

# **YOUTHS AND THEIR CHOICE OF CONTRACEPTIVES TOWARDS AN EFFECTIVE REPRODUCTIVE HEALTH: THE CASE OF EKITI STATE, NIGERIA**

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## **Abstract**

The study of investigated youth and their contraceptive usage toward reproductive health in Ekiti State. It was a descriptive design of the survey type, the sample was 200 youths drawn from both urban and rural areas that were randomly selected from the 16 LGAs in Ekiti State. The instrument used for the data collection was titled Youth and Contraceptive Usage (YAU). The instrument was personally administered to the respondents by the researchers. The instrument had a reliability coefficient of 0.78 at 0.05 level of significance. The data collected was analyzed using frequency counts and percentages as well as t-test analysis. The two hypotheses raised were tested at 0.05 level. The study revealed that there was a significant difference in education of youths and their contraceptive usage, and no significant difference in the location of youths and their contraceptive usage. It was, therefore, concluded that youths should have access to all forms of contraceptive which will lead to a healthy reproductive living and this should not be seen as a way of making our youths promiscuous, but rather lead to a reduction in the rates of abortion and morbidity among the youths.

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**Keywords:** Youth, Education, Rural, urban, Contraceptive Usage

## **Introduction**

When addressing the Sexual & Reproductive Health needs of young people, we must first identify the many obstacles they face. In most parts of the world and in Nigeria in particular, more than 90 percent of young people know at least one contraceptive method, but usage rates remain low, especially in rural areas. This is probably due, in part, to the lack of

youth-friendly services, myths about sexuality and reproductive health, lack of knowledge about sexual & reproductive rights as human rights, and gender inequality.

One of the largest obstacles that young people face today is the lack of health services that work with their priorities and needs. Adult experiences and perspectives are very different from those of young people. For information & services to effectively reach young people, youth-friendly services are needed that encourage youth to be agents of their own social & health welfare (Gonzola, 2012).

As the threat of reproductive health hazards confronting the youth in Nigeria become a focus of research, advocacy, policy and legal initiatives in developing countries, the problems associated with youth sexuality, such as unprotected sexual activities, low contraceptive use and inability to negotiate safe sex as well as clandestine abortion becomes readily apparent (Amazigo et al, 1997 & Osakinle 2003). Moreover, HIV/AIDS is hitting youth hard. Studies in Africa show that about 7 in every 10 new HIV infections among females occur among those aged 15 to 24 years (Katz 2006).

As young women (aged 15–24 years) are increasingly exposed to reproductive health risks such as sexually transmitted infections (STIs), unintended pregnancy and childbirth (Mfono, 1998; Creel & Perry, 2003). The exposure to these risks has attracted considerable research attention in different societies, in efforts both to understand its extent, causes and to address it as a problem. In Africa, studies (Muhwava, 1998; Burgard, 2004) have demonstrated that a large proportion of young women are exposed to the risk of conception, receive poor or no sex and contraceptive education, and experience a high incidence of adolescent childbirth.

Unfortunately, in many cases they are left to suffer alone and the responsible male goes scot-free. The over powering, elderly and in most cases wealthier men exploit young girls sexually. Worse still, these young people lack knowledge of their sexual rights and cannot assert themselves, even when they wish they could and/or should. They even lack skills for negotiating safe sex. The obviously stronger men backed with societal norms of ‘talk no sex’ by ‘good girls’ take advantage of this apparent weakness and ignorance among the young females. Results of different studies by GHARF show that many young girls in Enugu State have children out of wedlock and are out of school because of premarital pregnancies. A survey of post secondary girls in Enugu State revealed that 21 percent of the girls surveyed have induced abortion (Ozumba et al 1992). This is just a tip of the iceberg. It is important however to note that this has a multiplier effect on the general social, psychological and economic well being of the young girls.

Although reports indicate a decline in teenage pregnancy, most of the premarital births still occur among young women aged 15-24 years, the majority of whom are neither economically nor emotionally ready to deal with parental responsibilities (Creel & Perry, 2003). Thus, improving young women's reproductive health is key to improving the situation of women as well as the world's future generations. Young women often lack basic reproductive health information. They need information on the consequences of unprotected sexual intercourse and they also need to be well informed about developmental body changes. In addition to the above-mentioned information, young women need skills in negotiating sexual relationships, and knowledge about affordable confidential reproductive health services. In Nigeria among the Yoruba's, it is a taboo to discuss sex openly. Many do not feel comfortable discussing sexual issues with parents or other key adults with whom they can talk about their reproductive health concerns (Meekers & Ahmed, 1997; Whitaker et al, 1999). Likewise, parents, healthcare workers, and educators frequently are unwilling or unable to provide complete, accurate, age-appropriate reproductive health information to young people. This is often due to their discomfort in discussing the subject or the false belief that providing the information will encourage increased sexual activity (Karim et al. 2003 & Osakinle 2003). Because of this, most young women enter into sexual relationships with very little knowledge of the consequences, either shared by their peers or from the media; and also contributed to a low prevalence of using protective measures i.e. contraceptives.

Substantial evidence is also found in the existing literature that broadening the choice of contraceptive methods increases the overall contraceptive prevalence (Magadi & Curtis, 2003; Chen & Guilkey, 2003). The provision of a wide range of contraceptive methods increases the opportunity for individuals to obtain a method that suits their needs. (Ross et al. 2001) confirm that the prevalence of contraceptive use is highest in countries where access to a wide range of methods is uniformly high. However, studies of contraceptive use and contraceptive methods choice among young women in countries in sub-Saharan Africa are few, probably because of the generally low contraceptive prevalence in the region. Researchers have primarily focused on contraceptive use and method choice among married women, leaving the vulnerable unmarried young women unattended. A growing need, though, exists for an examination of contraceptive use and methods choice patterns among young women. In addition, improving contraceptive access and use is vital to overcome the challenge of unintended pregnancy among unmarried young women. However, young people tend to resolve to using contraceptive types that are not too expensive like taking salt solution

after the act, the use of withdrawal system, rings and parents most times would have worked with herbalists thereby putting ‘Teso’ on their children so that they can read (Osakinle, 2003).

Understanding the factors that influence contraceptive use is critical to the efforts of programs to increase prevalence. Much unmet needs for family planning persists, even in settings where knowledge of contraceptive methods is high. Studies suggests that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in Maldives found that knowledge of family planning was universal, but only 30% of couples were using a contraceptive method. Several studies, including one from Malaysia, found that non-use of contraceptives was linked to fears about side effects (Population Reports 1999; Oyedokun 2004).

Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro 2004). Better-educated women are argued to be more willing to engage in innovative behaviour than are less educated women, and in many Third World contexts, the use of contraceptive remains innovative (Caldwell 1979; Dyson & Moore 1983 & Osakinle 2003). Better educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy, greater familiarity with modern institutions, and greater likelihood of rejecting a fatalistic attitude towards life. There is good evidence that for whatever reason, women’s education does indeed promote the use of contraceptive in most developing countries outside of tropical Africa (Cochrane 1979). Koc (2000) finds a positive association between the educational level of both spouses and the use of contraceptive methods in Turkey. After all individual, cultural, fertility and contextual variables were controlled, a woman’s education was found to be a stronger predictor of method use and method choice than that of her husband. The study also showed that, to a great extent, contraceptive use and choice of modern method depend on the sex of a couple’s living children, implying some preferences or sons, although general women prefer to have children of both sexes.

Furthermore, female autonomy and seclusion, equality between spouses linked with spousal communication, have been argued to influence contraceptive use (Dyson and Moore 1983; Bechman, 1983; Hollerbach 1983; Narzary 2001). Shrestha (2000) found in a study in Nepal that spousal communication on family planning, spousal communication on family size preference, child loss, place of residence and women’s involvement in income-earning activities are the significant predictors of contraceptive use in the study area. In another study by Chacko in 2001, among married women, in four villages in rural West Bengal, India, it was found that the factors that most influence a woman’s use of contraceptive include her

age, the number of living sons she has, and her religious affiliation. The study also shows that the availability and quality of permanent village-based government health care affects the use of modern contraception. In a study in Guatemala, it was reported that after controlling for socio-demographic factors, access to services emerged as a significant correlate of contraceptive use among the Mayans (Bertrand et al. 2000).

Data from Nigeria Demographic Health Survey 1999 reveals that on overall use of family planning methods, among all women, about a quarter (27%) have ever used a method and less than a fifth (17%) have used a modern method. The percentage of married women who ever used a contraceptive method is highest among the 30-34 group (36%) and expectedly lowest among the 15-19 group (7%) but they engage in penetrative sex and the options are local contraceptives that are not expensive.

Many studies have identified age, residential area, length of marriage, level of education, number of living or deceased children, gender of living children, prior discussion of family planning, husband's approval, socioeconomic status, and religion as key factors affecting the use of modern contraceptive methods in Asia and some parts of Africa. However, in Africa, socioeconomic status, husband's approval, being the head of the household, the number of living children, level of education, work status, prior discussions of family planning and urbanization emerge as determinants of modern contraceptive use (Kayembe, et al. 2006; Chaudhury, 1984). Generally, there is a positive relationship between improvement in these factors and contraceptive use. For example, the higher the socioeconomic status, or the higher the level of education, the more likely women are able and willing to use contraceptives. Women in urban areas were more likely to use contraceptive methods (27 percent) than their rural counterparts (21 percent). The Greater Accra region, where Ghana's capital city is located, had the highest contraceptive prevalence rate (33 percent), followed by the Brong Ahafo and Volta regions (29 percent each). The Northern region, which is largely rural and a relatively poor region, reported the lowest current level of contraceptive use (6 percent). Women with at least some secondary education were more than twice as likely to use contraception as women with no education (30 and 14 percent respectively). Use of any method and use of any modern method increased with level of education. Use of contraception was also positively related to wealth status, increasing from 14 percent among currently married women in the lowest wealth quintile to 31 percent in the highest wealth quintile.

The pattern of current use of modern and traditional methods of contraception was similar across subgroups. Use of both modern and traditional methods was more common in

urban areas than rural areas, and increased with level of education and wealth quintile. Clements and Madise (2004) using logistic regression examined the various socio-demographic groups and modern contraceptive use among women in three sub-Saharan countries-Ghana, Tanzania and Zimbabwe are using DHS. The results show that though some groups or characteristics are country-specific, there were some similarities and consistencies in the factors influencing modern contraceptive usage such as education, age, wealth status and the number of living children. While most of the studies in Ghana and elsewhere have adequately addressed contraceptive use from different perspectives, investigating the phenomenon from the viewpoint of choosing traditional, modern or no contraceptive method in the context of a developing country has not been adequately explored.

However, in Nigeria, it was reported by Abdullahi (2012) that statistics from the National Demographic Health Survey conducted in 2010 has shown that 90% of adolescent women from the age of 14-24 in northern Nigeria have no access to contraceptive, 85% of the women from the age of 25-34 cannot access contraceptive in the region. This was disclosed to newsmen by the project manager of Expanded Social Marketing Project in Nigeria (ESMPIN), Dr. Yusuf Lawan at a one day workshop organized by BBC MEDIA ACTION in Jigawa yesterday. Dr. Lawan said only 66.6% of female adolescent and 57% of women between the ages of 20-34 in the south failed to access contraceptive, he said their concern is not to discourage childbirth but to encourage child spacing through the use of contraceptives so that the mother and the child will enjoy good health and live a better life. The project manager blamed misconception, poor attitude of health providers, irregular supply of contraceptives and religious as well as social beliefs as some of the reasons why access to contraceptives is low in northern Nigeria.

### **Method**

The paper is a descriptive design of the survey type. The population of the study is all the youths in Ekiti State, while the samples are 200 selected from randomly selected two local government headquarters and two rural areas from within the 16 LGAs in the state. One LGA headquarter as well as one rural settlement that was not part of the sample were used to get the reliability co-efficient. The instrument for the study was titled Youths and Contraceptive Usage (YAU). The 20 items instrument was administered to 100 youths in the two locations. A test-retest analysis was done after two weeks of first administration. Pearson Product Moment Correlation analysis was used to analyze and a co-efficient of 0.78 was getting at 0.05 level of significance.

The instrument had two sections A and B, section A has to do with the bio-data of the individuals, while section B of 20 items was to elicit information of their type of contraceptives the youths use which would determine their level of reproductive health. One general question was raised while two Hypotheses were generated to guide the study. Percentage and frequency scores were used to score the general questions while t-test analyses were used to analyze the data collected.

**General Question**

**Table 1:** Do youths in Ekiti State use contraceptives?

| Location | Frequency | Yes | No | %   |
|----------|-----------|-----|----|-----|
| Rural    | 100       |     | -  | 50  |
| Urban    | 100       |     | -  | 50  |
| Total    | 200       |     | -  | 100 |

Source: Researchers Survey

This analysis shows that the youths in Ekiti State use contraceptives. The type notwithstanding, the youths are aware that they have to use a form of contraceptive to avoid pregnancies. When asked verbally how they get the contraceptive they use, some said, they use salt solution which they drink immediately after the intercourse and that it had never failed them. Some said they asked their partners to withdraw but this has led to their becoming pregnant twice or more, then to abortion. This is in agreement with the finding out of Osakinle (2003).

**Hypothesis 1:** There is no significant difference in the use of contraceptive among educated and illiterate youths in Ekiti State.

**Table 2:** t-test showing illiterate and educated youths in Ekiti State on usage of contraceptives

| Variables  | N   | $\bar{X}$ | SD   | DF  | t cal | t tab | Decision at p<0.05 |
|------------|-----|-----------|------|-----|-------|-------|--------------------|
| Illiterate | 40  | 20.6      | 3.42 |     |       |       |                    |
|            |     |           |      | 118 | 2.69  | 1.96  | Significant        |
| Educated   | 180 | 23.7      | 2.86 |     |       |       |                    |

Number of illiterate youths 40 with a mean of 20.6 and standard deviation of 3.42, while the educated number was 180 with a mean of 23.7 and standard deviation of 2.86, they have a degree of freedom of 118. The t-cal (2.69) is greater than the t-table (1.96). This means that there is a difference in contraceptive use and their education. Therefore the hypothesis is rejected.

**Hypothesis 2:** There is no significant difference in the use of contraceptive among youths in urban and rural areas in Ekiti State.

**Table 3:** t-test showing location of youths in Ekiti State

| Variables | N  | $\bar{X}$ | SD   | DF  | t cal | t tab | Decision at p<0.05 |
|-----------|----|-----------|------|-----|-------|-------|--------------------|
| Urban     | 50 | 21.02     | 3.02 |     |       |       |                    |
|           |    |           |      | 118 | 0.75  | 1.96  | Not- Significant   |
| Rural     | 70 | 20.95     | 3.95 |     |       |       |                    |

Urban youths number 50 with a mean of 21.02 and standard deviation of 3.02 while rural youths number was 70 with a mean of 20.95 and a standard deviation of 3.95. The degree of freedom is 118. The t-cal (0.75) is less than the t-tab (1.96), this means that there is no significant difference in the location of youths and their use of contraceptives. Then, the hypothesis is accepted.

### **Discussion**

From the findings, it could be seen that the education of youths in terms of their knowledge of the types of contraceptives to use is very important. The first hypothesis is rejected, which is that there is a significant difference in the level of education of the youths and their contraceptive usage. This is in line with the research findings of Amazigo et al. (1997), Osakinle (2003) and Katz (2006). It is also in line with the findings of Caldwell, (1979), Dyson & Moore (1983) and Osakinle (2003) that better educated women are urged to be more willing to engage in innovative behavior than less educated; and in the Third World context, the use of contraceptive remains innovative. Furthermore, lack of education and contraceptive knowledge expose the reproductive risks of youths. This is supported by (Mfono, 1998; Creel & Perry 2003). They tend to experience high incidence of adolescent childbirth. Those that use a form of contraceptive resolve to the use of salt solution, rings and so on if their parents have not put “teso” on them, Osakinle (2003).

The research findings show that the location of the youth is not significant in that their location notwithstanding, if the youths can obtain a method that suits their needs they will know how and where to get it. This is in agreement with the findings of Ross et al (2001), Osakinle (2003) and Abdulahi (2012). The location of the youths notwithstanding, government and health service providers have focused more on married women, leaving the vulnerable unmarried women unattended to and this has led to the youths adopting method that their friends tell them that will probably fail and expose them to risks reproductively.

### **Conclusion**

It can thus be concluded that the government (Federal, States & LGAs) needs to do a lot to make sure that these contraceptive methods are made reachable the youths. By providing the methods and making it almost priceless, it is not a way of making the youths to the promiscuous but a way of living healthy reproductively, thereby lowering the risks they face without the contraceptives. Also, improving contraceptive access and usage is vital to overcome the challenge of unintended pregnancies among unmarried young women and this will reduce the rates of deaths and morbidity as a result of abortion.



### **Recommendation**

Non-Government Organizations could be involved in preaching this gospel of the use of modern contraceptive in all the nooks and crannies of Ekiti State so that whether rural and urban location, youths can get the supply of contraceptive for a healthy reproductive living. Also, there should be no disparity among who is supposed to use and who is not supposed to use (i.e. whether adults or youths) contraceptives since the methods are meant for people in their reproductive ages whether married or not.

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