ORIGINAL RESEARCH ARTICLE

Contexts and persistence of age of consent for accessing family planning services in Lagos, Nigeria: A qualitative study

DOI: 10.29063/ajrh2020/v24i3.15

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Abstract

Nigeria has one of the lowest adolescents family planning uptake in sub-Saharan Africa. Previous studies show that a high age of consent is a significant predictor. Little evidence exists about the contexts and persistence of the high age of consent for accessing family planning in Nigeria. Hence, this study used a qualitative methodology to explore the contexts, persistence and implications of high age of consent for accessing family planning in Lagos State. Forty-four in-depth interviews and 31 key-informant interviews were conducted in two Local Government Areas. NVIVO 12 plus was used to analyse data. The results suggest that contexts consisted of health and moral concerns, religious opposition and negative attitudes, which were underlying the persistence of high age of consent for accessing family planning. The contexts formed the basis for the exclusion of adolescents from family planning services. Consequently, sexually active adolescents adopted local herbs, a combination of different medicines, concoctions and local alcoholic drink (*ogogoro*) to prevent or abort pregnancies. Therefore, community-based NGOs should engage communities to promote perception change about adolescents accessing family planning and motivate the communities to begin to demand of their representatives in government a policy to lower age of consent for accessing family planning. *(Afr J Reprod Health 2020; 24[3]: 135-145).*

Keywords: Perspectives, parental consent, adolescents, contraceptive use

Résumé

Le Nigéria a l'un des plus faibles taux d'adoption de la planification familiale par les adolescents en Afrique subsaharienne. Des études antérieures montrent qu'un âge de consentement élevé est un prédicteur significatif. Il existe peu de preuves sur les contextes et la persistance de l'âge élevé du consentement pour accéder à la planification familiale au Nigéria. Par conséquent, cette étude a utilisé une méthodologie qualitative pour explorer les contextes, la persistance et les implications d'un âge élevé du consentement pour accéder à la planification familiale dans l'État de Lagos. Quarante-quatre entretiens approfondis et 31 entretiens avec des informateurs clés ont été menés dans deux zones d'administration locale. NVIVO 12 plus a été utilisé pour analyser les données. Les résultats suggèrent que les contextes se composaient de problèmes de santé et de moralité, d'opposition religieuse et d'attitudes négatives, qui sous-tendent la persistance d'un âge élevé du consentement pour accéder à la planification familiale. Les contextes ont constitué la base de l'exclusion des adolescents des services de planification familiale. Par conséquent, les adolescents sexuellement actifs ont adopté des herbes locales, une combinaison de différents médicaments, des concoctions et une boisson alcoolisée locale (ogogoro) pour prévenir ou interrompre les grossesses. Par conséquent, les ONG communautaires devraient engager les communautés à promouvoir un changement de perception concernant l'accès des adolescents à la planification familiale et motiver les communautés à commencer à exiger de leurs représentants au gouvernement une politique visant à abaisser l'âge du consentement pour accéder à la planification familiale. *(Afr J Reprod Health 2020; 24[3]: 135-145).*

Mots-clés: Perspectives, consentement parental, adolescents, utilisation de la contraception

Introduction

Adolescence is a developmental stage characterised by experimentation and exploration. These characteristics make the population highly vulnerable. Critical among the high risks adolescents face, primarily connected to widespread sexual activities among them, are unintended and unwanted pregnancies, unsafe abortion and sexually transmitted infections, including HIV[1-5]. These perils are serious public health concerns calling for attention all over the world, particularly in low-income countries. For instance, over 80 per cent of HIV infected persons

are in sub-Saharan African countries, and AIDS-related deaths have been rising among adolescents in the sub-region[6].

The most dependable way to address these sexual and reproductive health challenges is to promote unhindered access to family (FP) among all adolescents[1,7]. However, over 23 million adolescents (15-19-year-old) in developing countries are estimated to have unmet needs for FP[8]. Adolescents in Nigeria are at high risk because of the pervasive poor contraceptive behaviour, in which case the country is among those that have not made any reasonable progress since the 1990s[9]. For instance, in a recent study among adolescent 360 programme participants in Ethiopia, Nigeria and Tanzania, adolescents in Nigeria reported the lowest modern contraceptive use of 8.7 per cent compared with 47.2 per cent in Ethiopia and 19.4 per cent in Tanzania[10].

One major obstacle to uptake of FP services among adolescents is high age of consent (AoC)[11,12]. AoC refers to the legally and socially acceptable age adolescents can consent to sexual activities and access sexual and reproductive health services such as FP. This study focused on AoC for accessing FP. This definition suggests that any adolescents below the so-called AoC will require parental consent to access FP services. It is an instrument that legislatures and policymakers utilise to regulate the sexual behaviour of young people[13]. While the AoC for engaging in sexual activity is well researched and discussed, there is scanty information about the AoC for adolescent accessing FP services. AoC for adolescents accessing FP services varies across the globe, and many countries do not even have a well-defined AoC. For instance, in a recent study, only 40 per cent of the 15 countries sampled had a well-defined AoC[14]. This study listed Nigeria among the nations without a well-defined AoC, maybe because the colonial 18-year-old is implicit, only used when it is convenient and often disregarded even among highly placed government officials while engaging young people in sexual relationship.

High AoC for accessing FP is a significant contributor to poor contraceptive behaviour among adolescents through its obliterating effect on confidentiality, which is crucial to adolescent uptake of FP services[15-17]. AoC informs the requirement of parental consent by service providers, which they use to justify the exclusion of adolescents from services and thus push them away from accessing needed FP services[4,18-20]. Adolescents themselves argued that the negative attitude of service providers motivated by high AoC is pivotal in their exclusion from FP services[21]. Therefore, a high AoC will have dire implications for adolescent accessing FP because parental consent becomes mandatory before younger adolescents can access such services. The fact that lowering AoC is an arduous task[12], high AoC stands a challenge because it criminalises both providers who extend services to younger adolescents and the adolescents who seek such services.

Although Nigeria is considered in quarters to lack a clearly defined AoC[14], the colonial 18-year-old remains the reference point in the exclusion of adolescents from FP services. Series of debates have engaged the possibility of a lower AoC for accessing FP with little or no result. There was consensus that 16 years should be the minimum age for young people to participate in sexual and reproductive health research or access the services without parental consent[22], nevertheless, the influence of the colonial 18-year AoC has not diminished, because the policy has remained a draft for years. It is not yet a nationally adopted policy, and the States have not domesticated it for implementation. What are the contexts sustaining the high AoC for accessing FP in Lagos, and what are the implications for FP uptake and sexual and reproductive health in the megacity? No study, known to the author, has examined these questions. This study engaged those questions by considering three broad objectives. First, to unearth the contexts of persistent high AoC in Lagos State. Second, consider the influence of AoC for accessing FP services as well as implications for sexual and reproductive health among adolescents. Third, highlight policy outlines geared toward a lowered AoC in Lagos State.

Methods

Study settings

This study took place in Lagos State between 21 January and 20 February 2020, and it is the commercial capital of Nigeria, with a population size of over 22 million. It is the only megacity in Nigeria, the state has 18 urban and two largely rural Local Government Areas (LGAs). Through a random sampling procedure (lottery), Amuwo-Odofin and Badagry were selected to represent urban and rural LGAs, respectively. Amuwo-Odofin LGA recorded a population figure of 524, 971 in 2006 Census[23] and has a projected population size of 723, 678 in 2019 (using 2.5 per cent natural growth rate). The LGA has two Local Development Council Areas (LCDAs), namely Amuwo-Odofin and Oriade and they are integral paths of the Metropolis. The FESTAC and Satellite Towns are two famous large settlements. The study adopted the two LCDAs for data collection exercise.

In the 2006 Census exercise, Badagry LGA population size was 237, 731[23] and the projected population size for 2019 was 327, 715. Beside Badagry and Ajara that are rural Townships, the LGA's population is scattered across villages within its boundaries. Badagry LGA has three LCDAs, namely Badagry-Ajara, Badagry West and Olorunda. Badagry-Ajara and Badagry West were randomly selected for the study.

Study design

The study used a qualitative research design involving in-depth interview (IDI) and key informant interview (KII). The main goal for the choice of the study design was to capture the depth of various contexts of the AoC for adolescents accessing FP services in Lagos State.

Sampling design and sample size determination

Since the study deployed qualitative methodology, sampling of study participants followed purposive procedures in the four LCDAs selected for the study. The study population comprises parents and guardians (representing the community), health workers in active service in public and private facilities, community pharmacists (CPs), property and patent medicine vendors (PPMVs), a youth-based NGO and adolescents resident in Lagos State. The principle of saturation guided sample size determination in both IDI and KII. The saturation sampling process connotes conducting IDI and KII among appropriate study participants until an additional participant added no new information. Table 1 shows the distribution of the study participants across the selected LCDAs in the two LGAs.

Data collection methods

This study used IDI and KII methods in eliciting qualitative data in the study sites in Lagos State. Forty-four IDIs were conducted among sampled adolescents and parents or guardians. Inclusion criteria in the IDI adopted among adolescents was the awareness of FP. Although the World Health Organisation defines an adolescent population as young people between 10 and 19 years of age, this study limited adolescent study participants to between 16 and 19 years of age. This age group aligns the research with the Federal Ministry of Health consensus on the age for an adolescent to give consent to participate in sexual and reproductive health-related research[22]. Among adults, inclusion critaria were be a parent or guardian, male or female, between age 25 and 60 years and resident in the State. The choice of the age group was to ensure that such individuals were not too young and were still mentally active to engage in discussing the subject matter of the study. KIIs method was the data collection method used among the health care professionals (including PPMVs/CP). Inclusion criteria in the KII was male or female health worker in private or public health institution in Lagos State.

The researcher employed and trained two facilitators and two note-takers who were skilled in qualitative data collection as fieldwork assistants. They conducted the interviews and transcribed audio-records of the interview under closed supervision of the researcher. A study guide directed the interviews. The guide consisted of themes for discussion, including circumstances

Table 1: Distribution of study participants across selected Local Government Areas and Local Community Development Areas by sex

LGAs	LCDAs	Study Participants	Sex/Number	
			Female	**Male**
Amuwo-Odofin	Amuwo-Odofin	Adolescents	2	3
		Health workers	3	2
		Parents/Guardians	2	3
		PPMV/CP	2	0
	Oriade	Adolescents	4	3
		Health workers	4	2
		Parents/Guardians	3	4
		PPMV/CP	2	0
Badagry	Badagry-Ajara	Adolescents	3	2
		Health workers	3	2
		Parents/Guardians	3	2
		PPMV/CP	3	1
	Badagry West	Adolescents	2	3
		Health workers	2	4
		Parents/Guardians	3	2
NGO		Youth based and sexuality focused	1	0
Total			**42**	**33**

surrounding the AoC in Lagos State, perspectives over the AoC for accessing FP services, implications of high AoC for adolescents FP uptake and the likelihood of effecting a lower AoC. The interviews lasted for about one hour on the average.

Data analysis procedure

Data analysis involved NVIVO 12 Plus software. The first step involved checking the interview notes against the transcribed records by the researcher and uploading the file into the software as Microsoft Word files. The second stage was the creation of nodes consistent with the study objectives. Nodes are like tanks in the software where the texts coded are gathered during the coding process. This coding process gathered together all the relevant portions of the data files to generate referenced files in the software with statements (texts) from the interviews. The generated files formed the basis of the emerging categories from the data. The verbatim quotations inserted as quotes in the findings emanated from these generated files. They were copied directly from the data files referenced in the files created in the software.

Quality assurance

The first step undertaken to ensure quality assurance was training session organised for all the field assistants (including two facilitators and two note-takers). The training afforded the researcher the opportunity to share the study objectives with assistants and ensured they bought into the study goals. As noted earlier, the assistants were all sociologists with adequate experience in qualitative research methods. The study engaged this category of assistants to enhance quality assurance. The second step was the adoption of a two-steps quality check of generated data. The research assistants carried out the transcription of the interviews recorded and harmonised with notes taken in the field. For quality assurance, the researcher went through the recordings to authenticate the final transcribed data exported into the NVIVO software. Finally, the analysis adopted the NVIVO software to ensure proper data storage, retrieval and analysis, which promoted quality assurance.

Results

This section contains the study findings presented under the main themes addressed. The titles of the subsections are representing the objectives.

Sociodemographic background of study participants

Table 2 shows the distribution of the study participants by selected background

characteristics. The sex distribution of the participants indicates that females who agreed to participate in the study and completed the KIIs were nearly twice their male counterparts. In contrast, the same number of females and males participated in the IDIs. The participants' age distribution shows that majority of KII interviewees were between age groups 20-24 and 50-54. A similar pattern played out among the IDI participants, except that all adolescents were expectedly in the first age group (15-19). For the educational distribution of the participants, most of the KII interviewees had tertiary education. The level of education (mostly tertiary level) is consistent with the category of the participants. The two secondary school leavers were members of the PPMV community. Secondary education was the most popular among the IDI participants. The KII participants were mostly married, but among their IDI counterparts, the number of those who indicated never married exceeded those married by three. The religious distribution shows that most of the both KII and IDI participants reported Christianity. The Yoruba ethnic group dominated the two categories of participants followed closely by the Igbo ethnic group.

Contexts of high AoC in Lagos

The categories that emerged from data analysis suggested four contexts of high AoC for accessing FP, namely health concern, moral concern, religious opposition and negative attitude.

Health context

The anticipated widespread health consequences of a lower AoC among study participants include future fertility compromise, alteration of the reproductive system that may cause early menopause as well as physical health challenges owing to side effects of FP methods. The representative quotes below provide evidence to support the health-related circumstances from study participants' perspectives, which have inhibited lowering AoC in the study settings.

> Those that have access to FP early may have reduced fertility rate. It can eventually affect their future chances of conception and childbearing. (Female health worker, tertiary education, age 36)
>
> When an adolescent girl is exposed to family planning early, she is risking her future. She is compromising her chances of having children, as most of them use the wrong methods of FP. That is the FP methods that are not compatible with their system and so unsafe. (Female parent/guardian, tertiary education, age 52)
>
> I do not support an adolescent having access to FP services, even with parental consent. I cannot give my daughter such consent, even if she is sexually active. Because these contraceptives and FP services tend to affect their ability to conceive later in future. (Female CP/PPMV, secondary education, age 25)

Moral context

The popular stand of most of the study participants was that it is morally wrong to lower AoC because it would give adolescents express approval to indulge in premarital sex. Study participants opined that if the government takes the step to reduce AoC, parents will interpret the action as giving license to adolescents to be promiscuous. The traditional pride attached to virginity appears the underlining motivation for most study participants opposition to a lower AoC for an adolescent to access FP without parental consent. The popular view among the participants was that if adolescents below age 18 were allowed to access FP on their own accord, they would throw caution to the wind because they know that they could have sex void of pregnancy risk. Participants argued that any policy that lowers the AoC for accessing FP among adolescents would lead to moral chaos in society. Parents, guardians, health workers and adolescents expressed opposition to a lower age of consent motivated by such fears. Also, because the government prefers to avoid being labelled by parents as giving license to their children to engage in premarital sex, it has been quite slow and unwilling to lower the age.

The less popular view was that parents of sexually active adolescents could permit their access to FP to prevent unwanted pregnancy and

Table 2: Distribution of study participants by selected background characteristics

Background Characteristics	Key-Informants (number)	In-depth Interviewees (number)
Sex		
Female	20	22
Male	11	22
Age		
15-19	0	22
20-24	1	0
25-29	5	2
30-34	8	5
35-39	3	6
40-44	6	4
45-49	5	2
50-54	2	1
55-59	0	1
60 and above	1	1
Education		
None	0	4
Primary	0	1
Secondary	2	29
Tertiary	29	10
Marital status		
Never married	4	23
Ever married	27	21
Religious affiliation		
None		
Christianity	28	34
Islam	2	10
Traditional	1	0
Major ethnic group		
Igbo	12	10
Hausa	5	4
Yoruba	14	30

related consequences. In other words, it was not morally wrong to lower AoC for sexually active adolescents to access FP. Study participants argued broadly with the assumption that the majority of adolescents protect the societal norm of the dignity attached to virginity. As a result, some of them claimed that only those sexually active should be permitted to access FP with the caveat that they must obtain parental consent.

> Government is reluctant to lower the age of consent because our culture cannot condone it. (Female health worker, tertiary education, age 25)
>
> Even culturally, as a Yoruba, a female must remain a virgin until marriage. (Male health worker, secondary education, age 30)
>
> No parent will allow their adolescents to access FP services because they believe that their wards are too innocent for such things. (Female CP/PPMV, tertiary education, age 50)
>
> It is necessary to seek parental consent before accessing FP services because it is not proper in the first place for adolescents to use FP service. If they have to, their parents must permit them. (Male adolescent, secondary education, age 19)

Religious context

The consensus among the study participants was that it was against their religious belief for adolescents to access FP. The study participants predicated their opposition to adolescents accessing FP without parental consent upon the tenets of Christianity and Islam. Some participants considered Nigeria a religious society and culturally sound, and unlike the Western World, Nigerians see young people accessing FP as inappropriate and a sin. The participants viewed a lower AoC as issuing the license to adolescents to practice the sin of fornication or premarital sex, which corrupts religion. A study participant saw it as an insult to the '10 commandments', and that if adolescents adhered to the commandments, they might not need FP services until they are married'. This position was corroborated by another participant that 'sex is to be enjoyed'; if FP is legalised for adolescents younger than 18 years through lower AoC, it will encourage premarital sex because 'they will take advantage of it.' In consonant with that popular position, adolescent participants believed that if adolescents followed the religious teachings, especially in Churches, they would not engage in premarital sex.

However, a few study participants agreed that sexually active adolescents should have religious permission to access FP services. The proponents of this contrast argued that to avoid the shame of unintended or unwanted pregnancy, sexually active adolescents should be permitted to access FP irrespective of their age. Despite the general religious opposition to lowering the AoC, adolescents and parents/guardians supported the exception that parents of sexually active adolescents should find a way to facilitate such adolescents' access to FP services.

Table 3: Number of study participants who recommended each listed age as the age of consent

Age Recommended as AoC	Health professionals	Parent/guardians	Adolescents	CP/PPMVs
13 & Lower	2	1	-	1
14	1	-	-	-
15	1	1	-	-
16	2	-	2	-
17	-	-	-	-
18	5	3	7	5
Above 18	1	4	8	1
When married	1	2	-	2

If the government has shown a lackadaisical attitude towards this cause, then, I think culture, religion and the opposition of parents and adolescents are the primary cause. (Male health worker, tertiary education, age 33)

Access to FP services by adolescents is a sin, and I cannot be involved in sin nor encourage anybody to sin. FP should be restricted to married people only. (Male parent/guardian, secondary education, age 40)

I do not attend to adolescents when they come for FP services; it is for adults, and as a Christian, I cannot do that because it is a sin of fornication for unmarried adolescents to be sexually active. I don't even sell pills; I only sell condoms which I sell only to adults (Female CP/PPMV, tertiary education, age 45)

Attitudinal context

The attitudinal context of high AoC indicates the way study participants perceived the call to lower the age at which adolescents can access FP services without parental approval. Health workers' attitude is striking in this regard. A health professional's perspective was representative of the majority of the study participants. She indicated that if a 16 year old lady walked into the particular health facility where she worked, the first question to her would be 'are you married?' Of course, such an approach could be intimidating. It gives voice to a negative attitude towards a lower AoC for accessing FP among adolescents. A similar reaction was popular among the other study participants, including CPs, PPMVs, parents or guardians and adolescents. Many of these study participants maintained that they would not support giving consent to their wards to access FP services. This category of participants argued that they did not support a lower AoC.

Nevertheless, a less popular attitude in the KIIs was that because of the early sexual debut common among young people these days, whereby those as young as ten years old were sexually active, parental consent for adolescents below age 18 years was no longer necessary. It was unlikely for many parents to permit such adolescents to access FP services. Therefore, service providers should give sexually active adolescents access to FP services irrespective of their age, for them to prevent the consequences of unsafe sex. A few CPs, PPMVs, parents and adolescents demonstrated such positive attitude towards the provision of FP services to adolescents during the IDI sessions.

If a lady of 16 should walk up into this place seeking FP, my first question will be 'are you married'? There are constraints because a girl that is sexually active by 14 or 16 won't be able to access it until 18. They may feel deprived of the right, but FP has advantages and disadvantages. (Female health worker, tertiary education, age 27)

I do not support adolescent having access to FP. I will not allow my daughter to partake in that; I will only educate her on the dangers of premarital sex. (Female parent/guardian, tertiary education, age 52)

We don't need a lower AoC because we shouldn't be engaging in FP at our age. It is not something healthy because we are too young to do that. (Male adolescents, SSCE, age 18)

I support a lower Aoc because a lot of adolescents are already sexually active. For them to prevent diseases and unplanned

> pregnancies, and bring shame to the family, it is better to allow them to protect themselves. (Female, secondary education, age 27)

Implications of high AoC

As illustrated below, because of various contexts of the AoC presented above, adolescents rarely visited health facilities for comprehensive FP services. The patronage was as low as one or two in a year in some cases. Knowledgeable study participants argued that the opposition of parents and guardians, and the negative attitude of health workers, including CPs and some PPMVs, adolescents adopted alternative means of taking care of their sexual and reproductive health needs. The alternative ways itemised in various interview sessions include local herbs, a combination of different medicines, a combination of different drugs, concoctions and local alcohol such as *ogogoro.* Adolescents deployed those measures to prevent pregnancy or abort unintended and unwanted pregnancies. Health workers opined that those alternatives have devastating effects on the reproductive organs of adolescents and promoted the spread of STIs, and can even lead to death. Another implication of the inability of adolescents to access FP services as a result of high AoC was the patronage of quack doctors who assisted in the termination of unwanted pregnancies. The study participants suggested that the services of quacks have resulted in perforated uterus and other harmful effects on their overall reproductive system as well as death.

> Adolescents are afraid to come to the clinic for FP services. We rarely see them come to the health centres, maybe one or two in a year. Most of them tend to go for alternatives, using local herbs, concoctions and medicines, which are harmful to their health and can destroy their reproductive organs. These alternatives will result in various health issues. (Male health worker, tertiary education, age 42)
>
> Yes, the age of consent phenomenon is affecting the sexual and reproductive health of adolescents, especially females. They go into abortion; some use hard drugs like *ogogoro*, ampicillin capsules, and different kind of drugs. This behaviour eventually affects them in future when they finally get married, especially their reproductive health. (Female health worker, tertiary education, age 45)
>
> Parents that do not allow their sexually active adolescents to access FP services are paving the way for them to get pregnant. In a bid to avoid shame, they take all manner of drugs (a combination of different un-prescribed tablets) and local herbs to terminate the pregnancy. (Female adolescent, SSS2, age 18)

AoC recommended by study participants

The AoC recommended by the study participants presented in Table 3 illustrates the attitudes of the study participants towards AoC. The fashionable AoC for an adolescent to access FP services across the four categories of study participants without parental consent was 18 years or higher. A few participants recommended marriage as the condition that could permit an adolescent access to FP services. It was quite interesting to note that adolescent study participants preferred 18 or above as AoC in the study settings. Nonetheless, a negligible number of health professionals and parents or guardians suggested a lower AoC of 16 years or less.

Discussion

This study has explored the contexts and persistence of AoC in two LGAs in Lagos State. The data analysed have shown that only a few study participants were aware of the colonial-18-year AoC, which has been the reference point. In consonant with the recent study report that there was no precise AoC in Nigeria, most study participants could not claim knowledge of any well-articulated age of consent in Lagos State (or in Nigeria)[14]. However, the consensus among the participants was that it was inappropriate for adolescents to access and use FP services. They predicated their opposition to the call to evolve a policy that will lower the age at which adolescents can consent to FP use on health, moral and religious concern. The exploratory data suggest that the society and government were not favourably disposed to lower AoC because such a move was unacceptable to the two prevalent religions in Nigeria (Christianity and Islam). In

this regard, this study confirmed the report of previous studies that lowering AoC has always been a difficult task because of the opposing forces and the legislature and policymakers usually defend AoC as an instrument to protect adolescents[6,12].

However, the moral and religious contexts that informed the persistence of the prevailing high AoC have failed to check premarital sexual activities among adolescents regardless of age. Parents, guardians, and adolescents themselves, all defended opposition to lower AoC based on health, moral and religious justifications. It is a questionable position because if it is unacceptable on moral and religious grounds to reduce AoC to access FP services, then the same contexts should be sufficiently potent to prevent premarital sex among adolescents. Evidence shows that sexual debut remains early and premarital sex is on the increase[24]. This argument is consistent with the observation made about the case of the United Kingdom's AoC, which is the highest in Europe, that moral justification is the basis for resistance to lowering it. Still, sexual activities among adolescents sustained a fast lane [12]. A plausible explanation is a hypocrisy that is often associated with sex-related issues and the pretence inherent in religious justification. Nearly all in a patriarchal society tend to claim being oblivious of the sexual reality pervasive among adolescents despite the moral and religious contexts.

The same unrealistic moral and religious contexts might be the basis of service providers' negative attitude towards a lower AoC. The data analysis suggests that the majority of health workers argued against a lower AoC. The religious climate may also motivate health professionals and Registered PPMVs expressions of negative attitudes toward a policy to lower AoC. This negative attitude is crucial because it is an influential factor accountable for the exclusion of adolescents from family planning services[18,19]. It is also the most important factor identified by adolescents in a previous study as a critical inhibitor of their access to FP services[21]. Thus, the study findings have confirmed previous studies' report about the role of health providers negative attitude in the exclusion of adolescents from FP services.

As a result, sexually active adolescents who were likely in majority usually shifted to alternatives that were likely more dangerous to their health than the fears underpinning the justifications for high AoC. The unhealthy choices they embrace include local herbs, a combination of different drugs, a combination of different tablets or medicines, concoctions and local alcohol such as *ogogoro* to prevent pregnancy or abort unintended and unwanted pregnancies. Adolescents explored these alternatives to handle the consequences of premarital sex because of the high AoC that excludes them in comprehensive FP services. The effects reported in this study are consistent with those observed in previous studies, which include unintended and unwanted pregnancies, unsafe abortions, STIs and unintentional spread of same[1,2,6].

Ethical Considerations

The study was a pilot endeavour conducted within a limited time frame (fieldwork between 21 January and 20 February 2020). During the fieldwork, the assistants and researcher observed the following ethical considerations. Each study participant gave verbal consent to participate in the study. It was the primary yardstick for recruitment. Also, each participant was at liberty to discontinue participation at any stage of the interview. The fieldwork assistants made this clear before each interview commenced. Another ethical issue observed was that each participant gave verbal permission for the audio recording of each interview before starting. Lastly, the confidentiality of study participants identified was critical. Fieldwork assistants assured each participant of this principle before the interview. They confirmed to the study participants that the information gathered was purely for research purpose. The dRPC technical committee reviewed and approved the study proposal before the fieldwork commenced.

Conclusion

Since a well-implemented policy that lowers the AoC is capable of addressing the unmet need for FP and mitigate the sexual and reproductive health consequences[8], calls for action is imperative.

Given that most parents, guardians, service providers and adolescents are all singing sustenance of the present high AoC, the critical policy line the findings suggest is that the call to lower it should originate from the society. Therefore, community-based NGOs should engage the communities in social engineering targeted towards causing a sustainable change of perception about adolescent access to FP services. The second focus is to motivate the communities to begin to demand of their representatives in the legislature and executive an active policy to lower AoC to promote confidentiality and accelerate FP uptake among adolescents.

Acknowledgements

This exploratory study was made possible by a small grant from the Partnership for Advocacy in Child and Family Health Project (PAS), funded by the Bill and Melinda Gates Foundation (BMGF) in January 2020. I am therefore grateful to the dRPC Management for facilitating the support. My appreciation also goes to the four fieldwork assistants who worked hard to enable data collection within a limited time. Finally, I acknowledge the invaluable support given by Dr Adedoja D. Wusu, who gave me technical support when my personal computer crashed twice.

Contribution of Author

Onipede Wusu conceived, designed, analysed the data and prepared the manuscript. The field assistants who assisted in data collection were Olabusoye O. Oguntola-Laguda, Gabriel O. Ogbeyemi, Mariam Kikelomo Liasu and Motunrayo Ajoke Ajibola.

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