ACCESS TO CONTRACEPTIVE USE: IMPLICATION FOR SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR) OF YOUTH IN ABIA CENTRAL SENATORIAL ZONE, NIGERIA

Goodluck Nwaogwugwu[1]
Coal City University, Enugu Nigeria[1]
(iheanyigoody@gmail.com)
+2347032922687
&
Uduma Ulu Eke[, 2]
Abia State University, Uturu, Nigeria[2]
+2348027293644
(wembuduma@yahoo.com)

Abstract

This study used mixed method approach to ascertain access to contraceptive use: implications for sexual and reproductive health rights of youth's in Abia Central Senatorial Zone. The study adopted cross-sectional design, with a sample of 533 youth aged 15-39 years from Abia Central Senatorial Zone. Findings from the study established a strong statistically significant relationship between educational qualification and access to contraceptive use as indicated by the chi square values ($\chi 2$ =87.665; df = 1; P<.000). Also the result revealed that there is a statistically significant relationship between sex of the respondents and their views about health workers attitude to access to contraceptive use ($\chi 2$ = 58.582; df=1, p< .001). The result of the regression analysis shows that two variables, age and level of education are statistically significant (p = 0.000 and p = 0.003). The study recommended the implementation of ICPD framework on youths' health in Nigeria among others

Keywords: Contraceptive, Health, Reproductive, Sexual, Youth

Background

Globally, there is no established definition of youth. United Nations report (2012), the noted the following: "a chronological definition of who is young, as opposed to who is a child or who is an adult, varies with each nation and culture. However, the United Nations, for statistical purposes, defines those persons between the ages of 15 and 24 as youth without prejudice to other definitions by Member States." The use of 15 as the lower bound for youth, instead of 18, was driven by statistical considerations, since data are very often available only in terms of age groups that span five years (UN 2012).

However, World Health Organization (WHO 2018), reports 16 million youth aged 15-19 give birth each year, mostly in low and middle-income countries. For many youth, pregnancy and childbirth are neither planned nor wanted. Twenty-three million girls aged 15 to 19 years in developing regions have an unmet need for modern contraception (Darroch, Woog, Bankole & Ashford, 2016). As a result, half of pregnancies among girls aged 15 to 19 years in developing regions are estimated to be unintended (Darroch et al 2016). Many young women with unintended pregnancies resort to abortions which are mainly performed in unsafe conditions.

According to Singh, (2006), an estimated five million youth are admitted for treatment of complications from induced abortions each year, equating to an average rate of 5.7 per 1000 women per year in all developing regions. In Nigeria, it is estimated that 760,000 abortions are performed annually which translates to approximately 25 abortions per 1000 women aged 15-44 years, (Adinma, Eke, Iwuoha, & Akiode, Oji 2011). Since abortion is illegal in Nigeria, unless medically recommended to save a mother's life, many abortions are carried out in unsafe environments and the consequences of these clandestine abortions are grave and life threatening (Otoide, Oronsanya & Okonofua, 2001). Unintended pregnancy is a major challenge to the reproductive health of the youth.

However, Renzaho, Kamara, Georgeou and Kamanga (2017), asserted that sexual and reproductive health and rights (SRHR) applies the concept of human rights to sexuality and reproduction, and is focused on the intersection of four distinct fields namely, sexual health, sexual rights, reproductive health and reproductive rights. For one to maintain adequate sexual and reproductive health, access to accurate information (e.g. seek, receive, and impart information related to sexuality) and a choice of safe, effective, affordable contraception options are key (Renzaho et al 2017).

Family Care International (2015), emphasizes access to information empowers individual freedom of choice with respect to deciding whether to be sexually active or not (e.g. sexual debut); the pursuit of a satisfying, safe, and pleasurable sexual life; choosing a partner; consensual sexual relations and consensual marriage; protection from sexually transmitted infections (STIs); and family planning (e.g. whether or not, and when, to have children) (Family Care International 2015). Access to, health and information services for the youth is also essential to good sexual and reproductive health (United Nations 2015).

However, youth face barriers in accessing contraception including restrictive laws and policies regarding provision of contraceptive based on age or marital status, health worker bias and/or lack of willingness to acknowledge adolescents' sexual health needs, and adolescents' own inability to access contraceptives because of knowledge, transportation, and financial constraints (Morris & Rushwan. 2015). Additionally, adolescents face barriers that prevent use and/or consistent and correct use of contraception, even when adolescents are able to obtain contraceptives: pressure to have children; stigma surrounding non-marital sexual activity and/or contraceptive use; fear of side effects; lack of knowledge on correct use; and factors contributing to discontinuation (for example, hesitation to go back and seek contraceptives because of negative first experiences with health workers and health systems,

changing reproductive needs, changing reproductive intentions) (Igwegbe , Ugboaja & Monago (2009).

Nevertheless, if the contraceptive access does not increase, unplanned pregnancies among the youth in the country will remain high and will keep increasing. Consequently there is tremendous need for improvement on contraceptive access among the youth especially in rural communities. This is particularly true in Isiala Ngwa North local Government Area where it has been observed that there is a high incidence of unwanted pregnancies among young girls (Izugbara 2000; Ihejiamaizu, 2006). According to Okonta (2007), most of these girls who are victims of this situation usually drop out of school or married out at a very young age. There are also increases in the cases of abandoned babies, due to unwanted pregnancies. Newswatch (2011) reported that some of the babies are helplessly left either in gutters or market squares. According to Okonta (2007) these abandoned children sometimes are taken to where abandoned children or those whose parents died, are reared. According to National Agency for the Prohibition of Trafficking in Persons (NAPTIP 2010) there has been the discovery of some illegal baby making clinics in Isiala Ngwa where young girls who have unintended pregnancies are secretly kept until they give birth in exchange for a token or sold out for huge sums of money by the proprietor. Despite the existence of these unhealthy situations little or no scientific study has been conducted in Isiala Ngwa North to establish the access to contraceptive use: implication for sexual and reproductive health rights (SRHR) of youth using a mixed method approach. Access to contraceptives use has the potential to avert unplanned births, early marriage, high population growth, maternal morbidity and mortality, increase welfare, reduce dependency burden and protect future generations. Therefore, it is the major challenge of this study to ascertain access to contraceptive use: implication for sexual and reproductive health rights (SRHR) of youth in Isiala Ngwa North Local Government Area (LGA) of Abia State, Nigeria.

Methods

The study adopted cross-sectional design, with a sample of 533 youth from Abia Central Senatorial Zone. A multi-stage cluster sampling procedure, which entails successive selection of community clusters, villages, housing units and respondents, was employed. The study population were youth aged 15-39 years in Abia Central Senatorial Zone. Abia Central Senatorial Zone is made up of six local government areas of Ikwuano, Umuahia North, Umuahia South, Isiala Ngwa North, Isiala Ngwa South and Osisioma. The instruments for data collection were the questionnaire and FGD guide. Chi-Square ($\chi 2$) was used to establish relationships between socio-demographic characteristics of the respondents and access to contraceptives. Logistic regression analysis was used to predict the relationship between access to contraceptives and socio-demographic variables and also factors that may influence future access to contraceptives.

Results

Table 1: Distribution of respondents on educational qualification

Educational qualification	**Frequency**	**Percentage (%)**
No formal education	15	2.8
First School Leaving Certificate (FSLC)	17	3.2
Senior Secondary Certificate Examination(SSCE)	357	67.0
Bachelor's degree	144	27.0
Total	**533**	**100.0**

Sources: Field survey 2018

The above Table 1 shows that respondents who had no formal education were the least (2.8%). They were followed by those with First School Leaving Certificate (3.2%). Majority of the respondents had Senior Secondary Certificate Examination (67.0%) while

27.0% of the respondents had bachelor's degree. They were followed by those with First School Leaving Certificate (3.2%).

Table 2: Distribution of respondents on distance to the nearest health facility

How long does it take to get to the nearest health facility to you?	**Frequency**	**Percentage (%)**
2 hours and above	274	51.4
0-2 hours	259	48.6
Total	**49**	**100.0**

Source: Field survey 2018

Data in Table 2 above shows that respondents who accepted that it takes them 2 hours and above to get to the nearest health facility were the least (51.4%) and those who indicated that it takes them 0-2 hours to get to the nearest health facility were 48.6%.

The qualitative data also complements the quantitative data with the following responses from the various FGD sessions conducted in the LGA.

> "the place where you can get health centre or a hospital is not too close for someone to trek from this village. The place is far. The road is not smooth. Also, what prevents us from going there is that sometimes when you go there, you will not see someone to attend to you. Sometimes when you want to enquire about something about sexual issues you will be perceived as immoral especially if you are not married and such things discourage and prevents people from going to that health centre, instead, they would prefer to use any available method to solve their problems". **[Participant: FGD; Female Community Member, Amapu Ntigha]**

> "you know, the people who sell those things (condoms, pills etc) are your elders, relatives or in-laws and you know they are your senior, so it might be difficult to go to their shops to tell them that you want to buy condom or pill. They will start thinking that either you have become too wayward or you are carrying unwanted pregnancy that you want to do abort. That is a problem. Besides, where you can get it easily and cheaply is during main market days. You see, our main market is distant from here, about 4 kilometres away from our village. Another major problem we have in accessing contraceptives is distance to chemist shop. Sometimes you will trek distance before you reach the place. Sometimes you may not likely meet the chemist man/woman or nurse in the health centre because if it is during farming season forget it. The

chances are very small. So the only day you are sure of seeing chemist man/woman or nurse in the health centre is on a market day. Distance is a problem". **[Participant: FGD; Female Community Member Azuiyi Oloko]**

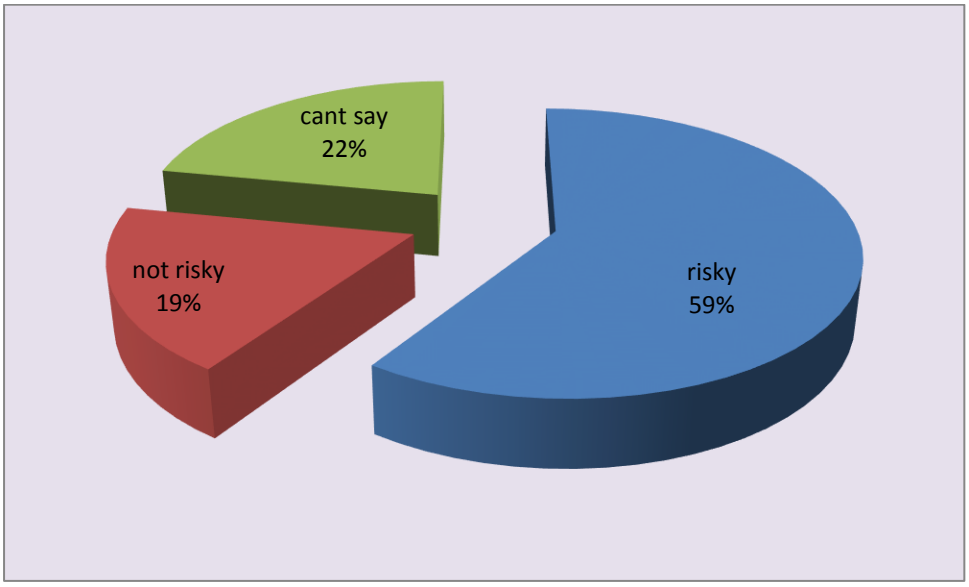

Figure 1: Distribution of respondents on how they perceive unprotected sex

Data from figure above shows that 59% of the respondents perceived unprotected sex as risky, 19% perceived unprotected sex as not risky while 22% can't say how they perceived unprotected sex.

This evidence is corroborated with the qualitative data, through which participants indicated that they perceived unprotected sex as risky as shown in the sample quotes below.

"Having sex without condom, is a big problem. People who have sex without condom to protect themselves may contact sexually transmitted disease. In most cases induced abortion will result because of unplanned pregnancy". **[Participant: FGD; Female Community Members, Amasaa Nsulu]**

Another participant in an FGD session with youth in Umunna Nsulu stressed that, the most common problem with youth especially some girls in this community is their inability to buy condom because some of them are young and are afraid of being seen buying condoms or pills. Instead they resort to the use of ***white-coria*** (a form of traditional contraceptive) which is not effective

enough to prevent pregnancy. This has caused death of some girls at one time or the other while some always fall sick due to complications in an induced abortion. On the other hand, "some men find it difficult to get their wives pregnant because of disease (***nsi-nwanyi***) contacted through an unprotected sex" **[Participant: FGD; Male Community Members; Mbawsi/Umuomainta]**

Table 3: Distribution of respondents on educational qualification and access to contraceptive use

Educational qualification	**Access to contraceptive**		**Total**
	2 hours and above	**0-2 hours**	
Low educational qualification	152 (39.1%)	237 (60.9%)	389 (100.0%)
High educational qualification	122 (84.7%)	22 (15.3%)	144 (100.0%)
Total	**274 (51.4%)**	**259 (48.6%)**	**533 (100.0%)**

$\chi 2$ =87.665; df = 1; P < .000, Critical $\chi 2$ value = 3.84146

Source: Field survey 2018

Table 3 is a cross tabulation of respondents educational qualification and access to contraceptives. In testing hypothesis two, the respondent's level of education was cross-tabulated with access to contraceptives. Level of education was re-coded as follows; all those that obtained "FSLC and SSCE" were re-coded as "low educational qualification" while all those that obtained "B.Sc, B.A, B.Ed, NCE, OND" were re-coded as "high educational qualification". The respondents were therefore grouped into two categories; those that attained low education and those that attained high education.

On the other hand, access to contraceptives was measured with reported hours it took respondents to get to a nearby health facility as shown in table 1 above. The category of 0-2 hours was grouped into "access to contraceptives" while the category for 2 hours and above was grouped into "no access to contraceptives".

The result in Table 3 shows that out of all those that attained low education, 39.1% do not have access to contraceptives while 60.9% did not have access to contraceptives. On the

other hand, of all those that attained high educational qualification, 84.7% do not have access to contraceptives while 15.3% have access to contraceptives.

From the results in the above table, it can be seen that greater percentage of the respondents that attained low educational qualification (60.9%) have access to contraceptives while a few percentage of those that attained high educational qualification (15.3%) have access to contraceptives. The Chi-square test showed that there is a strong statistically significant relationship between respondents' educational qualification and access to contraceptive. This was based on the calculated Chi-square test value of 87.665 which was greater than the tabulated value of 3.84146 with df of 1 and with the P value of 0.000 being less than the 0.05 maximum standard significance level. In other words, access to contraceptives use is indeed influenced by educational qualification.

Table 4: Respondents sex and their view on whether health workers attitude (N=533)

Variables	**Health workers attitude**		**Total**
	Yes	**No**	
Sex of respondents			
Males	199(69.8%)	116(46.7%)	315(59.1%)
Females	86(30.1%)	132(53.2%)	218(40.1%)
Total	285(100.0%)	248(100.0%)	533(100.0%)

$\chi 2$= (N=533), 58.582; df=1, p<.001; Critical $\chi 2$ value = 3.841
Source: Field survey 2018

From Table 4, it could be seen that of all the respondents that stated that health workers attitude could be a barrier to the access to use of contraceptive among the youth, 69.8% were males while 30.1% were females. Also, of all those that indicated that health workers attitude is not a barrier to access to use of contraceptive among youth, 46.7% were males while 53.2% were females. The result of the findings showed that more males indicated that health workers attitude is a barrier to the access to use of contraceptive among the youth than females. However, the chi-square value: $\chi 2$ = 58.582 which is greater than the Critical $\chi 2$

value = 3.841**;** df=1, p< .001 shows that there is a statistically significant relationship between sex of the respondents and their views on whether health workers attitude could be a barrier to access to use of contraceptives among the youth.

Table 5: Logistic regression predicting the influence of socio-demographic variables on dependent variable

Socio-demographic variables	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.366	.153		8.912	.000
Age	-.099	.025	-.205	-3.960	.000
Marital status	-.036	.047	-.037	-.769	.442
Educational qualification	.112	.038	.138	2.934	.003
Religious affiliation	-.003	.012	-.010	-.225	.822
Sex	.051	.044	.050	1.156	.248

Dependent Variable: Access to contraceptives
Field Survey, 2018

The analysis in Table 5, shows that independent variables are age, marital status, level of education and sex while access to contraceptive use is the dependent variable. The result of the regression analysis shows that two variables, age and level of education are statistically significant (p = 0.000 and p = 0.003). Therefore, age and level of education are good predictors of access to contraceptive use.

Discussion

Findings of this study indicated that majority of the respondents affirmed that it takes them 2 hours and above to get to the nearest health facility. Allen, Muhwezi, Kiwanuka, and Mbonye (2017), found that people living furthest from public facilities (8–10 km) indicated geographical barriers to care and barriers related to financial and other personal circumstances. Caretakers who lived closest to health facilities mentioned facility management and administration barriers twice as often as those who lived further away. Furthermore, the data obtained from qualitative assessment provided complementary

evidence of contraceptive access, which is mainly due to problem of distance. Munthali, Mannan, MacLachlan, Swartz, Makupe and Chilimampunga (2014) indicated that long distances to health facilities; poor attitude of health workers; belief in the effectiveness of traditional medicines; old age and their failure to walk. Some of these people who could not access the contraceptives believed in traditional medicine, and they stated that nothing could be done to transform them into users of health services.

Furthermore, the findings also showed that 59% of the respondents perceived unprotected sex as risky. In line with this finding, Kehinde, Mantue and Opeyemi (2010), found that respondents experience difficulty gaining access to family planning services due to little correct information about contraceptives; 42.9% had misperceptions about its safety, believing that contraceptives are dangerous and that chemicals in contraceptives can damage their reproductive system. In addition, the chi-square test showed that there is a strong statistically significant relationship between respondents' educational qualification and access to contraceptive. Olukayode & Idowu (2018) revealed that education influences access to contraceptives in Nigeria.

Conclusion and Recommendations

In this study, a critical look was taken on access to contraceptive use: implication for sexual and reproductive health rights (SRHR) of youth in Isiala Ngwa North Local Government Area (LGA) of Abia State, Nigeria. Accessibility of contraceptives is one of such factors that influence contraceptive prevalence. Access to contraceptives facilitates healthy pregnancies, births, mothers and babies are also essential to good sexual and reproductive health. The research revealed that distance is a barrier to contraceptive access.

However, the study also indicated that respondents perceived unprotected sex as risky as and is afraid of being seen buying condoms or pills because of their young age. The Chi-square calculated value of $\chi 2 = 4.379$ which was less than the tabulated or critical value Chi-

square of 5.99147, at the df of 2, P value of 0.112, which was higher than the maximum standard significance value (0.112), shows that there is no statistically significant relationship between perception of unprotected sex and access to contraceptive usage among the studied youth. Similarly, the Chi-square test showed that there is a strong statistically significant relationship between respondents' educational qualification and access to contraceptive. This was based on the calculated Chi-square test value of 87.665 which was greater than the tabulated value of 3.84146 with df of 1 and with the P value of 0.000 being less than the 0.05 maximum standard significance level.

Based on the findings of this study, the following recommendations are made to guide the government, organizations, institutions and others in addressing the access to contraceptives among the youth.

1. Government and Non-governmental organizations (NGOs), should assist in educating the people on the need to stop perceiving youth who come to any health facility for enquiry about sexually-related matters as immoral. This will help to increase investment in human capital development by incorporating youth focused, high-quality public education, livelihood training and health services (including reproductive health) into national development and investment strategies
2. The media should help to educate the youth to know the dangers of adopting any medication without receiving adequate health information from skilled health personnel.
3. Government and related authorities should consider it a matter of urgency to check out for communities where health centres are lacking in order to establish one in those communities.
4. Also the government should ensure that good access road are constructed and the existing ones in need of repair are rehabilitated

5. Governments should more political commitment to design rights-based, comprehensive programmes for adolescents and youth
6. Parents, communities and cultural leaders should be involved in efforts to promote adolescent reproductive health rights

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