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FEMALE ADOLESCENTS AND THE RIGHT TO ACCESS CONTRACEPTIVE INFORMATION AND SERVICES: FACING REALITY IN NIGERIA

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Abstract

Adolescent girls need increased attention. Too often, a girl is married off as a child. Too often, she becomes pregnant, with a risk of dying in childbirth, when she should be allowed to focus on school. Adolescent girls, like all young people, deserve better; they deserve health, education and opportunities to steer their own lives.¹

This article analyses the barriers and consequences occasioned by adolescent girls' non-access to contraceptive information and services due to Nigeria's ineffectiveness in fulfilling the obligations that arise from its ratification of international and regional human right instruments protecting the right to sexual and reproductive healthcare. The article concludes by stating that considering the magnitude of SRH challenges adolescent girls' encounter as a result of their subjection to unequal gender practices and refusal to recognise their SRH autonomy, it is necessary for the Nigerian society to face reality by adopting pragmatic attitudes that will not only allow adolescent girls access contraception but also result in the achievement of greater benefits which will overshadow supposed harmful effect for denial in the first place.

Introduction

Unlike yesteryears when sexual relations was most often initiated within the confines of marriage,² today the opposite is the case, as the period of adolescence is the stage when adolescents characteristically begin to engage in sexual activities.³ Numerous

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¹ Babatunde Osotimehin, UNFPA Executive Director
² D Meekers 'Sexual initiation and pre-marital child bearing in sub-Saharan Africa' (1993) 5 *Demographic & Health Survey Working Paper 1* <http://www.measuredhs.com/pubs/pdf/WP5/WP5.pdf> (24 June 2013).

³ A E Biddlecomet al *Protecting the next generation in sub-Saharan Africa: Learning from adolescents to prevent HIV and unintended pregnancy* (2007) http://www.guttmacher.org/pubs/2007/12/12/PNG_monograph.pdf (9 May 2013); J Tripp & R

factors have been associated with the surge in adolescents' pre-marital sexual relations. While some have credited the increase in adolescents' sexual activities to a breakdown of traditional values occasioned by the removal of sexuality from the control of the community and the recognition of individual autonomy and decision-making powers as people are no longer accountable for their private choices to the community, others are of the belief that adolescent girls use sexual relations and pregnancy to realise personal goals ranging from gaining economic benefits to achieving marital goals.⁴

Another reason which contributes to the increase in premarital sex is the tendency for young people to marry later than their parents due to changes in life style, the influence of western thinking and the increase in the amount of years spent studying.⁵ In addition, according to Biddlecomet *al*, while a number of sexual initiation among adolescents occur as a result of coercion especially in developing countries due to several influences, it does not discountenance the fact that in a majority of cases, sexual activities among adolescents' occur as a matter of choice due to the need to satisfy their curiosity.⁶

The rise in pre-marital sex also comes with attendant problems and risks linked with the beginning of adolescent sexual activities including a high occurrence of unwanted teenage pregnancies and the transmission of HIV and other STIs. The SRH problems of adolescents become magnified with the present world adolescent population standing at 1.2 billion, 88 per cent of whom reside in developing countries, sub-Saharan Africa inclusive.⁷ In Nigeria, the adolescent population represent 22% of the country's total population.⁸

Despite the large adolescent population and the attendant risk posed by the escalation of adolescent sexual activities; in sub-Saharan Africa including Nigeria, the

Viner, 'ABC of adolescence: Sexual health, contraception, and teenage pregnancy' (2005) 330 *British Medical Journal* 590.

⁴Meekers (n 2 above) 1 & 2.

⁵M H Kroone *Sexual practice of adolescents in Benin* (2010) 4 <http://www.aktiebenin.nl/userfiles/file/Papers/Sexual%20practice%20of%20adolescents%20in%20Benin%20Engels.pdf> (24 June 2013). See also S Singh & J E Darroch *Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012* (2012) 4 & 5 <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf> (24 June 2013).

⁶Biddlecomet *al* (n 3 above) 13.

⁷UNICEF *Demographic trends for adolescents: Ten key facts* <http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf> (8 May 2013).

⁸Unicef 'At a glance: Nigeria statistics' http://www.unicef.org/infobycountry/nigeria_statistics.html#91 (6 March 2013).

protection of female adolescents' SRH through their access to contraceptive information and services is a source of concern among stakeholders. While some canvass for the restriction of girls' access to contraceptive and other SRH care information or services on one hand, others champion the increase of their access to the life-saving information and services on the other.⁹

Besides the concerns expressed for and against adolescents' access to SRH services, ensuring adolescent girls access to contraceptive information and services continue to be a constant subject of government policies and programmes due to the spread of HIV in many African countries including Nigeria where a substantial number are young women are infected.¹⁰ Adding to the problem of HIV is the challenge of adolescent pregnancy which, apart from being dangerous, is a leading cause of death among adolescent girls.¹¹ Presler-Marshall & Jones, quoting the World Bank statistics on adolescent birth rates observe that -while the global birth rate among 15-19 year olds in

⁹L L Wynn *et al* 'Harm reduction or women's rights? Debating access to emergency contraceptive pills in Canada and the United States' (2007) 38(4) *Studies in Family Planning* 253-267; V Schiappacasse & S Diaz 'Access to emergency contraception' (2006) 94 *International Journal of Gynecology and Obstetrics* 302; B Grundfest Schoepf 'Uganda: Lessons for AIDS control in Africa' (2003) *Review of African Political Economy* 554-556; N NSarkar 'Barriers to emergency contraception (EC): Does promoting EC increase risk for contacting sexually transmitted infections, HIV/AIDS?' (2008) 62 (11) *International Journal of Clinical Practice* 1772.

¹⁰A Bankole *et al* 'Sexual behaviour, knowledge and information sources of very young adolescents in four sub-Saharan African countries' (2007(11)(3) *African Journal of Reproductive Health* 29; UNAIDS *Special report: How Africa turned AIDS around* (2013) 6 & 7 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf (10 November 2013); UNAIDS World AIDS day report (2011) 10 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf (7 April 2014). See also NACA *Key statistics on HIV in Nigeria* http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268 (9 November 2013).

¹¹A I Isa *et al* 'Socio-demographic determinants of teenage pregnancy in the Niger Delta of Nigeria' (2012) 2 *Open Journal of Obstetrics and Gynaecology* 240; S A Aderibigbe *et al* 'Teenage pregnancy and prevalence of abortion among in-school adolescents in North Central, Nigeria (2011) *International Journal of Asian Social Science* 123; WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes: Among adolescents in developing countries* (2011) IX http://whqlibdoc.who.int/publications/2011/9789241502214_eng.pdf (5 November 2013); UNFPA *Sexual and reproductive health for all: reducing poverty, advancing development and protecting human rights* (2010) 21 http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/uarh_report_2010.pdf (9 November 2013).

2010 was 53 births per 1,000 adolescents, teenage fertility rates in sub-Saharan Africa amounted to an enormous 107.6 per 1,000 adolescents.¹² As well, female adolescents account for over 14% of unsafe abortions that occur yearly as a result of unwanted pregnancies.¹³

Considering that a foremost cause of loss of health for women and adolescent girls relates to their susceptibility to SRH ill health due to the entrenchment of cultural beliefs which prevent their exercise of reproductive autonomy; in the last few decades, focus has shifted from providing access to contraceptives as a means of achieving demographic targets to acknowledging that guaranteeing access to contraceptives is a basic human right to which women and girls are entitled.¹⁴

Proceeding from the above and in line with human rights guarantees on the right to health care to which Nigeria is a signatory, the article scrutinises the barriers which prevent female adolescents from accessing contraceptive information and services in Nigeria and consequences elicited by their inaccessibility to these important information and services. The article will conclude by stating that considering the magnitude of SRH ill health adolescent girls' face as a result of their subjection to unequal gender practices and refusal to recognise their SRH autonomy, it is necessary for the Nigerian society to be realistic and adopt pragmatic attitudes that will not only allow adolescent girls access to contraception but also result in the achievement of greater benefits which will minimise expected harmful effect responsible for denial of access to contraception.

Barriers to Female Adolescents' Access to Contraceptive Information and Services

Adolescents constitute a large proportion of Nigerian society¹⁵ and, like adolescents in other countries,¹⁶ they continue to be a source of public health concern in

¹²E Presler-Marshall & N Jones *Charting the future: Empowering girls to prevent early pregnancy* (2012) iii & 4 <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7724.pdf> (23 September 2013).

¹³R J Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (2007) 98 *International Journal of Gynecology and Obstetrics* 183.

¹⁴R J Cook & M Fathalla 'Advancing reproductive rights beyond Cairo and Beijing' (1996) 22(3) *International Family Planning Perspectives* 115; UNFPA *Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004* (2004) IX http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_globalsurvey04.pdf. (5 October 2012).

¹⁵Unicef 'At a glance: Nigeria statistics' available at http://www.unicef.org/infobycountry/nigeria_statistics.html#91 (6 March 2013).

view of their poor SRH outcomes¹⁷ despite Nigeria being one of the state parties that have assented to international, and regional human rights instruments, and, consensus documents advocating for adolescents access to comprehensive SRH information, education and services.¹⁸

Realising that state parties have not given sufficient attention to the specific concerns of promoting the health and development of adolescents as rights holders, the Committee on the Rights of the Child explains that the obligation to respect, protect and fulfil the rights of children by state parties includes a duty to ensure that adolescents not only have access to available SRH information which is essential for their health and development but also access available contraception and other SRH care services of appropriate quality according to their evolving capacities.¹⁹ Additionally, noting that adolescents are constantly at risk of infection, STIs and HIV/AIDS inclusive, the committee mandates state parties to take several measures, including the development of

¹⁶S Ramos 'Interventions for preventing unintended pregnancies among adolescents' (2011) *WHO Reproductive Health Library Commentary* available at http://apps.who.int/rhl/adolescent/cd005215_ramos_com/en/index.html (10 March 2014).

¹⁷Federal Ministry of Health *Assessment report of the national response to young people's sexual and reproductive health in Nigeria* (2009) 5, available at http://hivaidsclearinghouse.unesco.org/search/resources/5713_AssessmentReportNigeria.pdf (9 October 2013).

¹⁸Nigeria is a party to international and regional human rights instruments that guarantee the right to health care and other associated rights relevant for the protection of the right to health. It is also a signatory to consensus documents such as the ICPD Programme of Action and the Beijing Platform of Action which advocate that the realisation of a successful transition to adulthood entail the fulfilment of several requirements such as adolescent access to health promoting information and adolescent friendly SRH care services. See generally Art 25 UDHR, art 12 ICESCR, art 24 CRC, art 12 CEDAW, Art 16 African Charter, Art 14 ACRWC and art 14 Women Protocol. Other rights relevant for the protection of the right to health care such as the right to right to life, dignity, privacy, information and non-discrimination are recognised in the International Covenant on Civil and Political Rights. Specifically, see arts 2(1), 3, 6, 7, 17, 19(2) & 26 ICCPR. The Women Protocol precisely protects the right of women and girls to contraceptive information and services. See also ICPD 1994; Beijing Platform of Action 1995; ICPD +5 document 1999 and most recently the Bali Global Youth Forum Declaration 2012 http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration.pdf (2 September 2014); S J Jejeebhoy *et al* 'Meeting the commitments of the ICPD Programme of Action to young people' (2013) 21(41) *Reproductive Health Matters* 18.

¹⁹Paras 35(b) & (c) & 37 CRC Committee general comment 4 *Compilations of General Comments and Recommendations Adopted by Human Rights Treaty Bodies, Vol II*, available at http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf (27 October 2012); C Ngwenya *Sexual health and human rights in the African Region* (2011) 206 - 207 http://www.ichrp.org/files/papers/185/140_Ngwenya_Africa_2011.pdf (9 October 2013).

effective prevention programmes aimed at changing cultural views about adolescents' sexuality and need for contraception, and the adoption of legislation to combat practices which increase adolescents' risk of infection. Likewise, the committee urged states to take measures aimed at removing barriers hindering adolescents' access to preventive measures, such as contraceptives.²⁰

Quoting Cook *et al*, Durojaye notes that four vital elements influence human health outcomes: providence, people, politicians and health care providers.²¹ First, providence determines the genetic constitution of people, including the kind of diseases to which they are vulnerable; second, the kind of lifestyle people adopt automatically has implications not only on their health but also for the health of others who relate intimately with them; third, politicians are catalysts affecting the society through the progressive nature, or otherwise, of the laws and policies on health which they enact and fourth, health care providers are essential in restoring and maintaining the health of all 'people', especially the vulnerable, who definitely include adolescents, women and children.²²

While agreeing that the above elements contribute to the health outcomes of female adolescents in relation to their access to contraceptives, it is noted that other barriers exist which prevents adolescents generally and female adolescents in particular from accessing contraceptive information and services. These hindrances, not peculiar to Nigeria, continue to prevent young people from obtaining genuine and factual SRH information and services and need to be overcome in order to ensure accessibility. The barriers affecting adolescent girls' access to quality contraceptive and other SRH care information and services in Nigeria are discussed below.

Socio-cultural Barriers

Cultural and social mores have a great impact on adolescents' reproductive lives and behaviour.²³ They are a major factor that has continued to impede calls for global action to ensure that female adolescents gain access to beneficial and lifesaving contraceptive and SRH information and services. In the majority of African societies, social norms, which perpetuate gender roles and stereotype women as primarily mothers and care-givers, have been used to restrict women's (including girls) access to affordable

²⁰ Para 26 CRC Committee general comment 4.

²¹ E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 91.

²² Durojaye (as above) 92.

²³ Presler-Marshall & Jones (n 12 above) 26.

contraception and other SRH care services and information.²⁴ According to Oloruntoba-Oju, women are generally more sexually vulnerable than men, but the sexual vulnerability of female adolescents is not only higher but is further aggravated by cultural values and perceptions of gender and sexual roles which are generally skewed against adolescent girls as a result of the unequal gender and power relations among male and female members of society.²⁵ Whereas male adolescents are encouraged to engage in sexual relations in order to prove their sexual prowess, the situation is different for female adolescents. Female adolescents are advised to either shun pre-marital sex or are discouraged from using contraceptives due to the cultural importance attached to female fertility and myths which associate contraceptive use with promiscuity and infertility, thereby resulting in their engaging in unprotected sex and high pregnancy rates.²⁶

A mistaken belief in Nigeria, which is fuelled by culture and held by parents, law makers and other gate keepers alike, relates to the view that allowing female adolescents to access contraceptive information will encourage their initiation and practice of sexual relations. This perception is, however, wrong. Abundant studies highlight, although female adolescents (especially the unmarried ones) are ill informed about contraception and other SRH matters, that it has not deterred them from engaging in sexual relations.²⁷ The above assessment is particularly true in relation to Nigeria, a patriarchal society, where in a majority of cases, adolescent girls not only indulge in premarital sex before the

²⁴ S Cusack & R J Cook 'Stereotyping women in the health sector: Lessons from CEDAW' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 50, 59-60; N Newton *Applying best practices to youth reproductive health* (2000) 3.

²⁵ A M Mwinga 'Factors contributing to unsafe sex among teenagers in the secondary schools of Botswana' University of South Africa (2012) 17; T Oloruntoba-Oju 'Young, female and African: Issues in sexual vulnerability' (2011) 7(1) *Sexuality in Africa: Magazine & Monographs* 3, available at <http://www.arsrc.org/downloads/sia/jun11/jun11.pdf> (15 October 2013).

²⁶ C O Izugbara 'The socio-cultural context of adolescents' notions of sex and sexuality in rural South-Eastern Nigeria' (2005) 8 *Sexualities* 607-609; C A Varga 'How gender roles influence sexual and reproductive health among South African adolescents' (2003) 34 *Studies in Family Planning* 160-172; A O Arowojolu *et al* 'Sexuality, contraceptive choice and AIDS awareness among Nigerian undergraduates' (2002) 6 *African Journal of Reproductive Health* 60-70; Y Enuamehe *et al* 'Perceived facilitators and barriers to interventions aimed at reducing unintended pregnancies among adolescents in low and middle income (developing) countries: A Systematic Review of Qualitative Evidence' (2012) 10 *Joanna Briggs Institute (JBI) Library of Systematic Reviews* 3351 & 3354.

²⁷ Newton (n 24 above) 3; Brenda 'The problems that sexually active teenagers experience in accessing contraceptive information and services in Lusaka (urban) and Sesheke (rural) Zambia' University of Zimbabwe (2004) available at <http://uzweb.uz.ac.zw/law/women/dissertations/Sexually%20active%20teenagers.pdf> (28 September 2013).

age of 18 years but also have multiple sexual partners,²⁸ even though they are expected to be ignorant about sexual matters and discussions relating to sex are a taboo in the home.

Apart from the fact that in Nigerian society parents, because of cultural inclinations, refuse to discuss matters pertaining to sexuality with their unmarried daughters, the situation of married adolescents is more precarious. In addition to the situation that the girls enter into marriage in a state of total ignorance about sexual matters, they face greater reproductive health risks even than their unmarried counterparts. They are exposed not only to the constant risk of HIV infection from their polygamously inclined older husbands but are also under frequent health risks due to early pregnancies for which they can neither negotiate contraception nor access contraceptive services because they need to obtain the consent of their spouse.²⁹ Sedghet *al* assert, the conservative social values of developing countries in which female adolescents in marriages are expected to justify and fulfil their new status by becoming pregnant as soon as possible may be responsible for their non-use of contraception despite the fact that that they may be exposing themselves to great health hazards.³⁰

The problem of provider-bias is also a major impediment to female adolescents' access to contraceptive services in Nigeria. Health care providers, who are meant to be 'understanding' and more interested in protecting the health of all, especially young members of the population, not only stigmatise clients but also exhibit unfriendly and judgemental attitudes to female adolescents. This attitude is the consequence of their socio-cultural belief that adolescent girls are still too young to be involved in using contraception. The above situation contributes to the disillusionment of adolescent girls regarding contraceptive use and therefore results in them not bothering to make further

²⁸B O Nwankwo & E A Nwoke 'Risky sexual behaviours among adolescents in Owerri municipal: Predictors of unmet family health needs' (2009) 13 *African Journal of Reproductive Health* 138-140; P I Okonta 'Adolescent sexual and reproductive health in the Niger Delta region of Nigeria: Issues and challenges' (2007) 11 *African Journal of Reproductive Health* 115-116; Izugbara 'The socio-cultural context of adolescents' (n 26 above) 602; E O Orji & O A Esimai 'Sexual behaviour and contraceptive use among secondary school students in Ilesha South West Nigeria' (2005) 25 *Journal of Obstetrics and Gynaecology* 271.

²⁹P Makinwa - Adebusoye *Hidden: A Profile of Married Adolescents in Northern Nigeria* (2006) 8, 9, 19-22, available at <http://www.actionhealthinc.org/publications/docs/hidden.pdf> (20 June 2013).

³⁰G Sedghet *al* *Meeting young women's sexual and reproductive health needs in Nigeria* (2009) 10 http://www.guttmacher.org/pubs/2009/06/03/ASRH_Nigeria.pdf (14 August 2013) 10.

attempts to access contraceptive services, since it is their belief that their privacy will not be assured anyway.³¹

In Monjoket *al's* view, the poor contribution and unfriendly attitude exhibited by health workers towards the dissemination and provision of contraceptive information and services to female adolescents is rooted in the cultural fabric of the Nigerian society. The common belief is that family planning services are the preserve of married people only and discussions about sex and contraception with young people is inappropriate.³² The same position relating to the use of oral contraception by adolescent girls also applies to their use of emergency contraceptives.³³

The importance of ensuring that female adolescents have access to contraceptive services in friendly settings with 'welcoming' health care providers can never be overstated. A common occurrence in Nigeria relates to the fact that adolescents (when they decide to use contraceptives) generally prefer to approach patent medicine dealers for contraceptive information and services³⁴ because they are usually made to feel unwelcome at the publicly funded family planning clinics and they cannot afford to access services provided at the private clinics.

³¹The reason is that the confidentiality of female adolescents who access contraceptive services in health care setting is not guaranteed as there exists a high probability that the health care providers will report the adolescents to their parents and other community members. See E Durojaye 'Realising access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 150; Enuamehet *al* (n 26 above) 3354-3355.

³²E Monjoket *al* 'Contraceptive practices in Nigeria: Literature review and recommendation for future policy decisions' (2010) 1 *Open Access Journal of Contraception* 14.

³³Although Nigeria integrated the use of emergency contraception into its family planning guidelines since 2006, it has not translated into an availability of the drug in health facilities to female adolescents. Health providers' attitudes towards emergency contraception use by adolescent girls are even more conservative. They believe that the use of emergency contraception promotes promiscuity and should be discouraged among adolescents. See K Williams *Provider-related barriers to accessing emergency contraception in developing countries: A literature review* (2011) 6 & 16, available at http://www.popcouncil.org/pdfs/2011RH_ECBarriersLitReview.pdf (19 October 2013). See also UNFPA & USAID *Contraceptive Security in Nigeria: Assessing Strengths and Weaknesses* (2009) 11, available at http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/NG_ContSecuStrcWeak.pdf (21 October 2013).

³⁴In a majority of cases, since the patent medicine sellers are just traders doing business and who may have little or no knowledge about contraception, the probability that the information and drugs given to the children will be incorrect and dangerous is high. See also Monjoket *al* (n 32 above) 14.

In line with the directive contained in the ICPD programme of action and its Key Action document,³⁵ the Nigerian government, as a matter of priority, has the undisputed obligation, in conformity with relevant existing international instruments and agreements, of ensuring that female adolescents have access to user friendly SRH care services, which should safeguard not only their right to privacy, confidentiality and informed consent but also respect their cultural values and religious beliefs.³⁶

Economic Barriers

The unavailability and non-accessibility of life saving contraceptive services to adolescent girls in Nigeria is an indication of unmet contraceptive need that not only traps them into a cycle of poverty but also results in their being burdened by poor SRH outcomes. Apart from the existence of socio-cultural barriers which impede female adolescents' use of contraceptives, the existence of economic barriers which prevents adolescent girls from accessing contraceptive services is connected with the affordability of family planning services, on the hand, and the economic and financial circumstances of female adolescent on the other.

The contraceptive-use prevalence rate among the Nigerian population is generally low³⁷ and a reason that is often attributed for its non-use relates to the issue of non-affordability,³⁸ especially by women and female adolescents with low economic empowerment. Even in situations where adolescents attempt to make use of contraception, the most common type of contraceptive utilised is the male condom, which requires male

³⁵ICPD Programme of Action - A/CONF.171/13/Rev.1, available at <http://www.unfpa.org/public/publications/pid/1973> (20 September, 2012); ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21sp/a21spr02.htm> (5 October 2012).

³⁶Para 73 (a) ICPD +5 Key Actions Document.

³⁷DFID Nigeria *Scaling up access to contraceptive commodities in Nigeria* (2011) 7, available at <http://profiles.unfpa.org/uploads/documents/1373287034-dfid-contraceptivesproposal-june-2011.pdf> (19 October 2013); CRR *Broken promises: Human Rights, Accountability, and Maternal Death in Nigeria* (2008) 27, available at http://www.unfpa.org/sowmy/resources/docs/library/R422_CenterRepRights_2008_NIGERIABrokenPromisesNigeriaCentre_for_Hman_Rights.pdf (16 August 2013); A Bankole *et al* *Unwanted pregnancy and induced abortion in Nigeria: Causes and consequences* (2006) 4, available at <http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-1A.pdf> (19 October 2013).

³⁸GSedghet *al* 'Unwanted pregnancy and associated factors among Nigerian women' (2006) 32(4) *International Family Planning Perspectives* 180. See also O'Onwujekwe 'Are people really using modern contraceptives and how much do they pay for them?' (2013) 1 *African Journal of Health Economics* 11 & 12.

approval and cooperation for successful use.³⁹ As Onwujekwe *et al* explain, the payment for contraception through out of pocket expenses automatically deters the vulnerable from accessing family planning services, thereby limiting their access to modern contraceptives and contributing to a low level of usage.⁴⁰

The problem of affordability was cited as a contributory factor to contraceptive non-use by the Center for Reproductive Rights (CRR) in their 2008 report on the causes of maternal mortality in Nigeria.⁴¹ The report revealed that not only do large discrepancies exist among rural and urban dwellers on contraceptive usage as a result of the high cost of contraception but also that contraceptive usage is significantly higher among rich people than poor people.⁴² The results from the 2008 *National Demographic and Health Survey* reveal that teenage pregnancy and child bearing is common among girls from the poorest households in comparison with their counterparts from rich homes.⁴³ In a report by Osanyin based on an assessment of the few facilities providing youth-friendly health services in Nigeria, in addition to noting that consumables and drugs were inadequate or lacking in most of the facilities visited, pointed out that while a majority of the centres were providing family planning services to young people, that contraceptives were only made available to the adolescents upon payment of fees. Thus, adolescent girls who need to access contraception can only do so if they can afford the cost.⁴⁴

The prospect of adolescents (especially female adolescents), who might be barred from accessing contraception as a result of the payment of user fees, led the CRC committee in

³⁹The fact that as a result of poverty, the male condom is the major form of contraception used by women and adolescent girls is still a major impediment for access to contraception as a main socio-cultural factor fuelling contraceptive non-use is the problem of gender imbalance, male dominance and partner objection. See Onwujekwe 'Are people really using modern contraceptives' (as above) 7; Monjoket *et al* (n 32 above) 13; L M Williamson 'Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research' (2009) 6 *Reproductive Health* 8, available at <http://www.reproductive-health-journal.com/content/pdf/1742-4755-6-3.pdf> (17 September 2013).

⁴⁰Onwujekwe 'Are people really using modern contraceptives' (as above) 3 & 4. See also AAnkomah *et al* 'Barriers to Contraceptive use among married young adults in Nigeria: A qualitative study' (2013) 3 *International Journal of Tropical Disease* 278.

⁴¹CRR 'Broken promises' (n 37 above) 27.

⁴²CRR - *Broken promises* (as above) 31-32.

⁴³National Population Commission (NPC) & ICF Macro *Nigeria Demographic and Health Survey 2008* (2009) 3, available at <http://www.measuredhs.com/pubs/pdf/SR173/SR173.pdf> (21 October 2013).

⁴⁴Y Osanyin Report *on assessment of facilities providing youth friendly health services in Nigeria* (2011) 7 & 14, available at <http://nccconline.net/download/files/Assessment%20of%20Youth%20Friendly%20Health%20Centers%20and%20Services.pdf> (3 August 2013).

its concluding observations/recommendation on Nigeria's combined 3rd and 4th reports to urge the Nigerian government to take action. Apart from urging the government to take cognisance of the committee's general comment No. 4 on adolescent health and development, the committee also recommended that the country should make efforts to abolish the payment of user fees in order to increase female adolescents' access to affordable health care services, including free contraceptives, so that they can prevent unwanted pregnancies.⁴⁵

While the Nigerian government's effort to guarantee access to free contraceptive services for women and female adolescents in response to calls by international bodies is noted and resulted in its 2011 policy removing the payment of user fees for family planning services in public hospitals in order to break down the barrier of non-affordability as a reason for contraceptive non-use,⁴⁶ it is, however, how unclear whether this directive has yielded positive results, especially in relation to female adolescents' access to contraceptives.

In addition to the problem of non-affordability as an economic barrier to contraceptive usage, further aspect which affects contraceptive use by adolescent girls relates to role played by the economic/financial circumstances of the female adolescent, viz the problem of poverty. Previously, attention has been concentrated on the increase in pre-marital sexual relationships among adolescents in sub-Saharan Africa and the fact that female adolescents do not use contraception despite engaging in risky relationships thereby contributing to their poor SRH including infection with STIs and HIV.⁴⁷ However, an important factor which fuels contraceptive non usage is the problem of inter-generational sex.

⁴⁵ Para 62(a) CRC Committee concluding observations on Nigeria (2010) CRC/C/NGA/CO/3-4, available at <http://www2.ohchr.org/english/bodics/crc/crcs54.htm> (accessed 22 October 2013). It is important to highlight that before the CRC committee's concluding observation in 2010, in 1998 & 2004 respectively, the CEDAW Committee had made similar observations and recommendation that the Nigerian government should increase women and adolescent girls' access to affordable health care services, including reproductive health care and that access to affordable family planning services should be for all and a priority for government. See CRR - Broken promises (n 37 above) 32.

⁴⁶ Nigeria Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children available at http://www.rhsupplies.org/fileadmin/user_upload/CoLSC/Meeting_Documents/Dakar_2-5_July_2013/NIGERIA-Implementation_Plan.pdf (21 October 2013).

⁴⁷ Currently among adolescent population in sub-Saharan Africa, female adolescents are more infected with HIV than their male counterparts. See UNAIDS Report on the global AIDS epidemic (2012) 15, available at http://www.unaids.org/en/media/unaids/contentAssets/documents/epidemiology/2012/gr2012/20121120_UAIDS_Global_Report_2012_en.pdf (23 October 2013).

According to Luke and Kurz, a motivator for the occurrence of inter-generational sexual activity is the problem of extreme household poverty. Adolescent girls, for reasons ranging from economic survival to increasing their life prospects, engage in relationships with older men who, more often than not, have higher rates of HIV infection than adolescent boys.⁴⁸ According to the writers, the girls are capable of negotiating to some extent modalities for relationship initiation and continuance, but because power imbalances are the norm in heterosexual relationships in Africa, they are not able to control the format of sexual activities in the relationship. The men not only control the conditions of sexual intercourse but also determine contraceptive and condom usage.⁴⁹

Even though the problem of inter-generational sexual relationships is not peculiar to sub-Saharan African settings, factors associated with poverty and gender imbalances which exist in African settings have contributed to the high prevalence of HIV and STIs among female adolescents who are involved not only in sexual liaisons with older partners for pecuniary gains but also cannot negotiate condom use for the safety of their SRH as they feel that they need to show appreciation of the man's generosity.⁵⁰ The position applies to Nigeria as female adolescents are involved in the practice of inter-generational sex.⁵¹ According to statistics from the 2008 *Demographic and Health Survey*, adolescent girls not only engage in sexual relationships with older men for pecuniary gain but also do not use any form contraceptives or condoms to prevent sexual and reproductive ill-health and infections.⁵² Confirming the proposition that poverty is a major factor contributing to adolescent girls engagement in risky sexual associations and therefore non contraceptive usage, Oyediran *et al* observe that the wealth index of female adolescents was negatively associated with the involvement of young females in inter-generational sexual

⁴⁸ N Luke & K M Kurz *Cross-generational and transactional sexual relations in sub-Saharan Africa: Prevalence of behavior and implications for negotiating safer sexual practices* (2002) 3-5, available at <http://www.icrw.org/files/publications/Cross-generational-and-Transactional-Sexual-Relations-in-Sub-Saharan-Africa-Prevalence-of-Behavior-and-Implications-for-Negotiating-Safer-Sexual-Practices.pdf> (22 October 2013).

⁴⁹ Luke & Kurz (as above) 3-4.

⁵⁰ D Clifton *Combating Cross-Generational Sex in Uganda* (2009) available at <http://www.prb.org/Publications/Articles/2009/crossgenerationalsex.aspx> (21 October 2013). See also Luke & Kurz (n 48 above) 1.

⁵¹ Ankomah *et al* (n 40 above) 81.

⁵² National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (n 43 above) 232.

relationships as adolescent girls from poorer households are more likely to engage in high risk affairs with older men than their wealthier counterparts.⁵³

Religious Barriers

In Nigeria, the two major religions practiced by the people - Christianity and Islam - place a great value on the sexual purity of adolescents before marriage. Adolescent girls are not only prevented from obtaining in-depth information on sexuality but are also expected to remain virgins until they enter into marital union.⁵⁴ It is rightly acknowledged, as Odimegwu observes, that religion plays the role of a moral custodian in the Nigerian society as evidenced by various religious groups' discouragement of premarital sex. While the success achieved by religion in positively influencing adolescent girls with strong religious beliefs into adopting greater commitment towards sexual abstinence before marriage is noted,⁵⁵ the effect of religion on the access to contraception and other SRH care services by non-religious adolescent girls ought to be taken into consideration as well. According to the writer, while religious adolescents held strict conservative views on the issue of premarital sexual relations, the results generated from the same study reveal that non-religious adolescents were not totally in support of adolescent sexual intercourse only in marriage.⁵⁶ Also, as Wusu notes, the role of religion in preventing adolescents from abstaining in sexual intercourse is only effective before the initiation of sex. Once the adolescent has initiated sexual intercourse, religion ceases to be effective in preventing further sexual acts⁵⁷ thereby giving rise to a situation where adolescents' access to contraception becomes imperative in order to avoid disastrous consequences.

⁵³K. AOyadiran *et al* 'Intergenerational sexual relationship in Nigeria: Implications for negotiating safe sexual practices' in G Letamo (ed) *Social and Psychological Aspects of HIV/AIDS and their Ramifications* (2011) 61, available at http://cdn.intechopen.com/pdfs/22543/InTech-Intergenerational_sexual_relationship_in_nigeria_implications_for_negotiating_safe_sexual_practices.pdf (23 October 2013).

⁵⁴It is necessary to point out that in a majority of cases, religious organizations address the issue of adolescent sexuality within the context of faith and abstinence from sexual acts which are deemed as being immoral.

⁵⁵C. Odimegwu 'Influence of religion on adolescent sexual attitudes and behaviour among Nigerian university students: Affiliation or commitment?' (2005) 9 *African Journal of Reproductive Health* 126-127; Ankomah *et al* (n 40 above) 82.

⁵⁶Odimegwu (as above) 133.

⁵⁷O. Wusu 'Religion, religiosity and adolescent risky sexual health behaviour in Lagos Metropolis, Nigeria' (2011) 3 *Inkanyiso Journal of Humanities and Social Science* 49-53.

The detrimental role played by religion in opposing access to contraception information and services for adolescent girls, especially in the wake of current global HIV and STI epidemic, cannot be over stated. Due to the value placed by religion on the issue of sexual purity, female adolescents who either seek to access contraceptive information and services are not only tagged as irresponsible and immoral but are also deemed as being unsuitable for marriage. The fear of stigma, exposure and punishment influences contraceptive usage and how contraceptives are sourced. This situation was noted by Monjoker *al* who reveal adolescent girls preference to patronise patent medicine shops rather than hospitals as a result of religious objection to the use of modern contraceptive methods.⁵⁸

Legal Barriers

A major area that generates controversy relates to the matter of sexual relations between adolescents and adults. Occasioned by the phenomenon of child sexual abuse and the perpetuation of sexual crimes against children,⁵⁹ the law prohibiting sexual activity with children has operated on the basis of the recognition of age limits below which children cannot consent to sexual activity with adults and other children.⁶⁰ Sexual relations with adolescents below the age recognised by law are usually categorised as the offence of statutory rape. Before the passage of the CRA,⁶¹ the offence of statutory rape was already recognised under the country's Criminal Code⁶² and Penal Code⁶³ Acts. On its part, the

⁵⁸Monjoker *al* (n 32 above) 14. See also Ankomah *et al* (n 40 above) 275; UNFPA & USAID - *Contraceptive Security in Nigeria* (n 33 above) 18.

⁵⁹C. A. Phipps 'Children, adults, sex and the criminal law: in search of reason' (1997) *Seton Hall Legislative Journal* 4.

⁶⁰K. Sutherland 'From jailbird to jailbait: Age of consent laws and the construction of teenage sexualities' (2002) 9, available at *William and Mary Journal of Women and the Law* 313; C. Ferguson 'Do teenagers have a human right to consensual sexual activity?' (2010) available at <http://www.theguardian.com/commentisfree/libertycentral/2010/apr/15/teenagers-law-human-right-consensual-sex> (9 October 2013).

⁶¹Child Rights Act cap c50 LFN 2004.

⁶²Criminal Code cap c38 LFN 2004. The Criminal Code not only forbids engaging in sexual intercourse, or attempting to engage in sexual intercourse, with a girl of less than 13 years but provides that such offences attract a punishment of life imprisonment or 14 years imprisonment. Also, offences of sexual assault against girls below the age of 13 and between the ages of 13 and 16 are punishable by terms of imprisonment ranging from two to three years. See secs 218, 221 & 222 Criminal Code.

⁶³Penal Code cap p3 LFN 2004. Under the Penal Code operating in Northern Nigeria, children under the age of 14 and 16 are incapable of consenting to sexual acts or acts of 'gross indecency'. See secs 39 & 285 Penal Code.

CRA 2003, provides that no one shall have sexual intercourse with a child and the penalty for a contravention of the law attracts a punishment of life imprisonment.⁶⁴

However, while the provisions of the CRA and the older Criminal and Penal Code Acts can be lauded for their attempts at protecting children (including adolescents) from sexual abuse, it is necessary to call attention to the apparent barrier that the provisions of the laws would have on the willingness of adolescent girls to access contraceptive and other SRH care services as girls would forgo obtaining contraception, which will protect them from unplanned pregnancies and STIs, rather than attempting to access the services and 'risk' exposing their older sexual partners.

Also, the fact that the offence of statutory rape as recognised under the laws does not take cognisance of consensual sexual relations between adolescents is a shortcoming as, in a majority of cases, female adolescents also have sexual relationships with their peers.⁶⁵ According to Amazigoet *al*, findings revealed during focus group discussions that adolescents are involved in two kinds of relationships: relationship with their peers and relationship with older men. While the adolescents described peer relationships as being 'for love', relationships with older men was mainly 'for money'.⁶⁶ The above was further confirmed by Oladokunet *al* in their study on the sexual behaviour and contraceptive usage of secondary school adolescents in Ibadan, a Nigerian city. They note, contrary to observations that most adolescents are involved in sexual activities with older partners, findings from their study reveal that in-school adolescents have sexual partners who are either younger, of their age or older as the case may be.⁶⁷

While not overlooking the reality that activities of sexual predators are on the increase in the country,⁶⁸ it is felt that an important issue which needs to be considered when

⁶⁴Sec 31(1) & (2) Child Rights Act. Given that the definition of a child under the CRA is a person under the age of 18, the CRA explains that where a person has been charged with the offence of statutory rape, it is immaterial that the offender believed the person to be of or above the age of eighteen years or the sexual intercourse was with the consent of the child. See secs 31(3) (a) & (b), 277 Child Rights Act.

⁶⁵U. Amazigoet *al* 'Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria' (1997) 23 *International Family Planning Perspectives* 30.

⁶⁶Amazigoet *al* (as above) 30.

⁶⁷A. Oladokunet *al* 'Sexual Behaviour and Contraceptive Usage of Secondary School Adolescents in Ibadan, Nigeria' (2007) 18 *Journal of Reproduction & Contraception* 287.

⁶⁸N. Odeh 'Why sexual abuse of kids is increasing' PM News 30 April 2013, available at <http://pmnewsnigeria.com/2013/04/30/why-sexual-abuse-of-kids-is-increasing/> (9 October 2013); A. AlhassanAhman 'Child rape: Who speaks for the victims?' Hope for Nigeria 5 May 2013, available at <http://www.hopeforigeriaonline.com/child-rape-who-speaks-for-the-victims/> (9 October 2013); E. Akinkuotu 'Child abuse, rape rise in Lagos -OPD' Punch 11 April 2012, available at

amending or replacing the criminal laws operating in the Nigeria relates to the amendment of the provisions on statutory rape contained in the laws.⁶⁹ In this instance, it is believed that instead of the existence of blanket penalty provisions contained in the laws, cognisance of consensual sexual relationships between adolescents of similar age-groups (for example, adolescents with a two year gap between them) should be taken as the continued existence of 'wholesale' sanctions have the tendency of failing in their endeavour to act as deterrent against the engagement in sexual relationships by adolescents since adolescents will continue having sex with each other whether the country's criminal laws sanctions such behaviour or not.

Instead, the general sanctions contained in the criminal laws on statutory rape have the potential effect of backfiring by rendering adolescent reproductive health policies which aim to protect the SRH of adolescent girls ineffective as female adolescents will rather not get their peers' into trouble with the law by attempting to access preventive or protective contraceptive information and services. The above reasoning aligns with that of the Constitutional Court in *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another*⁷⁰ where the court, taking note of the expert report which detailed the 'high rates of negative experiences and consequences of sexual behaviour', stated that if children are not made to feel that there are safe environments within which they can discuss their sexual experiences, they will not only be stripped of the benefit of guidance at a sensitive and developmental stage of their lives but will also silence and isolate adolescents thereby making the adoption of unhealthy behaviour and poor developmental outcomes more likely.⁷¹

Demographic Barriers

Another factor which affects access to contraception in Nigeria is the problem of demographic and physical accessibility. Results generated from the 2008 *National*

<http://www.punchng.com/metro/child-abuse-rape-rise-in-lagos-opd/> (9 October 2013); 'Rape: When old vice becomes new monster' Vanguard April 18 2012, available at <http://www.vanguardngr.com/2012/04/rape-when-old-vice-becomes-new-monster/> (9 October 2013); IRIN 'Nigeria: Child rape in Kano on the increase' (2008) available at <http://www.irinnews.org/report/76087/nigeria-child-rape-in-kano-on-the-increase> (9 October 2013).

⁶⁹The two laws which regulate criminal matters are both a colonial heritage, so there is an urgent need to either amend or replace them totally. While the Criminal Code which operates in the southern part of the country was enacted in 1916; the Penal Code that is applicable in the north was passed as law in 1959.

⁷⁰*The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35.

⁷¹Paras 45, 47 & 73 *Teddy Bear Clinic for Abused Children case*.

*Demographic and Health Survey on Nigeria*⁷² reveal several facts: First, female adolescents from poorer households constitute a greater portion of adolescents with unintended adolescent pregnancies. Second, the percentage of unmarried women (including adolescent girls) using contraception was higher than their married counterparts. Third, the survey also revealed that the use of modern contraception varied according to residence as the percentage of women residing in urban areas using contraception was higher than their rural counterparts.⁷³

The NDHS findings, which associate the relative ease of accessibility to the physical location of health facilities providing family planning services as a factor for higher contraceptive use among urban residents, was also noted by Onwujekwee *et al.*⁷⁴ According to the writers, while urban dwellers had more options from which they could access contraception; women (including female adolescents) residing in rural areas mostly rely on patent medicine dealers.⁷⁵ These dealers may not provide the best confidential environment for adolescent girls to get contraceptive drugs since every member of the community accesses their contraception from the same source. Automatically, access to modern contraceptive and family planning services are therefore, limited.

In addition, besides the problem of physical inaccessibility, the issue of inconvenient operating hours is a barrier to female adolescents' access to contraception. In some instances, not only are health care facilities where contraceptives can be obtained far-away but also that the facilities have operating hours that are inconvenient for adolescents thereby discouraging them from accessing SRH care services, including contraception.⁷⁶ It should be noted that the shortage of qualified health care providers, especially in the country's rural areas, also contributes to the problem of inaccessibility to contraception. Adolescent girls who live in rural areas are disadvantaged by the lack of qualified health practitioners who can ensure that female adolescents not only have access

⁷²National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (n 43 above).

⁷³National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (n 43 above) 69 & 75.

⁷⁴O Onwujekwee *et al.* 'Are modern contraceptives acceptable to people and where do they source them from across Nigeria?' (2013) 13 *International Health and Human Rights* available at <http://www.biomedcentral.com/1472-698X/13/7> (23 October 2013).

⁷⁵Onwujekwee *et al.* (as above) 13.

⁷⁶Osanyin (n 44 above) 12; Ankomah *et al.* (n 40 above) 278.

to contraceptives but also ensure that they are given contraceptives that is suitable for their body type after carrying out the necessary health checks and examinations.⁷⁷

Consequences of Barriers to Access Contraceptive Information and Services

The consequences occasioned as a result of the impediments barring adolescent girls' access to contraceptive information and services are numerous. While the Nigerian society requires adolescents be to sexually responsible, the existence of socio-cultural, religious, legal and other barriers hinders and prevents female adolescents in the country from accessing contraceptive information and services in confidential settings. This failure contributes to their SRH vulnerability and results in disastrous consequences such as teenage pregnancies, abortion, STIs HIV-infection, as well as the loss of economic developmental potential.⁷⁸

These consequences are briefly discussed below.

Teenage Pregnancies

While it is acknowledged that in spite of socio-cultural and economic differences among developed and developing countries, adolescents nowadays generally initiate sexual relationships at young ages and long before marriage,⁷⁹ the similarity however, ends immediately as the consequences occasioned by adolescent girls' early introduction

⁷⁷It should be noted that the availability of modern contraceptive methods in rural areas is usually limited and affected by existing weak distribution chain which causes situations where even the few primary health centres and SRH care centres in rural areas experience weeks of being out of contraceptive stock. See Family Health International *The effectiveness of community-based access to injectable contraceptives in Nigeria: A Technical Report* (2010) 11 <http://www.k4health.org/toolkits/cba2i/effectiveness-community-based-access-injectable-contraceptives-nigeria-technical> (21 October 2013).

⁷⁸The same problem afflicting the Nigerian society was noted by Davis as also affecting the American society which wants teenagers to adopt responsible SRH measures but at the same time develops and funds programmes that deny their access to information and services needed to protect them from unintended pregnancy, HIV and STIs. See L Davis *Adolescent sexual health and the dynamics of oppression: A call for cultural competency* (2010) 2, available at http://www.advocatesforyouth.org/storage/advfy/documents/adolescent_sexual_health_and_the_dynamics.pdf (5 November 2013).

⁷⁹A S Madkour *et al.* 'Early adolescent sexual initiation and physical/psychological symptoms: A comparative analysis of five nations' (2010) 39 *Journal of Youth and Adolescence* 1213; E Ketting & C Winkelmann *Sexual Health (SH) of young people in the WHO European Region in Sexual Health: A public health challenge in Europe* (2011) 72 *Entre Nous- The European Magazine for Sexual and Reproductive Health* 12, available at http://www.euro.who.int/_data/assets/pdf_file/0019/142570/en72.pdf (19 September 2013).

to sexual activities in the jurisdictions differ due to the reaction of governments and other relevant stakeholders (including parents) to adolescent SRH issues, including in relation to their access to contraceptives.⁸⁰

A very obvious outcome of the different reactions of stakeholders to adolescent girls' commencement of sexual activities relates to the problem of teenage pregnancy. According to the World Health Organisation (WHO), about 16 million adolescent girls give birth every year.⁸¹ While for some adolescents the pregnancies may actually be planned and wanted, however, in a lot of cases, pregnancies by adolescent girls are neither planned nor wanted.⁸² Evidence of the disparity between developed and developing countries on adolescent sexuality issues is further fuelled by the fact that, as the WHO notes, 95% of adolescent births not only occur in low and middle income countries, but more than 50% of births which take place during adolescence occur in sub-Sahara Africa, Nigeria inclusive.⁸³

In Nigeria, teenage pregnancy constitutes a huge problem as the adolescent birth rate in the country is estimated at 123 per 1 000 women aged 15-19 years⁸⁴ which, as Udoet *al* observes, is exceedingly high when compared to adolescent fertility rates quoted for most countries of the world outside sub-Saharan Africa.⁸⁵ Fuelled by the cultural practice of child marriage, which occurs predominately in Northern Nigeria, and the lack of access by adolescent girls (especially unmarried ones) to contraceptive services as a result of factors associated with socio-cultural beliefs, religious perceptions and lack of financial wherewithal, and coupled with the low utilisation of contraceptives by married teenage girls who require spousal permission in order to avail themselves of family planning services, the incidence of adolescent pregnancy, which is declining in many

⁸⁰For example, while parents in countries like the Netherlands and France exhibit openness and allow communication on sexuality issues to occur between themselves and their children, the opposite is the case in relation to parents in Nigeria and Africa generally. See J Friedman 'The battle for effective sexuality education' (2004) 2 *Journal of Student Social Work* 11; Madkour *et al* (as above) 1212-1213.

⁸¹WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes* (n 11 above) IX.

⁸²WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes* (as above) IX.

⁸³Apart from sub-Saharan Africa, other regions which contribute to the high level of pregnant adolescents include Asia and Latin America. See WHO *Adolescent pregnancy* available at http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/ (5 November 2013).

⁸⁴Adolescent fertility rates have been estimated to be between 121-123 live births per 1,000 births. See 'UNFPA country indicators - Nigeria' in *The state of the world's midwifery* (n 15 above).

⁸⁵A Udoet *al* 'Teenage pregnancy and adverse birth outcomes in Calabar, Nigeria' (2013) 17 *Internet Journal of Gynaecology and Obstetrics* available at <http://ispub.com/IJGO/17/2/2995> (10 November 2013).

countries, remains unabated in Nigeria as by the age of 18 years, a large number of female adolescents are already teen mothers.⁸⁶

Although adolescent girls get pregnant as a result of their non-use or incorrect use of contraceptives due to the barriers already highlighted above, as Durojaye remarks, this is because they are improperly educated about sexuality issues including important information on contraceptive use.⁸⁷ According to the writer, by reason of non-access to factual and in-depth sexuality education, both in schools and at home, young girls operate under the mistaken belief that a single act of sexual intercourse cannot result in pregnancy.⁸⁸

The non-access of female adolescents to contraceptive information and services as guaranteed under human rights instruments to which Nigeria accedes not only results in their vulnerability to experiencing unwanted teenage pregnancies but also leads to their being exposed to a higher risk of maternal deaths⁸⁹ and morbidity.⁹⁰

⁸⁶A S Erulkar & M Bello *The experience of married adolescent girls in northern Nigeria* (2007) 9 available at http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf (20 June 2013); G James 'Socio-cultural context of adolescents' motivation for marriage and childbearing in North-Western Nigeria: A qualitative approach (2010) 2 *Current Research Journal of Social Sciences* 269-270.

⁸⁷Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 21 above) 105.

⁸⁸As above.

⁸⁹Female adolescents are, in most cases, not yet physically ready to undergo the rigours of childbirth; they usually suffer negative medical outcomes. Various reports make reference to the fact that complications of pregnancy and childbirth are the leading cause of death among young women aged 15-19 years. Also children of adolescent mothers experience higher levels of morbidity and mortality. See Isa *et al* (n 11 above) 240; Aderibigbe *et al* (n 11 above) 123; WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes* (n 11 above) IX; C Cortes *To reduce teen pregnancies, start with educating girls* (2012) available at <http://www.ipsnews.net/2012/07/to-reduce-teen-pregnancies-start-with-educating-girls/> (7 November 2013); WHO *Adolescent pregnancy* (n 83 above).

⁹⁰As many as 65% of women with obstetric fistula develop the condition as adolescents due to the reason that pregnant adolescent girls face a greater risk of experiencing obstructed labour. See generally C U Iklakiet *al* 'Perinatal outcome in unbooked teenage pregnancies in the University of Calabar Teaching Hospital, Calabar, Nigeria' (2012) *International Scholarly Research Network (ISRN) Obstetrics and Gynecology* 2; UNFPA *Sexual and reproductive health for all* (n 11 above) 21; S Adebayo 'Teenage pregnancy' *The Punch* 2 August 2013, available at <http://www.punchng.com/healthwise/teenage-pregnancy/> (8 November 2013); WHO *Adolescent pregnancy* (as above); J Ebeniro 'The geography of maternal mortality in Nigeria' University of North Texas (2012) 15-16; A Aminu 'NPC Commissioner: North-West has Highest Number of Teenage Pregnancies' *Daily Times* 11 April 2013, available at <http://www.dailytimes.com.ng/article/npc-commissioner-north-west-has-highest-number-teenage-pregnancies> (5 November 2013); J T Muthir & W E Maduka 'Comparison of pregnancy outcome between

Abortion

Generally, the problem of unsafe abortions is a recurring reproductive health care problem, especially among women and female adolescents in developing countries.⁹¹ Involving the termination of unwanted and unintended pregnancies either by unskilled persons or in environments where minimal medical skills are observed,⁹² the effect of unsafe abortion to a greater extent is usually felt by unmarried adolescent girls who, as a result of numerous socio-cultural, religious and gender biases, experience prejudice that disallows them from having access to important contraceptive information and services that are required to protect them from teenage pregnancies and other negative SRH consequences.

A sensitive and contentious issue with religious, moral, cultural, and political undertones,⁹³ a majority of women and girls of reproductive age live in countries (including Nigeria) where abortion procedures are prohibited and permitted only to save the woman's life.⁹⁴ However regardless of the above fact, abortions still occur daily; with a majority of the procedures carried out by inexperienced and unqualified persons under insanitary and dangerous conditions.⁹⁵ Warriner comments that the issue of unsafe abortion is a preventable contributor to the challenge of maternal mortality which is ravaging

teenage and older primigravidae in Jos University Teaching Hospital, Jos, North-Central Nigeria' (2006) 5 *Annals of African Medicine* 101-106.

⁹¹ Abortion is the deliberate termination of a human pregnancy or intentional expulsion of a foetus from a woman's womb before it reaches a stage of viability.

⁹² K Warriner & I H Shah (eds) *Preventing unsafe abortion and its consequences: Priorities for research and action* (2006) vii; Population Reference Bureau Abortion: Facts & figures (2011) 13, available at <http://www.prb.org/pdf/1/abortion-facts-and-figures-2011.pdf> (8 November 2013).

⁹³ F Adeleke *Comparative abortion jurisprudence: Reproductive rights paradigm* (2013) 5.

⁹⁴ Population Reference Bureau Abortion: Facts & figures (n 92 above) 1. See Secs 228 & 229 Criminal Code cap c38 LFN 2004 & secs 232 & 233 Penal Code cap p3 LFN 2004.

⁹⁵ According to the Population Reference Bureau (PRB), estimates reveal that about 42 million abortions are performed yearly and almost half of them are procured outside the legal system. In sub-Sahara Africa, almost 60% of the women who undergo abortion are under the age of 25 years; 25% of whom are also adolescents. See Population Reference Bureau Abortion: Facts & figures (as above) 1, 5 & 7. See also J Benson *et al* 'Public hospital costs of treatment of abortion complications in Nigeria' (2012) 118 *International Journal of Gynaecology and Obstetrics* S134.

countries in sub-Saharan Africa.⁹⁶ This includes Nigeria, where abortion is illegal and unsafe abortion is recognised as a leading cause of maternal mortality.⁹⁷

It is important to highlight that as a result of the sensitive nature of the issue, it is impossible to get accurate data on the number of abortions that occur in Nigeria. However, the *Guttmacher Institute* reveals that as at 2006 the number of abortions carried out in the country was estimated to have risen to 760,000 with more than 3,000 women conservatively estimated as have died as a result of unsafe abortion.⁹⁸

Especially in Nigeria where societal stigma, patriarchy, conservative religious practices and economic disability prevent adolescent girls' from accessing contraceptive services making them vulnerable to unintended pregnancies, the prohibition of abortion services except to save a woman's life⁹⁹ automatically 'forces' pregnant adolescent girls, more often than not, to procure backstreet and unsafe abortions. A practice which further exposes them to complications which eventually contributes to the country's high rate of maternal mortality¹⁰⁰ or morbidity as the case may be.¹⁰¹ According to Adeleke, about half

⁹⁶ K Warriner 'Unsafe abortion: An overview of priorities and needs' in Warriner & Shah (eds) (n 92 above) 1.

⁹⁷ Aderibigbe *et al* (n 11 above) 124; Adeleke (n 93 above) 46-47. This is especially so in Nigeria where current maternal mortality ratio stands at 630 for every 100,000 live births. Nigeria's maternal mortality rate, which is the second highest in the world after India, makes it impossible for the country to meet the Millennium Development Goal 5 target of reducing maternal mortality ratio by three quarters by 2015. See generally K Singh *et al* 'Gender equality and childbirth in a health facility: Nigeria and MDG 5' (2012) 16 *African Journal of Reproductive Health* 122-128; World Bank *Maternal mortality ratio* available at <http://data.worldbank.org/indicator/SH.STA.MMRT> (15 February 2014).

⁹⁸ M Sudhinaraset *n brief Reducing unsafe abortion in Nigeria* (2008) available at http://www.guttmacher.org/pubs/2008/11/18/IB_UnsafeAbortionNigeria.pdf (9 November 2013). See also AA Akinyemiet *et al* 'Abortion and challenges of teenage pregnancy in Lagos, Nigeria' (2012) 3 *International Journal of Scientific & Engineering Research* 2; R Ogbu 'Illegal abortion in Nigeria: The cringing reality' *Daily Times* 11 April 2013, available at <http://www.dailytimes.com.ng/article/npc-commissioner-north-west-has-highest-number-teenage-pregnancies> (5 November 2013).

⁹⁹ Sec 228 & 229 Criminal Code cap c38 LFN 2004 & sec 232 & 233 Penal Code cap p3 LFN 2004.

¹⁰⁰ Maternal mortality rates in the country is currently estimated at 630 deaths per 100 000 live births. Out of the 287 000 maternal deaths that occurred globally in 2010, Nigeria accounted for 40,000 deaths. See WHO *Trends in maternal mortality: 1990 to 2010* (2012) 1 & 22, available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf (7 November 2013); CIA *The world fact book* (2013) available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html> (7 November 2013).

¹⁰¹ Apart from dying, female adolescents who procure unsafe abortion are at risk of suffering various complications, including uterine scarring, severe anaemia, pelvic inflammatory disease and infertility. See N

of the women who die from abortion complications are adolescents.¹⁰² The above fact was also corroborated by Aderibigbe who notes in a study on teenage pregnancy and the prevalence of abortion among in-school adolescents in North Central, Nigeria, that the procurement of induced abortion among pregnant teenagers was common as almost 100% of the adolescent girls in the study reported a case of having induced an abortion.¹⁰³ The above situation was also confirmed by Okereke in a study in which he notes that the occurrence of unintended pregnancy among adolescents in Owerri, a state in South Eastern Nigeria, is not strange.¹⁰⁴ According to the writer, not only is pre-marital sex on the increase but so also is the case of the induced abortion of unintended pregnancies. A majority of participants, while reporting having been previously pregnant, also revealed that the pregnancies had either led to their bearing a child or procuring unsafe abortions since they have no choice as they are not married.¹⁰⁵

Noting the adverse outcomes occasioned by the female adolescents' non-access to contraceptive information and services, there is need to emphasise, as the ICPD maintains, that the Nigerian government and its agencies have a duty to deal with the health impact occasioned as a result of non-access to contraceptive services. Not only should adolescent girls be assured of improved access to family planning services, information and counselling but preventing the need for abortion should be a priority and every attempt should be made to ensure the elimination of unsafe abortions.¹⁰⁶

HIV and STIs

Another side-effect of female adolescents' inaccessibility to contraceptive information and services relates to their susceptibility to HIV and other STIs. Today, worldwide, the menace of STIs among adolescents is of specific concern to many people, including those who work on improving the health status of populations.¹⁰⁷ Though not

AAkaniet al 'Hysterectomy in Adolescents, in Port Harcourt, Nigeria' (2008) 8 *Nigerian Health Journal* 20-23.

¹⁰² Adeleke (n 93 above) 47.

¹⁰³ Aderibigbe et al (n 11 above) 124.

¹⁰⁴ C I Okereke 'Unmet Reproductive Health Needs and Health-Seeking Behaviour of Adolescents in Owerri, Nigeria' (2010) 14 43-54.

¹⁰⁵ Okereke (as above) 43-54.

¹⁰⁶ Para 63 (i) & (ii) ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21/sp/a21spr02.htm> (5 October 2012).

¹⁰⁷ K L Dehne & G Riedner *Sexually transmitted infections among adolescents: The need for adequate health services* (2005) IX, available at <http://whqlibdoc.who.int/publications/2005/9241562889.pdf> (9 November 2013).

evenly distributed, infection with STIs and HIV is particularly common among some groups of adolescents', especially female adolescents.¹⁰⁸ Adolescent girls' are not only vulnerable to infection due to reasons associated with gender inequality which results in their initiation into sexual activities at an early age, but they are also prevented by cultural, religious and other man imposed barriers from assessing contraceptives and condoms that will naturally protect them from pregnancies and STIs, including HIV and AIDS.

Given the levels of the HIV and AIDS pandemic in the sub-Saharan African region where 23.5 million people out of the total of 35 million people living with HIV in the world reside,¹⁰⁹ the situation of female adolescents become more precarious, especially in Nigeria, where an estimated 3.7 million people are already infected with the virus.¹¹⁰ The reason for this is not far-fetched. Whilst adolescent sexual behaviour in Nigeria is similar to that of their international counterparts and they begin to engage in sexual relations at an earlier age than in the past, it has been noted, unlike the case in countries where a liberal approach is adopted to deal with the issue of adolescent sexuality through the impartation of sexuality education and free access to contraceptive services upon request,¹¹¹ that Nigerian society thrives on traditional values that encourage female submissiveness, on one hand, and advises them to shun pre-marital sex on the other thereby placing adolescent in a conflicting position which makes it easier for them to be coerced into sexual relationships.¹¹²

Additionally, the exclusion of adolescent girls' from discussions relating to sex as a result of societal taboos,¹¹³ negative and judgmental attitudes among health care providers, who do not guarantee confidentiality, and poverty, which increases the practice

¹⁰⁸ Apart from adolescent girls, STIs and HIV is also common among other adolescent groups including adolescent sex workers, out of school adolescents and adolescent boys who have sex with men or other boys. See Dehne & Riedner (as above) XI.

¹⁰⁹ UNAIDS *Special report: How Africa turned AIDS around* (n 10 above) 6 & 7.

¹¹⁰ Unicef 'At a glance: Nigeria statistics' [http://www.unicef.org/infobycountry/nigeria_statistics.html#91\(6](http://www.unicef.org/infobycountry/nigeria_statistics.html#91(6)

March 2013).
¹¹¹ C Moreau et al 'The impact of pharmacy access to emergency contraceptive pills in France' (2006) 73 *Contraception* 602; R Parker et al 'Sexuality education in Europe: an overview of current policies' (2009) 9 *Sex Education* 227-242.

¹¹² It is important to state that while sometimes, an overt encouragement of male adolescents engagement in sexual relations may not occur, the society silently encourages boys to prove their sexual prowess as a 'blind eye' is usually turned on boys who access condoms unlike the girls who are harshly termed promiscuous.

¹¹³ S T Omoyeni 'Adolescents and HIV-related Behaviour in Nigeria: Does knowledge of HIV/AIDS promote protective sexual behaviour among sexually active adolescents?' (2012) 4, available at <http://paa2012.princeton.edu/papers/120500> (9 November 2013).

of cross-generational sex with older men who have had previous sexual partners and with whom the girls cannot negotiate condom use, increases their powerlessness to prevent STI and HIV infection

The effect of the above situation was exposed when the UNICEF¹¹⁴ revealed, as a result of the entrenchment of socio-cultural values that promote girl submissiveness and the practise of gender roles fuelling myths about contraception, that cases of HIV and AIDS infection are also reported among pre-teenagers in the country as well. According to the National Agency for the Control of AIDS (NACA), not only do females constitute 58% of persons living with HIV in the country but also the prevalence rate among young women aged 15-24 years is estimated to be three times higher than that among their male counterparts.¹¹⁵

In line with the objective of the Committee on the Convention on the Rights of the Child in its general comment 3 that there is the necessity to identify measures and good practices that will allow state parties to fulfil their obligation of guaranteeing the right to health of children and protecting them from HIV and AIDS,¹¹⁶ the Nigerian government needs to be more pro-active in censuring third parties who, as a result of their rigid views and opinions, contribute to denying girls access to contraceptives information and services, thereby increasing their exposure to HIV and STIs.

Socio-economic Consequences

Poverty is a major factor that entices adolescent girls from poor families into engaging in transactional and unsafe sexual activities with older men who have higher rates of HIV infection than adolescent boys.¹¹⁷ In addition, stigmatisation also prevents young girls access to needed contraceptive services thereby further entrenching them in poverty¹¹⁸ in the sense that girls who can't access contraceptives become exposed to experiencing negative outcomes such as unintended pregnancies. Once pregnant, however,

¹¹⁴UNICEF Nigeria HIV/AIDS available at http://www.unicef.org/nigeria/children_1940.html (9 November 2013).

¹¹⁵NACA Key statistics on HIV in Nigeria (n 10 above).

¹¹⁶Para 2(3) general comment 3 CRC Committee 3 *Compilations of General Comments and Recommendations adopted by human rights treaty bodies Vol II*, available at http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf (8 November 2013).

¹¹⁷Luke & Kurz (n 48 above) 3-5.

¹¹⁸Onwujekwe 'Are people really using modern contraceptives' (n 38 above) 3 & 4; Durojaye 'Realising access to sexual health information and services' (n 31 above) 150; Enuamehet *al* (n 26 above) 3354 & 3355.

the girls where school-going, are either expelled from school as a result of the pregnancy or drop out of school due to the shame and stigma attached to adolescent pregnancy.¹¹⁹

It is important to emphasise that in most cases once the adolescent girl drops out of school as a result of pregnancy, in addition to the condemnation faced from community and family members, such girls are either forced into marriage, and their chances of returning to school after childbirth becomes slimmer, or have limited employment opportunities, making it challenging for them to take care of their children.

The above description of the situation is supported by the UNFPA in one of its publications in which it explains that because 40% of girls in developing countries give birth to their first child before the age of 20 years they usually face the prospect of dropping out of school and losing their chances of improving their economic status in life.¹²⁰

In Nigeria, the same situation was noted by Onyekaet *al*¹²¹ and Izugbara¹²² who explain that pregnant adolescents are not only expelled from school in order to prevent them from 'contaminating' other students but their situation is further compounded by sexual partners who deny being responsible for their pregnancies thus leaving them to suffer socio-economic consequences, including dismissal from schools, poor education and lower income later in life.¹²³

Conclusion

This article has revealed the barriers and attendant consequences associated with adolescent girls' non-access to contraceptive information and services in Nigeria. The barriers which prevent access to contraception continue to exist in the country despite

¹¹⁹CRR *Forced out: Mandatory pregnancy testing and the expulsion of pregnant students in Tanzanian schools* (2013) 74, available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/crr_Tanzania_Report_Part1.pdf (9 November 2013).

¹²⁰UNFPA *Sexual and reproductive health for all* (n 11 above) 21

¹²¹N Onyekaet *al* 'Unintended pregnancy and termination of studies among students in Anambra state, Nigeria: Are secondary schools playing their part?' (2011) 15 *African Journal of Reproductive Health* 109-116.

¹²²C O Izugbara 'Tasting the forbidden fruit: The social context of debut sexual encounters among young persons in a rural Nigerian community' (2001) 5 *African Journal of Reproductive Health* 28.

¹²³I Ayuba & G Owwoeye 'Outcome of teenage pregnancy in the Niger-delta of Nigeria' (2012) 22 *Ethiopian Journal of Health Sciences* 46.

Nigeria's commitment to ensure the protection and full realisation of the reproductive health rights of adolescent girls.

Considering the extent and gravity of the SRH ill health girls' face when denied access to contraceptive information and services, it is emphasised that the barriers preventing access to contraceptive information and services by adolescent girls fosters their adoption of unsafe and dangerous sexual lifestyles¹²⁴ and therefore occasions greater harm than good.

Accordingly, the article concludes that the country's inaction in ensuring actual access to contraceptives by female adolescents greatly out-weighs socio-cultural and other reasons that may be advocated for non-access. The continued susceptibility of adolescent girls to SRH ill-health requires the Nigerian society to face reality and adopt pragmatic attitudes that will speedily enable adolescent girls' obtain accurate contraceptive information and services as this will result in the country's achievement of greater benefits that will overshadow supposed harmful effects responsible for denial of access in the first place.

¹²⁴Adolescents being a curious group will still engage in sex either because they are forced into sexual relations or in order to satisfy their curiosity or for economic and monetary needs.