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ATTITUDES OF HEALTHCARE PROVIDERS TOWARDS PROVIDING CONTRACEPTIVES FOR UNMARRIED ADOLESCENTS IN JOS UNIVERSITY TEACHING HOSPITAL JOS, NORTH CENTRAL, NIGERIA

Ledornu F. Livinus [1]
9A Church Street Stourbridge, DY8 1LT
Pannan I. Da'ap* [2]
Department of Obstetrics and Gynecology Jos University Teaching Hospital Jos, Plateau State, Nigeria.
Oghenetega J. Oyaide-Ishaka [3]
22 Byron Street, SR5HJ, Sunderland.
Peter N. Odoh [4]
Anglea Avenue Royton, Oldham Greater Manchester.
Plangji S. Cinjel [5]
Department of Obstetrics and Gynecology Jos University Teaching Hospital Jos, Plateau State, Nigeria.
Francis A. Magaji, [6]
Department of Obstetrics and Gynecology Jos University Teaching Hospital Jos, Plateau State, Nigeria.

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ABSTRACT

Background: Contraception among adolescents is a public health issue with deep roots in society, culture, and religion. High levels of premarital sexual activity without the use of contraceptives have been recorded among adolescents. Over 3 million unsafe abortions occur annually among adolescents. The successful provision and adoption of contraceptives among adolescents is a crucial approach to preventing increased unintended pregnancy and the complications related to it.

Objective: To assess the attitude of healthcare providers towards providing contraceptives for unmarried adolescents in Jos University Teaching Hospital.

Methods: A cross-sectional descriptive study was conducted among 371 healthcare providers in Jos University Teaching Hospital Jos, Plateau State, Nigeria, using a self-administered questionnaire.

Results: The majority of the respondents (79%) had a positive attitude towards providing contraceptives for unmarried adolescents. More than half (52.4%) perceived the provision of contraceptives for unmarried adolescents as promoting sexual promiscuity. Close to half (45.8%), reported that unmarried adolescents should be asked to abstain from sex rather than providing them with contraceptives. There was a statistically significant relationship between the age, post-qualification years, and religion of the respondents (p=0.020, 0.036, and 0.033 respectively) when compared with attitudes towards the provision of contraceptives.

Conclusion: Findings from this study showed an overall highly positive attitude by healthcare providers towards providing contraceptives for unmarried adolescents even though some expressed mixed feelings. A positive provider attitude towards providing contraception to unmarried adolescents is a very strong factor in offering contraception to them which will in turn prevent unwanted pregnancies, unsafe abortions, and their complications.

KEYWORDS: Attitude, Healthcare Providers, Contraceptives, Unmarried, Adolescents, Nigeria.

INTRODUCTION

Contraception among adolescents is a current public health issue that has deep roots in society, culture, and religion.[1] An "adolescence" as defined by the World Health Organization (WHO) is the period between the ages of 10 and 19, including both "teenagers" and "young adults." Teenagers now make up a sizable percentage of the world's population. One in six people is a teenager (aged 10 to 19), and the vast majority of these adolescents (85%) reside in developing nations like Nigeria.[2] Nigerian adolescents have been reported to be engaged in increased levels of premarital sexual activity without the use of contraception;[3,4] many of which are aware of the contraceptive methods but do not use them.[4] This usually results in a high incidence of unwanted pregnancies and unsafe abortions;[5,6,7] with approximately, 21 million adolescents below 15 to 19 years becoming pregnant in developing regions and over 3 million unsafe abortions occurring annually.[4,8] Satisfying the unmet need for contraception has been shown to prevent maternal mortality by 30%.[9] Challenges among adolescents have been documented to include child marriage, early sexual debut, unplanned pregnancy, unsafe abortion, maternal morbidity and mortality, Sexually Transmitted Infections, Human Immunodeficiency Virus (STI/HIV), and gender-based violence.[10] These challenges mostly end in complications such as eclampsia, low birth weight, puerperal endometritis, and infections contribute significantly to maternal mortality and morbidity.[4] Making provision of contraception to the adolescents paramount to prevent them.

The Successful adoption and provision of contraceptives among adolescents is a crucial approach to prevent increased unintended pregnancy and its associated complications and to enhance their health status.[11] The 1994 International Conference on Population and Development Program of Action (ICPD PoA) in line with other conventions agreed to ensure Sexual and Reproductive Health and Rights (SRHR) for all and provide the information and services, including family planning for its fulfillment.[12] Still, evidence has indicated that adolescents only constitute 3.6 percent of family planning (FP) clients in Kaduna, Nigeria.[13] Modern contraceptive use has been reported to be low among sexually active, never-married teenage girls in Nigeria.[1] Adolescents in Nigeria have their own set of challenges when it comes to learning about and gaining access to contraception. Nigeria's approved curriculum for Family Life and HIV Education in 2003 did not include a discussion of contraception despite mentioning safer sex in the context of HIV prevention. Although the legal age of permission for sexual activity in Nigeria is 18 years, access to contraceptives is not formally regulated based on age, making it difficult for adolescents to obtain them, consequently, many providers put their own age or parity limitations on contraception.[1]

The 2023-24 Nigeria Demographic and Health Survey (NDHS) reported that 21% of currently married women and 36% of sexually active unmarried women have an unmet need for family planning.[14] Factors reported to be generally associated with the non-use of contraceptives among adolescents include fear of stigma, shame, and embarrassment;[15] inadequate information about contraceptives, unplanned sexual activities, inability to negotiate with partners, and the attitude of providers.[4] For instance, some adolescents have reported that they refused to go to public clinics because of the attitudes of the healthcare providers.[16]

A study conducted in Ebonyi state, southeast Nigeria reported the unfriendly and judgmental attitudes of some healthcare providers as a discouragement to adolescents from seeking contraceptive services from health facilities.[17] Additionally, in Ibadan, a study captured that more than half of the respondents reported that providing contraceptives to unmarried adolescents promotes sexual promiscuity, over a third reported that unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex and about half of all the respondents responded that it is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives rather than give them contraceptives when they request for it. On the other hand, more than a third reported that healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities, seventy percent believed that adolescents should be given contraceptive counseling before they become sexually active, and about a third reported that unmarried adolescents do not require parental consent before contraceptives are provided.[4]

In Uganda, providers imposed non-evidence-based age restrictions and consent requirements on the provision of contraception to young people because they were hesitant to give and had negative attitudes towards the provision of contraceptives for young people.[18] Nurses were reported to be generally stigmatized against adolescent sex and felt very uncomfortable giving contraception to adolescent girls in a South African study as they tried to influence the adolescents who came for contraceptives not to have sex and sought parental permission from adolescents before providing contraceptive services even though legally, parental permission is not needed for minors to be given contraception in South Africa.[19]

The belief that the provision of contraceptive services to adolescents promotes sexual promiscuity has been reported as a major reason why healthcare providers resist offering contraception to adolescents, thinking that by

restricting access to contraceptive services, they were protecting both the client and society.[4]

Adolescents' curiosity about the opposite sex, peer pressure, and the influence of social vices are constantly pushing them into premarital sex, such that efforts towards providing moral values like sexual abstinence among unmarried adolescents may do little or nothing to prevent them from indulging in premarital sex. The provision of contraception to these groups will not only prevent all the psychological, social, medical, and economic problems that follow an unwanted teenage pregnancy but will also encourage their mental growth and productivity. It is in line with this that it's paramount to study the attitude of healthcare providers towards the provision of contraception to adolescents.

Thus, this research seeks to study the attitude of healthcare providers toward providing contraception to unmarried adolescents.

MATERIALS AND METHODS

This was a cross-sectional descriptive study conducted in Jos University Teaching Hospital (JUTH) Jos, Plateau State, North Central, Nigeria; over 6 months (January to June 2022). The sample size was statistically determined using the proportion of health professionals favorably disposed to adolescent contraception as reported by a similar study.[4] Using the formula $N=(Z^2 \times P (1-P))/r^{2,20}$ which was calculated to be 341. A non-response rate of 10% was considered making the final minimum sample size 371. A simple random sampling technique was used for the study and the study population comprised of medical doctors, registered nurse-midwives, and pharmacists working with the family planning unit and the obstetrics and gynecology units. A semi-structured questionnaire was developed from a review of relevant literatures with the aim of exploring the attitude of healthcare providers towards providing contraceptives for unmarried adolescent this questionnaire was reviewed by the reproductive health specialist in JUTH and pretested among few healthcare workers in a different facility before onward administration to eligible study participants.

The procedure was conducted by collecting the following information: The type of provider, age, sex, religion, and marital status. Other questions were: Highest educational qualification, how long ago they obtained the qualification above, how long they have been working, whether they were taught adolescent sexual and reproductive health in school, and if they have received continuing education (CE) or training on adolescent sexual and reproduction health (ASRH) in the past. The attitude of the healthcare providers towards providing contraceptive services for adolescents was assessed using a 5-point Likert scale (strongly agree, agree, undecided, disagree, and strongly disagree) adopted from a previous study.[4] There were seven statements altogether; four were negatively worded while the other three were positively worded. The negatively worded questions were: (1) Providing contraceptives for unmarried adolescents promotes sexual promiscuity (2) Unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex (3) It is better to tell sexually active unmarried adolescents to abstain from sex when they ask for contraceptives rather than give them contraceptives when they request for it, (4) I will not attend to any unmarried adolescent seeking for contraceptives in the Hospital. The positively worded questions were: (4) Healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities (5) Adolescents should be given contraceptive counseling before they become sexually active and (6) Unmarried adolescents should not require parental consent before contraceptives are provided. The data analysis was conducted using IBM SPSS version 23 (IBM Corp, Armonk, NY). Ethical clearance was obtained from the research and ethical committee of the Jos University Teaching Hospital with the reference number: JUTH/DCS/IREC/127/XXXI/2957.

RESULTS

Table 1: Characteristics of Respondent (n = 371)

Variables	n (%)	Mean±SD
Age group (years)		35.3±7.5
20-29	93(25.1)	
30-39	193(52.0)	
40-49	63(17.0)	
≥ 50	22(5.9)	
Sex		

Male	172(46.4)	
Female	199(53.6)	
Marital Status		
Married	199(53.7)	
Single	163(43.9)	
Separated/Divorced	6(1.6)	
Widowed	3(0.8)	
Religion		
Christianity	352(94.8)	
Islam	18(4.9)	
African Traditional	1(0.3)	
Level of Education		
Diploma	90(24.3)	
First Degree	256(69.0)	
Masters	25(6.7)	
Cadre		
Doctor	150(40.4)	
Nurse/midwife	186(50.1)	
Pharmacist	35(9.4)	
Education		
Diploma	90(24.3)	
First degree	256(69.0)	
Masters	25(6.7)	
Post qualification years		8.7±7.4
≤ 5	149(40.2)	
6-10	125(33.7)	
≥ 11	97(26.1)	
Work experience		8.9±6.8
≤ 5	153(41.2)	
6-10	121(32.6)	
≥ 11	97(26.1)	

From Table 1 above, a total of 371 respondents participated in the study, 50.1% were nurse-midwives, 40.4% were Doctors and 9.4% were Pharmacists. The mean age of the respondents was 35.3 ± 7.5 years. About half (52.0%) of them were between 30-39 years. There were more female (53.6%) than male participants (46.4%). The majority were Christians (89.5%) (Table 1). More than half (53.6%) was married

Table 2: Training Received on Sexual and Reproductive Health

Variables	n (%)
Taught adolescent sexual and reproductive health in school	
Yes	330(88.9)
No	41(11.1)
Ever received continuing education or training on adolescent sexual and reproductive health?	

Yes	271(73.0)
No	100(27.0)

From Table 2 above, most of the respondents (73.0%) had received Continuing Education (CE) on Adolescent Sexual and Reproductive Health and were also taught adolescent sexual and reproductive health in school (88.9%).

Table 3: Responses on Contraceptives for Unmarried Adolescence (n = 371)

Statements	SA n (%)	A n (%)	U n (%)	D n (%)	SD n (%)
Providing contraceptives for unmarried adolescents promotes sexual promiscuity	84(22.6)	110(29.8)	66(17.8)	90(24.3)	21(5.7)
Unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex	36(9.7)	38(10.2)	26(7.0)	206(55.5)	65(17.5)
It is better to tell sexually active unmarried adolescents to abstain from sex rather than give them contraceptives when they ask for contraceptives	42(11.3)	128(34.5)	32(8.6)	120(32.2)	49(13.2)
Healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities	124(33.4)	185(49.9)	24(6.5)	22(5.9)	16(4.3)
Adolescents should be given contraceptive counseling before they become sexually active	206(55.5)	121(32.6)	8(2.2)	20(5.4)	16(4.3)
Unmarried adolescents do not require parental consent before contraceptives are provided	70(18.9)	154(41.5)	55(14.8)	64(17.3)	28(7.5)
I will not attend to any unmarried adolescent seeking contraceptives in the Hospital	78(21.0)	26(7.0)	24(6.5)	154(41.5)	89(24.0)

SA = STRONGLY AGREE, A = AGREE, U = UNDECIDED, D = DISAGREE, SD = STRONGLY DISAGREE

From Table 3 above, more than half (52.4%) of the respondents reported that providing contraceptives for unmarried adolescents promotes sexual promiscuity. Most of the respondents (73.0%) disagreed that unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex. Also, 45.8% reported that it is better to tell sexually active unmarried adolescents to abstain from sex rather than give them contraceptives when they ask for contraceptives. Most of the respondents (83.3%) reported that Healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities. Similarly, the majority of the respondents (88.1%) reported that Adolescents should be given contraceptive counseling before they become sexually active. However, most of the respondents (60.4%) reported that Unmarried adolescents do not require parental consent before contraceptives are provided and 65.5% disagreed that they will not attend to any unmarried adolescent seeking contraceptives in the Hospital while further 28.0% of the respondents agreed that they will not attend to any unmarried adolescent seeking for contraceptives in the hospital.

Table 4: Responses to Statements on Attitude Toward Providing Contraceptives to Unmarried Adolescents

Statements	SA n (%)	A n (%)	U n (%)	D n (%)	SD n (%)
I will not attend to any unmarried adolescent seeking contraceptives in the hospital	78(21.0)	26(7.0)	24(6.5)	154(41.5)	89(24.0)
I will report unmarried adolescent to their parents if they request for contraceptives	0(0.0)	90(24.3)	18(4.9)	117(31.5)	146(39.4)

I can only provide condoms to married adolescents and other contraceptives	0(0.0)	112(30.2)	38(10.2)	118(31.8)	103(27.8)
I will provide condoms and other contraceptives to unmarried adolescents who are less than 18 years old if they request it	24(6.5)	102(27.5)	70(18.9)	77(20.8)	98(26.4)
I will provide condoms and other contraceptives to unmarried adolescents who are 18 or 19 years old if they request it	56(15.1)	181(48.8)	32(8.6)	20(5.4)	82(22.1)
I will only provide contraceptives to adolescents who are married	12(3.2)	124(33.4)	8(2.2)	146(39.4)	81(21.8)
I will scold unmarried adolescents when they come for contraceptives	82(22.1)	24(6.5)	33(8.9)	116(31.3)	116(31.3)

SA = STRONGLY AGREE, A = AGREE, U = UNDECIDED, D = DISAGREE, SD = STRONGLY DISAGREE

From Table 4 above, 24.3% reported that they will report unmarried adolescents to their parents if they request contraceptives while 30.2% reported they can only provide condoms to married adolescents and other contraceptives. Another 34.0% reported they will provide condoms and other contraceptives to unmarried adolescents who are less than 18 years old if they request it. A majority (63.9%) reported that they will provide condoms and other contraceptives to unmarried adolescents who are 18 or 19 years old if they request it. Also, 36.6% reported they will provide contraceptives to adolescents who are married while 28.6% reported they will scold unmarried adolescents when they come for contraceptives.

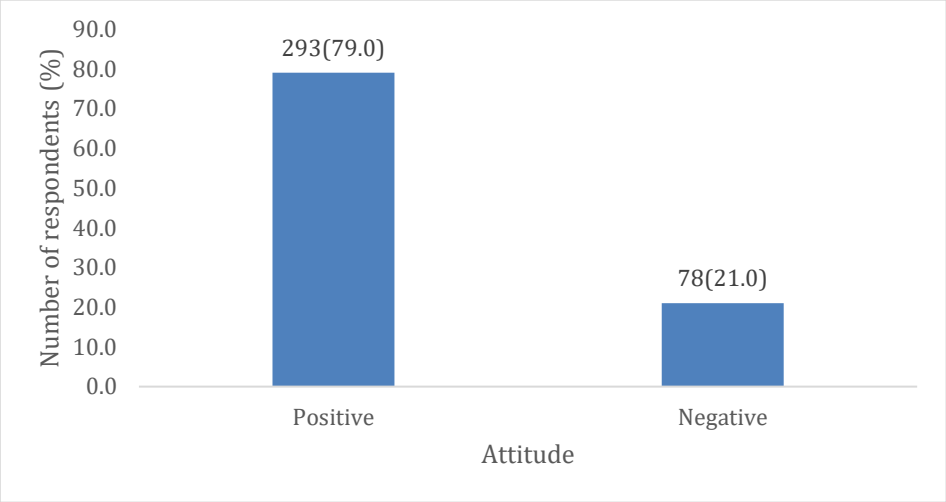

Figure 1: Respondents' Attitude Towards the Provision of Contraceptives for Unmarried Adolescent

From Figure 1 above, the study further revealed that the majority of the respondents (79.0%) had a positive attitude towards the provision of contraceptives for unmarried adolescents.

Table 5: Respondents' Attitude Towards Provision of Contraceptives for Unmarried adolescent by Cadre of Health Provider

Cadre	Attitude		
	Positive n (%)	Negative n (%)	Total n (%)
Doctor	118(78.7)	32(21.3)	150(100.0)
Nurse/midwife	146(78.5)	40(21.5)	186(100.0)
Pharmacist	29(82.9)	6(17.1)	35(100.0)
Total	293(79.0)	78(21.0)	371(100.0)

$\chi^2 = 0.352$, $p = 0.839$

From Table 5 above, the study revealed that the majority of the doctors (78.7%), Nurse-midwives (78.5%), and Pharmacists (82.9%) had a positive attitude toward the provision of contraceptives for unmarried adolescents. There was however no statistically significant difference between the cadre of healthcare givers in relationship to their attitude toward the provision of contraceptives for unmarried adolescents ($\chi^2 = 0.352$, p = 0.839).

Table 6: Association Between Sociodemographic Characteristics and Respondents' Attitude Toward the Provision of Contraceptives for Unmarried Adolescents

Demographic characteristics	Attitude			χ^2	p-value
	Positive	Negative	Total		
	n (%)	n (%)	n (%)		
Age group (years)					
20-29	68(73.1)	25(26.9)	93(100.0)	9.867	**0.020***
30-39	149(77.2)	44(22.8)	193(100.0)		
40-49	54(85.7)	9(14.3)	63(100.0)		
≥ 50	22(100.0)	0(0.0)	22(100.0)		
Sex					
Male	142(82.6)	30(17.4)	172(100.0)	2.478	0.115
Female	151(75.9)	48(24.1)	199(100.0)		
Education					
Diploma	71(78.9)	19(21.1)	90(100.0)	4.775	0.092
First degree	198(77.3)	58(22.7)	256(100.0)		
Masters	24(96.0)	1(4.0)	25(100.0)		
Post qualification years					
≤ 5	116(77.9)	33(22.1)	149(100.0)	6.663	**0.036***
6-10	92(73.6)	33(26.4)	125(100.0)		
≥ 11	85(87.6)	12(12.4)	97(100.0)		
Religion					
Christianity	262(78.9)	70(21.1)	332(100.0)	6.805	**0.033***
Islam	11(61.1)	7(38.9)	18(100.0)		
Orthodox	20(95.2)	1(4.8)	21(100.0)		
Work experience					
≤ 5	124(81.0)	29(19.0)	153(100.0)	3.252	0.197
6-10	89(73.6)	32(26.4)	121(100.0)		
≥ 11	80(82.5)	17(17.5)	97(100.0)		
Marital Status					
Single	127(77.9)	36(22.1)	163(100.0)	1.429	0.717*f*
Married	157(78.9)	42(21.1)	199(100.0)		
Separated/divorced	4(66.7)	2(33.3)	6(100.0)		
Widowed	3(100.0)	0(0.0)	3(100.0)		

f = fishers' Exact Test; **Statistically Significant*

From Table 6 above, there was a statistically significant relationship between the age of the respondents and their attitude towards providing contraception to unmarried adolescents (p=0.020). Similarly, the study observed a statistically significant relationship between the post-

qualification years (p = 0.036) and Religion (p = 0.033) of the respondents and their attitudes. However, there was no statistically significant relationship between the sex, education, work experience, or marital status of the respondent (p >0.05).

Table 7: Association Between Training Received and Respondents' Attitude Towards the Provision of Contraceptives for Unmarried Adolescents

Training	Attitude			χ^2	p-value
	Positive n (%)	Negative n (%)	Total n (%)		
Taught adolescent sexual and reproductive health in school					
Yes	265(80.3)	65(19.7)	330(100.0)	3.168	0.075
No	28(68.3)	13(31.7)	41(100.0)		
Ever received continuing education or training on adolescent sexual and reproductive health?					
Yes	210(77.5)	61(22.5)	271(100.0)	1.335	0.248
No	83(83.0)	17(17.0)	100(100.0)		

From Table 7 above, there was no statistically significant relationship between taught of adolescent sexual and reproductive health in school and continuing education or training on adolescent sexual and reproductive health (p>0.05).

DISCUSSION

Over half (52%) of the healthcare providers who participated in this study were nurse-midwives, followed by doctors (40.4%) and pharmacists (9.4%). This distribution was similar to the one found in a study conducted in Ibadan which reported that the majority of the healthcare providers were nurse-midwives (66.9%) and community health officers/community health extension workers (CHO/CHEW) (20.8%).[4] Community health officers were not included in this study as they are not providing contraceptive services in the study area. The fact that CHO, CHEW, and even social workers are rendering contraceptive services to adolescents in other parts of Nigeria calls for the need for JUTH community to as well train these healthcare providers so that they can also start administrating contraception thereby reducing the unmet need for it especially among unmarried adolescents.

The overall assessment from the study showed that the majority (79%) of the healthcare providers had a positive attitude towards providing contraceptives for unmarried adolescents while 21% had a negative attitude. These percentages were higher compared to what was found by Adekunle and co[21] in a study in Ibadan in which 52.6% of providers had a favorable disposition to providing contraceptives for unmarried adolescents. The reason for this may not be unconnected to the fact that over 80% of the index study participants were taught ASRH in school and more than 70% had continuous education on ASRH.

A majority (73%) of respondents disagreed that unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex. This finding was higher than what was reported in a study in Ibadan in which less than half (48.9%) of the respondents disagreed that unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex.[4] This may be because more healthcare providers are beginning to understand the importance of and are developing a positive attitude towards providing contraception for unmarried adolescents. Another reason for this variation may be the cultural differences that exist in different zones of Nigeria.

Most of the respondents of this study (83.3%) reported that Healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities. This finding was similar to what was reported in Botswana that three-quarters of respondents strongly agreed (median = 5 [IQR 5–6]) that they were comfortable with prescribing contraceptives to adolescents, more than two-thirds of the respondents disagreed (median = 3 [IQR 2–3]) that beliefs influenced their ability to offer contraceptive services to adolescents. Half of the respondents strongly disagreed (median = 2 [IQR= 2–3]) that it was morally wrong for adolescents to use a

contraceptive.[22] Additionally, in Abuja only 41% of respondents prescribed contraceptives to adolescents very often 71.9% reported to have often threatened to report adolescents to their parents if they requested contraceptives, 46.8% reported often refusing to prescribe contraceptives to adolescents who were not married while only 28.8% of respondents counseled adolescents on contraception irrespective of their age. The summary of practice in this study revealed that only 58.30% of respondents provided contraceptive services to adolescents.[23]

Despite the highly positive attitude towards contraceptives for unmarried adolescents, providers still had ambivalent attitudes. More than half of the respondents (52.4%) reported that providing contraceptives for unmarried adolescents promotes sexual promiscuity. This is similar to the 57.5% reported in a study in Ibadan.[4] The use of contraception is meant for people including unmarried adolescents to practice safe sex and consequently prevent unwanted pregnancy, unsafe abortion, and its complications. The assertion that providing contraceptives for unmarried adolescents promotes sexual promiscuity is just hearsay as there is no published research supporting it. The Nigerian government in this regard has to deliberately create programs and policies aimed at improving the reproductive health status of adolescents, including counseling about contraception irrespective of age; as this will help them lead a life devoid of unwanted pregnancy, unsafe abortion, and its complications, STIs and HIV/AIDS.

It was observed in this study that 45.8% of providers reported that it is better to tell sexually active unmarried adolescents to abstain from sex rather than giving them contraceptives when they ask for it. A similar finding has been reported in another developing country.[25] This might contribute to the reason why a majority of adolescents do not visit public health facilities for contraceptive counseling and other reproductive health services, rather, they visit patient medical stores where unfortunately, most times incorrect information will be given to them. Similarly, a study conducted in Ebonyi state found that Adolescents were reluctant to utilize contraceptive services and were uncomfortable disclosing their contraceptive needs to some health workers because these providers displayed some unfriendly and judgmental attitudes such as yelling and scolding them and even refused to attend to their contraceptive needs.[17]

In this study, the majority of the respondents (88.1%) reported that adolescents should be given contraceptive counseling before they become sexually active. It appears that the respondents are concerned about the reproductive health of adolescents. This is similar to a study done in South-West Nigeria,[1] Although the study was however unsure as to whether parental consent was required before contraceptives are provided for adolescents this study showed that 60.4% of the respondents reported that unmarried adolescents do not require parental consent before contraceptives are provided.

A comparison between socio-demographic characteristics and respondents' attitudes towards the provision of contraceptives for unmarried adolescents from the study showed a statistically significant relationship between the age, post-qualification years, and religion of the respondents (p=0.020, 0.036, and 0.033 respectively). However, there was no statistically significant relationship between the sex, education, work experience, or marital status of the respondents (p=0.115, 0.092, 0.197, and 0.717 respectively). Again, an association between training received and respondents' attitude towards the provision of contraceptives for unmarried adolescents showed no statistically significant relationship between being taught about adolescent sexual and reproductive health in school and continuing education or training on adolescent sexual and reproductive health (p=00.075 and 0.248 respectively). Our study was limited by the fact that there was no objective way of verifying the information provided by the healthcare providers.

CONCLUSION

Findings from this study showed an overall highly positive attitude by healthcare providers towards providing contraceptives for unmarried adolescents even though some expressed mixed feelings. Most respondents felt that Healthcare providers should provide contraceptive services for both married and unmarried clients in the healthcare facilities as they disagreed with the statement that unmarried adolescents should not be provided with contraceptives because the Nigerian culture does not support premarital sex. Even though more than half of the respondents felt that providing contraceptives for unmarried adolescents promotes sexual promiscuity and that sexually active unmarried adolescents be told to abstain from sex rather than giving contraceptives when they ask for them, they still opined that adolescents should be given contraceptives counseling before they become sexually active. A positive provider attitude towards providing contraception to unmarried adolescents is a very strong factor in offering contraception to them which will in turn prevent unwanted pregnancies, unsafe abortions, and their complications including the prevention of transmission of STDs and HIV/AIDS.

RECOMMENDATIONS

1. Training and retraining of all healthcare providers (not only Doctors, Nurses, and Pharmacists but also CHEWs and CHOs) on the provision of contraception and the sexual rights of all clients regardless of age or marital status.
2. Government and healthcare leaders should work towards the elimination of medical and social restrictions to the provision of contraception for unmarried adolescents.

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