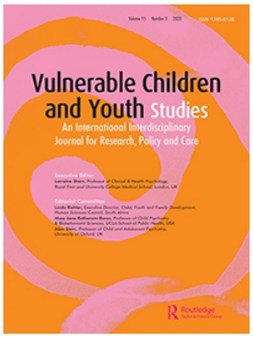

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ARTICLE

Adolescents' utilization of reproductive health services in Kaduna, Nigeria: the role of stigma

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ABSTRACT

The need to improve the sexual and reproductive health (SRH) and rights of adolescents is increasingly acknowledged. Unfortunately, many adolescents in Nigeria face significant barriers to accessing quality sexual and reproductive health services (SRHS), despite national policies promoting SRHS for adolescents. This paper explores the stigma influencing access to and utilization of SRHS among adolescents in Kaduna, Northwestern Nigeria. This qualitative study conducted semi-structured interviews with 14 adolescents and three nurses. Thematic analysis was employed for the study. The findings indicate that although the adolescents knew the importance of accessing SRHS, they were not inclined to utilize the services because of stigma. The stigma-related barriers to accessing SRHS were related to religion, community norms and the negative attitude of the community and health workers all resulting in adolescents feeling shy and ashamed to use SRHS. Suggestions made to address these challenges and promote access included the provision of youth-friendly services (YFS) that respect confidentiality and privacy and also having dedicated youth-only health clinics. Health workers emphasized the need for creating awareness in the community about adolescent SRH and rights and the need to improve resources to provide comprehensive youth-friendly SRHS. There is also the need to introduce targeted stigma reduction training programs for health workers providing youth-friendly services. The findings can inform context-specific interventions in Nigeria and better implementation of the country's policies related to adolescent SRH.

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Adolescents; access; utilization; sexual and reproductive health services; stigma; social norms

Introduction

Adolescents make up 31% of Nigeria's population (WHO, 2018). About a third of Nigeria's total population range between 10 and 24 years and more than 30 million Nigerians range between 10 and 19 years. Almost half (48.6%) of adolescents aged 15–19 years are sexually active (Federal Ministry of Health (FMOH), 2009). Furthermore, Kaduna State has a low contraceptive prevalence rate (3%) among

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adolescents (Sedgh et al., 2009). The HIV prevalence rate (3.3%) among adolescents aged 15–19 years in the Northwest zone of the country is similar to the global adolescent HIV prevalence of 4% but higher than the national adolescent prevalence rate of 2.9% (National Population Commission (NPC) & ICF Macro, 2014; UNICEF, 2019a). Adolescent marriages and parenthood are also common in Northern Nigeria (NPC & ICF Macro, 2014). Research in Nigeria has revealed the unmet reproductive health needs of adolescents, especially in the north (Federal Ministry of Health (FMOH), 2010; Sedgh et al., 2009).

Each year an estimated 21 million pregnancies occur among girls aged 15–19 years in developing countries (Darroch et al., 2016). In sub-Saharan Africa (SSA), an estimated 45% of the pregnancies among girls aged 15–19 years are unintended resulting in unsafe abortions and miscarriages (Darroch et al., 2016). In 2018, the estimated adolescent birth rate globally was 44 births per 1,000 girls aged 15–19 years (UNICEF, 2019b) with the highest rates of 115 births per 1,000 in West and Central Africa (UNICEF, 2019b). In Nigeria, according to the National Demographic Health Survey (2019), 19% of females have engaged in sexual intercourse by the age of 15 and 57% by 18 years. Three percent of males and 30% of females had engaged in sexual intercourse before the age of 20. National data also show that 19% of adolescents aged 15–19 have begun childbearing; 14% have given birth, and 4% pregnant with their first child (National Demographic Health Survey, 2018). Adolescents thus require services that are appropriate, accessible and user-friendly to effectively address their sexual and reproductive health (SRH) needs (WHO., 2012). These services ought to be confidential and private and their religious beliefs and cultural values must be respected. However, these services should also conform to relevant existing international agreements and conventions (United Nations Population Fund, 1994). Additionally, adolescents should be involved in discussions and decision-making regarding their SRH rights, beliefs, behaviours and service access (Cook & Dickens, 2000).

Stigma is a contextual and complex social process that marks a person for an attribute that violates social expectations and is devalued culturally (Norris et al., 2011). Stigma related to adolescent sexual behaviour, use of adolescent sexual and reproductive health services (ASRHS), sexually transmitted diseases (STDs), pregnancy and abortion, can result in adverse health conditions and social repercussions, including shame, marginalization and violence (Goffman, 1986). Studies in developed and developing countries have shown that adolescents' utilization of SRHS may be restricted due to fear, stigma, and shame (Blanc et al., 2009; Nyblade et al., 2017).

Community attitudes toward contraception stem from stigma around pre-marital sex (Morris & Rushwan, 2015). In Nigeria, like in some other developing countries, adolescents also face socio-cultural barriers making it difficult for them to access and utilize SRHS (Federal Ministry of Health (FMOH), 2009). Such norms can discourage discussions related to sex and sexuality and thereby also disapprove of adolescents' having access to SRHS (Chikovore, 2004). Adolescents therefore often end up being discriminated against if they do attempt to access SRHS (Chikovore, 2004).

Negative health-care worker attitudes have been shown to impact on adolescent SRH (ASRH) access and utilisation in many contexts. In Kenya and Zambia (Warenius et al., 2006) and Uganda (Kipp et al., 2007) health worker-related stigma

attributed to disapproval of adolescent sexual activity and utilization of SRHS services. The lack of confidentiality and privacy at health facilities can also expose the adolescents to being stigmatized for seeking SRHS (Lindberg et al., 2006). There is a paucity of information related to ASRH stigma in Nigeria. A better understanding of the factors contributing to ASRH stigma is needed to guide programs and policies that would combat this stigma in Nigeria. This paper explores stigma-related barriers associated with access to and utilization of adolescent SRHS and perceptions of how stigma could be addressed.

Methods

An exploratory qualitative study was conducted between January and April 2017 in Kaduna, North-Western Nigeria. The study protocol was approved by the Ethics Committee of University of the Western Cape and the Ministry of Health Kaduna State, Nigeria. Fourteen adolescents between 16 and 19 years were selected through convenience sampling from three purposively selected Primary Health-Care Centers (PHCC) based on their close proximity to schools. Convenience sampling was used because adolescents' patronage of SRHS specifically was poor and there were no dedicated ASRH clinics where adolescents could be accessed. Therefore, adolescents who attended the PHCCs to access any service during the duration of data collection were approached for participation. One nurse from each of the three PHCCs was also purposively sampled because of their experience and knowledge of providing SRHS to adolescents.

Semi-structured interviews were conducted with adolescents and nurses using a voice recorder, which were conducted in English, being the lingua franca in Kaduna, after consent was obtained. The recorded interviews were transcribed verbatim and analyzed thematically (Braun & Clarke, 2006). This included familiarization by reading and re-reading the transcriptions, generating initial codes, generating, defining and reviewing themes, and finalizing the analysis. Rigour was applied through credibility, dependability and transferability (Guba, 1981). The principal researcher developed the initial codes which were then discussed with the research supervisor to reach a consensus. A list of codes and their definitions was compiled which were revised as coding proceeded and new codes included. The codes were reviewed for patterns and developed into themes to address the study objectives. Both researchers discussed the themes to reach consensus and their coherence in representing the data.

Results

Participants' characteristics

The adolescent participants included nine females and five males. Two adolescents were married and both females. Two adolescents were attending secondary school, one had completed secondary school, and the rest were at various levels in tertiary institutions. Nine were Christians and six were Muslims (Table 1). The nurses were all female aged 30, 46 and 49 years (Table 2).

Table 1. Characteristics of adolescents

Location	Age (Years)	Sex	Marital status	Religion	Educational status
Health Facility A					
	18	Female	Single	Christian	Tertiary institution
	19	Female	Single	Christian	Tertiary institution
	18	Female	Single	Muslim	Tertiary institution
	19	Female	Married	Muslim	Tertiary institution
Health Facility B					
	18	Male	Single	Muslim	Tertiary institution
	18	Male	Single	Muslim	Tertiary institution
	18	Female	Single	Christian	Tertiary institution
	19	Male	Single	Muslim	Tertiary institution
	19	Male	Single	Christian	Tertiary institution
Health Facility C					
	16	Female	Single	Christian	Secondary School
	18	Male	Single	Christian	Secondary School
	17	Female	Single	Muslim	Secondary School
	19	Female	Single	Christian	Tertiary institution
	19	Female	Married	Christian	Tertiary institution

Table 2. Characteristics of key informants

Location	Age	Sex	Marital status	Religion
Health Facility A	46	Female	Married	Christian
Health Facility B	30	Female	Married	Muslim
Health Facility C	49	Female	Married	Christian

Religious and cultural norms

One major reason why adolescents were not accessing and utilizing SRHS was the prevailing religious and cultural norms. Adolescents of both represented religions and the nurses identified religious and cultural norms as significant barriers to adolescents' access to SRHS. Even though the adolescents knew the importance and benefits of accessing SRHS, all of them attested that religion prevents young people from accessing ASRHS because pre-marital sex is regarded as taboo.

> 'I cannot start going to ask about condoms because my religion does not allow it. If they offered it quietly here, I could come and collect it and go.' (Male, 18, single, Muslim).

> 'They [church] advise young people to stop using those things [contraceptives]' (Female, 16, single, Christian)

Parents, community members and society at large were said to be influenced by cultural and religious beliefs. The adolescents reported that cultural taboos prevented adolescents from openly discussing SRH issues.

> 'Adolescents do not normally talk freely to each other about contraceptives, it is a very secretive matter, and it is not culturally acceptable.' (Female, 18, single, Muslim)

> ' . . . or as an adolescent, you bring up the issue of contraceptives, and they will say you are spoilt [immoral], where did you learn it from?' (Female, 18, single, Muslim)

When utilized, unmarried adolescents mainly accessed health facilities for HIV screening and treatment of STIs. They admitted that they sought no contraceptive services at health facilities because of the associated stigma.

Marital status played an important role in perceptions about accessing contraceptives. The adolescents highlighted the negative community perceptions around unmarried young females accessing contraceptives and other SRH services when they are not meant to be sexually active.

> 'If you are married they [the community] approve that one [of adolescents using contraception] but in our community to say that a young girl is not married and she wants to access family planning, people begin to wonder that if she is not married then why family planning?' (Female, 19, married, Christian)

The adolescents who did access contraceptive services preferred to do so outside of health facilities including local shops, patent medical stores and pharmacies. They did so because of the privacy afforded, thereby avoided being judged.

> 'Well … [getting contraceptives] from the hospitals, I think no … because even if they [adolescents] want to, they have to act to be married because the people around turn to look at them in a disapproving manner.' (Female, 18, single, Christian)

The adolescents highlighted the stigma attached to HIV when seeking treatment for STIs and hence the secrecy around accessing such treatment.

'*We live in a society that when you mention STI, the first thing someone would say to you is HIV/AIDS* ….' (Male, 19, single, Muslim)

Interestingly, some adolescents perceived that access to services will encourage adolescent sexual behaviour.

> I think if you make it [contraception] open to everyone, so many young people will go ahead and do things [have sex] even when they know what they are doing is not good, because they know the services are there …' (Female, 18, single, Christian)

Adolescents' feelings of shyness and shame

Experiences of shyness and shame, associated with stigma, featured prominently as reasons to why adolescents did not access SRHS at health facilities.

> '… those that are considering having sex for the first time. It is hard for them, some of them are shy and … prefer to have unprotected sex than face that embarrassment of getting a condom. (Male, 18, single, Muslim)

> 'Some [adolescents] are shy, they are sexually active but they will not open to tell you the truth.' (Married, 30, Muslim, Nurse)

The adolescents discussed how negative community attitudes toward the various aspects of adolescent SRH (sexual activity, STIs, contraception and utilization of ASRHS) made them feel guilty about engaging in sexual activity and accessing SRHS.

> 'It's hard for them [adolescents] to accept they did it [had sex], they know in both Christianity and Islam it is wrong for you to have premarital sex, so they are usually weighed down by guilt.' (Male, 18, single, Muslim)

The adolescents highlighted the fear of being shamed by society. They expressed concern about being seen at health facilities by community members, which could lead to them being labeled as promiscuous.

> ' . . . society frowns at adolescents that seek treatments for STIs and looks at them judgmentally, making them feel bad for coming to seek for help, so an adolescent would not want to be seen seeking for treatment for an STD.' (Female, 19, married, Muslim)

> 'Well . . . because of what people will say; before you know it tomorrow the whole town will get to know what you went to see the doctor for. In cases of contraceptives, you will also have to go to where nobody knows you or you have to access them on your own without a prescription.' (Female, 18, single, Christian)

Negative attitude and behaviour of health workers

The other major reason why adolescents were not accessing health facilities for SRHS was fear of how the health workers would treat them. Some adolescents reported that they were dissatisfied with the care they received because of the judgmental attitude and unprofessional behaviour of some health workers.

> 'While I was waiting for my turn, I heard the nurses talking indiscreetly about a girl that had come to the clinic, they were saying . . ." see this girl, she is a small girl and she is coming for an abortion" . . .. So, imagine if I was there for the same purpose, I will simply walk away because I would also feel bad. They were saying it where people were, and the people sitting around were saying "God forbid" . . .'. (Female, 18, single, Christian).

The adolescents felt that health workers did not respect their confidentiality and privacy.

> ' . . . but in the hospital when you finish talking to the doctor, the doctor will take your file and gives to the next person, the next person will now say ok these are the drugs you need, then you are able to get the drugs. As you are leaving they are already 'gisting' [gossiping] about your matter. (Female, 18, single, Christian)

Suggestions for improving adolescents' access and utilization of SRHS

All participants were asked for suggestions to improve access and utilization of SRHS. The main recommendations were related to addressing stigma through health system changes by promoting adolescent privacy and confidentiality, on which they placed high value.

> ' . . . I think they should learn to be confidential and they should also learn to assure their patients that issues discussed will remain confidential.' (Female, 18 years, single, Christian)

The nurses highlighted the need for government to provide resources including educational materials, adequate infrastructure and facilities required for delivery of adequate ASRHS. They also recommended that more staff should be employed and be trained to deliver these ASRHS.

The participants also suggested youth-friendly services (YFS) including separate services for adolescents at health facilities or the establishment of health centers exclusively for adolescents that would ensure that adolescents do not share services with adults. They suggested that these centers should be situated in discrete locations where the risk of being seen by others was minimal. The nurses also suggested raising awareness of ASRH matters with parents and the community and the importance of communicating openly with the adolescents so that they could be properly informed.

'It can be done through churches, mosques, friends group and groups where parents can sit and talk. For me, churches and mosques present the best platform to reach out to parents – they will listen, we are not saying we should teach them immorality but know your child . . . '. (Female, 46 years, Christian, Nurse)

Discussion

This paper explored adolescents' experiences and perceptions of access to and utilization of SRHS and the related stigma. The findings show community and health system stigma-related factors which impacted on the adolescents at an individual level. The findings reveal that cultural and religious factors create unfavorable environments for ASRH due to the deeply rooted condemnation of adolescent sexual activity and use of SRHS.

Religion and culture were shown to be major reasons for stigma related to adolescents' utilization of SRHS, which is in keeping with studies from other African countries (Godia et al., 2013; Hall et al., 2018). Religious and cultural norms can prevent open discussions of sexuality issues that tend to reduce adolescents' access to SRHS because of the related stigma. Adolescents in this study recommended intergenerational communication as a solution to address these barriers. Yi (2013) advises an integrated approach that involves engagement with religious institutions. The approach emphasizes that contextual issues relating to the sexuality of adolescents should be situated within a religious framework of values that is balanced and responsive to SRH needs and rights.

Nigeria has policies related to adolescent health, which include the promotion of ASRH needs and rights. There are, however, challenges that impede the implementation of these policies. For example, the age of consent to sexual intercourse is not clearly set out in Nigerian law. It can, however, be inferred from criminal laws that criminalise sex with individuals below a specific age which varies in different parts of the country. In Southern Nigeria, it is a criminal offence for an unmarried girl below 16 to be taken out of the protection of her parents/guardian for purpose of marriage or sexual intercourse without their permission. In Northern Nigeria, it is criminal for girls below 18 to be forced to have sexual intercourse (Ahanonu, 2014). The Child Rights Act of Nigeria states that it is illegal to have sexual intercourse with a child below the age of 18 (Federal Government of Nigeria, 2003). There are still many Nigerian States that do not apply the child's right act in their internal legislation because federalism allows for states to determine the legal age for a child in its territory. There are no provisions under Nigerian law that regulate adolescents' access to contraceptives and other SRHS. In practice, however, health-care providers may not provide adolescents below 18 years access to SRHS without parental consent (UNFPA, 2017). Studies have shown that parental consent constitutes a huge hindrance for adolescents' access to contraceptives and other SRHS in Nigeria (Cortez et al., 2016).

The findings indicate strong community disapproval of adolescents who made use of SRHS and as such, they avoided these services for fear of being stigmatized for promiscuity. The finding is comparable to the findings of a study conducted by Mmari et al. (2016) in five diverse sites including USA, Nigeria, South Africa, India and China, revealing that adolescents were afraid of being seen by members of their families and the neighbourhood when utilizing SRHS. The affiliation of adolescents utilizing SRHS

with them engaging in sexual activity has played a role in contributing to the stigmatization associated with ASRH services (Hagey et al., 2015). The findings reveal that adolescents seemed to feel disempowered which goes against the notion of adolescents being involved in their own decision-making. The local norms dictated what socially acceptable behaviour was for adolescents in a family, community or healthcare context. These community norms influenced adolescents to the extent that their own mindsets anticipated stigma to ASRHS. Some of them believed that accessing services such as contraception would encourage sexual behaviour, others admitted to feeling guilty for requesting contraception. Therefore, adolescents should be involved in discussions around their SRH needs and rights in a meaningful way.

Findings from the current study concur with previous evidence showing that there are gaps between ASRH and rights and social norms which could be narrowed through interventions targeted at the community level (Cislaghi & Heise, 2018). There is a need to mobilize community members to foster better communication and support for ASRH such as conducting public educational sessions with them. ASRH issues can be brought to their attention taking into consideration their cultural sensitivities, thereby establishing possibilities for learning and attitudinal change. The involvement of key community gate-keepers such as parents, community and religious leaders has been shown to foster wider community support for ASRHS and rights (Denno et al., 2015). Studies have suggested that at the level of parents, intergenerational communication interventions might be useful in fostering communication between adults and adolescents, linkage to care, disclosure and reduced stigma (Essack et al., 2019; Van Rooyen et al., 2016).

The behaviour and attitude of the health workers can also be related to stigma, which significantly hindered adolescents' utilization of SRHS in this study. Similarly, previous studies on the attitude of health professionals to ASRH in Kenya and Zambia (Warenius et al., 2006), Swaziland (Mngadi et al., 2003) and Uganda (Kipp et al., 2007) have confirmed stigma due to health workers' disapproval of adolescent sexual activity. The adolescents in this study also seemed to mistrust the health workers because of anticipated breeches in confidentiality. Consistent with a study conducted in Ghana (Boamah et al., 2014), they felt that their confidentiality and privacy were respected better outside health facilities. There is a need to improve the PHCC capacity in Nigeria by establishing YFS that can cater to the specific needs of adolescents. The design of YFS is meant to make existing SRHS more acceptable to young people and protect them from stigma. Training should be provided for health workers to ensure that those who come into contact with adolescents have the necessary skills to address ASRH needs appropriately (Jonas et al., 2017). It has been demonstrated that interventions that aimed to address the negative attitudes of health workers are likely to improve adolescents' utilization of SRHS (Jonas et al., 2017). Such training should incorporate stigma reduction programs, which has been found to be an effective strategy to improve the provision and utilization of YFS (Parker & Aggleton, 2003).

One of the limitations of this study was that convenience sampling was used for the adolescents, hence a greater risk of bias than when using purposive sampling. However, it was difficult to find adolescents accessing ASRHS specifically at the selected PHCCs highlighting the problem of poor patronage of ASRHS and

reflecting the reality of adolescents not accessing these services. Some of the data are based on perceptions and not actual experiences of adolescents but still provide valuable insight into the challenges facing adolescents' utilization of SRHS especially related to stigma.

Conclusion

Adolescents in Kaduna face considerable stigma-related barriers to accessing SRHS, with socio-cultural and religious factors and the lack of sensitive, skilled service providers among the major deterrents to seeking ASRHS. This paper highlights the need for fostering community awareness of the importance of adolescents accessing SRHS and addressing the stigma resulting from cultural and religious norms. It also emphasizes the need for the provision for YFS that ensures confidentiality and privacy shielding adolescents from prevailing stigmatization. Further studies are needed to explore contextual strategies that can create more supportive environments for ASRH to address the associated stigma. The findings of the current study recommend context-specific interventions in Nigeria and advocate for policy and legislative direction to improve adolescent access to ASRH services and support health-care workers in meeting the SRH needs of adolescents.

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No potential conflict of interest was reported by the authors.

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