REPRODUCTIVE HEALTH ISSUES AMONG ADOLESCENTS IN NIGERIA

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Abstract

This study examined the issues of pregnancies and childbirth as indicators of adolescents' reproductive health behaviour. Data were obtained from female adolescents (15 – 24 years) from the three Senatorial Districts in Ekiti State. In all 1230 respondents were simple randomly selected from six communities (three rural and three urban, comprising of 330 and 900 respondents respectively). This sample responded to a structured questionnaire which contained both open and closed ended questions on reproductive health issues of pregnancies and childbirth. To corroborate the quantitative data, indepth interviews were conducted among older (48 years & above) and Focus Group Discussion session were held among selected adolescent in all the study locations. Data show that most respondents indicated that they were confirmed pregnancy by medical doctors in a pregnancy test in both the rural and urban locations and that pregnancy is a gift from God. About 29 percent preferred pregnancies as adolescents; the incidence of adolescent pregnancies was 18.5 in the study locations. The rate of attendance of pre-natal care was higher in the urban than the rural locations and only about 32 percent attended post natal care. The need for appropriate reproductive health policy and implementation among others are recommended.

Background

Adolescents' reproductive health is an integrated approach to the health and development needs of adolescents. It is defined as a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity in all matters relating to the reproductive system and to its functions and process of the adolescents (International conference on Population and Development, 1994). Reproductive health components include all forms of reproductive health practices such as pregnancies, pre-natal and ante-natal care, safe child delivery, family planning, management of complications of abortion and promotion of healthy sexual maturation (Federal Ministry of Health, 2003). In fact, Orubuloye (1998) indicated that adolescents constitute a high risk group in terms of reproductive health problems and studies among them are relatively rare and tend to be restricted to certain regions of the world.

The risks of pregnancies and childbirth among adolescents are numerous. It includes damage to the reproductive health organ, maternal mortality, and infertility, complication during pregnancies and childbirth and obstetric fistula. In a study in Ekiti, southwest Nigeria, Tinuola (2003) found that 80 percent of the adolescents interviewed in a rural community have engaged in premarital sex and that the mean age at first sexual intercourse has reduced to 17 years. Also that out the interviewee who has engaged in sexual relation, 62.5percent had experienced premarital pregnancies. At pregnancies, adolescent are left to take decision on weather to abort the pregnancies or give birth to the child. The decision to do away with the pregnancies or keep it, is often influenced by social, economic and cultural factors which Tinuola (2001)

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found to include education, urbanization, socialization, family type and nature of the pregnancy. When the decision is in favour of abortion, adolescents face the risks of abortion most especially in settings where abortion is illegal and facilities are not adequate provided by the existing health care delivery systems. Federal Ministry of Health (2003) found that about two-fifths of adolescent pregnancies in Nigeria are believed to end up in induced abortion and those adolescents constitute the majority of cases of abortion-related complications admitted in Nigeria hospitals. The complications are heightened in settings where adolescents visit inept medical personnel for services.

In view of the heightened risks of early pregnancies and childbirth among adolescents, more especially when the body is not mature enough to meeting bodily challenges of carrying the pregnancy and childbirth, concerted efforts should be made to conduct research on the reproductive health behaviour of the adolescents. This study concentrates on the issues of adolescent pregnancies and childbirth among adolescents in Ekiti, Southwest Nigeria

Objectives of the Research

1. To examine the knowledge, perception of and incidences of pregnancies among female adolescents (15 - 24 years) in Ekiti southwest Nigeria
2. To examine the childbirth practices among female adolescents (15 - 24 years) in Ekiti southwest Nigeria

Method of Data Collection

Data used for this study were generated from both primary and secondary sources. Primary data were obtained with the use of a structured questionnaire which contained mostly closed ended questions. Respondents were systematically selected from female adolescents (15 – 24 years) in the three Senatorial Districts in Ekiti State Nigeria. In each of the Senatorial Districts, two communities (one rural and one urban) were systematically selected, making a total of 6 communities (three rural and three urban) for the study.

For the survey component, a random sample of 1230 female adolescents (330 rural and 900 urban) was undertaken to respond to a series of questions bordering on adolescent reproductive health behaviour in all the study locations. To validate or invalidate quantitative data, sessions of in-depth interview were conducted among older women who are 48 years and above. This age group was chosen because most women in this group have passed through the reproductive health regimes. Responses from these older women provide data on the inter-generational gap between adolescent reproductive health practices in the past and in the present.

Secondary data on incidences of adolescents pregnancies were obtained from the record of government recognized health institutions located in all the study locations. The data present the record of women who attended prenatal and antenatal care in all selected health institutions in the year 1999, 2000, 2001, 2002 and 2003 respectively. Data obtained are analysed below.

Data Analysis

Pregnancies

Knowledge of being pregnant

There are wide variations among respondents who knew they were pregnant because they missed their monthly menstruation between the urban and rural locations. In the rural locations, almost half of the respondents knew they were pregnant because they missed their monthly period as against 14.1 percent urban respondents.

When a sexually active woman accustomed to monthly menstruation fails to menstruate, and subsequently does something to restore her menses, her actions may be interpreted in several ways (Renne, 2001). One obvious explanation is that she thinks she is pregnant. Another possibility is that she might take to emmenagogues (substances to promote "proper menstrual flow) perceived as part of normal reproductive health practice. The ambiguity of women's intention in such circumstances is rooted in the very nature of menstruation and its absence. However, the absence of menstruation can be interpreted as either an incapacity to conceive or the result of conception. How women interpret and react to menstruation and its absence reflects their individual needs as well a the cultural, social, economic and political context in which they live (Renne, 2001)

Well over half of the urban respondents knew they were pregnant as a result of doctor's confirmation (53.4 percent) against 30 percent in the rural locations. These respondents were among the married and others who were compelled by either their male sexual partners or parents to visit the modern hospital on occasion of an illness. Responses indicated some of the adolescents who were between 15-19 years did not know they were pregnant even when they missed their monthly menstruation. They were rushed to hospitals on treatment of common diseases associated with pregnancy. The doctor later confirmed them pregnant. There were some cases where the respondents indicated that they were confirmed pregnant while they were experiencing normal monthly menstruation period. One–tenth of these respondents indicated that they confirmed their pregnancy status in laboratory tests as against 0.5 percent in the rural locations.

Most older women interviewed responded to have missed their menstruation periods in the past and that it was accepted as a sign of pregnancy for married women. General opinion among them stressed that the most important thing was to find out the cause of

missing the menstration before taking any action. Affirming the opinion above, a sixty-five year old woman, an interviewee in one of the rural locations, who had no formal education said:

> *Missing menstruation is not new, it occurs for many reasons but the most important thing was to ascertain the cause so that proper and necessary actions could be taken. In case, it is temporary, there are leaves you take in concoction to restore your period but if pregnancy has occurred, you either visit a herbalist for cleansing or visit the doctor for abortion. The other alternative was to nurture the pregnancy to maturity.*

Adolescents in the FGDs mostly preferred the use of modern methods of inducing an abortion in case the pregnancy was not wanted. Popular opinion among them indicated that when a menstruation period is missed, it indicates pregnancy and early efforts at inducing it could work fast. As such, adolescents in the urban preferred D and C method carried out by qualified medical personnel. They indicated that the risks are not as high as other methods.

In the rural locations, adolescents identified the M.P Forth, Gynaecocid as useful drugs for inducing a pregnancy. Some of the preferred drugs like Alabukun, Paracetamol, and Postinol, are used immediately after sex. Another category of the adolescents used Table Salt or Andrew Liver Salt immediately after sex. According to them, the quantity of drugs used depends on the age of the foetus.

Perception on Pregnancies

People's perception about a particular phenomenon affects the belief, attitudes and behaviours towards such. Perceptions are internalised through the process of socialisation. Socialisation is a long time processes through which an individual gets accustomed to the norms and value system of the society through a long learning procedure. It is therefore important to note that socialisation, play important roles in determining the nature and the direction of one's perception of a situation.

Various questions were asked to examine the perception of adolescents on the incidences of pregnancies, to examine their knowledge of the risks, and consequences of adolescents' pregnancies. Table 1 presents the responses.

Table 1: Percent Distribution of Respondents Perception about adolescents' pregnancies.

Pregnancy Issues	Urban (N=900)			Rural (N=330)		
	Agree	Disagree	Don't know	Agree	Disagree	Don't know
Pregnancy is a gift from God	79.7	12.5	7.8	95.0	05.0	00
Pregnancy is risky	63.8	28.7	7.5	51.7	42.3	6.0
Pregnancy is normal	33.8	57.5	8.7	8.4	5.6	10.4
Pregnancy affects schooling	69.7	23.1	7.0	78.3	21.7	0.0
Laws prohibiting adolescents' pregnancy	47.8	42.5	9.7	12.4	81.6	6.0
Preference for pregnancies	15.6	59.9	33.5	41.6	51.4	7.0

Source: Authors' Adolescents' Reproductive Health Survey, 2004

As indicated in the Table 1 above, respondents varied in their perception about pregnancies among adolescents. Respondents who believed that adolescents' pregnancy is gift from God indicated that they were religiously committed to be engaged in pregnancy during adolescence and may encourage some other people to do so probably because they believed that it is divinely supported. About 80 and 95 percents of the urban and rural respondents indicated that pregnancy is a gift from God. These respondents indicated that God gives children at will and that any attempt to act contrary was considered anti-God. These respondents supported their argument with the Biblical injuction "Increase and multiply". However, 12.5 and 5.0 percents of urban and rural respondents respectively disagreed.

About 63.8 and 51.7 percents of the urban and rural respondents indicated that pregnancies among adolescents were risky. These respondents indicated that reproductive health risks associated with carrying pregnancies when the body is not fully prepared are numerous and could be life threatening. These reproductive health risks indicated to be associated with adolescents' pregnancies are damage to the reproductive tract, elevated risks of maternal mortality, pregnancy complications, and low birth weight. About 28.7 and 42.3 percents of the urban and rural samples respectively disagreed. Taking into cognizance

the reproductive health risks of adolescent pregnancies, 47.8 and 12.4 percents of the urban and rural respondents respectively indicated that laws prohibiting adolescent pregnancy should be enacted and enforced within the limit of the Constitution of the country. Majority of the sample in the rural locations disagreed that laws prohibiting adolescent pregnancy should be enacted. These respondents argued that people should be allowed to get pregnant and give birth at any time they thought it convenient.

On preference for pregnancies, in case it occurs during adolescence, about half of the urban respondents did not prefer pregnancy while only 15.6percent disagreed. In the rural locations, 41.6 percent agreed while 51.4 percent disagreed. These respondents indicated that they would prefer schooling than getting pregnant during adolescence. After all, at one's convenience after graduation, proper marriage will take place. This opinion was reported among urban respondents.

Incidence of Pregnancies

Respondents were asked whether they were ever pregnant.

Data show that 29.1 and 38.3 percent of those respondents in the urban and rural study locations respectively who ever had sex were ever pregnant. This shows that the incidences of adolescent pregnancy as reported by the respondents, as ever pregnant, are higher in the rural than in the urban locations.

In order to establish and seek validation of the report of the social survey presented above, secondary data on the incidences of adolescents' pregnancies were obtained from the modern health institutions in all urban and rural locations where the study was carried out. The information on adolescents (15-24 years) in the ante-natal records of all the General Hospitals in all the urban locations and three Maternity Centers in all the rural and urban locations between the years 1999-2003 are presented below.

Table 2: Incidences of Adolescents' Pregnancies – Data from the ante-natal records of Modern Health Institutions.

Quarter of the year	1999		2000		2001		2002		2003	
	U	R	U	R	U	R	U	R	U	R

	N =317	N =68	N =424	N =50	N =446	N =85	N =469	N =60	N =424	N =58
1st (Jan – March)	21.8	28.3	26.4	32.0	30.0	48.1	20.0	11.1	35.8	31.6
2nd (April – June)	24.3	29.4	25.0	16.0	24.9	14.8	23.9	27.8	27.1	38.8
3rd (July – Sept)	27.8	23.5	23.5	23.1	36.0	21.3	22.3	29.0	27.8	05.3
4th (October – Dec)	26.1	0.88	25.5	16.0	23.8	14.8	27.1	33.3	9.0	26.3
Total (in percent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean ages					1					

at Pregnancy	18.5	16.6	18.5	18.5	8.5	18.5	18.5	18.5	18.5	18.5

Source; Records of ante-natal care attendees from Specialist Hospital, Ikole; General Hospitals, Igede and Ilawe and all the maternity / dispensaries centres in Araromi, Ogotun and Awo-Ekiti between 1999 – 2003.

Table 2 above showed that in 1999, there were slight differences in the percent distributions of reported cases of pregnancies among adolescents in the designated health institutions in selected towns in three Senatorial District in Ekiti State. For example, the first quarter witnessed 21.8 percent of cumulative for the year in the urban locations, the rural locations had 28.3 percent. Also in the second quarter of the same year, the gap in the percent between the urban and rural locations was lesser than the 1st quarter. In the year under review, there was a sharp difference during the last quarter when 26.1 and 8.8 percents were recorded for the urban and rural locations respectively. Looking at the general trend, as indicated in the table, the urban locations often recorded at one-quarter of the reported cases of pregnancies during the last quarter of all the years (1999 – 2002) under review except 2003 when just 9 percent of the total cases were recorded in the last quarter. There seemed to be no general trend of reported cases per quarter in the rural locations. For example, while the rate of reported cases was as high as 32 percent in the first quarter in year 2000, it was just 11.1 percent in the same quarter in the year 2002.

The data further showed that the first two quarters in the urban locations recorded almost half of the total cases recorded for the period. For example, the first two quarters in 1999 reported 46.1 percent, in 2000 about 51.4 and it reached as high as 62.9 percent in 2003. Rural figures were somewhat higher with 57.7 percent in 1999 to as high as 70.4 percent in 2003 although it was considerably lower for 2000 (48 percent) and 2002 (39.9 percent). The mean percent of the incidences of pregnancies in the first two quarters of the period 1999 – 2003 were 50.5 and 55.8 percents in the urban and rural locations respectively. This indicates that from 1999 to 2003, of all cases of adolescent pregnancies presented for prenatal care in designated health institutions in the study locations, an average of 50.5 and 55.8 percents were recorded in the first two quarters of the years in the urban and rural locations. The mean cases reported in the last two quarters of the period were 49.5 and 44.2 percents in the urban and rural locations respectively.

On a general note, the reported cases of pregnancies increased in the urban locations for the first 4 years (1999-2002) but later dropped in the year 2003. The same trend was noticed in the rural locations only that the trend began to drop as from 2002. The mean

age at pregnancy was 18.5 years for both the rural and the urban locations throughout the years under review (1999-2003) except in 1999 the mean age at pregnancy for adolescents (15-24 years) was 16.6 years

On the incidences of pregnancies among adolescents, there was the general belief among older women that the incidence was higher than in the past. The difference between the two was found in the linkage between age at first sexual intercourse and age at marriage. In the past, age at first sexual intercourse was directly linked with marriage. Consequently, the timing of pregnancy was linked with marriage. The major reason for sex, marriage has a direct relationship with childbirth. This is because of the importance attached to child bearing. So, pregnancies in the past occurred when it was expected. Pregnancy was reported to be God's gift. A sixty-seven year old woman responded by saying;

> *Children are gifts of God, it begins in pregnancy. Any married woman without children was believed to have either misused here body or that there is a curse on her. In fact, she cannot be fully integrated into the family setting. It is the plan of God for us to increase and multiply, hence childbearing. We did not know any pregnancy that was unwanted. Whenever it comes, it is a gift of God. The families expect their baby(ies)*

Adolescents reported that pregnancy before marriage is now deemed enough reason for marriage: they indicated that their fiancées would want them pregnant before marriage. To buttress this point, a twenty-two year old woman responded in one of the FGDs by saying:

> *Immediately, a guy is interested in marrying you, he wants you pregnant before marriage. This is to ensure the fertility behaviour of the woman. Look, I've a brother who got married to a woman before she was pregnant and the woman did no get pregnant for years after marriage. The man spent a lot of money in medical tests and check ups on the woman. The man is just hoping that God will answer his prayers one day by giving him children.*

Corroborating the responses above, consensus among adolescents in one of the FGDs session that:

> *There is a general belief today that any woman who was not pregnant on time was blamed to be promiscuous before marriage. Also that she would have aborted a lot of pregnancies before marriage. The intending husband would always want you to be pregnant before marriage in order to be sure of your reproductive ability. This is because one of the major aims of marriage is*

procreation and that in families without children, the purpose of marriage was defeated.

Some adolescents stressed that pregnancy before marriage may not necessarily lead to childbirth; there may be cases of still births, ectopic pregnancies and premature birth. There was a general consensus on the belief that pregnancy is a gift from God. Older women and adolescents were of the opinion that pregnancy is a mystery. Only adolescents were aware of the risks of early childbirth. They indicated that the reproductive health risks associated with pregnancy when the body is not fully developed are complications during childbirth, contracting of sexually transmitted infections, damage to the reproductive tract, infertility and obstetric fistula.

Childbirth Practices

Planning Status of Births

Respondents were asked whether they have ever given birth. Responses show that 3.6 percent of the total respondents have given birth in the urban locations compared to 10 percent of the total respondents in the rural locations. The data shows that experience of childbirth among adolescents was higher in the rural locations then in the urban locations.

Table 3: Percent distribution of respondents who have ever given birth, who desired their last pregnancy

Variables	ARHS, 2004		
Location	X	Y	Z
Urban	28.9	62.9	8.2
Rural	20.0	73.3	6.7
Age group			
15-19	26.1	60.9	13.0
20-24	23.8	71.4	4.8

Urban – (N = 32) Rural (N=33), Note: X = Desired the pregnancy then, Y = Desired the pregnancy but later, Z = Not sure of desire for pregnancy Sources: ARHS = Adolescents' Reproductive Health survey

To examine the planning status of births, adolescents were asked questions on whether they desired the pregnancy or not. Some respondents desired the pregnancy then and later while some were not sure whether they desired the pregnancy. Some respondents desired the pregnancy then but would have preferred to be pregnant later. This gives room for multiple responses among respondents. About 92 percent of women reported that their last pregnancy

was desired in the rural locations. About 8.2 and 6.7 percents had their pregnancy unplanned in the urban and rural locations respectively. The planned status of pregnancy also depended on age of adolescents. About 87.0 and 95.2 percents of the adolescents in 15-19 and 20-24 age groups reported that their pregnancies were unplanned (Table 3).

Antenatal care

Table 4 shows that 62.2 and 31.4 percents received antenatal care during pregnancy in the urban and rural locations respectively in Ekiti. The breakdown according to age shows that 38.1 and 75.6 percent of adolescents between 15-19 years and 20-24 years respectively received antenatal care during their last pregnancies.

Table 4 – Percent distribution of respondents who gave birth over the past 5 years, who attended Antenatal care during their last pregnancy according to selected characteristics.

Characteristics	ARHS,2004
Location	
Urban	62.2
Rural	31.4
Age group	
15-19	38.1
20-24	75.6

Sources: Reproductive Health Survey, 2004

Frequency of Antenatal care during pregnancy

Less than one-fifth of the adolescents in the urban location who were pregnant received antenatal care between 1-5 times in the urban locations compared to less than one-tenth in the rural locations. The mean number of times respondents received antenatal care was approximately 9 times and 10 times in the urban and rural locations respectively.

Adolescents received antenatal care from different care providers in both the rural and urban locations. For in-depth analysis, the term “skilled attendants” was adopted from the report of National AIDS and Reproductive Health Survey by the Federal Ministry of Health in 2003. According to the report, skilled attendants refer exclusively to care providers who have delivery skills, which include the capacity to initiate the management of complications and obstetric emergencies. In the category are medical doctors, nurses, and midwifery professionals. The proportion of respondents attended by “skill attendants” varied according to locations. More adolescents in the urban locations and those with more than primary school education who delivered in the last 5 years received antenatal health care from skilled Attendants.

Table 5: Percent Distribution of Respondents who have delivered in the past 5 years who received antenatal care from different cadres of providers during their last pregnancy

	ARHS, 2004				
Location	A	B	C	D	E
Urban	82.5	9	1	0	0
Rural	50.1	8	2	3	1
Age Group					
15 – 19years	48.6	8	1	3	0
20 – 24	66.4	8	0	1	1
Education					
Primary	56.4	9	1	1	0
Secondary	57.2	8	1	2	0

Post secondary	80.1	9	1	3	0

Source: Reproductive health survey, 2004
Note: A = Doctor, B = Nurse, C = Auxiliary nurse, D = Community Health Extension Worker, E= Traditional Births Attendants

Among the adolescents, with primary education, well over half sought care from doctors and nurses / midwife and the percent increases with in the level of education. Most respondents with post secondary education received antenatal care from skill attendants; only 0.5 percent sought antenatal care from Traditional Birth Attendants (TBA). Generally respondents between 20-24 years sought skill attendants more than respondents between 15-19 years of age (Table 5).

Table 5 shows that the higher the level of education, the higher the tendency to visit the Doctors and the Community extension workers. This is evident in the data, while 56.4 and 5.8 percent patronized Doctors and CHEWS, among holders of primary education, the percent increased to 80.1 and 34.4 percent among holders of post secondary education. This case was similar among adolescents who patronised CHEW, 15.8 percent had primary education, 18.3 percent had secondary education while 25.6 percent had post secondary education. Greater percentage (81.1 percent) of the adolescents between 15-19 years patronized nurses for ante-natal cares.

There was similarity in the preference for a particular place to receive antenatal care between the older women interviewed and adolescents in FGDs. Some older women reported to have delivered with Traditional Birth Attendants. In the words of a Sixty nine year old woman who had below secondary education responded in one of the rural locations:

> *You see, at the time I gave birth to my first child, there was no maternity / dispensary center in this village, I received the antenatal care in a traditional birth attendant home and I delivered my baby safely. These women used herbs and little knowledge of delivery to help us and they actually tried. During the antenatal care, they offered leaves/herbs for concoction. She stressed the need for me to abstain from eating some meat because of the danger they pose to health and the well being of the child and the mother. For instance, the traditional birth attendant told me not to eat snail and snake. According to her, eating snail during pregnancy will affect the production of saliva of the baby while it would be difficult for the child to walk if the mother eats snake during pregnancy.*

Corroborating the response of the fifty-nine year old woman above, a sixty-eight year old woman who had formal education and attended TBA for antenatal responded in one of the rural locations by saying:

> *Traditional birth attendants were effective machineries for ensuring safe delivery in the past. They did not only recommend the needed herbs, they also toldl you the dos and don'ts so that one did not offend the spirit. When I was pregnant with the second child, the woman told me that I should not move out in the midday and at nights. According to her, evil spirits moved out in the afternoon and in the evening and could harm the*

> *pregnancy. Today, the situation is not the same. We have a lot of modern hospitals where pregnant women received ante-natal cares*.

Stressing the later view that pregnant women mostly visit modern health care for antenatal cares today. A 48 year old woman with past secondary education interviewed in one of the urban locations said:

> *At the time I was to give birth, there was a general hospital and many maternity / dispensary centers in the town. I attended general hospital for ante-natal care. This did not rule out totally the use of herbs. My grand mother often gave me some herbs which I took occasionally. With the current technology in Medicare and medical practice, I advise my children to attend the modern practitioners for antenatal care whenever they are pregnant.*

Among adolescents in FGDs, there was general consensus that they preferred to receive antenatal care from Modern Doctors and nurses to ensure adequate care. A twenty-four year old, woman who had secondary education, in one of the rural locations said:

> *When I was pregnant, I attended government hospital to receive pre and antenatal care. I was given adequate care and I gave birth successfully. They told me to observe some rules of hygiene and took prescribed drugs. I went for regular check-ups and I gave birth successfully.*

These responses indicated generally that both the users of traditional birth attendants and Modern medical care justified their positions and agreed that modern medicine is just a development over the traditional medicine (herbal) only that there is a level of *spiritism* introduced into the traditional medical practice believed to be absent in the current modern medicine.

Places where postnatal care were received by location

About half (51.4 percent) of the urban and 13.3 percent rural respondents received postnatal care from government hospitals respectively. Only 15 and 8.3 percent received postnatal care from private modern hospitals and 4.6 and 5.0 percent received postnatal care from faith based maternity and traditional birth attendants (Table 6).

Table 6 – Percent distribution of adolescents according to places where postnatal care were received by locations

Places	Urban (N=32)	Rural (N=33)
Govt. hospital	51.4	13.3
Private hospitals	15.0	8.3
Maternity hospital	18.7	15.0
Faith maternity / IBA	4.6	5.0
No response	10.3	58.5
Total	100.0	100.0

Source: -Authors Adolescents Reproductive health survey, 2004

Awareness of risks of early childbirth

Adolescents varied on their responses on awareness of the risks of early childbirth according to age, education and locations. Adolescents between 20-24 years who had post secondary education were aware that early childbirth exposes them to the risks of pre-mature labour, miscarriage and stillbirth. However, only 34.6 and 40.1 percents of the respondents between 15-19 years were aware of the risks of early childbirth in the urban and rural location respectively. About 24 percent and 15.4 percent adolescents in the urban and rural areas respectively who had primary education were aware of the risks of early childbirth. However, the percentage increased with the level of education. About one-half of those with secondary education in the urban locations were aware of the risks of early childbirth compared to 48.1 percent of those in the rural locations. In the urban and rural locations, 65.4 and 52.2 percent of those with post secondary education had adequate knowledge of the risks of early childbirth.

Table 7 - Percent distribution of respondents who have ever given birth who desired their last pregnancy

Variables	ARHS, 2004		
Location	X	Y	Z
Urban	28.9	62.9	8.2
Rural	20.0	73.3	6.7
Age group			
15-19	26.1	60.9	13.0
20-24	23.8	71.4	4.8

Urban – (N = 32) Rural (N=33), Note: X = Desired the pregnancy then, Y = Desired the pregnancy but later, Z = Not sure of desire for pregnancy Sources: ARHS = Adolescents' Reproductive Health survey

Conclusion

The study examined two reproductive health indicators (pregnancies and childbirth) among adolescents in Ekiti, Southwest Nigeria. The study confirmed that despite a high level of literacy among the Ekitis, majority still hold the opinion that pregnancies are God given and this accounts for the reason why majority of pregnant adolescents do not prefer abortion. This opinion is popular among the rural respondents and subsequently resulted in higher incidences of pregnancies among them. Older women reported marriage based pregnancies; in fact any married woman who has no children was not, in the context, of the culture, believed to have settled martially in the study locations. This is the general belief that any woman who was not pregnant on time was blamed to be promiscuous before marriage and also that she would have aborted a lot of pregnancies before marriage.

Majority of the married women actually desired the pregnancy and generally the planning status of pregnancy depended on the age of adolescents. Most of them received antenatal care from skilled attendants and this influenced the quality and extent of labour during childbirth.

Considering the data above, there is the need of reproductive health education. To achieve this, such programme should be inculcated into the formal education curriculum of secondary schools. This will curtail the extent of incidences of adolescent pregnancies risk in Ekiti, Nigeria.

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