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Meeting Young Women's Sexual and Reproductive Health Needs in Nigeria

Gilda Sedgh, Akinrinola Bankole, Friday Okonofua, Collins Imarhiagbe, Rubina Hussain, Deirdre Wulf

HIGHLIGHTS

- Educational attainment of young women in Nigeria has increased in all parts of the country since 1990, but levels and trends vary widely across regions; by 2003, the proportion of women aged 15–19 having some secondary education ranged from 17% in the North West to 78% in the South East.
- The proportion of young women living in urban areas has risen in all regions except the South West.
- The prevalence of marriage among female adolescents declined in Nigeria, from 39% to 33%, between 1990 and 2003. As of the latter year, early marriage was far more common in the North East and North West regions (59–73%) than in the southern regions (3–10%).
- Early childbearing is also declining but still common: In 2003, almost one in three women aged 20–24 had had a child by age 18.
- Use of modern contraceptives among sexually active female adolescents has increased in most parts of the country but remains extremely low. Nationally, the proportion using modern methods doubled from 4% in 1990 to 8% in 2003. It is far higher in the South South and South West (26–39%) than in other regions.
- Nearly one-third of sexually active women aged 15–24 had an unmet need for modern contraceptives in 2003.
- Government policies and strategies promoting the sexual and reproductive health of young people in Nigeria have not been successfully carried out.
- International, national and local nongovernmental organizations are implementing programs to promote the reproductive health of Nigerian youth.
- Improving the sexual and reproductive health of young people will require coordination of disparate efforts; financial commitment on the part of the federal and state governments; and consideration of the varying religious, sociocultural, familial and educational circumstances of adolescents in Nigeria.

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Introduction

With a population of about 140 million,[1,2(p. 42)] Nigeria is home to more than one-fifth of the entire population of Sub-Saharan Africa. The restoration of civilian rule in 1999 and the election of a new president in 2007 strengthened the country's sense of hope for progress toward a more developed society, a stronger economy and a healthier population.

During the past decade or so, Nigeria signed on to a number of regional and international conventions* focusing specifically on the welfare and health of young people and women. Sexual and reproductive health among adolescents (15–19-year-olds) has become an area of focus of the Federal Ministry of Health and of health-based nongovernmental organizations (NGOs). Official policies at both the national and state levels in Nigeria now promote the goal of improving adolescent sexual and reproductive health. Added to these political developments, the declaration of the United Nations Millennium Development Goals has given momentum to efforts by international and national stakeholders to rise to the development challenges facing the world's less developed regions, particularly Sub-Saharan Africa. The United Nations' goals underscore the importance of women and children for any country's improved future.

Worldwide, but particularly in countries where poverty is widespread, as it is in Nigeria, early pregnancy and childbearing as a result of both early marriage and early sexual activity outside of marriage are generally disadvantageous for young women. Motherhood at a young age jeopardizes women's health, their economic prospects and the health and well-being of their families.

Many adolescent women are not sufficiently developed physiologically to safely experience pregnancy and childbirth, especially in countries with inadequate or inaccessible maternal health care services. In addition, pregnancy and motherhood before the age of 18 often force young women to curtail their schooling. Poor education reduces the likelihood that young women can develop their full human potential, adapt to changing economic circumstances, obtain well-paying work outside the home, contribute to their family's well-being and play an active role in social development.

Some young women, especially unmarried ones, who experience an unwanted pregnancy seek induced abortions to resolve the situation.[3] However, because abortion in Nigeria is highly restricted by law, the procedure is often performed clandestinely and under unsafe conditions. Such procedures pose serious health and social risks for all women, but particularly for young and disadvantaged women, who may not have the means to obtain a safe abortion.

With an estimated HIV prevalence of 3.9% among 15–49-year-olds in Nigeria,[4] sexually active adolescent women must also consider how to protect themselves from HIV and other STIs, even as they seek to prevent unplanned pregnancies. In fact, a low level of knowledge of reproductive health among adolescents and limited access of young people to youth-friendly health services have been identified as underlying factors contributing to the rising trend of HIV/AIDS in Nigeria.[5]

About This Report

This report focuses on the reproductive health status and needs of young women aged 15–19 in Nigeria, drawing mainly on findings from the Nigeria Demographic and Health Surveys of 1990 and 2003 and on unstructured interviews with key stakeholders in the government and NGOs involved in promoting adolescent reproductive health in the country (see Data Sources box, page 4). It assesses the current status of and recent trends in the sexual and reproductive behaviors and health needs of these women. It also examines social and health policies and programs addressing such needs and highlights the gaps in policies and services that suggest priority areas for improving the implementation of adolescent sexual and reproductive health and development policies.

The report looks specifically at changes in sexual activity, contraceptive behavior and adolescent childbearing in Nigeria over the past 15 years or so. It seeks to identify trends in the timing of key events—marriage, sexual initiation, use of contraceptives, pregnancy and childbearing—among young Nigerian women, and to understand the factors that may have contributed to these changes. These dynamics are examined at the national and regional levels and across differing social and cultural settings.

*These include but are not limited to the Cairo Declaration on Population and Development, 1994, and the Adolescent Health Strategy for the African Region, approved by the 51st session of the Regional Committee in 2001.

The purpose of this report is to inform future reproductive health policies and programs designed to improve the lives of young women and their families and communities. To be effective, policies and programs must respond to the wide variations in young women's needs for reproductive health care information and services in Nigeria.

DATA SOURCES

This report is largely based on data from the Nigeria Demographic and Health Surveys (NDHS) of 1990 and 2003.[6,7] The first survey was undertaken by the Federal Office of Statistics, Nigeria, and Macro International Inc., United States. The second survey was conducted by the National Population Commission, Nigeria, and Macro International Inc. These surveys are part of a worldwide project designed to collect and disseminate data on fertility, family planning, maternal and child health, and HIV/AIDS, and are sponsored mainly by the U.S. Agency for International Development. The samples are nationally representative and are large enough to permit estimates for the country's current six geopolitical regions.

The surveys used similar methodologies, and most of the variables were standardized across the surveys, making it possible to compare their findings. The 1990 survey interviewed 8,781 women aged 15–49, and the 2003 survey interviewed 7,620 women this age. Data from the intervening 1999 NDHS are not included in this report because the quality of the data for some indicators in the survey, including many of the ones discussed here, have been questioned. Because the report focuses on female adolescents, analysis was restricted largely to data collected from women aged 15–19. Occasionally, data from women aged 20–24 were analyzed to examine their sexual and reproductive behaviors as adolescents.

In addition to drawing on the NDHS, we consulted a number of published and unpublished reports, including publications by government agencies and NGOs. The report's policy, program and funding findings derive largely from these sources. We also had informal discussions with colleagues in and outside of the government who work in the area of adolescent sexual and reproductive health to obtain their views on the existing programs, policies and funding situation, including their adequacy and implementation.

A Snapshot of Nigeria and Adolescent Nigerian Women

Nigeria's population is growing by 2.2% a year[5]; at this rate, it will double every 32 years. Poverty is widespread: Nine out of 10 Nigerians live on less than US$2 a day.[5]

Topographically, the country ranges from marshes and rain forests in the South, to arid savannas in the North. Nigerians belong to about 250 ethnic groups, speak 380 languages and dialects, live in six distinct geopolitical regions, and ascribe to a wide range of traditional political institutions, cultural practices and religions. The North West and North East regions are predominantly Muslim, the North Central and South West regions are just over a third Muslim and almost two-thirds Christian (both Catholic and non-Catholic denominations), and the South South and South East regions are largely Christian. In general, the South is more economically advanced than the North.

Six in 10 women aged 15–19 live in the country's three northern regions.[7] Many states in these regions operate primarily under Sharia law, a set of Islamic laws and norms governing religious, political, economic and social conduct. By contrast, the three southern regions operate under secular laws. In cultural, ethnic, religious and geographic terms, Nigeria might therefore be viewed as two distinct states within a single federated country. This profound division and the widely differing cultural and ethnic influences prevalent in the North and the South are reflected in substantial differences in levels of and recent trends in adolescent women's reproductive behavior.

However, this dichotomization does not capture the full complexity and diversity of Nigeria's cultural, demographic and social landscape. Even within individual northern and southern regions, the course and potential of young women's lives can vary across geographic zones.

Urbanization and education are slowly rising

Most young women live in rural areas, except in the South West region, which includes Lagos state, the country's largest urban metropolitan area (Figure 1, page 6). At the end of 1991, the seat of government was moved from Lagos to Abuja, in the North Central region.[8] As a result, many federal government offices and staff, politicians as well as private companies, moved to Abuja, thereby radically altering the demographic profile of the population of that region, including the level of urbanization.

Some young women—especially in the South—are staying in school longer. A positive development in the lives of young Nigerian women today is the growing likelihood that they will achieve some secondary schooling. Overall, the proportion of 15–19-year-old women who had had seven or more years of schooling rose from 34% in 1990 to 50% by 2003 (Figure 2, page 7). This is an important and encouraging trend, given the significant role that girls' education is known to play in their social and economic well-being and autonomy as women.

However, the experience of young women in the North and South remains very different. By 2003, the proportion of women aged 15–19 with some secondary education was only 17% in the North West region, 22% in the North East region and 55% in the North Central region. It is noteworthy that in the three northern regions, the proportion of female adolescents with more than an elementary education doubled or almost quadrupled in some cases (up from 5–20%), even though the absolute level remained low.

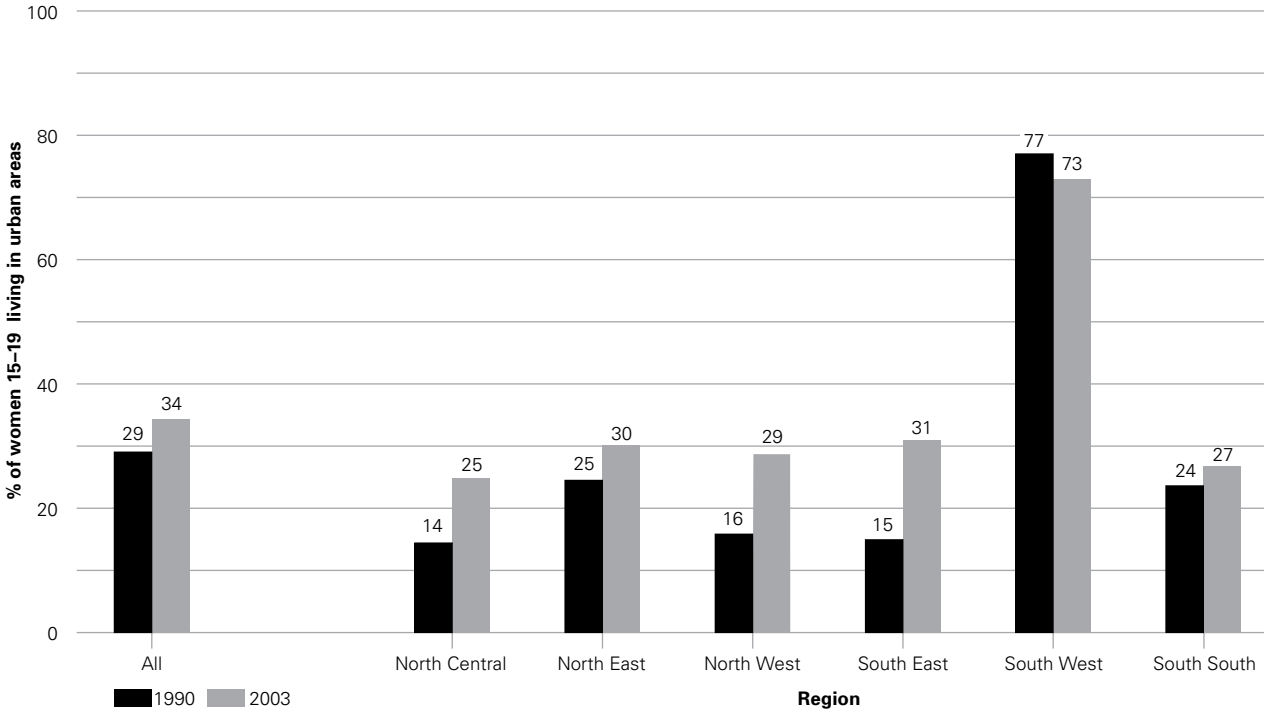
By contrast, the proportion of young women with some secondary schooling increased to 76–78%, from 43–63%, in the three southern regions. By 2003, despite some gains, young women's educational achievement in two northern regions was still far below levels present 13 years earlier in the three southern regions.

Nationally, the proportion of adolescents in the highest tier of wealth declined, albeit slightly, from 37% to 34% between 1990 and 2003 (Appendix Table 2). This trend seems to be driven by increasing levels of poverty in the South West (although this region remains the wealthiest in the country). The South East has seen the greatest improvement in the proportion of youth who are well-off, and the economic conditions of women in the North East and North West have also improved moderately.

The mass media play a growing role in the lives of some young women

Radio and television play a major role in informing audiences and shaping life aspirations and personal values, particularly of young people. Women of childbearing age in Nigeria cite radio as being their most common source

FIGURE 1. Few female adolescents in Nigeria live in urban areas, with the exception of those in the South West.



Sources: References 6 and 7.

of family planning messages: In 2003, 40% of women aged 15–49 said this was the major way they obtained such information.[7]

Of the two types of media, radio is the more common: Almost six in 10 adolescent women listen to the radio on a regular basis (Appendix Table 2). There appears to have been no change in this proportion between 1990 and 2003 at the national level (58% in both years). However, patterns and trends by region are inconsistent. For example, regular listening actually fell in the North East and, to a lesser degree, in the South West during the 13-year period; remained unchanged in the South South; and rose in the other regions. In general, regular radio listening is more common in the more developed South than in the North. As of 2003, 75% of adolescent women living in the South West were regular listeners, compared with only 30% of their counterparts living in the North East.

North-South differences are even more notable in the case of exposure to TV (Appendix Table 2). Overall, the proportion of adolescent women regularly exposed to programming from this medium rose slightly, from 34% in 1990 to 41% in 2003. Levels of TV exposure for the more recent year were highest in the South West and the South South (62% in each), and lowest in the North East (17%) and the North West (29%). However, with the exception of the South West, which recorded a decline in TV exposure, modest to substantial increases occurred in all regions over that period.

In most developing countries, growing access to western-style entertainment and to images of urban, consumer-oriented lifestyles is often associated with an increased tendency to adopt some of the other behaviors associated with modernization—for example, the decision to marry later or to have small families. Media have also been successful tools for the dissemination of new social and cultural ideas in many settings. Radio and TV could be used directly to make reproductive health information widely available. However, such use might not be acceptable in the country's more socially conservative regions.

The need for popular and accessible family life and sex education programs of the kind that the mass media can deliver is made all the more urgent by findings that knowledge of these topics is very low among Nigerian adolescents; moreover, if Nigeria resembles other West African countries, most of what young people think they know is incorrect.[9] Informed stakeholders have therefore suggested that young people should be provided with relevant and accurate information beginning in their early teens, preferably before the initiation of sexual activity, when values, attitudes and behavior are still in formation.[9]

One in three female adolescents live in poor households

Many studies have associated poverty with risky sexual behavior among female adolescents. For example, in Nigeria, a study found that young women from less well-off households are more likely to have sex without using condoms than their peers from better-off households.[10] Similarly, in Burkina Faso, Ghana and Malawi, female adolescents from poor households are more likely than their counterparts from wealthy households to have had sex.[11] In 2003, about one in three Nigerian female adolescents lived in poor households—just as they had in 1990 (Appendix Table 2).

At the regional level, some important differences are noticeable. First, the proportion of young women dwelling in poor households is higher in the northern regions than in southern ones, with the South West and South East having the lowest proportions in 2003 (14% each). Second, while the North West and South East recorded a decline in the proportion of female adolescents living in poor households between 1990 and 2003, the reverse was the case in the South West, where the proportion rose from 7% to 14%.

Women are marrying somewhat later, particularly in southern Nigeria

The earlier young women marry, the sooner they are likely to start childbearing, and the greater their maternal health risks. Moreover, early marriage compromises young women's education, perpetuating a vicious cycle in which their economic prospects are diminished and they will likely have fewer resources to invest in their own children's well-being and education.

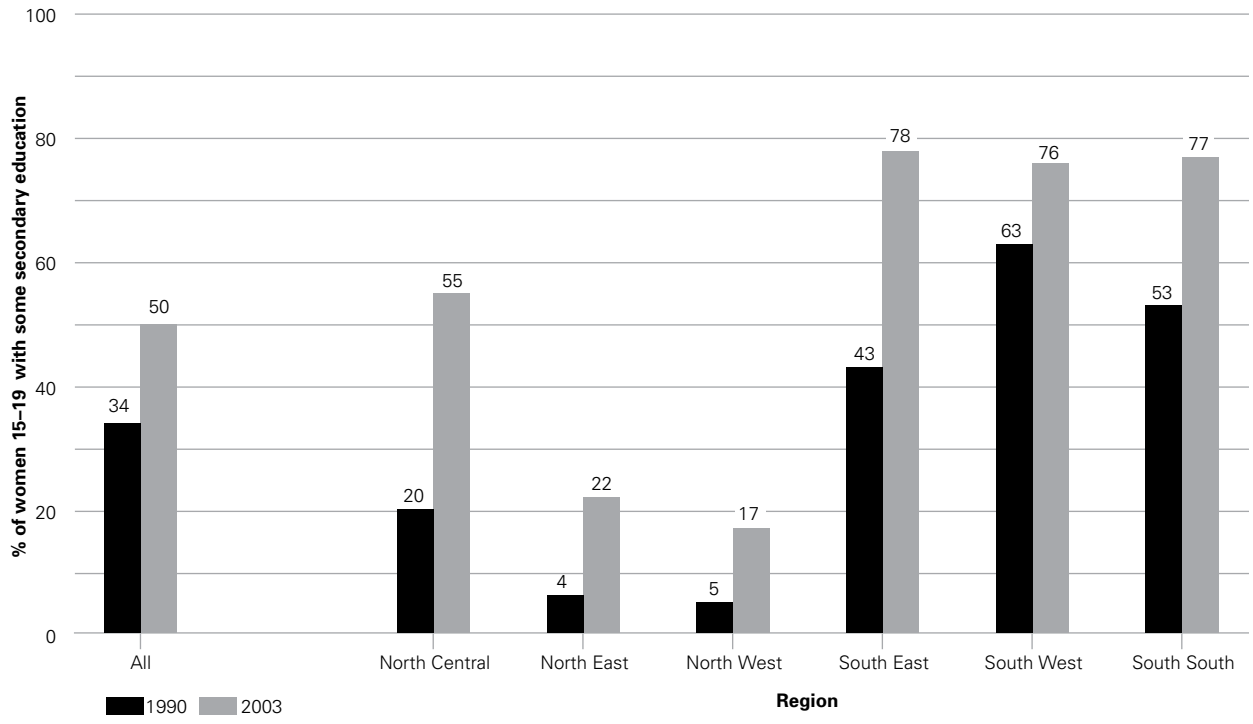
One-third of all women aged 15–19 in Nigeria are married (in a marriage or a cohabiting union), and there has been very little change in this proportion since 1990, when 39% had married (Figure 3, page 8). However, adolescent marriage is much more common in the North East and North West (where 59–73% of adolescent women have married) than in the three southern regions (where 3–10% have done so). In the North Central region, which fits neither extreme pattern closely but more closely resembles the southern pattern, 17% of young women have married.

Nationally, the proportion of women aged 15–19 who had married dropped by only 14% between 1990 and 2003, but it declined by 82% in the South East, by 57% in the South West and by more than half in the North Central region. This suggests a very rapid change in the perceived desirability of early marriage in at least three regions of the country.

As early marriage declines, young women are more likely to have sex outside of marriage

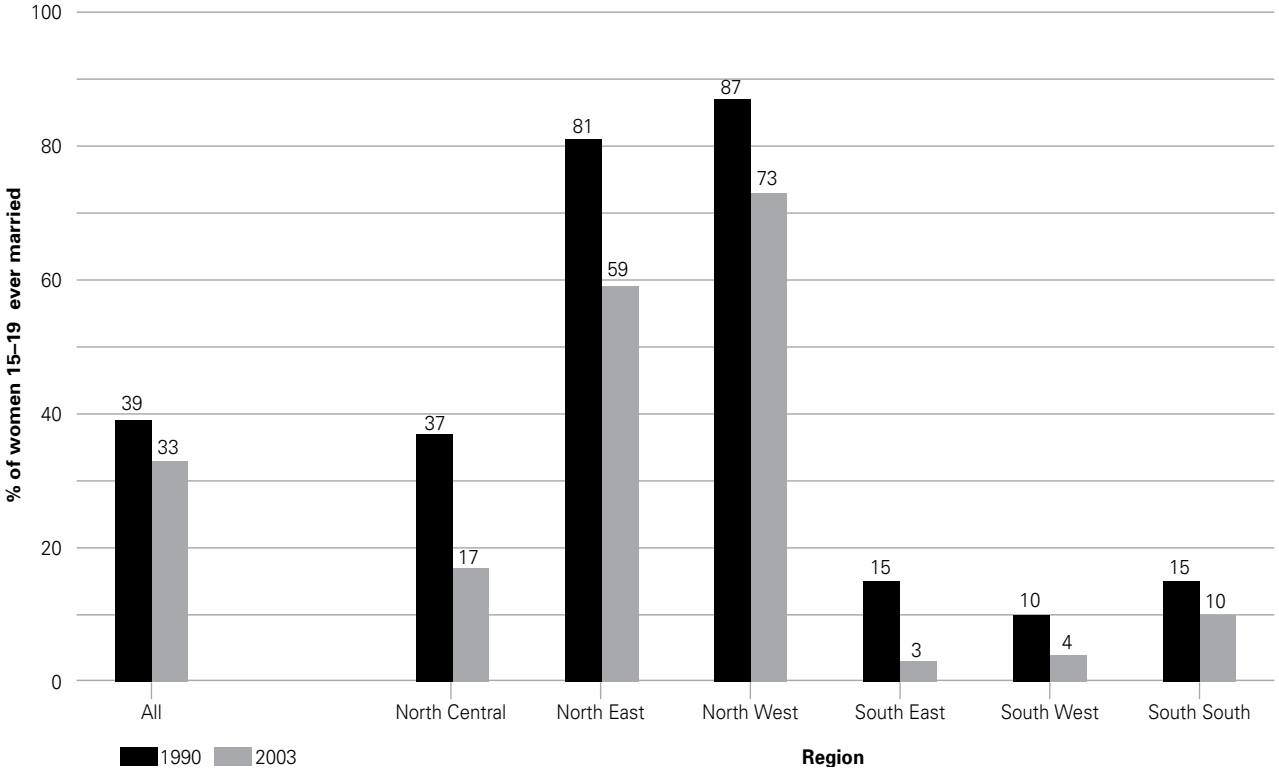
In some areas of the country where marriage in the adolescent years is becoming less common, sexual experience among never-married teenagers is becoming more prevalent. As of 2003, in the North East and

FIGURE 2. More young women in 2003 than in 1990 had had some secondary schooling.



Sources: References 6 and 7.

FIGURE 3. Adolescent marriage is very common in two northern regions and quite rare in the southern regions.



Sources: References 6 and 7.

North West regions, hardly any never-married women aged 15–19 had ever had sex—4% and less than 1%, respectively—even though the proportions married during their adolescence declined in these regions as well (Appendix Table 3).

By contrast, 39% of young women in the South South were never-married and had ever had sex, as had 33% in the South East, 21% in the North Central region and 18% in the South West. It is interesting that there is considerable variation in this measure among the three southern regions, despite similar levels of adolescent educational attainment and roughly similar proportions of adolescents who are married. A reported decline in premarital sexual activity in the South West region (from 30% to 18%) appears anomalous. This decline should be monitored in future surveys to investigate whether it is spurious or whether it represents a real change; in the latter case, a decline in premarital sexual activity might correspond to the much smaller but similarly atypical decreases in the percentage of female youth living in urban areas and having exposure to mass media in this same region.

*The total fertility rate is the total number of children a woman would have by the end of her reproductive life if she experienced the currently prevailing fertility rates throughout her childbearing years.

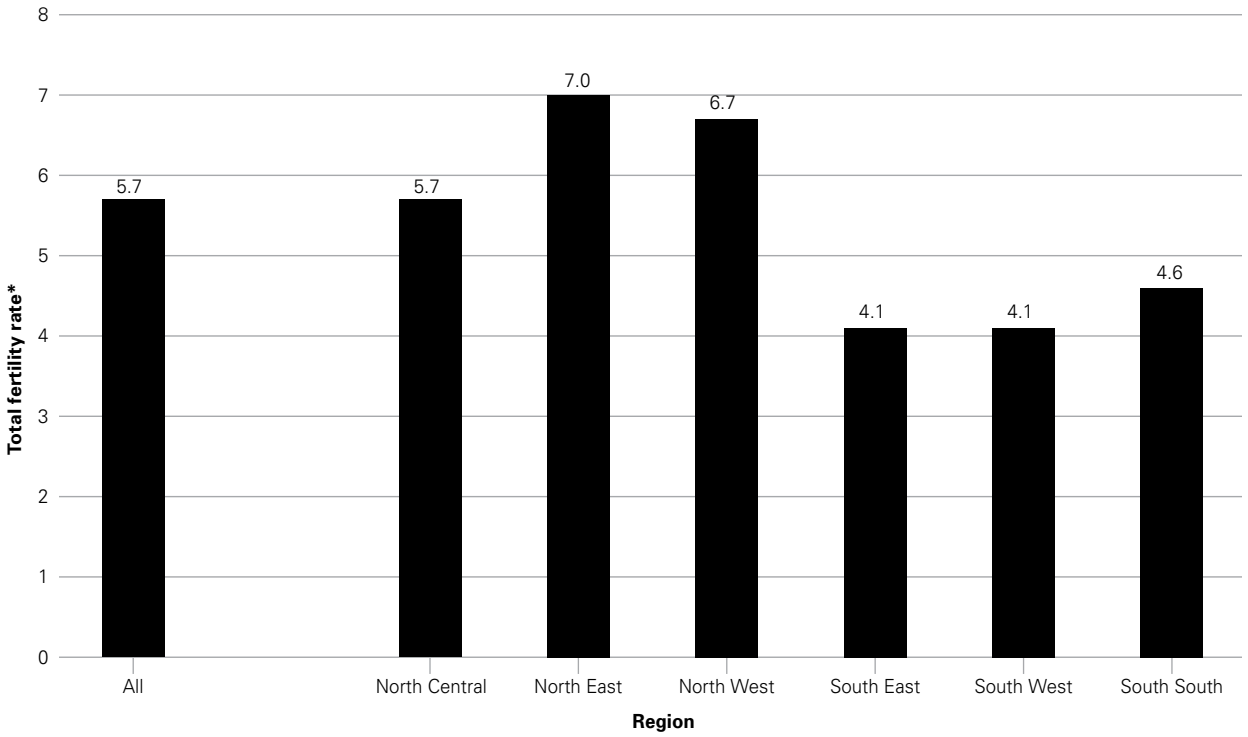
As is true in most countries of the world, reports of sexual activity among unmarried adolescents in Nigeria are probably underestimates. Many teenage women are understandably reluctant to admit to behavior that society disapproves of. In addition, we do not know whether nonmarital sexual activity among this group reflects coerced sex, a one-time event, occasional sex within a transient relationship or sex with a regular boyfriend. An earlier study found that about two-thirds of sexually experienced never-married adolescent women had intercourse in the three months before the study interview, suggesting that they were sexually active to some degree.[12(Table 3)]

Average family size in Nigeria is still large, but young women's childbearing is on the decline

The average size of families in Nigeria is declining, although the total fertility rate* is still about six children (5.7 children per woman—Figure 4). But women in the North would have an average of one to two-and-a-half children more than their counterparts in the South, at current rates. Fertility is lowest among women in the South East and South West (4.1 children in each region) and highest in the North East (7.0).

In Nigeria as a whole, in 2003, one-fifth of women aged 15–19 had had a child, down from one-quarter in 1990 (Figure 5, page 10). Aside from the South South,

FIGURE 4. Average family size was larger in the North than in the South in 2003.



*The total fertility rate is the number of children a woman would have if she experienced the currently prevailing fertility rates throughout her childbearing years. *Source:* Reference 7.

where there was no change between the two survey years, every region experienced noticeable declines in the proportion of adolescent women who had become mothers. In the South East and the South West, only 4–6% of women aged 15–19 had had a child, down from 8–13% in 1990. Adolescent childbearing was far more common in the North East and North West, where 37–38% of women this age had had a child, down from 46–48%.

By 2003, about half of women aged 20–24 in the two least developed northern regions had had a child before their 18th birthday, compared with only 3% in the South East and 8% in the South West (Appendix Table 3). There has been a moderate drop in the frequency of this behavior nationally.

Despite declines in the level of adolescent childbearing, the number of births to women aged 15–19 increased from 700,000 in 1990 to 924,000 in 2003.[2,6,7] This increase is attributable to a substantial increase in the size of the female adolescent population between the two time periods.*

Taken together, these patterns and trends reveal certain dynamics. Adolescent childbearing is clearly on the decline in Nigeria. At the same time, the rate of change has varied substantially across regions, and early childbearing remains common in some parts of the country.

Overall, the correlation between urbanization, longer schooling and a lower likelihood of early childbearing among adolescent women is striking. For example, in the North Central region (where change has been most marked), urban residence increased by nearly 80%, levels of secondary education among young women more than doubled, and the proportion who became mothers declined by 40% between 1990 and 2003.

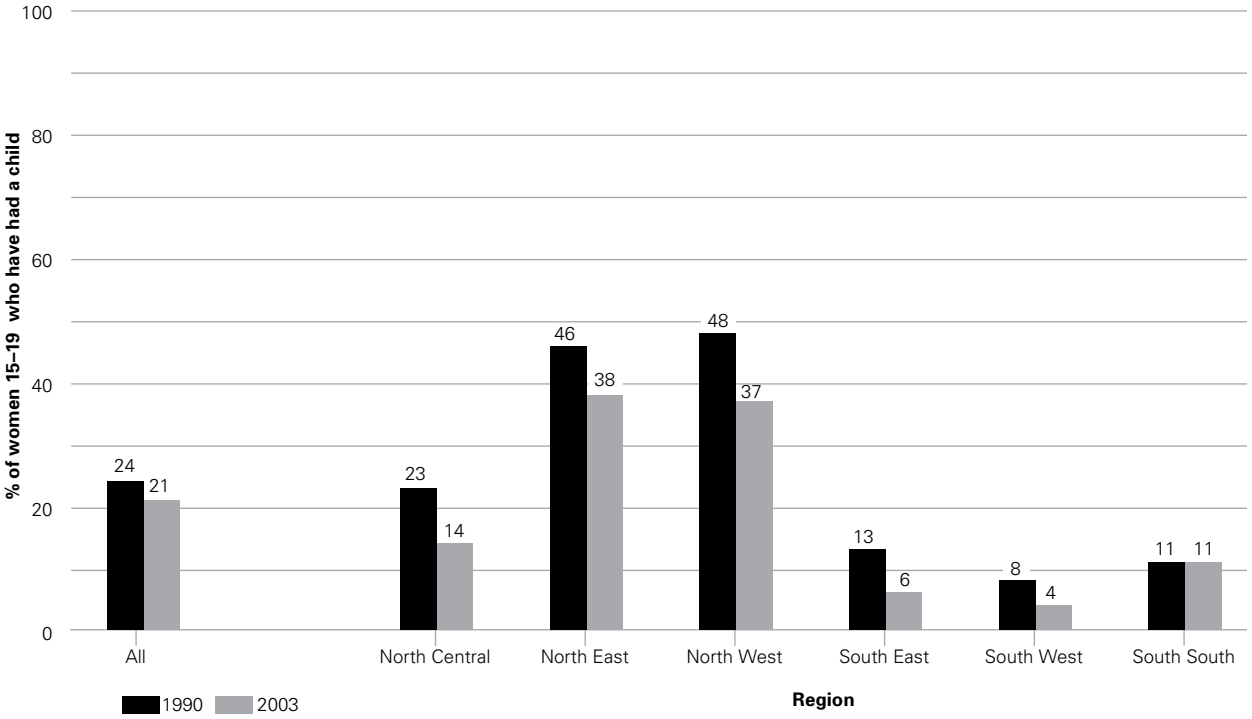
Although a causal association cannot be established through these surveys, it can be theorized that urban residence and earlier contact with and acceptance of western education, economic development and, perhaps, changing cultural values make it easier for young women in the South to stay in school beyond the primary level. These same young women will be more motivated to avoid having to raise a child while they pursue their schooling. In addition, the more educated young women are, the more likely they are to want a smaller family and to understand the benefits of having a job and some degree of economic independence.

Unplanned childbearing among young women is increasing

Not all young Nigerian women who become mothers had planned to do so. In 1990, 10% of births to all women aged 15–24 in the past three years were unplanned (Appendix Table 4). By 2003, this proportion had increased to 16%. In the South West and South South regions, the increase was much steeper than average,

*The numbers of Nigerian women aged 15–19 in 1990 and 2003 were obtained from reference 2.

FIGURE 5. One in five teenage women in Nigeria have already become mothers.



Sources: References 6 and 7.

rising from 12–14% to 32–43% during the 13-year period. In stark contrast, in 2003, only 5% of women this age in the North West reported an unplanned birth in the past three years.

Very few married female adolescents practice family planning

In many developing countries, especially those influenced by conservative social values, women who marry when they are still adolescents are expected to justify or fulfill their new status by becoming pregnant and having a child as soon as possible. This could help explain why only 4% of married young women in Nigeria are using any type of contraceptive (Figure 6). In contrast, among sexually active never-married young women, who are unlikely to want to become pregnant, 39% are doing so—18% are using the condom, 7% other modern methods* and 14% traditional methods.

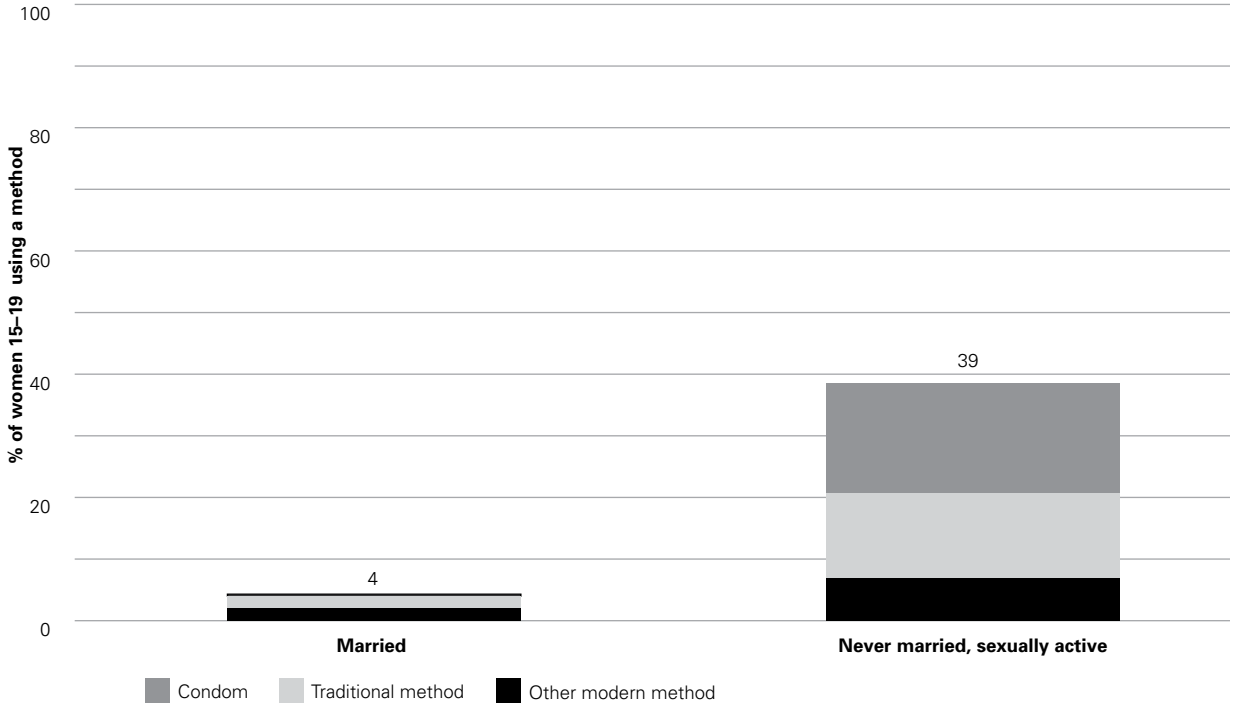
Overall, use of modern contraception by sexually active adolescents is highest in the South South and South West (26–39%), and it is lowest in the North East and North West (0–2%).

Sexually active women who do not want to become pregnant in the near future but are not using modern contraceptives to help them prevent an unwanted pregnancy are defined as having an unmet need for effective contraception. In Nigeria, unmet need is high among married young women and never-married sexually active young women alike. Nationally, among all married women aged 15–24, the proportion with unmet need fell slightly from 22% in 1990 to 19% in 2003 (Figure 7, page 12). Contraceptive use among married women this age has not increased (not shown); rather, the demand for contraception has decreased, as is evident from the fall in the proportion of these women who do not want a child soon from 60% to 52% (Appendix Table 4). Possible reasons for this change deserve further investigation. For example, as young women marry later (but still before they are 24 years old), they might initiate childbearing more quickly after marriage, space their first two births more closely in time, or both.

By comparison, among never-married sexually active women aged 15–24, the overall proportion with an unmet need for modern contraceptives is very high—60% as of 2003 (Appendix Table 4). This large proportion reflects the increasingly strong motivation of sexually active single young women to avoid childbearing. In the South East, the region with the highest level of unmet need, almost three-quarters of never-married sexually active women this age have an unmet need for a modern method of contraception.

*Modern methods include the pill, IUD, injectables, spermicide, barrier methods, and male and female sterilization.

FIGURE 6. Few married female adolescents practiced family planning in 2003.



Source: Reference 7.

Knowledge of family planning services is poor, leaving young women vulnerable

Knowledge and use of family planning services is vital to young women's sexual and reproductive health, regardless of their marital status. Young women who are involved in sexual relationships outside of marriage and do not use a condom face not only the likelihood of unwanted pregnancy, but also the risk of exposure to STIs, including HIV. This risk increases with the number of partners young women have. Married adolescents experience a different kind of reproductive health risk: Many of their husbands are much older than they are and thus have a high risk of having contracted an STI before their marriage. Given the fact that use of contraceptives of any kind—but particularly condoms—is virtually nonexistent among couples in which the wife is a teenager, her risk of contracting an infection from such an older husband can be very high.

Low levels of contraceptive use among married or sexually active adolescent women are hardly surprising in light of their poor knowledge of where family planning services can be obtained. What is more, the proportion of sexually active young women knowing where to obtain these services fell by almost half between 1990 and 2003, dropping from 32% to 18% (Figure 8, page 12). The level of knowledge in 2003 was lowest in the North East and North West (10% in each) and highest in the South West (31%), which includes Lagos. However, it is striking that a decline in knowledge of a family planning source has occurred in every region.*

Progress in Nigeria has been real but slow

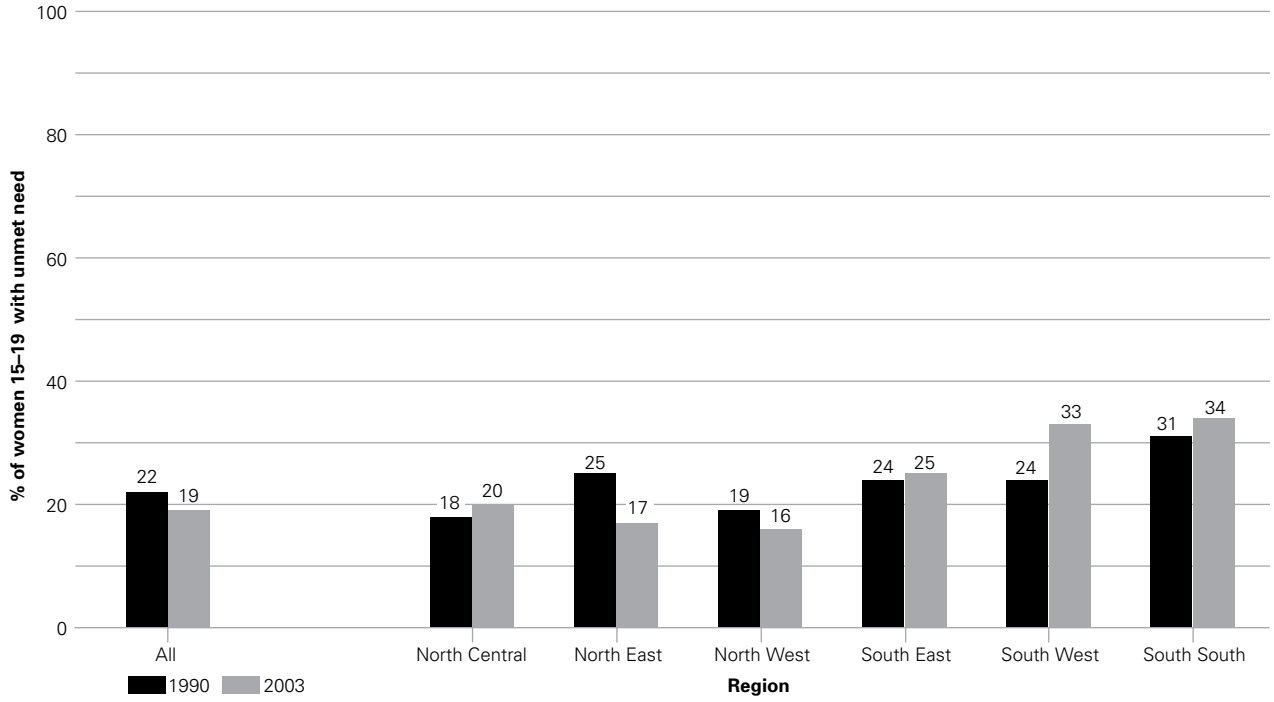
Overall, the level of early childbearing in Nigeria has declined modestly, by 13%, since 1990. The decline appears to be due to a combination of factors, including an increase in contraceptive use, especially among never-married women, and later age at marriage.

There is still, however, a long way to go toward meeting the reproductive health needs of young Nigerian women, and the country is lagging behind the region and the developing world in some critical respects. In the developing world as a whole, about 19% of married women aged 15–19 use a modern method of contraception, and the corresponding figure for the African subcontinent is 15%.[13] In this light, the prevalence of contraceptive use among young Nigerian women (3%) is all the more cause for concern. Unmet need for contraception among married adolescent women in Nigeria is also high at 16%, albeit somewhat lower than the 23% in a similar population in Sub-Saharan Africa.[9 (Figure 2.5)]

A significant finding of this report's analyses is that the dramatic improvements in educational attainment have been accompanied by modest declines in early marriage and much more attenuated decreases in adolescent fertility, while unwanted childbearing is on

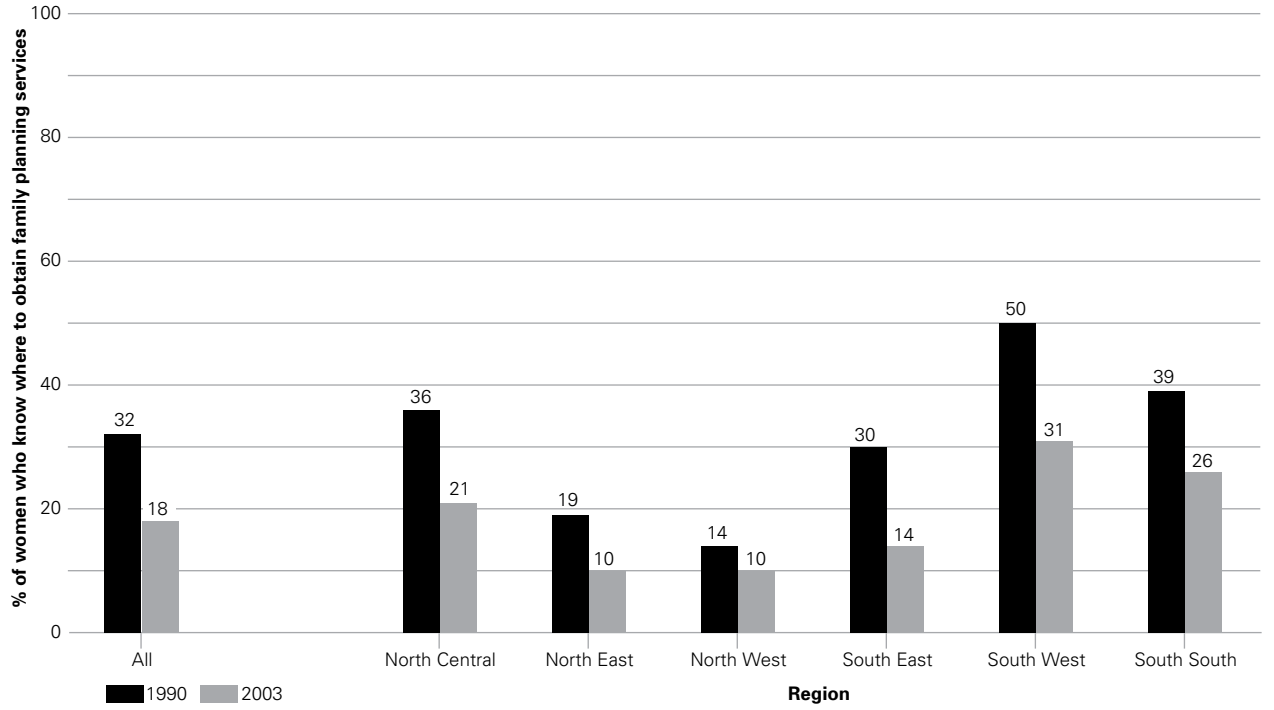
*Since this trend is highly unexpected, it should be emphasized that the question asked and the groups of women compared were exactly the same in both survey years.

FIGURE 7. Unmet need for modern methods among young married women has declined in some regions and risen in others.



Sources: References 6 and 7.

FIGURE 8. Knowledge of a source of family planning has declined among Nigeria's young women.



Sources: References 6 and 7.

the rise. The evidence suggests strongly that women do not have the means at their disposal to implement the changes they want to make in their reproductive lives. The case for this hypothesis is strengthened by the observation that young women's knowledge about family planning sources has deteriorated in recent years, and unmet need among young never-married women is high.

Policies and Programs to Promote the Sexual and Reproductive Health of Nigerian Youth

In 1995, the Federal Ministry of Health developed the first National Adolescent Health Policy, which was designed to create a climate for laws necessary to meet adolescent health needs and to promote and support the dissemination of knowledge and information to adolescents. The ministry revised this policy in 2006, in collaboration with other ministries, government agencies and NGOs.[14]

In 1999, the government formulated a National Adolescent Reproductive Health Strategic Framework,[15] which was revised in 2008. The revised framework encompasses a broad range of issues addressing adolescents, including sexual behavior, nutrition, drug abuse, education, career and employment, and parental responsibilities and social adjustment techniques. This strategic framework was designed to facilitate implementation of the National Adolescent Health Policy by translating the policy into actionable plans to promote adolescent sexual and reproductive health in Nigeria. The revised framework was also produced through partnerships with various federal ministries, government agencies and NGOs, as well as with input from the World Health Organization and young people themselves.

The government's promulgation of these policies and strategic frameworks suggests that it is aware of and responsive to the needs of adolescents. At the same time, however, it appears that mechanisms are not in place to fully implement these measures.

A range of small-scale programs are in place

A number of programs being carried out by federal and state ministries of health, government agencies and NGOs have arisen from these new policies. One of the most recent and notable federal programs aimed at improving adolescent sexual and reproductive health in Nigeria is the Family Life and HIV/AIDS Education (FLHE) curriculum and program, launched in 2002 and implemented by state Ministries of Education with the support of other government agencies and international partners, as part of an attempt to improve sex education in junior secondary schools across the nation. But uptake of the curriculum has been slow; so far, it has been implemented in only 10 of the 36 states.

A pilot project has been introduced to provide Family Life and HIV/AIDS Education services over the Internet and by telephone. The project is aimed at youth with access to computers and mobile phones. For example, a service called MyQuestion allows young people to ask questions about sexual and reproductive health and get accurate answers through text messages and e-mails.[16] The impact of such services would obviously be limited to wealthier or predominantly urban youth.

Several private international, national and local NGOs have carried out projects aimed at improving adolescent sexual and reproductive health in parts of the country. These projects include:

- centers for in- and out-of-school youth that build communities and provide channels for information dissemination;
- programs that provide counseling and referrals to social, economic and health care resources;
- youth-friendly health services, including HIV counseling centers;
- vocational training programs; and
- programs that develop educational curricula for adolescents.

Many of these pilot initiatives have improved adolescent health in Nigeria in small ways and have contributed to increased attention being paid to the issue of adolescent sexual and reproductive health. However, the impacts of these programs are too modest to measure at the national or regional levels.

Moreover, a barrier to the effectiveness of efforts to improve adolescents' sexual and reproductive health has been a lack of coordination among governmental and nongovernmental stakeholders, resulting in piecemeal efforts with limited impact.

Few of these programs are paid for by the government

Most service programs aimed at improving young people's sexual and reproductive health are subnational in scope, and most are funded by international donors such as the U.S. Agency for International Development (USAID) and private foundations (including the Ford Foundation, the Bill & Melinda Gates Foundation, the Rockefeller Foundation, the William J. Clinton Foundation, the David and Lucile Packard Foundation, and The John D. and Catherine T. MacArthur Foundation). The major developed country governments contributing to improved adolescent sexual and reproductive health ser-

vices in Nigeria are those of Canada, China, France, Germany, Italy, Japan, Switzerland, the United Kingdom and the United States. International agencies working on these programs include the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

Nigeria's federal government, state governments, Federal Ministry of Health and state Ministries of Health have yet to allocate specific funds in their yearly budgets for programs of this kind. The federal government, through the Federal Ministry of Health, does provide limited funding for the promotion of certain areas of adolescent sexual and reproductive health programs. However, there is no evidence of a budgetary allocation specifically for such programs.

The overall national health budget in 2007 was 122 billion naira, which translates into US$7 per person. Thus, the public sector—the health provider on which most Nigerians depend—is not funded adequately, and programs to implement well-intended policies fail when donors pull out of pilot projects that they have initiated.

Summary and Implications

The findings of this report confirm that in a broad sense, the sexual and reproductive lives of adolescent women in two out of the three northern regions of Nigeria differ quite substantially from the lives of those in the three southern regions. Accordingly, the reproductive health needs of these disparate groups also differ. In addition, young women's needs vary depending on their circumstances and life goals, particularly on whether or not they are married.

- Two northern regions (the North East and North West) are characterized by increasing but persistently low levels of education and high rates of early marriage and childbearing. Premarital sex is almost nonexistent. Most salient is the finding that the proportion of 15–19-year-olds who have had a child is up to 9–10 times higher in these two northern regions than in the three southern ones.
- In all three southern regions, about three out of four young women have had some secondary education, early marriage is uncommon, and adolescent fertility rates are dropping. In two of these regions, premarital sexual experience during adolescence is on the rise; in the South West, it appears to be declining.
- In the North Central region, certain characteristics of the population have changed dramatically in recent years and, by 2003, the proportion of adolescent women with some secondary schooling had risen to a level intermediate between that in the rest of the North and the South, as have rates of adolescent marriage and childbearing.

In all regions, modern contraceptive use among married women is almost nonexistent, and young women's knowledge about where family planning methods can be obtained is low. What is more, knowledge actually declined in all six regions between 1990 and 2003. Unmet need for modern contraception is high in Nigeria, and is especially so among never-married women.

In the northern regions where educational attainment is still low and desired family size remains high, programs that promote schooling and provide antenatal care to adolescent women are essential to ensuring adolescent reproductive health. In all of the southern regions, there is a dire need for efforts to address the growing levels of unintended pregnancy and the ominously high levels of unmet need for modern contraception among sexually active never-married adolescents.

Throughout the country, family planning information, counseling and services that are accessible to adolescents will help young Nigerian women achieve their fertility aspirations, even as these continue to change over time and with ongoing development.

A noteworthy feature of adolescent reproductive health interventions in Nigeria is the fact that they are sponsored by a variety of governmental and nongovernmental stakeholders. The result is piecemeal efforts with limited impact. Success in the future is contingent on coordinating efforts as well as broadening their scope. Forums that bring stakeholders together are a viable component of efforts to move in this direction. These forums could include events focused on strategic planning, technical exchange, the formation of synergistic collaborations or a combination thereof.

Some of the small-scale programs undertaken by the private sector represent models of interventions that could be successfully implemented on a wider scale. Efforts by the public sector (such as the curriculum for Family Life and HIV/AIDS Education) can also positively impact adolescent reproductive health more broadly if scaled up. These program expansions require sizeable investments, ideally from the Nigerian government, which has the potential to be the most stable source of program support in the country.

Finally, it is clear that approaches to the health problems of adolescents must come from a broad disciplinary spectrum, to reflect the wide-ranging experiences—religious, social, familial, educational—that shape young people's development. Efforts that extend beyond reproductive health interventions can positively affect this aspect of young people's lives as well. These include policies and programs that address domestic violence, economic welfare and women's empowerment in their communities and in their relationships.

Overall, young women's lives have improved in some but not all parts of the country. Policies supporting adolescent sexual and reproductive health are now on paper, but they are yet to be translated into meaningful program interventions that can catalyze progress on this front. One certain obstacle is a severe lack of funding at the national and state government levels. Therefore, a burning question remains: Who will invest in transforming the government's noble policy declarations into concrete programs and services that will improve the sexual and reproductive health of Nigeria's adolescents?[17(Table 8)]

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APPENDIX TABLE 1. Unweighted sample sizes for women grouped according to age and sexual status, overall and by region, Nigeria, 1990 and 2003

Group	All		North Central		North East	
	1990	2003	1990	2003	1990	2003
Women aged:						
15–19	1,678	1,749	224	260	138	305
20–24	1,682	1,464	208	261	157	242
25–29	1,658	1,356	206	260	156	252
Women aged 15–19:						
Married*	573	486	76	42	102	150
Never married, sexually experienced	287	287	31	57	3	18
Sexually active in last 3 months	811	667	109	74	105	166
Sexually active in last 12 months	858	764	112	95	106	174
Never married, sexually active in last 3 months	228	171	28	32	2	11
Never married, sexually active in last 12 months	272	258	30	49	3	17
Women aged 15–24:						
Sexually active in last 3 months	2,229	1,712	292	268	255	369

*Women who are married or in a cohabiting union. *Sources:* references 6 and 7.

	North West		South East		South West		South South	
	1990	2003	1990	2003	1990	2003	1990	2003
	355	385	245	278	484	276	232	245
	392	325	219	220	528	228	178	188
	471	325	202	152	441	206	182	161
	295	253	30	10	37	11	33	20
	2	6	32	64	150	47	69	95
	299	258	51	52	150	33	97	84
	300	265	59	68	180	51	101	111
	2	3	20	42	112	22	64	61
	2	6	28	58	141	40	68	88
	681	552	198	143	557	172	246	208

APPENDIX TABLE 2. Selected social, demographic and economic characteristics of young women, overall and by region, Nigeria, 1990 and 2003

Characteristic	All		North Central		North East	
	1990	2003	1990	2003	1990	2003
No. of women 15–49 (000s)	21,012	30,949	3,698	4,550	1,828	5,540
No. of women 15–19 (000s)	4,792	7,333	842	1,078	419	1,316
% of women:						
15–19	18.4	22.5	17.3	21.6	17.7	21.5
20–24	19.1	19.6	21.6	21.8	22.6	18.2
% of 15–19-year-old women who:						
Live in urban areas	28.6	33.8	14.4	24.8	24.6	30.2
Have some secondary education*	33.7	49.8	19.9	54.5	5.9	21.8
Regularly listen to the radio	58.0	58.4	44.7	47.5	44.9	29.9
Regularly watch TV	33.8	41.3	18.1	39.7	11.0	17.3
% distribution of women 15–19 by religion						
Christian	54.4	52.5	43.8	69.8	17.6	14.7
Muslim	42.3	47.0	54.0	28.9	80.1	84.9
Traditional/other	1.7	0.5	2.3	1.2	0.7	0.3
% distribution of women 15–19 by socioeconomic status†						
Low	29.4	29.4	26.3	31.8	52.2	48.0
Medium	33.4	37.1	52.3	41.7	32.4	36.1
High	37.2	33.5	21.4	26.4	15.4	16.0

*Seven or more years of schooling. †Socioeconomic status is based on an index of household amenities and characteristics.
Sources: references 6 and 7.

APPENDIX TABLE 3. Selected measures of sexual experience, marriage and fertility among young women, overall and by region, Nigeria, 1990 and 2003

Measure	All		North Central		North East	
	1990	2003	1990	2003	1990	2003
SEXUAL EXPERIENCE AND MARRIAGE						
% of women 15–19:						
Ever married	38.6	33.3	36.7	17.4	81.0	58.8
Currently sexually active*	51.0	43.6	44.9	29.8	80.9	60.1
Ever sexually active	54.4	51.2	47.6	38.4	83.1	63.3
Sexually experienced and never married	15.8	17.9	10.9	21.1	1.5	4.4
Median age at:						
First sex among women 20–24	16.6	17.4	17.5	17.8	14.8	15.6
First marriage among women 25–29†	17.2	18.5	18.3	18.9	15.1	15.9
First birth among women 25–29†	19.6	20.3	19.6	20.4	18.4	18.1
FERTILITY EXPERIENCES						
% of women 20–24 who gave birth before:						
Age 15	12.1	6.6	10.8	8.2	23.6	10.1
Age 18	34.9	28.0	34.3	18.9	54.6	46.6
Age 20	53.6	45.7	53.5	43.9	74.7	69.5
% of women 15–19 who:						
Have a child	23.5	21.0	22.5	13.7	45.6	38.1
Have ≥2 children	6.2	4.2	6.4	3.3	9.6	9.5
Age-specific fertility rate for women 15–19‡	146	126	116	107	241	221

*Had intercourse in last three months. †The 25–29 age-group is shown because sample sizes for the 20–24 age-group in southern regions are small. ‡Rate is for the three-year period preceding the survey. *Sources:* references 6 and 7.

	North West		South East		South West		South South	
	1990	2003	1990	2003	1990	2003	1990	2003
	5,274	8,511	3,047	3,002	3,635	3,900	3,530	5,447
	1,204	2,016	693	709	828	922	806	1,291
	15.5	20.0	19.6	24.4	18.6	22.8	22.7	27.0
	17.3	18.9	16.8	20.6	20.8	19.5	17.6	20.0
	16.0	28.6	15.2	31.1	77.0	73.4	23.6	26.5
	5.3	17.4	43.4	77.8	62.9	76.3	53.0	77.0
	47.4	71.4	60.2	68.9	86.9	75.3	58.9	58.0
	10.9	28.6	30.1	46.7	74.2	61.5	47.0	61.8
	4.4	5.5	88.8	98.9	63.3	59.4	96.1	98.9
	95.3	94.0	0.4	0.6	35.7	40.1	0.3	0.8
	0.0	0.5	6.0	0.6	0.7	0.5	0.9	0.3
	49.1	35.0	26.2	14.4	7.1	14.3	23.5	22.7
	30.4	44.0	40.3	42.8	18.0	23.0	29.8	32.3
	20.5	21.0	33.5	42.8	74.9	62.7	46.7	45.0

	North West		South East		South West		South South	
	1990	2003	1990	2003	1990	2003	1990	2003
	87.4	73.0	15.3	2.8	9.5	4.1	14.9	9.7
	87.4	72.6	21.3	24.0	31.9	12.8	44.9	34.3
	88.3	73.8	26.5	35.6	39.4	22.5	47.0	48.6
	0.9	0.7	11.6	32.8	29.8	17.9	32.1	39.1
	14.2	15.6	18.4	20.2	18.4	19.1	17.5	17.8
	14.4	15.1	19.4	23.8	20.5	22.7	20.3	21.4
	17.9	18.3	20.5	25.7	21.3	23.7	20.3	22.2
	23.8	9.8	7.0	0.7	0.9	0.5	6.9	5.2
	59.6	50.1	19.7	2.6	13.9	7.5	24.6	15.3
	79.0	71.7	37.6	9.3	28.2	17.7	45.9	26.9
	48.0	36.9	12.5	5.6	8.1	4.1	11.3	11.3
	13.5	7.2	4.0	0.0	1.4	0.9	3.3	1.1
	252	208	96	21	73	40	90	66

APPENDIX TABLE 4. Selected measures of contraceptive knowledge, use and needs among young women, overall and by region, Nigeria, 1990 and 2003

Measure	All		North Central	
	1990	2003	1990	2003
CONTRACEPTIVE KNOWLEDGE AND USE				
Average no. of modern methods* known among women 15–19	1.2	1.9	1.8	2.5
% of all sexually active women† 15–19 using:				
Modern methods*	3.7	8.3	5.0	9.9
Traditional methods	7.1	5.1	1.7	1.4
% of married women§ 15–19 using:				
Modern methods*	0.6	2.5	0.0	2.7‡
Traditional methods	0.7	1.9	2.2	0.0‡
% of never-married sexually active women†† 15–19 using:				
Modern methods*	12.3	24.9	**	**
Traditional methods	25.1	13.8	**	**
CONDOM USE				
% of never-married sexually active women‡‡ 15–19 who used a condom at last sex	§§	21.5	§§	13.3‡
Reason for condom use at last sex among all sexually active women†† 15–19				
Did not use	§§	92.5	§§	90.9
Family planning only	§§	4.1	§§	5.2
STI protection only	§§	0.4	§§	1.3
Both family planning and STI protection	§§	2.4	§§	1.3
CONTRACEPTIVE NEEDS				
% of married women§ 15–24 who do not want a child soon	59.7	52.4	50.7	55.3
% of births in past 3 years to women 15–24 that were unplanned among:				
All women	10.4	16.2	14.1	16.5
Married women§	8.9	12.6	12.9	12.8
Never-married women	60.3‡	79.3	**	§§
% 15–19 with unmet need*† among:				
All sexually active††	**	30.2	**	48.6
Married§	23.8	16.4	19.1	21.6‡
Never married, sexually active††	**	67.5	**	79.4‡
% 15–24 with unmet need*† among:				
All sexually active††	**	28.3	**	31.8
Married§	21.9	19.2	18.3	19.6
Never married, sexually active††	**	60.2	**	67.2
RECEIPT OF INFORMATION AND SERVICES*‡				
% 15–19 who know a source for:				
Family planning services	31.5	17.6	36.0	21.3
Condoms	§§	19.0	§§	19.1
% of sexually experienced 15–19 who know a source for family planning services	33.4	21.9	56.8	30.8

*The pill, IUD, injectables, spermicide, barrier methods, and male and female sterilization. †Includes all married women, and all never-married women who had intercourse in the last three months. ‡Number of women in denominator is 25–49. §Married or in a cohabiting union. **Not available. ††Had intercourse in last three months.

	North East		North West		South East		South West		South South	
	1990	2003	1990	2003	1990	2003	1990	2003	1990	2003
	0.6	1.4	0.4	1.6	0.8	2.1	2.0	1.7	1.5	2.4
	0.0	0.0	0.7	2.0	1.9	13.6	14.4	39.3‡	5.3	25.8
	0.0	0.6	0.0	2.6	5.8	18.6	21.1	7.1‡	22.0	14.5
	0.0	0.0	0.7	2.0	0.0‡	**	4.2‡	**	0.0‡	**
	0.0	0.0	0.0	2.6	0.0‡	**	0.0‡	**	6.1‡	**
	**	**	**	**	**	**	**	**	**	**
	**	**	**	**	**	**	**	**	**	**
	§§	**	§§	**	§§	19.3	§§	35.3‡	§§	23.9
	§§	100.0	§§	100.0	§§	81.4	§§	69.2	§§	80.1
	§§	0.0	§§	0.0	§§	15.3	§§	10.3	§§	10.3
	§§	0.0	§§	0.0	§§	0.0	§§	2.6	§§	1.3
	§§	0.0	§§	0.0	§§	1.7	§§	12.8	§§	7.1
	56.4	52.5	64.2	46.4	53.0	38.3	70.8	75.7	60.1	67.3
	14.7	16.3	3.5	5.1	12.2	22.5	11.9	31.7	14.3	43.1
	14.3	15.9	3.5	5.2	8.5	13.0	9.2	29.6	11.9	27.8
	**	§§	**	§§	**	§§	**	§§	**	§§
	**	18.1	**	14.8	**	68.2‡	**	46.4‡	**	57.3
	27.1	13.0	20.7	14.6	44.1‡	§§	24.0‡	§§	29.2‡	41.4‡
	**	§§	**	§§	**	70.0‡	**	§§	**	61.8
	**	21.1	**	15.9	**	53.3	**	35.8	**	48.7
	25.0	16.7	18.8	15.7	23.7	25.0	23.6	33.3	31.3	34.2
	**	§§	**	§§	**	72.2	**	39.0	**	58.0
	19.1	9.6	14.0	9.5	29.6	14.0	49.6	31.0	38.7	25.9
	§§	8.5	§§	3.3	§§	25.6	§§	41.1	§§	29.3
	18.6	8.1	12.9	11.0	29.5	25.0	64.4	65.2	52.8	40.8

‡‡Had intercourse in last 12 months. §§Number of women in denominator is fewer than 25. *†Women have unmet need if they are sexually active and do not want a child in the near future, but they are not using a modern method of contraception.*‡Includes those who mentioned any source. *Sources:* references 6 and 7.

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