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PERCEPTION OF IN-SCHOOL ADOLESCENT GIRLS ABOUT STIGMA ASSOCIATED WITH SELECTED SEXUAL AND REPRODUCTIVE HEALTH ISSUES IN IBADAN NORTH LOCAL GOVERNMENT AREA

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Abstract

The conceptualisation of stigma has been in existence for a while among adolescents. Presently, Nigeria has no country-specific report about stigma associated with sexual and reproductive health issues most especially risky sexual activity, unwanted pregnancy, indiscriminate contraceptive use and unsafe abortion. This study therefore described the rate of perceived stigma among the in-school adolescent girls in Ibadan North Local Government Area, Nigeria. It also examined the perception of the respondents about the sexual and reproductive health stigma. A descriptive cross-sectional study was conducted that included 633 female students from the senior secondary classes in Ibadan Local Government Area. A self-administered semi-structured questionnaire was used to obtain data about socio-demographic characteristics and perceived stigma about selected sexual and reproductive health issues using a 20-item set of sexual and reproductive health stigma scale on a 3-point modified Likert scale (agree, neutral and disagree). Descriptive statistics, Chi-square test, and correlation at p=0.05 were used to analyse the data. The respondent's mean age was 15.3 ±1.5 years. Two hundred and five (32.4%) of the respondents were in early adolescence and, 370 (58.5%) were in mid-adolescence. Five hundred and ten (80.6%) of the respondents were from the Yoruba ethnic group and three hundred and ninety-three (62.1%) of them were Christians. More than half (82.8%) of the respondents were from monogamous families, 59 (88.3%) of the respondent's parents were married and 38 (6%) were separated. Two hundred and fifty-nine (40.9%) of the respondents were from low socioeconomic class. Respondents in early, mid and late adolescence who had high perceived stigma were 174 (84.9%), 311 (84.1%) and 54 (93.1%) with high perceived stigma respectively. Among the ethnic groups, 441 (83.1%) of the respondents who were Yoruba had a high perceived stigma with regard to sexual and reproductive health issues. Common reasons for high perceived stigma about sexual and reproductive health issues among the respondents were, 370(58.5%), 401(63.3%), and 399(63%) of the respondents agreed to the queries that people would behave differently from adolescents who are known to have had sex, abortion and used modern contraceptive respectively. Also, more than half of the respondents (81.4%) agreed that being pregnant would bring shame to their family, and 275(43.4%) agreed that modern contraceptives would have a negative effect on adolescent health. There was a high perceived stigma among the in-school adolescent girls in Ibadan North local government area. It is therefore necessary to sensitize the community about the stigma associated with sexual and reproductive health issues.

Keywords: Adolescents, girls, perception, stigma, sexual and reproductive health issues

Introduction

The health of adolescents creates a major global burden (WHO, 2021). It has a great deal of additional and diverse complications such as risky sexual behaviour, lack of contraceptive use, unwanted pregnancy, difficulties accessing contraception and safe abortions, lack of healthcare access, high rates of sexually transmitted infections and mental health issues (Akorede et al., 2019; Morris & Rushwan, 2015). According to the International Conference on Population and Development (ICPD) (1994), "safe sexual and reproductive health (SRH) is basically a human right". It has to do with the right to life, the right to be free of torture, the right to health, the right to freedom, the right to education, and the prohibition of discrimination, among other things (United Nations High Commissioners for Refugees (UNHR), 1996).

Stigma has been recognised as a major cause of adolescent health disparities and a key social factor of health (Hatzenbuehler et al., 2013). However, the vast majority of studies on adolescents' health-related and the consequences of stigma have focused on stigma associated with minority sexual orientation, likewise mental illness, lack of self-esteem, and obesity. The selected SRH issues for this study were risky sexual behaviour, contraceptive use, unwanted pregnancy and unsafe abortion which have been a result of the stigma associated with the SRH issues. Several studies show that adolescent stigmatization can lead to lack of use of health services, an increase in morbidity and mortality rates, loss of self-esteem, feelings of hopelessness and many more (Fatusi & Hindin, 2010; Hall et al., 2018; Laura et al., 2019).

Improving adolescent SRH knowledge and identifying the factors that influence their perception will directly contribute to their lifestyles, health and well-being. Therefore, this study hopes to assess the perception of adolescents and the factors influencing their perception of stigma associated with selected SRH issues. This will help appropriate stakeholders like the Federal Ministry of Health and Education, community heads, NGOs and others, to provide a holistic approach to guide them properly and help in policy formation if the need be in order to prevent adverse consequences like an increase in morbidity and

mortality rates, and also help in remodelling societal norms thereby strengthening their health as a whole. This study will also serve as a template for future studies.

Research Questions

1. What is the perception of in-school adolescent girls about the stigma associated with selected sexual and reproductive health issues in Ibadan North LGA?
2. What are the factors influencing the perception of in-school adolescent girls about the stigma associated with selected sexual and reproductive health issues in Ibadan North LGA?

Methodology

This study was conducted in Ibadan North Local Government Area (LGA) of Oyo State, Nigeria. Ibadan North is one of the five urban local government areas in Ibadan having an estimated population of 3,649,000 (United Nations, 2021). Ibadan is the capital city of Oyo State which is situated in the southern-western part of Nigeria and it is the third-largest city in Nigeria after Lagos and Kano. The local government area consists of multi-ethnic. This study was a descriptive cross-sectional study, and the study participants were in-school adolescent girls in Ibadan North LGA, Oyo State. The sample size was determined using the Leslie Kish formula and due to the clustering of the schools in the LGA, the sample size was multiplied by a design effect of 1.5. This resulted in the final sample size of 633 students. The study followed a four-stage sampling which included; the random selection of 6 wards out of 12; the selection of schools; the selection of class arm using stratified random sampling with the proportional allocation of students from the different classes in the selected secondary schools; stratification was done according to the senior secondary school classes (SS1 to SS3) and finally, selection of respondents using systematic sampling technique (with the sampling fraction calculated based on the number of students present in the class and the number of respondents to be selected) using the class register.

A semi-structured questionnaire was used for data collection for this study and the data was properly cleaned, coded, and entered using Statistical Package for Social Science (SPSS) version 20. The questionnaire was divided into two sections; Section A: Socio-demographic information and Section B: Sexual and reproductive health stigma. This section adopted the validated questionnaire for sexual and reproductive health stigma scale developed by Hall et al., in 2018. The scale covers sexual and reproductive health issues such as sexual behaviour, contraceptive use, pregnancy, abortion and family planning service use. It is a 3-point Likert scale (disagree, neutral and agree) comprising 20 items measuring three primary domains of environmental stigma. The environmental domains were disgrace and shame (internalized stigma), discrimination and marginalization (enacted stigma), and negative community norms (stigmatizing lay attitudes).

The socioeconomic class of the respondents was computed using the socio-index score of Oyedeji (1985). The scores were awarded to each respondent based on the occupation and educational attainment of the parents. The social economic class was determined using the mean of the parent's occupation with their level of educational attainment and classified into high social class (I-II), middle social class (III) and low social class (IV-V). Data cleaning was done to check for accuracy, missing values, and variables. A 20-item scale on a 3-point modified Likert scale was used to assess the sexual and reproductive health stigma of the respondents. 3 = agree, 2 = neutral and 1 = disagree, with total score 60. A score from 1-20 indicated a low level of stigma, 21-40 neutral/moderate and 41-60 high level of stigma.

Results and discussion

Table 1: Socio-demographic characteristics of the study participants (n=633)

Socio-demographic characteristics	Frequency (n)	Percent (%)
Age		
10-14	205	32.4
15-17	370	58.5
18-19	58	9.2
Ethnicity		
Hausa	24	3.8
Igbo	97	15.3
Yoruba	510	80.6
Others	2	0.3
Religion affiliation		
Christian	393	62.1
Muslim	229	36.2
Traditionalist	10	1.6
Others	1	0.2

Table 2: Socio-demographic characteristics of the study participants' family in Ibadan North Local Government Area, Nigeria

Sociodemographic characteristics	Frequency (n)	Percent (%)
Family type		
Monogamous	524	82.8
Polygamous	109	17.2
Parents' status		
Married	559	88.3
Separated	38	6.0
Divorced	21	3.3
Widowed	14	2.2
Never married	1	0.2
Social class		
High	213	33.6
Middle	161	25.4
Low	259	40.9

4.1 The perception of the in-school adolescent girls about sexual and reproductive health stigma

Among the respondents age group in Table 3, 10-14 and 15-17 years of age recorded high perceived stigma scores of 174(84.9%) and 311(84.1%) respectively.

Table 3: The relationship between the perceived stigma and socio-demographic characteristics among the study participants

Socio-demographic	Perceived stigma			P-value
	High n (%)	Moderate n (%)	Low n (%)	
Age group				
10-14	174(84.9)	30(14.6)	1(0.5)	0.47
15-17	311(84.1)	58(15.7)	1(0.3)	
18-19	54(93.10)	4(6.9)	0(0.00)	
Ethnicity				
Hausa	24(100.0)	0(0.0)	0(0.0)	0.14
Igbo	89(89.7)	8(10.3)	0(0.0)	
Yoruba	424(83.1)	84(16.5)	2(0.4)	
Other	2(100.0)	0(0.0)	0(0.0)	
Social Class				
High	197(92.5)	16(7.5)	0(0.0)	0.01
Middle	132(82.0)	27(16.8)	2(1.2)	
Low	210(81.1)	49(18.9)	0(0.0)	
Religion				
Christian	351(89.5)	42(10.7)	0(0.0)	0.00
Muslim	180(78.6)	48(21)	1(0.4)	
Traditionalist	7(70.0)	2(20.0)	1(10.0)	
Other	1(100.0)	0(0.0)	0(0.0)	

Table 4: The scores of enacted stigma subscale and distribution of study participants in Ibadan North Local Government Area, Nigeria

Full SRH stigma scale (mean =48.2± SD =8.1)	Mean	SD	Agree (%)	Neutral (%)	Disagree (%)
Enacted stigma item (mean = 14.8± SD = 3.4)					
People behave differently to adolescents they know is having sex.	2.3	0.88	58.5	14.4	27.3
People behave differently to adolescents they know is having an abortion	2.4	0.88	63.3	9.3	27.3
People behave differently to adolescents they know are using modern family planning methods (contraceptives like condom).	2.4	0.82	63.0	15.5	21.6
An adolescent whose parents know about having sexual intercourse often leads to being beaten or physically harmed by the parents.	2.6	0.71	73.8	12.8	13.4
Being pregnant and having a baby when I am still an adolescent will cause people around me to treat me differently.	2.5	0.8	69.8	8.2	22.0
Being pregnant and having a baby when I am still an adolescent will cause people to mock, humiliate, swear or gossip about me.	2.6	0.73	79.3	5.5	15.2

Table 5: The score of internalised stigma and perceived stigma distribution of study participants in Ibadan North Local Government Area, Nigeria

Internalized stigma items (mean 17.8± SD 3.4)	Mean	SD	Agree (%)	Neutral (%)	Disagree (%)
Having sexual intercourse when you are an adolescent is a form of disobedience.	2.7	0.7	78.7	8.8	12.5
Adolescents who abort are bad.	2.4	0.8	61.9	14.1	24
Adolescents who use modern family planning (an effective contraceptive method) are who have sexual intercourse with those who come to them (promiscuous).	2.3	0.9	53.7	18.8	27.5
Adolescents who use modern family planning (contraceptive method) are seen as bad girls and boys	2.4	0.8	64.5	15.8	19.7
Having sexual intercourse while young is a disgrace and shame for the adolescent and his/her family.	2.7	0.7	81.4	7.6	11.1
If I become pregnant as an adolescent, having a baby will disgrace my family.	2.7	0.7	81.0	6.6	12.3
Being pregnant and having a child when I am young caused me to feel embarrassed and ill.	2.7	0.7	79.5	7.4	13.1

Table 6: The score of stigmatising lay attitude and perceived stigma distribution of study participants in Ibadan North Local Government Area, Nigeria

Stigmatising lay attitudes item (Mean=15.5± SD=3.5)	Mean	SD	Agree (%)	Neutral (%)	Disagree (%)
Adolescents who have had an abortion will encourage others to have an abortion.	2.2	0.9	48.8	19.3	31.9
It is unacceptable for unmarried adolescents to use modern family planning methods (contraceptive-effective methods).	2.2	0.9	49.1	21.6	29.2
Modern contraceptives have negative effects on adolescent's health.	2.0	0.9	43.4	15.5	41.1
Having children (being curetted) is about murder.	2.3	0.9	62.1	10.4	27.5
The media, including television, the internet, and magazines, have a strong impact on adolescents' sexual behaviour.	2.6	0.8	73.9	9.0	17.1
The first time that adolescents have sexual intercourse, it is usually under the pressure of their friends or partners.	2.2	0.8	47.6	28.6	23.9
Children born from adolescents are worse than those born from adult parents.	2.0	0.9	36.3	27.2	36.5

4.2 The sociodemographic factors predicting the enacted stigma of the respondents

Sociodemographic factors predicting the enacted stigma are in Table 7 as most of the respondents 263 (71.1%) in the age group 15-17 agreed to the perceived stigma compared to their counterparts. With regards to social class, respondents from high-class families recorded 178 (83.6%).

Among the Yorubas ethnic group, it's recorded that 347 (68%) of the respondents agreed with the high stigma associated with sexual and reproductive health issues and 152 (29.8%) reported being neutral. The ethnicity of the respondents was statistically significant with a p-value < 0.05. Of those who were Christians among the respondents, 304 (77.7%) recorded high perceived stigma.

Table 7: The association between enacted stigma and the sociodemographic information of female adolescents in Ibadan North Local Government Area, Nigeria

Variable	Enacted perceive stigma						
	Low n (%)	Moderate n (%)	High n (%)	Total n (%)	X^2	Df	P value
Age							
10-14	6(2.9)	52 (25.4)	147 (71.7)	205(100)	7.713	4	0.103
15-17	4 (1.1)	103(27.8)	263(71.1)	370(100)			
18-19	1 (1.7)	8(13.8)	49(84.5)	58(100)			
Ethnicity							
Hausa	0(0.0)	0(0.0)	24(100)	24(100)	2.090	6	0.00
Igbo	0(0.0)	11(11.3)	86(88.7)	97(100)			
Yoruba	11(2.2)	152(29.8)	347(68.0)	510(100)			
Other	0(0.0)	0(0.0)	2(100)	2(100)			
Social class							
Low	6(2.3)	85(32.8)	168(64.9)	259(100)	21.892	4	0.00
Middle	4(2.5)	44(27.3)	113(70.2)	161(100)			
High	1(0.5)	34(16.0)	178(83.6)	213(100)			
Religion							
Christian	4(1.0)	85(21.6)	304(77.7)	393(100)	19.345	6	0.004
Muslim	6(2.6)	77(33.6)	146(63.8)	229(100)			
Traditional	1(10.0)	1(10)	8(80)	10(100)			
Other	0(0.0)	0(0.0)	1(100)	1(100)			

4.3 Sociodemographic factors predicting internalized stigma of the female adolescents in Ibadan North Local Government Area, Nigeria.

Sociodemographic factors predicting internalized stigma is in Table 8. The social class and religion of the respondents were statistically significant with p-value < 0.05. Respondents within the age group 10-14 had the most perceived stigma compared to others. Among the respondents from the Yoruba ethnic group, 274 (53.7%) were reported to have most perceived internalized stigma.

Table 8: The association between the internalised stigma and sociodemographic characteristics of female adolescents in Ibadan North Local Government Area, Nigeria

Variable	Perception internalized stigma						
	Low n (%)	Moderate n (%)	High n (%)	Total n (%)	X^2	Df	P value
Age							
10-14	6(2.9)	80(39.0)	119(58.0)	205(100.0)	3.683	4	0.451
15-17	20(5.4)	153(41.4)	197(53.2)	370(100.0)			
18-19	1(1.7)	25(43.1)	32(55.2)	58(100.0)			
Ethnicity							
Hausa	1(4.2)	8(33.3)	15(62.5)	24(100)	2.090	6	0.911
Igbo	3(3.1)	36(37.1)	58(59.8)	97(100)			
Yoruba	23(4.5)	213(41.8)	274(53.7)	510(100)			
Other	0(0.0)	1(50)	1(50)	2(100)			
Social class							
Low	13(5.0)	103(39.8)	143(52.2)	259(100.0)	12.004	4	0.017
Middle	12(7.5)	58(36.0)	91(56.5)	161(100.0)			

High	2(0.9)	97(45.5)	114(53.5)	213(100.0)			
Religion							
Christian	6(1.5)	177(45.0)	210(53.4)	393(100.0)	35.731	6	0.000
Muslim	18(7.9)	79(34.5)	132(57.6)	229(100.0)			
Traditional	3(30.0)	2(20.0)	5(50.0)	10(100.0)			
Other	0(0)	0(0)	1(100.0)	1(100.0)			

4.4 Sociodemographic factors predicting the stigmatising lay attitude

The sociodemographic factors predicting lay attitude are shown in Table 9. The social class of the respondents was statistically significant with $p<0.05$. The age group of the respondents and ethnicity were not statistically significant. Among the ethnic group, Yorubas had the most perceived stigma 112 (22%). Among the respondent's religious affiliations, Muslims had the most perceived stigma 60 (26.2%).

Table 9: The association between the lay attitude stigma and sociodemographic characteristics of female adolescents in Ibadan North Local Government Area, Nigeria.

Variable	Perceived stigma						
	Low n (%)	Moderate n (%)	High n (%)	Total n (%)	X^2	Df	P value
Age							
10-14	20(9.8)	148(72.2)	37(18.0)	205(100.0)	11.828	4	0.190
15-17	30(8.1)	252(68.1)	88(23.8)	370(100.0)			
18-19	1(1.7)	51(87.9)	6(10.3)	58(100.0)			
Ethnicity							
Hausa	0(0.0)	20(83.3)	4(16.7)	24(100.0)	10.513	6	0.105
Igbo	4(4.1)	79(81.4)	14(14.4)	97(100.0)			
Yoruba	47(9.2)	351(68.8)	112(22.0)	510(100.0)			
Other	0(0.0)	1(50.0)	1(50.0)	2(100.0)			
Social class							
Low	33(12.7)	169(65.3)	57(22.0)	259(100.0)	21.299	4	0.001
Middle	13(8.1)	111(68.9)	37(23.0)	161(100.0)			
High	5(2.3)	171(80.3)	37(17.4)	213(100.0)			
Religion							
Christian	22(5.6)	302(76.8)	69(17.6)	393(100.0)	22.497	6	0.001
Muslim	26(11.4)	143(62.4)	60(26.2)	229(100.0)			
Traditional	3(30.0)	5(50.0)	2(20.0)	10(100.0)			
Other	0(0.0)	1(100.0)	0(0.0)	1(100.0)			

4.5 Factors predicting the perception of the respondents using the regression model

Table 10 shows the predictor of the SRH stigma among sociodemographic characteristics. The social class, ethnicity of the respondents and religion were statistically significant at $p<0.05$.

Table 10: The factors predicting the perception of the respondents about sexual and reproductive health stigma

Predictors	B	S.E	Standard coefficient	95% CI		P value
Age	0.029	0.024	0.048	-0.190	0.077	0.231
Ethnicity	-0.086	0.029	-0.118	-0.142	-0.030	0.003
Social class	-0.021	0.007	-0.120	-0.035	-0.007	0.003
Religion	0.068	0.028	0.096	0.013	0.124	0.016

Discussion

Adolescents who are said to be vulnerable individuals are exposed to different health issues and they should not only be cared for but also catered for while preparing them for adulthood. From the study, it was deduced that stigma associated with sexual and reproductive health issues may lead to adverse effects like violence which are being beaten by the parents, mental morbidity, internalization of negative beliefs, hopelessness and isolation, feelings of shame, lack of understanding by family, friends and social interaction are mostly experienced by adolescents who are stigmatized. These findings were similar to the claim of the Mayo Clinic (2017) that adolescents who are stigmatized experience such adverse effects which include getting

beaten by parents, mocked by their peer group and their environment (religious leaders and other relevant stakeholders in the community) shame them as well.

The findings from this study show that there is bad perception among in-school adolescent girls about sexual and reproductive health issues and this is consistent with the study done by Hall, et al., (2018). This study also shows that adolescents in the older age group have the least value for high perceived stigma. This finding is supported by the claim that they are able to make decisions on their own at this age (Vicki, M. et al., 2019), and are already resistant to any form of discrimination because they picture themselves as an adult and make decisions about whether to engage in sexual activity or not.

The majority of the respondents agreed to the question that getting pregnant while in school would hinder their opportunity to attend school again and this is because they are seen as mothers already and they are easily shamed by people when there is dispute or disagreement among them. Most of the respondents in this study agreed that "Being pregnant and having a baby when I am still an adolescent will cause people to mock, humiliate, swear or gossip with me". This could lead to a high mortality rate of adolescent girls and necessary actions should be taken to avoid being stigmatized by this issue. However, the international development communities focused on efforts to lower adolescent pregnancy rates. It was essential to achieving the Millennium Development Goals (MDGs), which led WHO to promote capacity development, positive outcomes, and the reduction of adolescent pregnancy among LMICs. Additionally, it has played a crucial role in the establishment of the present sustainable development objectives and plans for global health (SDGs). Goal 3 in particular aims to ensure universal access to reproductive health care facilities. Despite these initiatives, the issue still exists, particularly in LMICs where access to healthcare, information, and educational opportunities is poor.

The study shows that social class, ethnicity of the respondents and religion were predicting factors that influenced the perception of the respondents as all of them were statically significant $p< 0.5$ except for the age group which was not significant. These findings are similar to Hall et al. (2018) study carried out in Ghana which reported that age, city, religious affiliation, educational attainment, relationship status, self-rated health, histories of sexual intercourse, receipt of family planning services, modern contraceptive use, pregnancy, and number of sexual partners were all statistically significant. SRH stigma scores were higher among the girls of younger age, high social class, Yoruba ethnic group and Christians compared to their counterparts. But the religion is in contrast with the work of Hall et al., (2018) that reported Muslim religious affiliation had a higher score of stigma. Regression analysis was carried out to be sure of the real predictors and social class, ethnicity and religion all came out to be statistically significant. According to Fisher, J.W. (2013), in his study he said, even though religious practices vary according to culture, political boundary, local community, and individual, religion plays an important role in the lives of many people all over the world, and in some cases is central to their lives. This is strong enough to be a predicting factor on the perceived stigma about sexual and reproductive health issues. Also, different scriptures preach against premarital sex, which shows religion plays a major role in their decision-making.

Conclusion

1. This study has shown that there is bad perception of sexual and reproductive health issues among the in-school adolescent girls in Ibadan North LGA.
2. Adolescents between the age group 10-17 years of age had more perceived stigma compared to the age group 18-19 who might have built the bridge between personal choices and environmental norms.
3. Peer group/pressure also had a great impact on the decision-making regarding sexual and reproductive health issues because they feel more safe to disclose to friends than family members.
4. The predicting factors for high perceived stigma among in-school adolescent girls were ethnicity, social class and religion. All of these contribute to the lifestyle of in-school adolescent girls whether positively or negatively in making decisions.

Recommendations

Based on the findings from this study, the following recommendations are made:

1. Communication should be paramount in the family to avoid bad advice from friends.
2. Family and friends should embrace the adolescents if they are experiencing any form of sexual and reproductive health issues instead of castigating them.
3. For girls who are pregnant or who are already mothers, certain tactics and interventions are required to prevent from them being stigmatised.
4. Relevant stakeholders should encourage adolescents free from being stigmatized as they are undergoing a transition period and the environment should not be harsh on them.
5. Future research should include in-school adolescent boys as well as out-of-school adolescents.

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