MODERN CONTRACEPTION AMONG SEXUALLY ACTIVE UNMARRIED ADOLESCENTS AGED 15-19 YEARS IN NIGERIA

Young people in all regions are reaching puberty earlier, habitually engaging in sexual activity at a younger age, and marrying later (Blanc, Tsui, Croft, & Trevitt, 2009). As a result, they are sexually mature for longer before marriage than has historically been the case. Early onset of sexual activity could expose these young people to various ills such as unwanted pregnancies, which in turn lead to voluntary terminations of pregnancy and hence aggravate maternal mortality as well as create room for other health challenges. .

In Nigeria, adolescents account for up to 74% of all induced abortions—approximately 60% of all gynecological hospital admissions (WHO, 2007). The physically destructive possible aftermaths of unsafe abortion include cervical tearing, perforated uterus and bowel, hemorrhage, chronic pelvic infection and abscesses, infertility, endotoxic shock, renal failure, and death. The long-term sequelae include ectopic pregnancy, chronic pelvic pain, and infertility (Ibrahim & Onwudiegwu, 2012).

Pregnancy put younger mothers at an increased risk of obstetric fistula, anemia, eclampsia, postpartum hemorrhage, and puerperal endometritis (Haldre, Rahu, Karro, & Rahu, 2007; Michaud & Ambresin, 2014). Girls below age 19 have a 50% increased risk of stillbirths and neonatal deaths, as well as an increased risk for preterm birth, low birth weight, and asphyxia (Haldre et al., 2007). In addition to affecting the health of the mother, early childbearing also often prevents girls from attending school and perpetuate the cycle of poverty (Michaud & Ambresin, 2014).

A major way to avoid unintended pregnancies and its associated risk is through effective contraception. This is one of the most important health interventions of the twentieth century (Bongaarts, Cleland, Townsend, Bertrand & Gupta,2012). Its use has far reaching benefits for individuals, couples, households, communities, and society at large, including: pregnancy postponement, maternal and child health improvements, educational advances, reduction of poverty and empowerment of women. Yet despite these benefits and ongoing efforts to expand its access, contraceptive use is still low and unmet need for contraception is high in developing countries. Contraceptive use among young women (aged 15–24), especially unmarried, is lower than among relatively older women in the developing world. As a result, over 39.5% of young unmarried women in low and middle-income countries have an unmet for modern

contraception (MacQuarrie, 2014). Unmet need is highest among young unmarried women in Africa, primarily, the West and Central African regions (41.7%), in Ghana (45.7%) and Haiti (44.8%) ; and lowest in Egypt (8.8%) and Indonesia (8.0%) (Cleland, Conde-Agudelo, Peterson, Ross & Tsui, 2012). The high unmet need levels underscore the importance of understanding the factors that promote or hinder utilization of contraceptives among young women.

The World Health Organization (WHO) in 2011, released guidelines on averting early pregnancy and poor reproductive outcomes in adolescents from developing countries of which increasing access to and use of contraceptives is a crucial aspect (WHO,2011).

All women, irrespective of their sociodemographic status, should have access to and practice lifesaving contraception as long as they desire. This is a critical milestone to ensuring universal access to sexual and reproductive health care services by 2030, as laid out in Sustainable Development Goal 3.

By using a more comprehensive Health Belief Model-guided approach to assess modern contraceptive behavior among Nigerian adolescents aged 15-19 years, this study will be able to clarify factors that facilitate contraceptive behaviour. The Health Belief Model (HBM) as applied to contraceptive behaviour, is a cognitive, interpersonal framework that perceives humans as rational beings who use a complex approach to decision-making regarding whether to perform a health behavior (Rosenstock,1974). HBM has been widely used to evaluate health-related beliefs in respect of protective behaviors.

This model contains several primary constructs that predicts why people will take action to prevent a condition; these include perceived susceptibility, severity, benefits and barriers to a behaviour, health motivation and cues to action. HBM variables will be used to predict adolescent contraceptive behaviour as reviewed from previous studies.

This study is a cross sectional study and will use data from the 2013 Nigeria Demographic and Health Survey (NDHS). This survey is nationally representative and it is the sixth conducted in Nigeria. Four previous ones were conducted in 1990, 1999, 2003 and 2008. It is a five-year periodic worldwide survey programme designed by USAID with support from other international donors.

Data analysis will be of both descriptive and inferential statistics using STATA v14 to obtain the estimates of key indicators, and odds ratios (ORs) with 95% CIs, and a p-value of 0.05 as the cut-off point for statistical significance.

PRELIMINARY RESULT

Table 1: Descriptive characteristics, prevalence of modern contraception and associated factors among adolescents

VARIABLE	FREQUENCY(%)	PREVALENCE	ODDS RATIO	ADJUSTED ODDS RATIO
AGE	M=17.5 SD=1.3	31.3	1.234*	1.137*
RELIGION				
Catholic	200 (17.9)	39.6	RC	RC
Other Christians	741 (66.4)	29.2	0.674*	0.563*
Islam	158 (14.2)	30.5	0.745	0.821
Others	16 (1.5)	33.3	0.978	0.763
EDUCATION				
At most Primary	145 (13.0)	13.0	RC	RC
At least Secondary	971 (87.0)	34.0	3.066*	1.759*
RESIDENCE				
Urban	564 (50.6)	35.7	RC	RC
Rural	552 (49.4)	26.8	0.621*	1.036
REGION				
North Central	150 (13.4)	27.1	RC	RC
North East	63(5.6)	6.5	0.271*	0.353*
North West	78 (7.0)	25.6	0.856	0.760
South East	215 (19.3)	38.9	1.988*	1.970*
South South	345 (31.2)	31.7	1.444	1.678*
South West	262 (23.5)	34.6	1.864*	1.806*
LIVING ARRANGEMENT				
Parent	745 (66.7)	29.7	RC	RC
Grandparent	88 (7.9)	27.8	0.773	0.688
Other relation	219 (19.7)	35.9	1.356*	1.215
Non relation	64 (5.7)	39.9	1.768*	1.643
HOUSEHOLD WEALTH				
Poorest	46 (3.6)	5.7	RC	RC
Poorer	199 (15.5)	20.1	2.398	1.459
Middle	364 (28.4)	29.3	4.314*	2.085
Richer	350 (27.3)	35.1	5.409*	2.174
Richest	321 (25.1)	38.0	7.146*	2.395
AGE AT FIRST SEX				
<15	304 (27.2)	22.3	RC	RC
>=15	812 (72.8)	34.7	1.786*	1.476*
EVER GIVEN BIRTH				
No	980 (87.8)	33.9	RC	RC
Yes	136 (12.2)	12.9	0.300*	0.311*
ABORTION HISTORY				
No	1085 (97.2)	31.1	RC	RC
Yes	31 (2.8)	38.0	1.422	1.042
HEARD OF STD				
No	43 (3.9)	8.0	RC	RC
Yes	1073 (96.1)	32.3	4.490*	2.587
NUMBER OF SEXUAL PARTNER				
One	802 (72)	30.0	RC	RC
More than one	315 (28)	35.1	1.274	1.451*

Weighted frequency and percentages *p<0.05, RC reference category, NDHS 2013

Adjusted analysis in table 1 above reveals that age was positively associated with modern contraceptive use among adolescents in Nigeria [AOR: 1.137,CI 1.015-1.274] as well has having higher education [AOR:1.759,CI 1.071-2.890]. Residing in South East [AOR: 1.970,CI 1.200-3.233], South South [AOR: 1.678,CI 1.083-2.600] and South West [AOR: 1.806,CI 1.153-2.827] was associated with higher odds for modern contraceptive use compared to residing in North Central region while it is lower for adolescent residing in the North East region [AOR: 0.353,CI 0.154-0.811].

Older age(≥15) at first sex is associated with higher odds of modern contraception [AOR:1.476,CI 1.037-2.101] compared to lower age (<15) at first sex. Having fertility history was associated with lower odds for modern contraceptive use [AOR:0.311,CI 0.189-0.511] compared to not having fertility history. Multiple sexual partner is associated with higher odds of modern contraceptive use[AOR:1.451,CI 1.083-1.945] compared to having one sexual partner.

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