casual workers and unemployed.

Secondly, low education among young people is positively associated with low self-esteem, and a belief in preparing children for self-fulfilment (Oppong 1995). This psychological disposition puts the adolescent mothers in a disadvantaged position in negotiating sex, use of contraceptive and prevention of sexually transmitted diseases. Invariably, they derive satisfaction in uncontrolled fertility as means of being relevant to their matrimonial home and the society at large. Several factors may be responsible for the low level of education. These include early pregnancy. In Nigeria, secondary school girls who become pregnant are usually expelled from schools. Majority does not have the opportunity to return to school because of the demands of child rearing. Another possible cause of the problem is the relatively low socio-economic status of the parents, majority of whom are petty traders.

Reproductive History

Majority of the adolescent mothers had an average of two pregnancies. Given their relative young ages, they are at risk of pregnancy related complications resulting from the fact that their reproductive organs are not fully developed yet. The World Health Organization (1986) data from several countries consistently show a high risk of maternal death among teenage girls compared to women between 20 and 30 years.

Another source of concern is the fact that a high percentage of the pregnancy wastage. This is a further confirmation of the risks and outcome associated with adolescent pregnancy. The complication of adolescent pregnancy include hypertensive disorders, eclampsia, obstructed Labour, stunted growth, death of mother and baby, vesico-vaginal and recto-vaginal fistulas may follow obstructed Labour (FOS/IRD, 1990).

Although many adolescent mothers could not give account of pregnancies not carried to term, these pregnancies were most probably aborted. Rates of abortion continue to increase among adolescents in Nigeria despite local and international efforts to control it (Adewole, 1998). This is an indication that many pregnancies are unwanted and the use of contraceptives remains low in this population. Brabin et al (1995) found that more than half (63.8%) of adolescents aged 17-19 years who reported themselves to be sexually active, had had at least an abortion. In addition,

the NDHS of 1991 has shown that in Nigeria, abortion among young women accounted for over 10% of abortion rates in the country.

Outcome of Pregnancy

A majority (81.7%) of adolescent mothers desired their last pregnancies, but less than a quarter of them said their pregnancies were not wanted. This result shows that although the number not desiring to be pregnant at the time was significant, none of them used any contraceptive devices to prevent pregnancy. Since many adolescent mothers are unable to control their fertility, some are either compelled to terminate them, discontinue schooling and go through the ordeal of carrying the pregnancies to full term or childbirth.

Majority (75%) of the subjects mentioned as their immediate need, to engage in vocational training or apprenticeship. This finding is consistent with previous studies, hence going into these alternative trades will assist them acquire skills for paid or self-employment in the informal sector.

Contraceptive Knowledge

Many of the subjects had good knowledge (77.5%) of any type of contraceptives. The most commonly known contraceptives were condoms, oral pills, injectables and foaming tables, in that order. Several reasons may be adduced for this present knowledge level on contraceptives. There is now a relatively favourable policy environment as a result of the National Population Policy (NPP) launched in 1990 and disseminated nation-wide. Secondly, the Non-Governmental organization

(NGO), which is based in the research community, had mounted active campaigns to raise awareness and increase demand for family planning services

Also, the findings showed that older adolescent mothers had more knowledge than young adolescent mothers. This is not withstanding the fact that educational level of respondents was generally low and had no significant effect in contraceptive knowledge. This is comparable to other studies as the NDHS (1991) and Oladepo and Dawa (1994). These studies reported increased knowledge of contraceptives among adolescent mothers

The study showed that knowledge of STDs was poor. The most known STDs were gonorrhoea and HIV/AIDS. Specifically, the respondents who heard of HIV/AIDS were able to mention at least three routes of transmission and also were aware of the preventive measures against the spread of HIV. In the same vein, the general knowledge of HIV/AIDS was high and is comparable to the World Bank Report (1996) which placed awareness level at 65% and 100% for rural and urban population of Africa, respectively. This high awareness level has been attributed to the increased education programme organised by several governmental and non-governmental agencies. On the contrary, the knowledge of STD prevention was poor

It is suprising that the findings showed that many subjects had a good knowledge of Reproductive Health Rights (RHR). This is against the background of limited or no efforts to create awareness on RHR in the communities. In the contrary, the results showed low awareness level on existing Laws concerning sexual offences

against adolescent in Nigeria. Hence, this discordant result may indicate the wishful thinking on RHR among adolescent mothers and not necessarily showing good knowledge of RHR as portrayed. As a relatively new area in adolescent reproductive health, additional studies are required.

Attitude towards Contraceptives

In general, many of the subjects had a positive attitude towards use of contraceptives. Religion, marital status and age of subjects did not affect this attitudinal disposition. However, the poor educational level affected attitude. This result is consistent with NDHS (1991) where respondents with little or no education had a negative attitude towards use of contraceptives.

Even though most of the subjects have shown positive attitude towards contraceptive use, few actually use them. The reasons may include that most sexually active adolescent mothers are less likely to use contraceptives, even within marriage. For married couples, this may be because of the desire to have more children or probably because marriage resulted from pregnancy. To some of the adolescent mothers, the expression of the fertility prowess may be a source of fulfilment and consolidation in the matrimonial home.

Contraceptive Use or Practice

About a third of the respondents (29.1%) had ever used any form of contraceptives. This result is not surprising as most of the respondents were in matrimonial relationship and has on the average one child. Invariably, the

respondents had overwhelming attributed their non-use of contraceptives tp the desire for more children, lending further credence to the low uptake of contraceptives. Consistently, there was lower use on other specific contraceptives methods. Other studies have posited similar low utilization of contraceptives (between 4 and 11%) by adolescents; NDHS (1991), Oladepo and Bawa (1994), and Brabin (1995).

Comparing current use to 'ever' use, there was a gap of 3.5%. The difference between 'ever' use respondents may have been those in-school who had used contraceptives on experimentation. On the contrary, the current users are in stable marital relationship and have the different goals on needs for contraception. As has been found in a previous report, current use is affected by level of education, sources of information and ability to make decision (Robey, 1995).

Even those who have ever used contraceptives, the commonly used ones were oral pills and injectables. The explanation for this is that these contraceptives are female specific, convenient and are readily available. Both contraceptives are easily obtained from medicine stores or health facilities. It is also possible that provider bias may have promoted the use of these methods more than the others.

The sources of contraceptives to majority of subjects were mainly the Patent Medicine Store (PMS) and private and public health facilities. There is a potential danger of obtaining hormonal contraceptives from PMS due to the associated complications. The PMS dispenses these pharmaceutical products without any clinical assessments to exclude vascular and weight problems. In some parts of

Nigeria, a formal training is not required to obtain a license to operate a PMS. Thus, PMS sellers who dispense prescriptive contraceptives may be some source health risks to unsuspecting clients.

Generally, knowledge of contraceptives lagged behind use of these products. This gap existed despite the reported positive attitude among respondents, indicating that the needs of many adolescents are unmet. According to Westoff and Ochoa (1991), sexually active people who do not desire pregnancy, but are not using contraception are defined as having unmet need for contraception.

The reasons given by subjects who had never used any contraceptives are similar to those found in previous studies, Anyan (1978), Lambert (1972), and Brabin (1995). These reasons include high value of procreative ability or fertility, intrusive nature and psychological barriers attaining certain contraceptives. Others are related to the negative attitude of health workers, lack of proximal health facilities and cost of contraceptives.

The main sources of information on contraceptives to the current users were the mass media and health workers. As part of past campaigns on family planning, a lot of investment was made in both the electronic and print media. In addition, community-based health workers were trained and kited to give door-step information on family planning in the communities.

Implication for Health Education

From the discussions, it is apparent that the adolescent mothers are products of an environment that is essentially poor, low in educational attainment, and have limited opportunities for good jobs. There is also evidence of high parity and pregnancy wastage among the respondents. Study results also showed that during their last pregnancy, most adolescent mothers neither used contraceptives nor are they currently using any contraceptives to prevent pregnancy.

The issues raised on contraceptive knowledge and practice have implications for health education. Health education will target and influence the motivation towards adolescent mothers' use of contraceptives and to compel them in taking action towards obtaining and using suitable contraceptives. Based on their experience, each adolescent mother will evaluate the effectiveness of contraceptives and make the decision to continue or discontinue use.

A very important element in educating adolescent mothers is the quality of counselling and technical information given at the point of taking-up the services. A trained and skilled family planning provider will not only influences and assist clients to make informed choice of contraceptive, but will prepare her to handle side effects and assure follow-up support. It is evident that the ancillary health workers and especially patent medicine store sellers (PMS) are highly patronized by adolescent mothers for contraceptive services. It has become urgent to form an alliance with this

category of health workers and to provide quality services to clients, including making referrals.

A community based health education strategy may be more supportive to adolescent mothers in clarifying their misconceptions. It will also assist them in building confidence in accessing contraceptive services from the provider, who is nearest to them.

CONCLUSION AND RECOMMENDATIONS

Result of this study showed the contraceptive knowledge and practice of adolescent mothers in a sub urban setting. The knowledge of contraceptives is fairly high when compared to previous studies. Also, the attitude of most respondents was positive. However, use of contraceptives remained relatively low and parity is high. Some of the factors that may have affected utilization include low educational attainment, inadequate knowledge of contraceptive technology, poor quality of information and services obtained through Patent Medicine Stores (PMS) and the private clinics and maternity homes in the study area. This situation may predispose adolescent mothers to much higher parity and related social consequences. There is therefore an unmet need for contraception among adolescent mothers.

In the light of these findings, the following recommendations are made.

1. The three tiers of government in Nigeria (Federal, States and Local Councils) should at their various levels, form a working partnership with NGOs to design and implement sustainable community based health education programme to promote contraceptive use among adolescent mothers.
2. Educational materials should be developed which target adolescent mothers with strong motivational content. They should be printed and distribute in both English and local languages.

3. Health education strategies should explore and identify other effective means of providing contraceptive information to adolescent mothers in the communities.

4. Both the government and NGOs should initiate contact with Patent Medicine Store Sellers (PMS) to negotiate their role and participation in the proposed community based contraceptive services. Thereafter, basic training in family planning will be organized to equip them as partners for quality contraceptive service delivery to adolescent mothers.

5. Health workers in both public and private section health facilities should be given basic or up-date training in family planning to assure quality services to adolescent mothers.

REFERENCES

Action Health Incorporated Lagos Guidelines for Comprehensive Sexuality Education in Nigeria, National Guideline Task Force 1996, V

Adetoro, O.O., Septic Induced Abortion at Ilorin, Nigeria: An increasing gynaecological problem in the developing countries. Asia-Oceania Journal of Obstetrics and Gynaecology, 12(12): 201-205, June 1986.

Acquired Immuno-Deficiency Syndrome (AIDS) Action (1992), Young people first.

Arkutu A. A. (1995), Health mothers. An information Guide, Family Care International. 1st edition

Ajuwon Ademola Johnson, (2000), Effects of Educational Intervention on Knowledge, Attitude and practice of Reproductive Health among selected\ Secondary school students in Oyo State, Nigeria, Doctoral thesis submitted to Department of PSM, University of Ibadan

Akande J., legal Rights and protection of Adolescent Reproductive health, paper presented at the national conference on Adolescent reproductive health, Abuja, Jan 26-29, 1999, Pages 1-10.

Akinla O, Experience with the plastic intra-uterine contraceptive device in Lagos, its effectiveness, acceptability and safety. West African Medical Journal 17, 218-222 December 1968

Amazigbo U, Silva N, Kaufman J and Obikeze D. S. (1998), Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria, International Family Planning Perspectives, 23 (1): 28-33.

American College of Obstetricians & Gynaecologists, Safety of oral contraceptives For Teenagers. Journal of Adolescent Health. 1992 Jun; 13(4): 333-6.

Anyan W.R.(Jr), Adolescent Medicine in Primary Care, Wiley medical publication, New York, 1978

Aral, S. O. (1992), sexual behaviour as a risk factor for sexually transmitted diseases.

Reproductive tract infections: global impact and priorities for woman's Reproductive health (ED), Germain K. K. Piot P and Wasswehelt Plenum press, New York, 185 – 198.

Armitage P and Berry G (1988). Statistical Methods in Medical Research, Oxford Publications Limited.

ARFH (1996), Adolescent Reproductive Health in Nigeria, a comparative review of four Studies by ARFH, CHESTRAD, SFH and WDG.

Asamoah-Odei E, Ogundiran N, Gwarzo N S and Gboun M F (C). The Technical Report, 1999 HIV/Syphilis Sentinel Sero-prevalence Survey in Nigeria, Natural AIDS/STD Control Programme, Federal Ministry of Health, WHO, DFID, UNICEF, UNAIDS, November 1999.

Blum, R. N. Rinehart P. M. (undated), Reducing the risk: connections that make A difference in the lives of youth. University of Minnesota, Minneapolis, USA.

Brabin L, Reproductive tract infection and abortion among adolescent girls in rural Nigeria, LANCET, vol. 345, February, 1995.

Bruyn M., Facing the challenges of HIV/AIDS/STDs, A gender-based Response, KIT and SAFAIDS, 1998, Pages 10 – 22.

Casterbine J B., Perez A E and Biddlecom A E., Factors Underlying Unmet need In the Philippines, Studies in Family Planning, Volume 28, Number 3, September 1997, page 173-187.

Campaign Against Unwanted Pregnancy (CAUP), Abortion in Nigeria, Fact sheets, 1996 Page 1 (a).

Campion Mukti Jain, who's fit to be a parent? 1st edition, Rout Lodge London, 1995.

Casterline J, Population Council, Lack of information: findings from research in Pakistan. Factors underlying unmet need, multi-country study, personal Communication, July 11, 1996.

Coutinho E. M, Results of a user satisfaction study carried out in women using Uniplant Contraceptive Implant, ELSEVIER contraception 1996, 54 313 - 317

Coutinho E M, Ivan Mascarenhas, oscar mateo de Acosta, Josue Garza Flores, Zhi-Ping Gu, O A Ladipo, A O Adekunle, E O Ololotin, Mamdouh M Shaaban Mohammed Abul Oyoon, A Kamal Abdel Plah, N C Sikazire and Sheldon J Segal Clinical Pharmacology and therapeutics, Nov 1993, Vol 54 Number 5, page 545

Creatas G , Improving adolescent sexual behaviour a tool for better fertility outcome and safe motherhood, International Journal of Gynaecology & Obstetrics, 1997 Vol ; 58(1), 85-92

Cullins U E and Garcia F A, Implantable hormonal and Emergency Contraceptive, Current opinion in obstetrics and gynaecology, 1997 Jun 9 (3) 169-74

Dada J O, Olascha I O and Ajuwon A J (1999) Sexual Behaviour and Knowledge of AIDS among Female Trade Apprentices in a Yoruba Town in South Western Nigeria, International Quarterly of Community Health Education, 17 (3) 255-270

Dixon-Mueller and Wasserheit Judith, The Culture of Silence Reproductive Tract Infections Among Women in the Third World, International Women's Health Coalition (IWHC), 1991

Duncan E M, First Coitus before menarche and risk of sexually transmitted disease in Ethiopia, LANCET, February 10, 1990, vol 335, No 8685

Earp J A and Ernest S T, Precede Model Health Education Research, Theory and Practice, Vol 6, No 2, 1991

Egbeda Local Government Area Brochure, 1997

Evelyn Landry et al, Repon of profiles of users of long term and permanent Contraceptive methods Results from operation research project at hospital in Nigeria. 1989-1991, Funded by AVSC, New York, February, 1992

Farr G, An evaluation of the Copper-T 380A IUDs safety and efficacy of three African Centres, Contraception, 1996 May; 53(5) 293-8

Faturoti T O., Legal perspectives on the Girl child and sexual abuse in Nigeria. Women's Behavioural Issues, vol. 1, No 2, July 1994.

FHI/AIDSCAP, Female Condom: from Research to the market place, August 1997.

FMOH/National AIDS/STD Control Program, AIDS care reporting profile – A decade of Nigeria experience, (1986 - 1995), Yaba, Lagos, 1996.

Foege William H, Family Planning Methods and Practices, Africa, CDC Atlanta USA. 21-52, 1987.

Federal Office of Statistics/IRD - Macro International, Nigeria Demographic and Health Survey(NDHS), 1990.

Glens Williams, A Common Cause: Young people, sexuality and HIV/AIDS in three African countries – Strategies for Hope, Series Number 12, DFID/UNAIDS, 1997.

Greydanus D E. Alternatives to adolescent pregnancy: a discussion of the Contraceptive literature from 1960 - 1980. Seminars in Perinatology. 1981 Jan; 5(1): 53-90.

Hatcher A. Robert. The Essentials of Contraceptive Technology. A Handbook for Clinic Staff. Johns Hopkins Population Information Program, 5-1, July 1997.

Hatcher A. Robert (ed), Contraceptive Technology, International Edition, Printed Matter Incorporated, Atlanta GA USA, 122-394, 1989.

Heise, L. Ellsberg, M. and Gottemoeller M. Ending Violence Against Women. Population Reports. Series L, No 11, Baltimore, JHU School of Public Health, Population Information Program, December 1999, Page 3.

Henshaw S.K. Singh S. Oye-Adeniran B.A. et al, The Incidence of Induce Abortion in Nigeria, International Family Planning Perspectives Volume 24, Number 3 December 1998, pages 156-164.

International Planned Parenthood Federation (IPPF) Special Report. The need for quality care. Annual report 1991-1992. London, IPPF, 1992 36p

IRD/Macro International Demographic and Health Surveys (NDHS), Adolescent women in Sub-Sahara Africa: A chart book on marriage and child-bearing, population reference Bureau Washington, 1992.

James L.M. Human sexuality, 2nd edition, New York, 1973.

Jinadu M. K., Odesanmi W. O. (1993), adolescent sexual behaviour and condom use in Ile-Ife, Nigeria. Clinical Nursing Research 1993, 2 111 – 118.

Kols A I., Sherman J E., Family Planning Programs: Improving Quality, Population Reports, Series J, Number 47, 1998. Pages 13-16.

Ladipo O.A, Pre-introductory clinical trial of Norplant contraceptive subdermal Implants, Report on the 5 year experience at 5 family planning clinics in Nigeria, 1993.

Lambert B G, Adolescence, transition from childhood to maturity, 1st edition, California, 1972.

Liskin Laurie and Rutledge Ann. After Contraceptive: Dispelling Rumours About Later child bearing, Population Reports, series J, Number 28, Volume xii, Number 5, J-698-J724, September 1987.

Lydia O'Donnell. The effectiveness of the reach for health community youth Service Learning programme in reducing early and unprotected sex among urban middle school students, American Journal of Public Health, 89 (2), 76-181, February, 1999.

Makinwa Adebusoye, Adolescent Reproductive behaviour in Nigeria, a study of five cities, NISER Monograph Series, No 3, 1991, page v.

McCauley A P and Salter C: meeting the needs of Young Adults, Population Reports, Series J, Number 41, October 1995, pages 3-18.

McCauley Ann P and Geller J S, Population Reports, Decisions for Norplant Program, Series K, Number 4, November 1993.

McLaughlin S, Skills Training for Informal Sector: Analysing the success and

Limitations of Support programs, in the informal sector revisited, Development centre of the organisation for Economic Co-operation and Development, pp 156-186, 1990.

Nare C, Katz K and Tolley E Adolescents Access to Reproductive Health and Family Planning Services in Dakar (Senegal), African Journal of Reproductive Health. 1(2), 5-25, 1997.

Nare Chrisuine, Adolescents: Access to Reproductive health and Family Planning services in Dakar (Senegal), African Journal of reproductive health, Sept. 1997, Vol 1, No 2, pages 15-25.

National Demographic and Health Survey (NDHS) report 1991, page 45.62

National Population Commission (Nigeria) 2000, Nigeria Demographic and Health Survey 1999, Calverton, Maryland: NPC and ORC/MACRO

National Population Commission (NPC), Population area delineatioo report Ibadan 1997.

National Population Policy (NPP), Federal Republic of Nigeria (1990)

Nelson A L. Adolescent Contraception of Western Journal of Medicine 1996 Dec, 165(6): 374-6

Nicholas D, Ladipo A O, Paxman J M, Ololoin E O (1986) Sexual behaviour, Contraceptive practice and reproductive health among Nigerian adolescent. Studies In Family Planning, 17 100-106

Nkoyo Toyo, Tomorrow is now – promoting Adolescent reproductive health in Nigeria, NYAP, 1997

Ogbuagu S Depo-provera a choice or an imposition on the African woman a case study of Depo Provera usage in Maiduguri' Women and the family in Nigeria, 1985, 81-92

Okonofua F E, Onwudiegwu U and Odunsi O A (1992) Illegal induced abortion a study of 72 cases in Ile-Ife, Nigeria Tropical Doctor, 22 75 – 78

Oladepo O and Bawa H Factors Responsible for unwanted pregnancies among

Secondaty school teenagers in an Urban Northern Nigeria, Women's Beliavioural Issues, vol 1, No 2, July 1994

Oluyemi B , Sexual offiences and the Law in Nigeria, an injustice to female Adolescents. Women's Behavioural Issues. vol 1, No 2 July, 1994

Oppong C , A High Price To Pay: For Education. Subsistence or a Place in the Job market, Health Transition Review. supplement to Volume 5, pp 35-56, 1995

Ololorin E O & Ladipo O ,A, Comparison of intramenstrual IUD insertion with Insertion following menstrual regulation, Advances in contraception, 1985 Mar, 1(1) 45-9

Ololorin E O , et al, outpatient interval female sterilization at the University College Hospital, Ibadan, Nigeria. African Journal of medicine and medical sciences 1985 March-June, 14 (1-2) 3-9

Overby K J and Kegeles S M, The Impact of AIDS in an Urban Population of high-risk female minority adolescents Implication for intervention Journal of adolescent health 1994 May, 15(3) 216-27

Oyediran K A, Isiiola G P and Adedimeji B A (compiled), Adolescent Reproductive Health in Nigeria, A comparative Review of four studies, December 1996

Parman J M and Zukerman R J , Laws and Policies affecting adolescent health, WHO, Geneva 1987

Population Reports After contraception, dispelling rumours about later child-bearing, series J. number 28, Volume xi, Number 5, page J-699 (reprinted Sept 1987)

Prentice D Roger W R , Protection Motivation theory, Health education Research, Theory and Practice, vol 1, No 3, 1986

Robey B , Ross J and Bhushan I, Meeting unmet need new strategies, Population Reports, series J, No 43 Baltimore, Johns Hopkins School of

Public Health, Population Information Program, September 1996

Rosebery W. R, AIPs Prevention and Mitigation in Sub - Saharan Africa An updated World Bank Strategy, Report NO 15569-AFR, April 20, 1996, pg31

Smith R., Promoting the sexual health of young people Part 1, Pediatric Nursing, 1997, March, 9(2) 24-7.

Speizer I, Heller G and Brieger W (2000) Survey findings from the West Africa Youth Initiative, Final project evaluation of peer Educators intervention, January 2000

Tones Keit and Tilford Sylvia, Health Education - effectiveness, efficiency, 2nd edition Chapman and Hall, London, 11p

United Nations, Population and Development A programme of action adopted at the International Conference on population and Development, Cairo, 5-13 Sept 1994, New York, UN, 1995

United Nations General Assembly, Declaration on the elimination of violence Against women, proceedings of the 85th plenary meeting, Geneva, December 20, 1993 (UN Resolution No A/RES/48/104)

Westoff C F and Ochoa L H, Unmet need and the demand for family planning, Columbia, Maryland, Macro International, July 1991, DHS Comparative Studies No 5, page 43

Westoff C F and Rodriguez, The Mass Media and Family Planning in Kenya, International Family Planning Perspectives volume 21, Number 1, March 1995, page 26-31

Westoff, C F and Bankole A, Unmet need 1990-1994 Cal-Verton, Maryland, Macro international, June 1995, DHS comparative Studies No 16,55p

WHO A prospective multi-centre trial of the ovulation method of natural family Planning V Psychosocial aspect Fertil steril 1987, 47(5) 765-772

WHO, Women's Health and Development, Violence against Women- A Priority Health issue, WHO/FRH/WHD/97 8

Wildemeersch D et al, Intrauterine Contraception in Adolescent Women

The Gynefix Intrauterine Implants. Annals of the New York Academy of Science 1997 Jun 117, 816 4-10-50

Williams C D and Jelliffe D B (1982). Mother and child Health. Delivering the Services. Oxford University Press. page 88

WHO the health of young people, A challenge and a promise, Geneva 1993

WHO technical Report Series, Young people, a challenge for society, WHO, Geneva, 1986

WHO (1998), unsafe abortion Global and Regional estimates of incidence of mortality due to unsafe abortion with listing of available country data 3rd edition Geneva, Switzerland

APPENDIX 1A

Contraceptive Knowledge and Behaviour of Adolescent Mothers in Ogbere Community, Egbeda LGA, OYO STATE.

INDIVIDUAL INTERVIEW QUESTIONNAIRES

(This questionnaire is to be administered to adolescent mothers aged 10 - 30 years)

Date of Interview _____

Introduction.

This interview is designed to obtain information on your knowledge and contraceptive experience. It is part of a research effort to contribute to the knowledge base on adolescem reproductive health. All information volunteered by you during this interview will be treated with utmost confidentiality and used for research purpose without reference to your name. Hence your openness and candid answers to the questions will be highly appreciated.

Identification	
Individual Identification Number	
Cluster Unit Number	
Line Number of Teenager (from HHIQ)	
Household Address	
Name of Household	
Age of Respondent	

Interviewer's Name ..... Investigator's signature .....

(for the following questions, please cycle only the numerals of the responses)

Section 1 - Personal Information

Q1. How old were you on your last birthday? ..... years

What is your Date of Birth? .....

Q2. Are you presently in school? Yes ☐

If No, go to Q5 No ☐

Q3. What is the name of your school? .....

Type of school .....

Q4. In which class are you now? .....

Q5. What is the highest level of schooling that you attended?

1. No schooling
2. Formal Primary
3. Formal Secondary
4. Koranic Primary
5. Koranic Secondary
6. Beyond secondary school (specify)
7. Informal school (specify) .....
8. Others (specify) .....

Q6. In whose accommodation are you currently residing?

1. Husband's apartment
2. Parent-in-law's house
3. My parent's house
4. Apartment rented by boy friend
5. Staying with a friend
6. Others (specify) .....

Q6(a) What is your State of Origin? .....

Q7. What is your marital status?

1. Single
2. Married (year married) .....
3. Living together (cohabiting)
4. Divorced
5. Separated
6. Widowed
99. Others (specify) .....

Q8. What kind of work do you do? .....

Q9. What religion do you practice now? Sect .....

1. Christianity
2. Islam
3. African Traditional Religion
4. Others (specify) .....

Q10. What is your parents' marital status?

1. Father .....

88 Do not know

2. Mother ..... 88 Do not know

Q11. What is your parents' occupation?

1. Father ..... 88 Donot know

2. Mother ..... 88 Do not know

SECTION 2 - Reproductive History

(Some of the following questions are very personal and may appear embarrassing. You may choose to answer or not. You have assurance of confidentiality)

Q12. How many times have you been pregnant since you started menstruation?

1. ..... (If pregnant for the first time, go to Q.21)

88 Do not know

Q13. In how many of the pregnancy (ies) was the baby borne alive?

1. ..... 88 Do not know

Q14. How many of the children borne alive are living with you now?

Indicate number .....

Q15. What happened to the pregnancy (ies) not carried to full-term?

1. Terminated 88 Do not know
2. Miscarriage 100 No response
3. Still borne

(If 2, 3, 88 or 100, go to Q19). If terminated, ask Q16

Q16. Where was the pregnancy (ies) terminated?

1. Hospital 6. Friend's house
2. Clinic/Maternity 7. Own home
3. Patent/Medicine Store 88 Do not know
4. Herbalist home 99 Others (specify) .....
5. Church healing centre 100 No response

Q17. Do you have any reasons for terminating the pregnancy?

Yes ☐ No ☐

If YES, explain .....

.....

Q18. Who made the decision to terminate the pregnancy? .....

Q19 What problems did you encounter during the last pregnancy?

a Health .....

b Relationship with other people .....

c Education .....

None (if NONE, skip Q20)

Q20 What did you do about them?

.....

.....

SECTION 3 - Consequences of Pregnancy

Q21 For the pregnancy you had/have, did you desire it?

Yes ☐ No ☐

Give reasons .....

.....

Q22 Mention at least 3 major problems/challenges you face(d) as a result of the pregnancy

1. ..... 2 .....

3 ..... 4 .....

5 .....

Q23 Who gave you the most support/assistance during your last pregnancy?

Please specify 1. Relationship .....

2 Location .....

3 Types of support .....

4 Nobody ☐

Q24 Do you have any needs over the upbringing/welfare of your children

Yes ☐ No ☐

If YES, please specify .....

Q25 What are your greatest personal needs now? (circle all that apply)

1 Need Education (specify level) .....

2. Vocational training (specify) .....
3. Apprenticeship (specify) .....
4. Get a husband? .....

88. Do not know. 99. Others (specify) .....

Ask Q26 - 29 from the unmarried adolescent mother.

Q26. Give information on the father of your child (ren).

Please specify:
- His occupation .....
- Marital status .....
- Level of Education .....

Q27. Do you plan to marry him?

Yes ☐ No ☐

Give reasons .....

.....

Q28. What type of support did you receive from your male friend?

(circle all that apply)

1. Housing
2. Feeding
3. Clothing
4. Medicine
5. None
99. Others (specify) .....

Q29. During your last pregnancy, what support did your parents give?

SECTION 4 - Contraceptive Knowledge, Attitude And Practice

(Now let us focus more specifically on child-spacing or family planning method - these are the various ways or method that a person can use to delay/avoid pregnancy, pregnancy complications and sexually transmitted diseases including HIV/AIDS)

Q30. Which contraceptive methods do you know of?

1. Pills (taken daily e.g. Lofemenal)
2. Condoms/Durex
3. Foaming Tablets

4. Rhythm methods (specify) .....
5. Withdrawal method
6. Periodic abstinence
7. Injection
8. Norplant
9. IUCD/Coil
10. Traditional methods (specify) .....
11. None
12. Others (specify) .....

Q31. Have you ever used any of these methods?

1. Pills (taken daily) e.g. Lofemanal
2. Condoms/Durex
3. Foaming Tablets
4. Rhythm methods (specify) .....
5. Withdrawal method
6. Periodic abstinence
7. Injection
8. Norplant
9. IUCD/Coil
10. Traditional method(s) (specify) .....
11. None
99. Others (specify) .....

Q32. If never used any contraceptive method, give reasons

.....

.....

.....

Q33. How did you hear about the contraceptives?

1. Peer/Relative
5. Church/Religious leader

2. Health worker
3. Radio
4. Television
6. Mother
7. Father
8. Others (specify) .....

Q34. For the contraceptives you used, where did you get it?

1. Government Hospital/Primary Health Care Centre
2. Patent Medicine Store
3. Hawker stand
4. Private Hospital/Clinic
5. Private Maternity
6. Religious Centre
7. Others (specify) .....

Q34(a) What contraceptive method are you currently using?

1. Pills (taken daily) e.g. Lofemenal
2. Condoms/Durex
3. Foaming Tablets
4. Rhythm methods (specify) .....
5. Withdrawal
6. Periodic abstinence
7. Injection
8. Norplant
9. IUCD/Coil
10. Traditional methods
11. None (If NONE, go to Q37)
99. Others (specify) .....

Q35. What difficulties do you experience in obtaining contraceptives?

1. Contraceptives are expensive
2. My sexual partner(s) do not approve the use of condom
3. My peers/friends disapprove use of contraceptives
4. The Health Workers refuse to give service to me
5. Contraceptives are not available
6. None
7. Others (specify) .....

Q36. If you are not currently using contraceptives, give reasons

.....

.....

For Questions 37 - 44 please indicate your level of agreement.

SA (Strongly Agree), A (Agree). NAD (Neither Agree nor Disagree),

D (Disagree), SD (Strongly Disagree)

	SA	A	NAD	D	SD
Q37 It is not important to counsel adolescents on the problems of unwanted pregnancy					
Q38 Adults are not willing to discuss contraceptive use with adolescents					
Q39 Contraceptives will make me unable to have children in the future					
Q40 Contraceptives cause abortion in people					
Q41 One should not use contraceptive unless approved by her sexual partner					
Q42 It is bad for a teenager to have sexual intercourse with anybody she likes					
Q43 Contraceptives will prevent me from showing ability to have children					
Q44 It is against ones religious faith to use contraceptives					

SECTION 5 – Sexually Transmitted Diseases

Q45. What types of STDs do you know?

1. 4.
2. 5.
3. 6.

Q46. What type of STDs have you been infected with?

1. 3.

2. 4. None (If NONE, go to Q50)

Q47. Where were you treated?

1. Self-medication (home) 5. Herbalist (home)
2. Hospital/Clinic 6. Religious centre
3. Maternity 7. Others (specify) .....
4. Patent Medicine Store

Q48. What was the result of your treatment?

.....

Q49. Did the treatment include your sexual partner(s)?

Yes ☐

No ☐ 88. Do not know

Please explain .....

.....

Q50. What can you do to prevent contacting STDs?

1. 3.

2. 88. Do not know

Q51. Have you heard of AIDS?

Yes ☐ No ☐ (If NO, go to Q54)

Q52. List ways by which AIDS is spread from one person to the other?

1. ..... 2 .....

2. ..... 4 .....

3. ..... 88. Do not know

Q53. List the ways of preventing HIV/AIDS infection

.....

.....

.....

SECTION 6 - Reproduction Health Rights

Q54. Which of the following rights do you know of?

1. Your right to all necessities of life for adequate growth and development?

Yes ☐ No ☐

2. Your right to reject betrothal or forced marriage before 18 years of age?

Yes ☐ No ☐

3. Your right to basic education and skills acquisitions

Yes ☐ No ☐

4. Your right to report sexual assault and indecent sexual advances

Yes ☐ No ☐

5. Your right to use contraceptives

Yes ☐ No ☐

6. Your right to good health

Yes ☐ No ☐

88. Do not know 99. Others (specify) .....

Q55. Mention any existing Nigerian Laws/Policies on sexual offences against adolescent

1. 2.

3. 4.

88. Do not know

Q56. Would you want to suggest any ideas to assist in formulating Nigeria adolescent reproductive health/policies and laws

1. Yes ☐
2. No

If YES, give your suggestion(s).....

.....

Thank you.

APPENDIX 1B

IMO IDENA OYUNNINI ATI ISESI AWON IYA ODO NI AGBEGBE OGBERE NI IJOBA IBILE EGBEDA, IPINLE OYO.

ATOJO IBEERE IWADII FUN ENIKOOKANATOJO IBEERE IWADII FUN ENIKOOKAN

(Atojo ibeere iwadi yii wa fun awon abiyamo ti oju ori won ko ju odun mewaa si ogun odun lo)

Ojo Iforowanilenuwo _____

Ifaarafaara

Iforowanilenuwo yii da lori mimo iriri yin lori idena oyunsiri. O je ara akitiyan iwadi lati se afikun imo lori itera awon abiyamo ti won je odo. Gbogbo idahun ti o ba fi sile nipa iforowanilenuwo yii ni a ko ni je ko lan sita fun eniyeni, a o si tun loo fun iwadi ijinle lai daruko re rara.

Fun idi eyi, inu wa yoo dun ti idahun re si awon ibeere yi ba je okodoro labi otito

Idarinko	
Nomba idanimo enikookan	
Isupo nomba olorijoi	
Iye nomba awon odo laugba	
Oruko idile ere	
Ojo on oludahun	

Oruko Oluforowanilenuwo _____

Ifowosi Olowadi _____

(Fun awon ibeere wonyi, jowo je ami rubutu si awon orika idahun re nikan.)

IPIN KINNI: MIMO NIPA YIN IPIN KINNI: MIMO NIPA YIN

Ibeere 1: Omo odun melloo ni o je ni ojo ibi re to koja?

Odun_____

Ojo wo ni won bi e?_____

Ibeere 2 N je o wa ni ile-iwe bayii?

Beeni_____

Beeko_____

Bi o baje beeko, lo si ibeere 5

Ibeere3 Daruko ile-iwe e re ?_____

Iru ile-iwe wo _____

Ibeere 4: Kilaasi wo ni o wa bayii ?_____

Ibeere 5 Iwe ori wo logba gbogbin

1. Nko lo ile -iwe rara
2. Ile-iwe alakobere
3. Ile-iwe girama eleto
4. Ile-eko kurare alakobere
5. Ile-eko kurani giga
6. Mo koja ile-iwe girama (je kanso) _____
7. Ile-iwe alaileto (Je kanso) _____
8. Eyi ti o tun yato (Je kanso nipato) _____

Ibeere 6 Odo ta a ni o n gbe lowolowo bayii ?

1. Odo oko
2. Ile obi oko nii
3. Ile awon obo nii
4. Ile ti ore-kunrin mi gbe
5. Mo n gbe pelu ore

6. Eyi ti o ba yato (nipato) ____________________

Ibeere 6a: Dabuko ipinle re ? ____________________

Ibeere 7: Nje o ti ni oko bi ?

1. Daduro
2. O ti se igbeyawo (odun ti o se igbeyawo) ____________
3. Se e n gbe po
4. Se e ti ko oko
5. Se e tituka
6. Opo
7. Eyi ti o ba yato (Je kamo nipato) ____________________

Ibeere 8: Ise wo ni o n se ?

Ibeere 9: Esin wo ni o n se ? (Ijo) ____________________

1. Esin igbagbo
2. Esin musulumi
3. Esin ibile
4. Eyi ti o ba yato (Je kamo nipato) ____________________

Ibeere 10: Se igbeyawo awon obi re si duro?

1. Baba ________________-88 N ko mo
2. Iya ________________-88 N ko mo

Ibeere 11: Ise wo ni awon obi re n se?

1. Baba ______________-88 N ko mo
2. Iya ______________-88 N ko mo

IPIN KEJI - ITAN IBISIIPIN KEJI - ITAN IBISI

(Awon koo yoo awon ibeere wonyi je ti ara eniyan won si ile ikoko ... O le dahun bi o ba wu e, ikoko ... wa pe ko ni han si eniyan ...)

Ibeere 12: O ti loyun to igba meloo lati igba ti o ti bere si se nkan osu ?

1 ________ (bi o ba je pe oyun akoko ni eleyi, lo si ibeere 21)

88 nko mo

Ibeere 13: Igba melo ninu igba ti o ti n loyun ni o bi omo ye?

1. _____ 88 n ko mo

Ibeere 14: Melo ninu awon ti o bi ye ni o n gbe pelu re?

So iye _____

Ibeere 15: Kinni o sele si oyun ti o wa le ki osu re to o pe

1. Baaje 88 Nko mo
2. Wale 100 ko si idahun
3. Bi ni oku omo

(Bi o ba je 2, 3, 88 tabi 100, lo si 19). Bi o ba je pe o baje, dahun 16

Ibeere 16: Ibo ni o ti ba oyun naa je?

1. Ile iwosan
2. Ile itoj uaisan abe -ile tabi ile igbodi
3. Ile ita oogun
4. Ile babalawo/ Adahunse
5. Ile-iwosan omigbagbo
6. ile ore
7. Ile e mi
88 N ko mo
99 Bi o ba yato (Je kamo nipato) _____

Ibeere 17: N je idi pataki kan wa fun bi ba oy naa je?

1. Beeni 2 Becko ☐

Bi o ba je beeni, salaye _____

Ibeere 18: Ta ni o se ipinnu lati ba oyun naa je? _____

Ibeere 19: Kinni awon isoro ti o koju nigbati o loyun gbeyin?

a. Ilera _____

b. Ibasepo pelu awon eniyan ____________

c. Eko ____________

d. Beeko (Bi o ba je beeko fi ibeere 20 sile)

Ibeere 20 Kinni o se nipa awon isoro naa?

____

____

____

IPIN KETA - ABAJADE OYUN NINIIPIN KETA - ABAJADE OYUN NINI

Ibeere 21 Fun oyun ti o ti ni ri tabi ti o ni, nje o fe boo bi?

1. Beeni 2. Beeko [ ]

So idi ____________

Ibeere 22 Daruko o kere ju, isoro meta ti o ni la taari oyun ti o ni

1. ____________ 2. ____________

3. ____________ 4. ____________

5. ____________

Ibeere 23 Ta ni o fun e ni iranlowo julo nigbati o loyun gbeyin?

Jowo so nipato 1. Ibasepo ____________

2. Ibi ti o wa ____________

3. Iru iranwolowo ti o se ____________

Ibeere 24 Nje o fe iranlowo nipa tito tabi alaafia (awon) omo re?

1. Beeni 2. Beeko

Bi o ba je beeni, jowo so nipato ____________

Ibeere 25 Kinni awon nkan ti iwo fun raare ife bayii ?

(Yi ami rubuto si awon ibi ti o ba kan gbongbon).

1. O fe kawe (so gbedeke) ____________

2. Ekose owo (nipato) ____________

3. Omo ise sise (nipato ____________

4. Oko nini ______________

88 oko mo 99 Eyi ti o ba yato (je kanmo) ______________

Beere ibeere 26 si 29 lowo abiyamo ti o je odo ti ko l loko

Ibeere 26 Je ka mo nipa Baba (awon) omo re

Jowo so niapto • Ise ti o n se ______________

• Nje o ti ni iyawo ______________

• Gbedeke eko re ______________

Ibeere 27 N je o fe fe e ☐

1. Beeni 2. Beeko

So idi ______________

____

Ibeere 28 Iru iranlowo wo ni o n ri gba lati owo ore kunrin re?

(Yi ami roboto si eyi ti o ba je mo e)

1. ile gbigbe 2. Ounje
3. Aso 4. oogun
5. Rara 99 Bi o ba yato (Je kamo) ______________

Ibeere 29 Nigbati o loyun ani gbolun, iru iranlowo wo ni awon obi re se fun e?

IPIN KERIN: IMO IDENA OYUNNINI, IWA ATI ISE SI IPIN KERIN: IMO IDENA OYUNNINI, IWA ATI ISE SI

(Nibayi, e je ka se akiyesi nipa lori idena oyun awon omo tabi ikana ifeto somobibi. Eleyi ni awon ogbon tabi ikana ti a le lo fun idaduro tabi yago fun oyun nini, ati awon arun ti a le ko nipa ibalopo (STDS) ati bee bee lo)

Ibeere 30 Iru ona idenaoyun wo ni o mo?

1. Ogun (lilo lojoojumo bi apeere lofemenal)

2. Roba idaa bobo/Tereedadi/kondoomu
3. Foaming tablets
4. Rhythm method (nipato)
5. Itana Yiyokuro
6. Yera fun ibalopo lawon asiko kan
7. Abere gbigba
8. Noriplant
9. IUCD/coili
10. Ilana Ibile (nipato)
11. Kosi
12. Bi o ba tun yato (je kamo) _____

Ibeere 31: Nje o ti lo okan ninu awon ilana yi ri?

1. Oogun (lilo lojoojumo bi apeere Lofemenal)
2. Roba idabobo/Tereedadi/Kondoomu
3. Rhythm methods (nipato)
4. Foaming tablets
5. Ilana Yiyokuro
6. Yera fun ibalopo lawon asiko kan
7. Abere gbigba
8. Norplant
9. IUCD/coil
10. Ilana ibile
11. Kosi
12. Bi o ba tun yato (nipato) _____

Ibeere 32: Bi o ko ba tii lo ona idenaoyun kankan re?

So idi _____

_____

Ibeere 33: bawo lo se gbo nipa ilana idena oyun

1. Egbe tabi alabagbee
2. Osise ilera
3. Redio
4. Telifisan
5. Soosi tabi Olori Esin
6. Iya
7. Baba
8. Bi o ba yato (Nipalo

Ibeere 34(a) Ilana idena oyun nini wo ni o nlo bayii?

1. Oogun (Jijo lojoojumo bi apeere lofemenal)
2. Roba idaabobo/Femidadi/Kondoomu
3. Foaming tablets
4. Rhythm methods
5. Ilana Yiyokuro
6. Yiyera fun ibalopo lawon asiko kan
7. Abere gbigba
8. Norplant
9. IUCD/coil
10. Ilana ibile (nipalo)
11. Rara (bi o baje taro lo si ibeere 37)
12. Bi o ba yato (je kamo)

Ibeere 35 Awon isoro wo ni o wa ni o maa nkoju re lati ni ohun idenaoyun?

Awon ohun idenaoyun won pupo

1. Awon ti a jo n sere ife ko fara mo lilo roba idaabobo tabi kondoomu
2. Awon ebge tabi ore e mi ko fowo si ilo adenaoyun
3. Awon osise ilera kii se ise fun mi
4. Awon ohun idenaoyun ko si ni arowoto
5. Ko si

6. Bi o ba yato (nipato) ____________________

Ibeere 36 Bi o ba ba lo ohun ikedanu... bayii

je ki a mo ohun ti o fa ____________________

Fun ibeere 37 titi de 44, je ki a mo bii o se faramo on lo

Sa (mo gba dajudaju) A (mo faramoon) NAD (nko faramoon bee si ni nko takoo) (takoo) SD (mo takoo gan)

	SA	A	NAD	D	SD
Ibeere 37 ko pon dandan lati gba odo ti o je abiyamo nijanju lori oyun airotele					
Ibeere 38 Awon agbalagba ki I fe soro nipa lilo adenaoyun pelu awon odo ti o je abiyamo					
Ibeere 39 Awon adenaoyun ki ni I je ki nko bi mo lojo iwaju					
Ibeere 40 Adenaoyun ... n ba oyun je lara awon eniyan					
Ibeere 41 Eniyan ko ... lo adenaoyun ayafi bi onikuarin ba fowo si					
Ibeere 43 Lilo adenaoyun yoo dun ... lati bi omo lu					
Ibeere 44 O takoo ilana ... igbagbo ... lati adenaoyun					

IPIN KARUN-UN

IPIN - AWON ARUN TI A LE KO LATI ARA IBARAENISEPO (STD)

Ibeere 45 ... awon arun ... ti ... ri?

1 ____________________

2 _____

3 _____

4 _____

5 _____

6 _____

Ibeere 46 Iru awon arun ibalopo wo ni o ti ko ri?

_____

_____

_____

Rara kosi (bi ko ba si, lo si ibeere 50)

Ibeere 47 Nibo ni o ti gba itoju?

1 Ryan Oogun fun ara eni

2 Ile - iwosan

3 Ile igbebi

4 Ile ita Oogun

5 Ile isegun ibile

6 Ile Esin

7 Bi o ba yato (je kamo)

Ibeere 48 kinni abayade itoju naa?

Ibeere 49 Nje itoju naa kan (awoon) orekunrin re?

1 Beeni 2 Beeko

Jowo salaye _____

Ibeere 50 kinni o le se lati dena kiko arun ibaraenilopo?

1 _____

2 _____

Ibeere 51 Nje o ti gbo nipa arun AIDS?

Beeni Beeko (bi o ba je beeko lo si ibeere 54)

Ibeere 52 Daruko awon ona ti AIDS n gba a ran lati odo enikan si elomiran?

1 _____

2 _____

3 _____

4 _____

8 n komo

Ibeere 53 Daruko awon ona ti a le gba lati dena kiko arun HIV/AIDS?

_____

_____

IPIN KEFA : ETO ILERA IBISI

Ibeere 54 E wo ninu awon eto wonyi ni o mo?

Eto re si awon olutun amoyederun fun idaghasoke ati ilosiwaju

Beeni Beeko

Eto re lati ko oko tabi igbeyawo tipatipa siwaju ki o to o pe omo odun mejidinlogun

Beeni Beeko

Eto re si eko ta ye kooro ati imo nini

Beeni Beeko

4 Eto re lati se ifisun ibalopo aito ati gbigbero ibalopo itiju

Beeni Beeko

5 Eto re lati lo adenuoyun

Beeni Beeko

6 Eto re si ilera ti o ye kaora

Beeni Beeko

10 88 Nko mo 99 Bi o ba yato (je kamo) _____

Ibeere 55 Daruko akoso tabi ofin orile ede Naijiria marun -un lori esun ibalopo awon odo

_____

_____

N ko mo

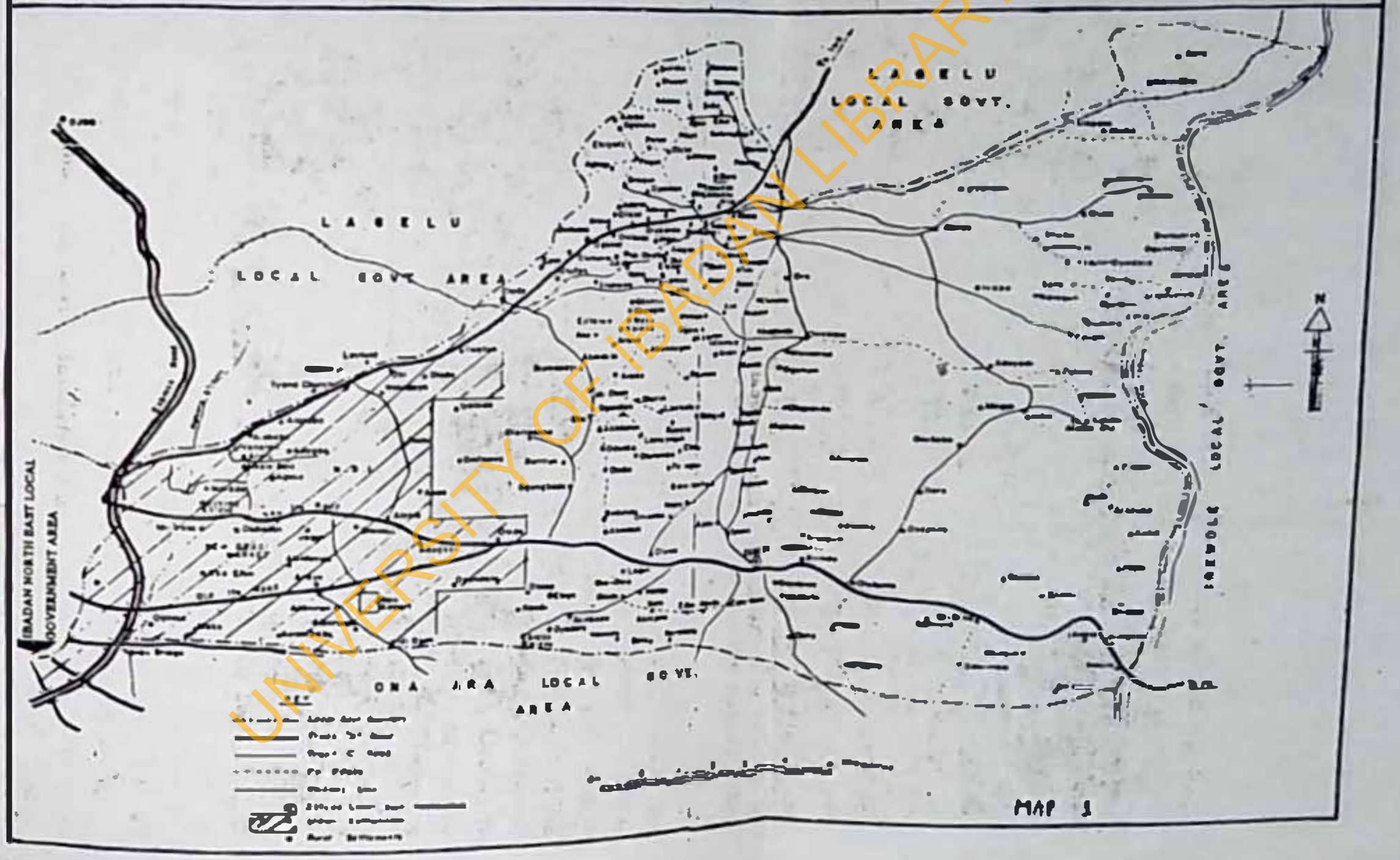
Ibeere 56 Nje o le da aba lati onile ode yi lowo lori a bada fun tabi akoso lori ilera abisi awon odo

1. Beeni 2. Beeko

Bi o ba je beeni, nu (awon) abaa re wa

E sec

THE SETTLEMENT PATTERN OF EGBEDA LOCAL GOVERNMENT AREA



MAP 1