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Early Childbearing in Nigeria: A Continuing Challenge

Between 1980 and 2003, the birthrate among Nigerian women aged 15–19 decreased by 27% (from 173 to 126 births per 1,000 women this age). Nonetheless, 46% of women nationally and about 70% of those in some regions still give birth before their 20th birthday.[1] Nigerian women who start having children while they are still adolescents face severe social and health disadvantages, including curtailed educational opportunities, which reduce women's social and economic status long term, elevated rates of perinatal death, and maternal complications and death.

This report provides a profile of the current childbearing experience of adolescent women in Nigeria, explores the factors associated with widely varying levels of teenage childbearing across the country and identifies the continuing reproductive health needs of young Nigerian women. The report provides data for the nation as a whole, as well as for the country's major regions, to help inform decision-making at both the national and regional levels. It does not attempt to synthesize the substantial body of in-depth research on issues related to adolescent childbearing in Nigeria, which consists largely of small-scale studies that do not permit national generalizations or regional comparisons.

Young women's lives are shaped by many factors.

With a population of close to 124 million in 2003, Nigeria is one of the 10 most populous countries in the world and the most populous country in Africa. The country's population more than tripled between 1960 and 2000, and is expected to double again by the year 2025.[2]

Nigeria has endured two decades of economic stagnation. Despite the country's rich natural and human resources, its per capita gross domestic product of $860 (in 2004) is one of the lowest in the world.[3] In addition, Nigeria has experienced the deterioration of its democratic institutions, long periods of ethnic and civil war, and a series of military coups. In fact, military rule ended only in 1999, when a democratically elected president took office. However, major social, economic and political problems continue to challenge the country.

The extent of the public's exposure to the mass media is often regarded as an important indicator of a country's degree of modernization. In 2003, about 66% of Nigerian women aged 15–19 had weekly access to at least one of the three main types of media—newspapers, radio or television—and about 10% had access to all three types. However, 34% did not have any media exposure in the average week.[4]

HIV is now a factor that must be taken into account in health care service provision in Nigeria, given estimated prevalence rates of 5% among all adults aged 15–49 in 2003 and 4% among pregnant women aged 15–24 living in the capital city in 2001.[5] Despite these moder-

Key Points

- **The birthrate among Nigerian women aged 15–19 declined by 27% between 1980 and 2003. However, because the country's population grew rapidly at the same time, the annual number of births to teenage women increased by 50% over this period.**
- **Declines in adolescent birthrates are associated with improved educational levels, the related postponement of marriage among certain groups and above-average levels of modern contraceptive use among more educated sexually active adolescent women in urban areas.**
- **Almost all adolescent childbearing occurs within marriage, even though substantial proportions of unmarried teenage women are sexually active.**
- **Only 4% of married adolescent women use a modern contraceptive method, compared with 24% of unmarried sexually active women this age. Overall, 17% of women aged 15–19 have an unmet need for effective contraception.**
- **Among women aged 15–24 who have given birth, only half receive care from a trained health care professional during their pregnancy, and fewer than a third receive such care during their delivery.**
- **Policies and programs promoting reproductive health for young women exist, but greater support and resources will be needed to better address early childbearing. In addition, greater use of the mass media to disseminate family planning information will be essential.**

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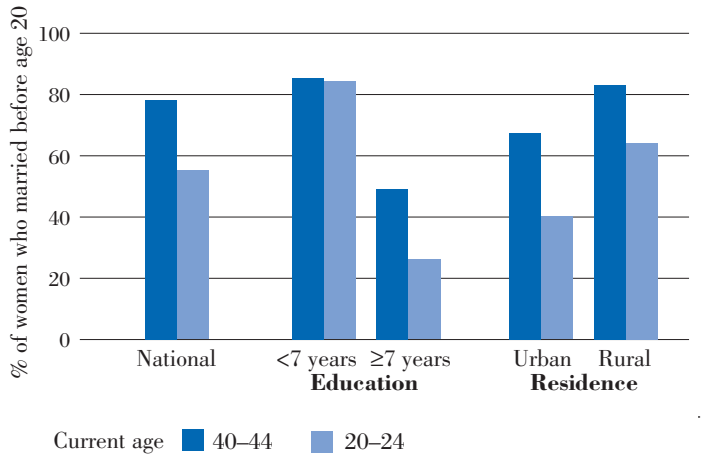
chart a
Adolescent Marriage

Nationally and among most subgroups, levels of adolescent marriage have declined over the past two decades.



Source: Table 1, rows 3 and 4.

ately high rates, knowledge of HIV risk and ways to prevent infection is quite poor in Nigeria, even among young women who have the highest levels of infection and risk in Sub-Saharan Africa.

Fewer than half of women 15–19 know that a healthy-looking person can be infected with HIV, or that the virus can be transmitted from mother to child through breastfeeding.[6] And only about two in five know that condom use can prevent HIV transmission.[7] Among married teenage women, only 24% have ever discussed HIV with their husband.[8]

Nigeria is made up of six major geopolitical regions—North East, North West, North Central, South East, South West and South South. It is ethnically and religiously diverse, and economic development and educational levels vary widely across the country. The North East and North West regions are largely agrarian and predominantly rural. The population is almost completely Muslim, and women's level of education is low. The North Central region, where the population is two-thirds Christian and one-third Muslim, is one-third urbanized. The South East region is slightly more urbanized than the northern regions and is largely Christian. The South West region, which includes Lagos, the former capital, is one-third Muslim and is the most urban of the six regions. The South South region is 97% Christian and the least urbanized of the three southern regions.[9] Not unexpectedly, Nigerian women's childbearing experiences, and the factors influencing these experiences, vary widely by region.

*Total fertility rates and wanted fertility rates are based on events during the three years before the survey.

Young Nigerian women now stay in school longer.

Nigerian women's educational attainment is improving, a trend that can be seen by comparing the proportion of older and younger women who have at least a primary school education (seven or more years of schooling). Nationally, only 20% of women aged 40–44 attained this educational level, compared with 48% of those aged 20–24 (Table 1, rows 1 and 2). Moreover, this difference in schooling between older and younger women is evident in both urban areas (38% vs. 71%) and rural areas (11% vs. 37%). Regionally, the most substantial changes have occurred in the country's southern, more urbanized regions. Parental support and societal approval of young women attending school and completing their secondary education are likely to be important factors behind the increasing proportions of adolescent women in Nigeria extending their education.

As their educational level increases, many Nigerian women are marrying later.

The proportion of Nigerian women who marry before age 20 is decreasing. It is substantially lower among those aged 20–24 than among those aged 40–44, both nationally (55% vs. 78%) and among all subgroups, except for women living in the North West and those with less than a primary education (Chart A and Table 1, rows 3 and 4). By far the largest relative decline in early marriage, a drop of 42 percentage points (from 70% to 28%), has occurred among women living in the South South region, where women's educational attainment has also increased dramatically.

Among women aged 20–24, the proportion marrying during their teens is high among those with fewer than seven years of schooling (84%) and those in the North East and North West regions (80–89%), intermediate among women in urban areas (40%), and low among those in the southern regions (20–28%) and those with more education (26%). Nationally, the large majority of women this age with little schooling still marry before age 20 in both urban and rural areas (76% and 85%, respectively), indicating that young women's educational achievement, rather than urban or rural residence, is

Data Sources

Data presented in this report are derived mainly from the most recent national-level reproductive health survey in Nigeria—the 2003 Nigeria Demographic and Health Survey (DHS) carried out by the National Population Commission in collaboration with ORC Macro. The female component of the 2003 survey interviewed 7,620 women of childbearing age (15–49), both married and unmarried. It obtained information on sexual activity, marriage, reproductive preferences, fertility experiences, contraceptive use, maternal and child health, and women's knowledge of and experience with sexually transmitted infections (including HIV/AIDS). The DHS has a large enough sample to permit analyses of adolescents by geopolitical region, urban or rural residence, and level of education. The report also draws on two earlier national surveys of Nigeria, the 1980 National Fertility Survey and the 1990 DHS. Population estimates come from the United Nations Population Division.

table 1

Selected Measures

Selected demographic and reproductive measures among women, by region, educational level and residence, Nigeria, 2003

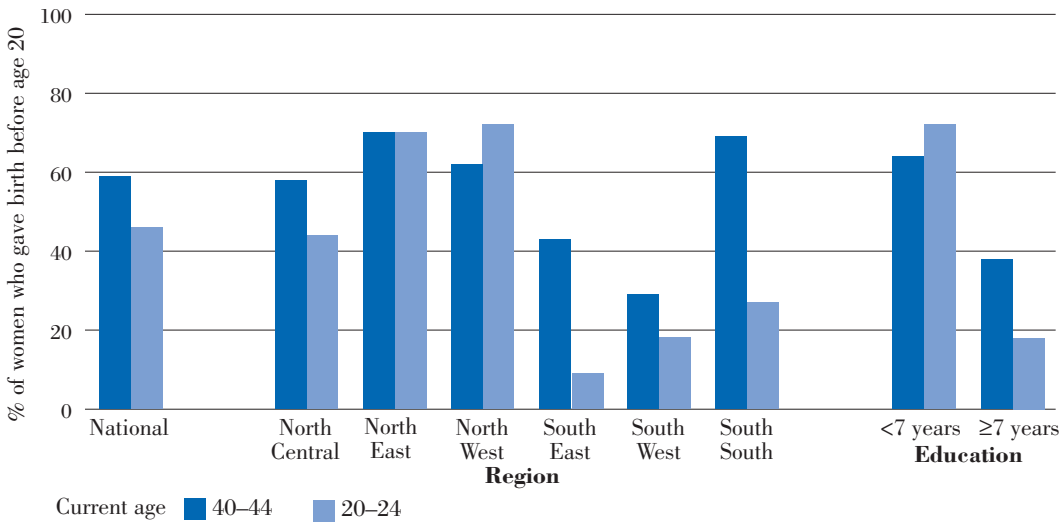
Measure	All	Region						Years of education		Residence		Years of education, by residence			
		North Central	North East	North West	South East	South West	South South	<7	≥7	Urban	Rural	<7		≥7	
												Urban	Rural	Urban	Rural
% with ≥7 years of education															
(1) Women 40–44	19.6	21.3	13.6	9.0	33.9	46.5	21.3	na	na	38.1	11.0	na	na	na	na
(2) Women 20–24	48.2	42.8	23.8	19.7	87.5	77.4	75.8	na	na	70.6	36.5	na	na	na	na
% married before age 20															
(3) Women 40–44	77.7	77.5	90.4	90.6	54.1	49.3	70.1	84.5	48.9	66.8	82.5	81.2	85.5	43.9	57.7
(4) Women 20–24	55.4	53.1	79.9	89.1	22.4	20.3	28.4	83.5	25.5	40.0	63.6	76.2	85.2	24.7	26.4
(5) **% aged 15–19 who have ever married**	33.3	17.4	58.8	73.0	2.8	4.1	9.7	56.1	7.9	20.9	39.6	44.0	59.7	7.5	8.1
(6) **% aged 15–19 who are unmarried and sexually active**	11.8	14.0	4.8	0.7	21.7	8.7	26.0	5.9	18.5	12.4	11.5	7.3	5.5	15.4	21.2
% who gave birth before age 20															
(7) Women 40–44	59.1	57.5	70.4	62.2	42.6	29.2	68.5	64.3	38.1	49.8	63.4	58.6	66.0	35.4	42.3
Women 20–24															
(8) Before age 20	45.7	43.9	69.5	71.7	9.3	17.7	26.9	71.5	18.4	31.0	53.4	62.9	73.5	17.7	19.0
(9) Before age 18	28.0	18.9	46.6	50.1	2.6	7.5	15.3	48.8	5.8	16.6	34.0	45.0	49.7	4.7	7.0
(10) Before age 15	6.6	8.2	10.1	9.8	0.7	0.5	5.2	11.9	1.0	2.7	8.7	9.3	12.6	0.0	2.0
(11) **% aged 15–19 who have given birth**	21.0	13.7	38.1	36.9	5.6	4.1	11.3	32.8	7.7	13.6	24.7	24.2	35.4	7.3	8.1
(12) **% aged 20–24 with a premarital birth before age 20**	3.0	2.9	2.4	3.5	0.0	1.6	5.6	4.3	1.7	1.2	4.0	2.6	4.7	0.6	2.8
(13) **% aged 20–24 who had premarital sex before age 20**	32.3	31.6	14.1	5.9	41.3	50.8	69.3	18.2	46.6	36.2	30.3	21.3	17.7	42.1	50.9
(14) **% of adolescent births in past 5 years that were unplanned**	18.2	21.6	16.5	3.4	56.0	69.0	44.2	14.1	37.8	20.5	17.6	15.3	13.8	30.9	43.5
(15) **% of sexually active women 15–19 who do not want a child soon***	60.8	69.0	54.0	43.9	83.7	92.9	91.9	50.1	88.8	72.2	56.8	60.6	47.7	88.8	88.8
(16) **% aged 15–19 who know of any modern method†**	66.7	68.2	50.2	58.2	77.8	76.1	77.6	51.7	83.2	78.6	60.6	63.3	48.3	87.1	79.9
% aged 15–19 using a modern method among															
(17) Married women	3.7	2.7	0.0	4.3	‡	‡	10.3§	2.5	16.7	8.2	2.8	1.2	2.7	34.8§	3.2§
(18) Unmarried, sexually active women	24.3	20.6§	‡	‡	12.8§	44.4§	30.9	14.8	28.7	27.8	22.9	‡	13.5§	31.6	26.6
(19) All sexually active women	10.3	14.1	0.0	4.5	13.6	45.8§	28.4	3.8	26.4	16.8	8.0	3.1	3.9	34.2	21.5
% aged 15–19 who have unmet need for an effective method and who are															
(20) Married	7.9	1.2	16.7	16.9	1.1	0.9	2.5	12.9	2.5	3.8	10.0	9.7	13.8	0.5	4.3
(21) Unmarried	9.2	12.0	5.1	0.7	18.9	4.1	18.8	5.3	13.5	8.8	9.3	6.3	5.0	10.2	16.3
(22) All	17.1	13.2	21.8	17.6	20.0	5.0	21.3	18.2	16.0	12.6	19.5	15.9	18.8	10.8	20.4
% aged 15–24 who received professional care**															
(23) Prenatal	49.6	68.6	40.1	36.4	97.7	57.1	87.3	38.6	81.4	78.3	40.4	63.8	33.2	94.2	71.1
(24) Delivery	29.7	48.3	21.1	12.1	90.9	76.1	42.2	18.5	61.7	52.7	22.2	31.9	15.8	76.3	49.7
Unweighted N															
Women 15–19	1,749	260	305	385	278	276	245	868	880	689	1,060	260	608	428	452
Women 20–24	1,464	261	242	325	220	228	188	714	745	593	871	182	532	410	335
Women 40–44	695	97	130	183	112	86	87	546	149	269	426	180	366	89	60

*Women who do not want a child in the next two years. †The pill, injectables, implants, sterilization, the IUD, diaphragm or condom. ‡Suppressed because the unweighted N is fewer than 20 cases. §Denominator is small (20–40 unweighted cases). **Denominator is women who have given birth. *Notes:* Sexually active=had intercourse in last three months. na=not applicable. *Source:* 2003 Nigeria Demographic and Health Survey.

chart b

Adolescent Childbearing

Changes in adolescent childbearing have varied by region and educational level.



Source: Table 1, rows 7 and 8.

the more important determinant of the timing of marriage.

Wide differences can also be seen in the proportion of teenage women who have ever married. Although 33% of all women 15–19 have done so, the proportion ranges widely by region, from 73% in the North West region to fewer than 5% in the South East and South West regions (Table 1, row 5). It also varies substantially by education and by residence: Marriage is much more common among adolescent women with fewer than seven years of schooling than among their counterparts with more schooling (56% vs. 8%) and also more common in rural areas than in urban areas (40% vs. 21%). More educated women are likely delaying marriage because of their desire to be self-sufficient and to be able to obtain paid work in the modern sector, especially in periods of economic hardship.

Among women who do marry in adolescence, many wed much older men. Fifty-six percent of married women aged 15–19 have husbands at least 10 years their senior.[10] The age gap is likely due in part to the substantial proportion of married teenage women who are in polygamous relationships—28% in 2003—as these relationships contribute to the pattern of large age differences between partners.[11] The tendency to marry much older men is far stronger in the north than in the south. Globally, teenage women who are much younger than their husbands often cannot act independently if they disagree with them, especially in the areas of obtaining health care, timing childbearing and using contraception.[12]

As young women postpone marriage, adolescent childbearing is declining.

As fewer young women are marrying in their teens, adolescent childbearing is declining in many parts of Nigeria (Chart B). Nationally, 59% of women aged 40–44 gave birth before their 20th birthday, compared with 46% of those aged 20–24 (Table 1, rows 7 and 8). The generational change has been much greater in two southern regions, with dramatic declines in the South East region (from 43% to 9%) and in the South South region (from 69% to 27%). However, in the North East region, there has been no reduction in the high proportion of women having a child before 20—70% of women do so. And in the North West region, where the pattern of early marriage has not changed, women aged 20–24 are in fact substantially more likely than their older counterparts to have given birth by this age (72% vs. 62%). Childbearing before age 20 has also increased among less educated women, in both urban and rural areas. This trend is likely due to the improved nutrition, health and fecundity of Nigerian women over the past two decades or so.[13]

Education is a key factor behind the decline in adolescent childbearing seen at the national level. The large increase in the proportion of women with seven or more years of schooling—from 20% among women aged 40–44 to 48% of women aged 20–24—is important, because having a higher level of education is associated with a large decline in adolescent motherhood, while a lower level of education is related to an increase in childbearing during adolescence. Better educated women aged 20–24 are about half as likely as their equally educated older counterparts to have had a child in their adolescent years (18% vs. 38%), while among less education women, this proportion increased from 64% to 72%.

Despite the decline in early childbearing in many parts of Nigeria, very early motherhood (before age 18 or even before age 15) has by no means disappeared. Nationally in 2003, 7% of women aged 20–24 had a child before they were 15, and 28% did so before they were 18 (Table 1, rows 9 and 10). In addition, just over one in five adolescent women in Nigeria are mothers (Table 1, row 11). These measures of early childbearing are above average among women with fewer than seven years of schooling and in the North East and North West regions.

The falling rate of childbearing among teenage women, although encouraging, has not been accompanied by a reduction in the number of births to adolescents (Table 2). In fact, despite the sub-

stantial decline in the birthrate of women aged 15–19, the annual number of births among teenagers increased by 50% between 1980 and 2003 because the number of women in this age-group more than doubled. In 2003—as in 1980—more than one in six births occurring in Nigeria were to adolescent women.

Few unmarried teenagers have births, but one-third are sexually experienced.

Nearly all adolescent childbearing in Nigeria occurs among married women: Only a very small proportion of 20–24-year-old women—3% in 2003—give birth as teenagers before marriage (Table 1, row 12).

Although few young women have births before marriage and as adolescents, substantial proportions become sexually experienced before marriage. Nationally, 32% of women aged 20–24 had premarital intercourse before they were 20 (Table 1, row 13). The level of premarital sexual experience before age 20 does not differ greatly from the national average in either urban or rural areas (36% and 30%, respectively), but is above average in the three southern regions (41–69%). In addition, women with at least a primary education have a rate more than twice that of their less educated counterparts (47% vs. 18%), partly because women with less schooling marry younger, reducing the period of time during which they could have initiated sexual activity before marriage.

Several factors may explain the very low rate of premarital births among teenage women despite a relatively high rate of premarital intercourse. The likelihood that many unmarried women who become pregnant marry to legitimize a pregnancy is probably one factor, and the fact that in many parts of Nigeria marriage is a process with several steps, rather than an event occurring at a single point in time, may be another. Contraception contributes to the low premarital birthrate—about one-fourth of unmarried sexually active women are using an effective, modern method (Table 1, row 18). A final possibility is that some young unmarried women resort to clandestine abortion to end an unwanted pregnancy (see below).

It is striking that even though women with at least seven years of schooling are more likely to have had premarital intercourse before age 20 than their less educated counterparts, they are less likely to have a premarital birth before this age. A possible explanation for this pattern is that among unmarried sexually active young women, those who are more educated are more likely both to use contraception and to have an abortion if they become pregnant.

Almost one in five adolescent births are unplanned.

In the country as a whole, 18% of recent births to adolescent women (married and unmarried) are unplanned—that is, the mother would have preferred the birth later or not at all (Table 1, row 14). However, this proportion ranges widely by region, from a low of 3% among women in the North West region to a high of 69% among those in the South West region. The proportion unplanned is also above average in the case of births to more educated adolescent women in both urban and rural areas (31% and 44%, respectively). Estimates of unplanned pregnancy, which includes unplanned births and abortions, are not available, because of the absence of national data on abortions among adolescents. However, the fairly high rate of unplanned births is consistent with substantial levels of unplanned pregnancy and further implies that some women are seeking abortions.

Perhaps even more striking, 61% of sexually active teenage women (married and unmarried) say they do not want a child in the next two years (Table 1, row 15). This proportion is especially high—about 90%—in the South West and South South regions and among women with at least a primary education, regardless of whether they reside in rural or urban areas. This finding among more educated women is understandable because these are probably the young women with the greatest motivation to obtain work and attain some measure of independence before they marry and start having children.

Few sexually active adolescent women use a modern method of contraception.

Although the majority of sexually active adolescent women do not want a child soon, only 10% of this same group use a modern method of contraception—the pill, injectables, implants, sterilization, the IUD, diaphragm or condom (Table 1, row 19). The proportion is notably higher among those who are unmarried (24%) and especially low among those who are married (4%) (Table 1, rows 17 and 18). Among more educated married teenagers, the difference in proportions using modern contraceptives between urban and rural residents is marked (35% vs. 3%), which suggests greater availability of contraceptive services in towns and cities.

One factor that contributes to low levels of contraceptive use among sexually active teenage women is a lack of knowledge. Nationally, about one-third of all adolescent women have not heard of any modern contraceptive methods, with below-average levels of knowledge in the North East and North West regions and among women with less schooling or living in rural areas (Table 1, row 16). The common perception that long-term use of modern contraceptives is harmful to future fertility and has other side effects also deters many adolescents from using effective contraception.[14] Among married adolescents, the

table 2
Adolescent Births

Births among women 15–19, by year

Year	No. of births per 1,000 women	No. of women (in 000s)	No. of births (in 000s)	As % of all births in Nigeria
1980	173	3,258	564	18.1
1990	146	4,355	636	16.2
2003	126	6,754	851	17.6

Sources: Data for 1980 and 2003—reference 1. Data for 1990—Federal Office of Statistics of Nigeria and IRD/Macro International, *Nigeria Demographic and Health Survey 1990*, Columbia, MD, USA: IRD/Macro International, 1992.

power imbalance between many teenage wives and their much older husbands may also be a barrier to contraceptive use.

One in six adolescent women have an unmet need for effective contraception.

Overall, 17% of adolescent women in Nigeria—about one-half of whom are unmarried—have an unmet need for effective contraception; that is, they are sexually active, are capable of becoming pregnant and do not want a child soon, but they are not using an effective contraceptive method (Table 1, rows 20–22). If we apply this proportion to the almost seven million adolescent women in Nigeria in 2003, about 1.2 million women aged 15–19 have a need for effective contraception that is not being met.

Differences in the contribution to total unmet need for contraception among adolescents by marital status vary across population groups. Among adolescents who live in the North East and North West regions and those with less than a primary education, most of the unmet need for contraception occurs among married women. In contrast, among adolescents who live in the other four regions, those who are more educated and those residing in urban areas, women who are unmarried and sexually active account for the majority of unmet need.

Young women account for most abortion complications.

Abortion is illegal in Nigeria, but roughly 610,000 abortions are performed in the country each year.[15] Because of the restrictive law, many abortions are performed under unsafe conditions and by untrained persons, with potentially harmful consequences for women. In Western Africa, about 10% of all maternal deaths are attributable to unsafe abortions, a proportion similar to that found worldwide.[16] Hospital-based studies conducted in the 1990s in Nigeria showed that adolescents make up a disproportionately high proportion of women treated for abortion complications—between 61–75%.[17] This overrepresentation is likely due to the fact that compared with their adult counterparts, adolescent women are less likely to use contraceptives and more likely to resort to an unsafe abortion. In particular, because young women worry about the long-term effects of modern contraceptives but perceive the possible complications and risks of abortion as rare, they resort to abortion as an immediate solution to an unintended pregnancy.

Maternal health services are inadequate.

Attendance by medically trained personnel (a doctor or nurse-midwife) during pregnancy, at delivery and postpartum (e.g., a follow-up visit 4–6 weeks after delivery) can improve birth outcomes, ensure safe delivery and reduce the likelihood of maternal death. However, the health infrastructure available to serve Nigerian women who give birth in their adolescent years is grossly inadequate.[18] In addition, many young women and their families clearly lack the information—as well as the access to services—necessary to obtain health care when they are pregnant or giving birth.[19]

Nationally, only half of women aged 15–24 who have given birth received prenatal care from a trained health professional (Table 1, row 23). A minority (36–40%) of women in the North West and North East regions receive such care, while most of those in the South South and South East regions do (87–98%). Young women in rural areas are much less likely than those in urban areas to have professional care during their pregnancy (40% vs. 78%), as are less educated women relative to their more educated counterparts (39% vs. 81%).

Women's likelihood of receiving obstetric care during delivery is even poorer. Only 30% of women aged 15–24 giving birth are attended by a trained health professional (Table 1, row 24). In the North West region, this proportion is particularly low—12%. Young women living in the South East and South West regions and those with seven or more years of schooling are most likely to receive professional health care when they give birth. Of note, in rural areas, 50% of more educated young women are attended by a doctor or nurse during delivery, compared with 16% of less educated women. This finding suggests the powerful influence of education in helping young women and their families understand the importance of professional health care at the time of delivery and enabling them to obtain such services.

The health risks of childbearing are especially high in settings where women commonly have their first birth before they turn 18 and seldom receive professional prenatal and delivery care. Most adolescent childbearing in Nigeria occurs in two northern regions—the North East and North West regions (Table 3). Seventy-one percent of all births to women aged 15–19 occur in these two regions, even though only 42% of women that age live there. Nationally, women in these regions are also the least likely to have professional care while pregnant and during a delivery.

The inadequacy of Nigeria's maternal and child health services has tragic consequences. The rate of infant mortality is high (88 deaths per 1,000 births), as is the rate of maternal mortality (533 maternal deaths per 100,000 live births).[20] In addition, many women live with serious reproductive complications, such as an obstetric fistula, a condition resulting from obstructed labor that results in the passage of fluids from the bladder and rectum into the vagina.[21]

Policies to improve reproductive health are in place.

The Nigerian government has given considerable attention to the reproductive health issues and needs of its young people. The country's official 1995 Adolescent Health Policy, which promotes adolescent sexuality as a natural and positive part of life, was developed in response to a large amount of research showing that many adolescents, including those in secondary school, were already sexually active, engaging in risky sexual behavior and lacking information on reproductive health issues.[22] However, greater effort is still needed to translate policies into action.

A 1999 government report found that the introduction of

family life education in some schools and the development of youth centers were inadequate to meet the needs of the large adolescent population. Services were unequally distributed across the country, with most programs found in the southern and urban regions, where women are better educated. The report also identified a lack of political support for reproductive issues, an insufficient number of trained professionals to provide adolescent-appropriate services and inadequate educational materials for young people.[23]

In 2000, the Federal Ministry of Health issued a draft of the National Reproductive Health Policy and Strategy to Achieve Quality Reproductive Health for All Nigerians. This policy acknowledges deficiencies in the current reproductive health care system, including unclear implementation strategies, insufficient funding and the failure of the framework for delivering services to cover the specific needs of underserved groups such as youth, men and underprivileged groups. Under this policy, the government assumes responsibility for providing comprehensive, high-quality reproductive services, especially to these underserved populations. The policy's specific goals include improved reproductive health awareness among youth and increased knowledge of reproductive biology and responsible sexual behavior.[24] The nongovernmental sector is also playing an important role in implementing programs to improve young women's access to information, education and youth-friendly services.

Wider youth policies also are in place.

In 1996, the Ministry of Women Affairs and Youth Development established girl-child education units in all state ministries of education and at the federal level. In 2000, the government adopted a National Policy on Women, which recommends that "enrollment and retention of girls in schools [be] compulsory," and suggests legal sanctions for withdrawing girls younger than 18 from school to be married. However, it is unclear whether and to what extent this policy is being enforced throughout the country.[25]

Among its plans to implement the 1995 Beijing Platform for Action, Nigeria lists raising the minimum age for marriage as a critical step toward improving the status of girls. However, there has been no federal legislation addressing early marriage. Several states have made efforts to raise the legal age of marriage. For example, Cross River State passed the Girl-Child Marriage and Female Circumcision Law in 2000, making marriage before age 18 illegal. Parents who force their young daughters to marry face fines, and mandatory imprisonment for a second offense. Similarly, in Edo State, the legal age of marriage has been raised from 16 to 18.[26]

The media can play an important role.

In Nigeria, as in developing countries in general, globalization, urbanization, increased levels of education and increasing exposure to the mass media (radio, television and large-circulation newspapers and magazines) are changing attitudes and values about early marriage and early childbearing, as they also reduce the desire for large families. The mass media can also be an effective vehicle for disseminating family planning and other health information to young people as well. A 2000 study in public secondary schools in Oyo State found mass media to be the leading source of information on family planning.[27]

Addressing the challenge of early childbearing will require action on many fronts.

Although this report documents some encouraging trends and highlights important government actions, additional steps are needed to successfully address the challenge of early childbearing in Nigeria.

- Policymakers and advocates should continue to actively promote policies and programs to improve educational attainment among girls and young women, nationally and especially in Nigeria's northern states.
- Government and nongovernmental organizations must do a better job of increasing young women's awareness and knowledge of contraceptive methods and of the value of obtaining professional care during pregnancy and at delivery.
- Nigeria's health infrastructure will have to be improved, especially in rural areas, to ensure that teenage women wanting and seeking such care have access to maternal health services. At a minimum, greater attention must be given to increasing the use of the basic standards and guidelines of emergency obstetric care and to improving the training of traditional birth attendants.
- The high proportion of unplanned births—and likely high prevalence of unsafe abortion—among adolescent

table 3
Births by Region

Births among women 15–19, by region, 2003

Region	No. of women (in 000s)	% distribution of women 15–19	Annual no. of births per 1,000 women	Estimated annual no. of births	% distribution of births to women 15–19
Total	**6,754**	**100**	**126**	**851,054**	**100**
North East	1,155	17	221	257,197	30
North West	1,655	25	208	346,822	41
North Central	952	14	107	102,679	12
South East	709	10	21	15,007	2
South West	858	13	40	34,573	4
South South	1,425	21	66	94,777	11

Sources: Numbers of women—United Nations (UN), *World Population Prospects: The 2002 Revision,* New York: UN, 2003, Vols. I and II. Birthrates—Nigeria Demographic and Health Survey 2003.

women, coupled with low levels of use of modern contraceptives (especially among married adolescents) point to the glaring need for more widespread information about and access to effective family planning methods. The mass media should be more widely used to disseminate such information.

• In addition, because many teenage women are married, husbands should be involved in efforts to protect their young wives' reproductive health and safety.

• Relevant government agencies should strengthen their collaboration with nongovernmental organizations that are committed to promoting adolescent health.

• Finally, the Nigerian government should endeavor to commit more resources to implementing its policies for improving the reproductive health of the country's adolescents.

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Credits

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