Sexual Exposure and Knowledge of Safe Reproductive Health Practices among Female Adolescents in Enugu East Local Government Area of Enugu State, Nigeria

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Abstract

This field study examined the subject of sexual exposure and knowledge of safe reproductive health practices among female adolescents in Enugu East local government area of Enugu State, Nigeria. Anchored on the sexuality-gender framework which is complemented by the empowerment Model, the study surveyed 500 respondents through the use of multi-stage sampling technique. The instruments used for data collection comprised of structured questionnaire, in-depth interview guide, and the Focus Group Discussions guide. Six research questions raised for the research formed the basis for data analysis. The findings, among other things, show that exposure to sexual encounter which many respondents considered as a vehicle for expression of love to their partner, was relatively high (58%) among female adolescents in Enugu East Local Government Area. Similarly, although respondents' knowledge of safe reproductive measures was reasonable, unwanted pregnancy, contracting and spreading of STDs as well as emotional and psychological damages remained consequences of early sexual exposures. This is particularly so because many female adolescents in the area failed to put their knowledge into practice and instead adopted unsafe sexual behaviours. Finally life education and promotion of the knowledge and benefits of contraceptives use among adolescents through the media, amongst others were canvassed as solutions to enhance a more positive sexual behaviour of female adolescents in Enugu East Local Government Area towards their reproductive health.

Keywords: *adolescents, sexual exposure, sexual debut, sexual behavior, reproductive health,*

Introduction

In the International Conference on Population and Development (ICPD, 1994) framework, reproductive health care is divided into three major components (Plotts, Walsh, McAnich, Nobuko, and Wade, 1999:510); "Family planning, prevention of sexually transmitted diseases (STDs), including Human Immunodeficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS), and basic reproductive health service (other services needed to reduce maternal mortality e.g. safe motherhood programmes, abortion related services, reproductive health education and communication, STD diagnosis and treatment; infertility prevention and treatment)". The ICPD programme of action endorses reproductive health care as a universal right, further recommending

"that comprehensive and factual information and a full range of reproductive health care services should be accessible, affordable and convenient to all users" (ICPD, 1994).

Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services (Oyekanmi, 1999).

It is worthy to note that initiation of reproductive capability generally occurs in the second decade of life known as "adolescence" (which is the period of transition from childhood to adulthood). Although the change is biological, the duration and nature of adolescence are primarily a social construct and thus vary greatly from culture to culture. In a number of societies, menarche is taken as a sign of maturity and the readiness to marry or commence sexual activity (Riley, Samuelson and Huffman, 1993), although in a few, marriage precedes menarche. Traditionally in African societies, marriage is the event used to mark the initiation of sexual activity and therefore the beginning of exposure to reproduction (United Nations, 1988b; 1989).

The social setting in Africa is playing a vital role in seeing that women do not exercise their reproductive rights as should be done. Women in most Nigerian societies are expected to marry or start a union at a younger age. Parental pressure on young girls to do so borders on coercion. In some parts of Nigeria, daughters are withdrawn from primary school to marriage (Oyekanmi, 1999), just to ensure chastity and virginity of the girl child at marriage (Usman, 1999) as well as to promote the desired long-lasting relationship between the two families (Adedokun, 1999).

Given the prevailing circumstances in Nigeria, pregnancy and childbirth are decision areas the adolescents (in marriage or yet to be married) have little or no control even though there is growing awareness that early childbearing poses a health risk for the mother and the child, and may truncate a girl's educational career, threatening her economic prospects, earning capacity and over-all well-

being. Child bearing during adolescence has emerged as an issue of increasing concern throughout the developing and the developed world. It is estimated that worldwide about 15 million women aged 15-19 give birth each year and that about 11 percent of all babies are currently born to adolescents (United Nations, 1998). In terms of environmental influence on adolescents' sexual behaviour, studies have shown that pre-marital sexual activity is particularly high among urban than rural based youth (Gyeipi-Garbrah, 1985; Makinwa-Adebosuye, 1991), while sexual relations begin at an earlier age in rural areas (United Nation, 1998).

Regardless of where adolescents live in Nigeria, either in rural or urban area, their family's social status and economic resources available to then may determine whether the child hawks on the street, is given out in marriage in her teen, is in school or not and which school (Obasi and Umoh, 2000). Among the 467 itinerant female hawkers interviewed in Ibadan by Orunbaloye and Caldwell (1994), with an average age of 20 years, only 5% had never had sexual relations. 15 percent reportedly lost their virginity through rape, while a substantial number began sexual activity before age ten or slightly older. At the time of the survey, 38 percent of the sexually active hawkers reported only one sexual partner, 26 percent had two partners, 33 percent had three or more partners. Despite their young age, the authors note, 29 percent had already had six or more sexual partners and 8 percent had ten or more. Generally, since the competition among them is tremendous, and the earnings almost devisory while they may receive very little support from their family, these hawkers are therefore dependent on selling goods and sex.

Sexual experiences of adolescents come usually as a result of deception, force, abuses and enticements, and apparently with an older man otherwise branded "sugar daddy". Among adolescents in school, Owuamanam (1994:61) found that "persuasion, celebration, love and proximity" accounted for 6.4%, 9.6%, 48.2% and 30.8% respectively of circumstances surrounding first sexual encounter. Furthermore, it has been shown that a large percentage of girls typically feel it is antisocial to refuse a boy friend sex. This predisposes many to early forms of prostitution (Obasi and Umoh, 2000).

Evidently, the much-vaunted promotion of family planning services and sexuality education has not been accorded an extensive impetus by government. Maternal and child health have remained particularly deplorable especially in the rural and sub-urban areas where childhood and maternal morbidity and mortality rates have been kept high by poor hygiene, under nutrition, paucity and or inaccessibility of health facilities as well as the proliferation of quacks and injurious alternative (Ukwu, 1995; Omeje, 1998).

In spite of improved levels of literacy and systems of communication in the country, a number of traditional myths, practices and taboos pertaining to human sexuality, fertility and reproduction are still adhered to in rural and urban areas, by both men and women, and even by some of the educated segments of the population. For example, in many societies of developing countries, men consider family planning to be a woman's concern (Sujatha and Murthy, 1993; Danforth and Jezowki, 1994; Greene and Biddlecom, 1997). Moreso, since adolescents are usually outside the existing channels for sexual, contraceptive and health information, reproductive health are not designed to respond to their needs (Bongaarts and Bruce, 1995).

It is against this background that this study is aimed at investigating the sexual exposure and knowledge of safe reproductive health practices among female adolescents in Enugu East local government area of Enugu state, Nigeria

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Statement of the Problem

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. As observed by Usman (1999):

> The more severe the effect of a practice, the more likely that the victim will either be a woman or a child, particularly a female child; ...these harmful traditional practices include female genital mutilation (FGM); forced feeding of women; early marriage, various taboos or practices which prevent women from controlling their own fertility; traditional birth practices; son preference and its implication for the status of the girl child; female infanticide, early pregnancy; and dowry prices. Despite their harmful nature and their violation of international human rights law, such practices persist because they are not questioned.

Young people's sexual risk behaviours are influenced by both cultural and economic factors. As noted by Okeibunor (2000), it has been suggested that culturally determined gender relations have far-reaching implications for the sexual practices of members of the cultural milieu. The study carried out by Mariasy and Radlett (1990) show lower status for women in relation to their male counterparts in most societies. Bassett and Sherman (1994) observed that:

> Stereotyped sexual norms and peer pressure encourage young males to prove their manhood and enhance their social status by having sex. At the same time, young women are socialized to be submissive and not to discuss sex, which leaves them unable to refuse sex or insist on condom use.

Usman (1999) and Sai (1995) recorded that adolescent girls in many parts of Nigeria are married out legally before they are 16 years old, and are expected to get pregnant and give birth to children. According to Arkutu (1995), this reflects both structural and ideological forces, power and resource imbalances, which are played out in ways that impinge deeply on girl's and women's ability to determine their own sexual and reproductive life.

The dangers associated with adolescent child birth are graphically captured by McCauley and Salter (1995), who observed that young adolescents, especially those younger than 15, experience distressing or even tragic pregnancy outcomes more often than adult women. Younger adolescents, they note, are more likely to experience premature labour, spontaneous abortion, and still births. Besides, they are up to four times as likely as women older than 20 to die from pregnancy related causes. Furthermore, Buvinic and Kurz (1997) observed that, pregnancy related illness such as hypertension and anaemia are more common among adolescents than among adult women. The pathetic cases of Vesico-Vaginal Fistula (VVF), which is rampant in Northern Nigeria attests to the preponderance of early child bearing (Shehu, 1992; Hellandu, 1992). There is also the other dimension of adolescents' high risks sexual behaviour as regards their social and economic conditions. Early childbirth poses health risks for the mother and child, as well as leads to stoppage of education, which in turn generates a chain of socio-economic problems including unemployment, hunger, poverty, disease and powerlessness.

Despite increased knowledge of contraception and improved access to services in Africa, young people remain poor contraceptive users. In Nigeria and in some countries in other developing regions, substantial proportions of the population still do not know that any type of contraception exists. Data from the Nigerian Demographic and Health Survey (NDHS, 1990) shows that only 5.6% of married adolescents in the 15-19 age bracket were currently using contraceptives (Federal Office of Statistics, 1995). The low practice of contraception among adolescents in Nigeria may not be unconnected with the numerous obstacles they face when seeking a method. Following their survey in Zimbabwe, Kim, Kols, and Nyakuru et al 92001) observed that young people's access to reproductive health information, commodities and services is controlled by adults, including parents, service providers and political leaders. Thus, problems of limited knowledge of and access to family planning are a reflection of the difficulties many governments have themselves experienced in extending services nationwide rather than the result of a deliberate policy to restrict access (United Nations, 1998).

Partly as a result of the unmet need for contraception, in 1990 an estimated 25 million legal abortions were performed worldwide, or one legal abortion for every six births. The World Health Organization (WHO, 1994) estimated that some 20 million unsafe abortions are performed each year. Global estimates of the number of young women that experience pregnancy and seek an abortion range from between 1 million and 4.4 million in developing countries (International Planned Parenthood Federation, 1994). The majority of the abortions is illegal and occurs in unsafe conditions. Many of these result in death, severe morbidity and infertility.

Until recently, the prevention and control of sexually transmitted diseases was a low priority for most countries and development agencies. The transmission of knowledge about sex and reproductive matters among Nigerian youths is unfortunately not accorded serious priority in our communities not even by parents (Umoh, 1998). Yet, most young people in developing countries, including Nigeria, still engage in unprotected sex. (Campbell, and Mbizvo 1994).

According to WHO (1995), about 13 million adolescents, the parents of next generation are infected at present by STDs. Another interesting dimension is the fact that female adolescents as

observed by Owuamanam (1994), are less inclined to disclose their infection to people because of the social stigma associated with STD, and the tendency to view a girls contracting of STD as evidence of moral laxity. On source of treatment, it was shown that, self-medication, and traditional healers were highly patronized. The untreated cases of STDs, as it were, can lead to infertility, which is yet another devastating blow to the lives of these individuals in a society where childbearing gives a measure of acceptance for the married (Obasi and Umoh, 2000).

The prevailing consequences of the sexual activities and adventures by adolescents include unintended pregnancy, increased number of deaths from unsafe abortions, and the increasing incidence of sexually transmitted diseases. In Nigerian communities, as in other communities around the world, gender roles and social norms – along with a host of economic and legal factors – contribute to risky sexual behaviour of adolescents (Bassett, et. al, 1999).

Based on this scenario, the specific focus of this study stands out. The study will investigate sexual exposure and knowledge of safe reproductive health practices among female adolescents in Enugu East local government area of Enugu State, Nigeria. Accordingly,
Socio-cultural issues influencing reproductive health behaviour of female adolescents in area will also be exposed.

Research Questions

The following research questions are put forward to guide the study;

1. To what extent are female adolescents in Enugu East Local Government Area of Enugu State exposed to sexual experiences/pre-marital sex?

2. In what ways do female adolescents in Enugu East Local Government Area of Enugu State perceive sexual exposure and involvement in premarital sex?

3. What is the level of awareness and knowledge of safe reproductive health information by female adolescents in Enugu East Local Government Area?

4. What is the scale of contraceptive use amongst female adolescents in Enugu East Local Government Area?

5. What are the factors militating against safe reproductive health behaviour and contraceptive use by female adolescents in Enugu East Local Government Area?

6. What are the consequences of the reproductive health behaviour of female adolescents in Enugu East Local Government Area?

Theoretical Framework

The sexuality-gender framework by Dixon-Mueller (1996) and the empowerment Model by Doan (1994) will provide the theoretical framework for this study. In the sexuality-gender framework, Dixon-Mueller (1996) reviewed the four dimensions of sexuality gender connotations and the ways they impact on reproductive health behaviours of men and women.

The issue of asymmetry, that is double standards and inequities in the rights and responsibilities for men and women in sexuality has important implication for reproductive health behaviour of women in general and indeed Enugu East L.G.A female adolescents, who are socialized into the traditional practices of ensuring the happiness of their male partners. In such situation, where the objective of sexuality for men is enjoyment and pleasure but for women, it is a duty they owe their husbands / partners, adoption of safe reproductive health behaviour could be greatly undermined.

Studies have identified that economic independence is an essential ingredient for the attainment of women's empowerment. A woman's power to make[1] decisions sometimes increases with her level of education. It may also depend on her age. Generally, younger women who marry or have partners of much older men have less power than women who marry or have partners of someone closer in age (Balk, 1997; De Silva, 1994; and Gage, 1995). These issues will be examined in this study.

Study Hypotheses

The following hypotheses are stated to guide the investigation of the issues identified for the present study:

1. There is a significant relationship between the age of adolescents and their engagement in sexual intercourse in Enugu East Local Government Area.
2. There is a significant relationship between the level of education of adolescents and use of contraceptives in Enugu East Local Government Area.

Materials and Methods

The area of study is Enugu East Local Government Area which is one of the seventeen (17) local government areas in Enugu State. It was created in October, 1996. The Local Government consists of twenty-three (23) communities, which are largely rural and culturally homogeneous.

The predominant occupation of the people is subsistent farming with crude implements, and labour is largely family based, as well as trading. Following the urbanization of some areas, some of the residents especially the urban residents are engaged in civil service and teaching. There are presently three health centers, about twenty (20) secondary schools, and two higher institutions of learning in the local government.

The study population is limited to female adolescents aged 12-25 years, which constitutes 18 percent of the entire population (NPC, 2006). Thus, the target population for the study is 50,236. The sample size for this study is five hundred (500) respondents which is considered large enough applicable statistical computations. A breakdown of the sample size is as follows: four hundred and fifty respondents were administered with questionnaires; forty respondents were used in the Focus Group Discussion (FGD); while ten respondents were interviewed in depth

The multi-stage sampling technique was adopted for this study. First, Enugu East L.G.A was stratified into rural and urban communities. Then using the simple random sampling technique, two (2) rural communities namely (Amorji Nike and Ugwugo Nike) and two urban communities (Iji Nike and Emene) communities were selected. All the post primary schools in the selected communities were identified and numbered. Again, using the simple random sampling technique ten schools (eight in the urban and two in the rural communities) were selected. In each of the selected schools, a random sample of forty-five adolescents aged 12-25years were selected, thereby making a total of four hundred and fifty (450) respondents selected for the administration of the questionnaire.

The major instrument chosen for the purpose of collecting data in this study is the questionnaire because of the need for measurable data, which will bring about easy quantification. In addition, qualitative data were gathered through the use of focus group discussions (FGDs) and in-depth interviews. These were considered necessary to give some contextual meaning to the quantitative findings in the study, as well as provide some vital information, which the questionnaire will be weak in eliciting.

For the qualitative data, a total of four FGDs sessions were conducted with ten participants in each session (two FGD sessions each for rural and urban dwellers respectively). The discussions were held with female adolescents, who were segregated into two homogeneous groups 12-17 and 18-25. Participants in the FGDs were selected from persons within the age group who were not administered with the questionnaire. On the other hand, ten respondents, of selected parents, teachers and health care service workers of these adolescents, were interviewed in-depth. These instruments were administered on the respondents during lesson breaks when the respondents were available and willing to attend to the researcher as well as fill the questionnaire schedule.

The questionnaire data was computer processed and analyzed using SPSS software programme. Simple statistics as well as graphic illustrations were used to describe the main characteristics of the study participants. The chi-square (x^2) was used to test the hypotheses while Pearson's product co-efficient was used to establish the relationship between the socio-cultural variables and the respondents' reproductive health behaviour. The qualitative data from the FGD and in-depth interview were analyzed is using the descriptive method of qualitative data.

Data Presentation and Analysis

The researcher distributed 450 questionnaires and collected 433 (96.22%) of them. Consequently this analysis was based on 433 correctly filled and returned questionnaires. The analysis is done in sections as follows:

Personal Data of Respondents: Personal data of respondents are presented in Table 1

Table 1: Personal Data of Respondents

Distribution of respondents by	**Variables**	**Frequency**	**Percent**
place of Residence	Ugwugo Nike	41	9.5

	Iji Nike	179	41.3
	Emene	174	40.2
	Amorji Nike	39	9.0
	Total	**433**	**100.0**
Distribution of respondents by Age	12-15	67	15.5
	16-19	156	36.0
	20-23	170	39.3
	24 and above	40	9.2
	Total	**433**	**100.0**
Distribution of respondents by	FSLC	201	46.4
Level of Educational attainment	JSSC	164	37.9
	SSCE/TCII	48	11.1
	OND/Degree	20	4.6
	Total	**433**	**100.0**
Distribution of respondents by	Singles	388	89.6
Marital Status	Married	45	10.4
	Total	**433**	**100.0**
Distribution of respondents by	Self	58	13.4
person who pays your bills	Parents	309	71.4
	Boy Friend/Fiancé	42	9.7
	Guardians	13	3.0
	My husband	8	1.8
	Brother	3	.7
	Total	**433**	**100.0**

Table 2 Ctd

Distribution of respondents by	**Variables**	**Frequency**	**Percent**
parent's occupation	Farming	34	7.9
	Trading	167	38.6
	Civil Service	216	49.9
	Banker	10	2.3
	Contractor	3	.7
	Artisan	3	.7
	Total	**433**	**100.0**
Distribution of respondents by	N5,000-N1 5,000	88	20.3
Parent's Monthly Income	N16,000-N25,000	68	15.7

	N26,000-N35,000	144	33.3
	N36,000-N79,000	14	3.2
	N80,000-N100,000	44	10.2
	N 120,000 and above	22	5.1
	I don't know	53	12.2
	Total	**433**	**100.0**
Distribution of respondents by	Christianity	407	94.0
Religious Affiliation	Islam	19	4.4
	African Traditional Religion	7	1.6
	Total	**433**	**100.0**

Table 1 shows that most of the respondents are from urban areas (Iji Nike and Emene), while the rest of the respondents are from rural areas. Age distribution of respondents shows that 170 (39.3%) of the respondents are between the ages of 20-23 years, while just 40 (9.2%) of them are 24 years and above. The mean age of respondents is 16.46years. Enugu East Local Government Area is predominantly populated by Christians hence they constitute 94% of study participants

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Analysis of Research Questions

Research Question 1: "To what extent are female adolescents in Enugu East Local Government Area of Enugu State exposed to sexual experiences/pre-marital sex?

The findings are shown in tables 2, 3, 4 and 5.

Table 2: Have you ever had any sexual experience?

Responses	Frequency	Percent
Yes	251	58.0
No	182	42.0
Total	**433**	**100.0**

Table 2 shows that 251 (58.0%) of the respondents agreed they have had sexual involvement at least once, while 182 (42.0%) of them said they have no sexual experience. Respondents were further asked if their parents have any idea of their sexual involvement status. The responses are shown in table 3.

Table 3: Do your parents know about your sexual experience?

Responses	Frequency	Percent
Yes	98	22.6
No	335	77.4
Total	**433**	**100.0**

In table 3, 98 (22.6%) of the respondents said that their parents know their sexual experience status while 335 (77.4%) of them said their parents have no such knowledge.

In the words of one participant in the FGD in the rural area, *"it is a taboo for parents to discuss matters pertaining to sex with their children; parents believe that to discuss such matters will make them become wayward"*. Respondents who maintained their parents' knowledge of their sexual experience were asked what their parents' reactions were. These are shown in table 4.

Table 4: Responses on parents' reactions to adolescents' sexual experience.

Responses	Frequency	Percent
Supportive	42	9.7
I don't care	23	5.3
In opposition	29	6.7
Others (Advice on how to avoid problems of premarital sex)	4	9
Total	98	22.6
Not Applicable	335	77.4
Total	**433**	**100.0**

It could be seen from table 4 that 42 (9.7%) of the respondents' parents are in support of their adolescents sexual experience status, while just 4 (0.9%) of them give advice on how to avoid problems of premarital sex. Respondents whose parents are in support were further asked of the reasons. These are shown in table 5.

Table 5: Frequency of reasons of supportive parents'

Responses	Frequency	Percent
Culture	5	1.2
Financial gain	16	3.7

Security	11	2.5
Because I'm married	10	2.3
Total	42	9.7
Not Applicable	391	90.3
Total	**433**	**100.0**

Table 5 shows that 16 (3.7%) of respondents' parents support their sexual involvement because of the financial gain they get from the experience, while 5(1.2%) of them do so on account of culture (maintenance of chastity before marriage).

Research Question 2: "In what ways do female adolescents in Enugu East Local Government Area of Enugu State perceive sexual exposure and premarital sex?" The findings are shown in tables 6, 7 and 8.

Table 6: Perception on Right age to indulge in sexual intercourse

Responses	**Frequency**	**Percent**
Anytime	24	5.5
Before 1 7 years	23	5.3
Between 17 and 20 years	206	47.6
21 and above	87	20.1
When married	87	20.1
No idea	6	1.4
Total	433	100.0

Table 6 shows that 206 (47.6%) of the respondents believe that the right age to indulge in sexual intercourse is between the ages of 17 and 20 years, while 6 (1.4%) of them had no idea on when it is right to have sex. It was gathered from the in-depth interview however, that there is no exact age at which female adolescents indulge in sexual intercourse. This is because of the fact that adolescents are predisposed to different social settings, which invariably have differing effects on them. The focus group discussions show that female adolescents indulge in sexual intercourse not necessarily as a matter of choice but because of the particular events in the.ir life setting. This

implies that most female adolescent indulge in sexual intercourse because of their social milieu and also on attainment of the age of maturity i.e. between 17-20 years.

Table 7: Perception of adolescents' exposure to early sexual intercourse

Responses	Frequency	Percent
It is good and should be encouraged	45	10.4
It is not morally right	295	68.1
It is a mark of maturity	93	21.5
Total	433	100.0

Table 7 shows that 295 (68.1%) of the respondents see adolescents' engagement in early sexual intercourse as an act that is not morally right, while 45 (10.4%) of them j see it as good and should be encouraged. Data from the qualitative instruments show that the society frowns at adolescents' engagement in early sexual intercourse. This could mean that the society does not approve of adolescents involvement in early sexual intercourse. The study further sought to understand why many adolescents engage in pre marital sexual activities and the findings are shown as in table 8.

Table 8: Reasons why adolescents engage in pre-marital sexual activities

Responses	Frequency	Percent
To enable them know their sexual strength or weakness	53	12.2
To express love for the partner	180	41.6
To meet up with financial obligations	90	20.8
It is anti-social not to do so	53	12.2
To satisfy themselves	10	2.3
Lack of sex education and parental care	7	1.6
Impatience and irresponsibility	16	3.7
Ignorance and peer pressure	12	2.8
To understand each other	12	2.8
Total	**433**	**100.0**

It is indicated in table 8 that 180 (41.6%) of the respondents said that female adolescents engage in pre-marital sexual intercourse in order to express their love for their partners, 7 (1.6%) of them engage in pre-marital sex because they lack sex education and parental care. One of the key

informants during in-depth interview said *"Most adolescents from poor parental background engage in pre-marital sex because of hardship and financial difficulty"*. Majority of the participants of the FGD expressed that *"We get some things like money, clothes even outing to fast food joints from our partners"*. It therefore follows that though some adolescents engage in pre-marital sex to express their love for their partners, majority of them do so because of the pecuniary gains they derive from it.

Research Question 3: "What is the level of knowledge on safe reproductive health practices among female adolescents in Enugu East L.G.A?" The findings are shown in tables 9, 10, 11, 12 and 13.

Table 9: Do you know ways of preventing unwanted pregnancy?

Responses	Frequency	Percent
Yes	400	92.4
No	33	7.6
Total	**433**	**100.0**

Table 9 shows that 400 (92.4%) of the female adolescents agreed they have knowledge of ways of preventing unwanted pregnancy while just 33 (7.6%) of them said they have no such knowledge. Respondents who maintained that they have knowledge of measures of preventing unwanted pregnancy highlighted some of the ways they know. These are shown in table 10.

Table 10: Responses on Ways of preventing unwanted pregnancy they know

Responses	Frequency	Percent
Condom	159	36.8
Contraceptive pills, injectibles etc	105	24.2
Withdrawal	82	18.9
Abstinence	54	12.5
(Not Applicable)	33	7.6
Total	**433**	**100.0**

In Table 10, 159 (36.8%) of respondents who agreed to have knowledge of ways of preventing unwanted pregnancy said that condom is a sure means of preventing unwanted pregnancy, while 54 (12.5%) subscribe to abstinence. Respondents were further probed on the other dangers associated with casual sex. Their responses are prevented in table 11.

Table 11: Responses about dangers associated with casual sex.

Responses	Frequency	Percent
Gonorrhoea	84	19.4
Staphylococcus	60	13.9
Candidiasis	62	14.3
HIV/AIDS	139	32.1
All of them	52	12.0
Death resulting from abortion	21	4.8
Missing (Not Applicable)	15	3.5
Total	**433**	**100.0**

Table 11 shows that 139 (32.1%) of the respondents identified HIV/AIDS as one of the problems associated with casual sex, while 21 (4.8%) said that the danger of casual sex is death resulting from abortion. Respondents were asked to state also the dangers of untreated STDs. Details of these are shown in table 12.

Table 12: Dangers of untreated STDs

Responses	Frequency	Percent
Infertility	89	20.5
Death	128	29.6
Increased spread of STDs/HIV	149	34.4
No Idea	67	15.5
Total	**433**	**100.0**

Table 12 shows that 149 (34.4%) of the respondents agreed that untreated STDs can lead to increased spread of STDs / HIV, while 67 (15.5%) of the respondents have no idea. Respondents were further probed on ways of preventing the dangers of untreated STDs and their responses were presented in table 13.

Table 13: Ways of preventing the dangers of untreated STDs

Responses	Frequency	Percent
Use of condom	128	29.6
Abstinences	118	27.2
Use of traditional herbs /charms	162	37.4
Others	25	5.8
Total	**433**	**100.0**

It could be seen from table 10 that 162 (37.4%) of the respondents subscribe to use of traditional herbs and charms in preventing the dangers of untreated STDs in Enugu East L.G.A while only 25 (5.8%) take to other ways rather than condom usage, abstinence and use of traditional herbs / charms. Two-third of the focus group discussion participants shouted, *"No! What we know about sex and contraceptives are things our friends told us. We can* Y *ask anybody even our parents".* Consequently, it can be concluded that the level of awareness and knowledge of safe reproductive health information is above average in Enugu East Local Govt. Area.

Research Question 4: What is the scale of contraceptive use amongst female adolescents in Enugu East L.G.A of Enugu State? Findings are shown in tables 14-16

Table 14: Do you know if female adolescents use contraceptives?

Responses	Frequency	Percent
Yes	348	80.4
No	85	19.6
Total	**433**	**100.0**

Table 14 shows that 348 (80.4%) of the respondents believe that female adolescents use contraceptives while 85 (19.6%) of them do not think so. Respondents who believed that female adolescents use contraceptives were asked to identify the type of contraceptive adolescents prefer to use. This is shown in table 15.

Table 15: Percentage responses on adolescents' choice of contraceptives

Responses	Frequency	Percent
Condom	191	44.1
Pills and Injectables	112	25.9
Abstinence	30	6.9
Withdrawal	15	3.5
Total	348	80.4
Others	85	19.6
Total	**433**	**100.0**

In table 15, 191 (44.1%) of the respondents identified condom to be adolescents' preferable choice of contraceptives while just 15 (3.5%) of them said it is the withdrawal method. All respondents were further asked if they personally make use of contraceptives. The responses are shown in table 16.

Table 16: Do you make use of contraceptives?

Responses	Frequency	Percent
Yes	176	40.6
No	257	59.4
Total	**433**	**100.0**

Table 16 shows that 257 (59.4%) of the respondents do not make use of contraceptives while 176 (40.6%) of them agreed they do. Respondents who agreed to the personal use of contraceptives were further asked their choice of contraceptives. This is shown in table 17.

Table 17: Responses on respondents' personal choice/usage of contraceptives

Responses	Frequency	Percent
Condom	136	31.4
Pills and Injectibles	29	6.7
Use of traditional herbs / charms	11	2.5
Others	-	-
Total	176	40.6

Not Applicable	257	59.4
Total	**433**	**100.0**

It could be seen from table 16 that 136 (31.4%) of the respondent prefer the usage of condom in Enugu East L.G.A, while only 11 (2.5%) of them would use traditional herbs and charms for contraceptives. Information gathered from the focus group discussions showed that the choice of condom is due to the fact that it is easily accessible and obtainable from shops around their neighbourhood. According to one of the participants in the FGD in the urban area *"condoms are available in almost every patent medicine shop in my neighbourhood and they are very cheap"*. Consequently, it can be said that adolescents prefer the use of contraceptives that would not let adults know that they are sexually active

Research Questions 5: "What are the factors militating against safe reproductive health behaviours and contraceptive use by female adolescents in Enugu East L.G.A of Enugu State?" The findings are shown in table 17.

Table 17: Adolescents' reasons for non-use of contraceptives

Response	Frequency	Percent
It is not necessary	60	13.9
It is expensive	43	9.9
My partner doesn't approve of it	56	12.9
I don't know where to get them	35	8.1
No idea	25	5.8
I don't engage in sexual act	38	8.8
Total	257	59.4
Not applicable	176	40.6
Total	**433**	**100.0**

It could be seen from table 17 that 60 (13.9%) of respondent who don't use contraceptives do so because they feel it is not necessary, while only 25 (5.8%) of them have no idea of what

contraceptives are. According to the health care workers interviewed, *"we are hesitant in rendering any contraceptive information and services to adolescent especially those that are unmarried. Such knowledge makes them wild and beyond control".*

Research Question 6: "What are the consequences of the reproductive health behaviour of female adolescents in Enugu East L.G.A of Enugu State?" The findings are shown in tables 18-.

Table 18: Have you ever been pregnant?

Responses	Frequency	Percent
Yes	55	12.7
No	378	87.3
Total	**433**	**100.0**

In table 18, 55 (12.7%) of the respondents agreed that they have ever been pregnant, while 378 (87.3%) of them said they have never been. Respondents who agreed to have ever been pregnant were further asked what they did with the pregnancy. The responses are shown in table 19.

Table 19: Have you ever tried to terminate pregnancy?

Responses	Frequency	Percent
Yes	16	3.7
No	39	9.0
Total	55	12.7
Not applicable	378	87.3
Total	**433**	**100.0**

Table 19 reveals that 39 (9.0%) of respondents who were ever pregnant sought for its termination before its full term, while only 16 (3.7%) of them kept the pregnancy till its full maturation. This reveals that adolescents would not want to be seen with pregnancy and therefore will always resort to abortion whenever pregnancy occurs. Furthermore, respondents who agreed to have had an abortion were asked which method they used and their responses are presented in table 20.

Table 20: Percentage responses on the method of abortion.

Responses	Frequency	Percent
Self-inducement	16	3.7
In a chemist store	16	3.7
By a qualified medical practitioner	7	1.6
Total	39	9.0
Not applicable	394	91.0
Total	**433**	**100.0**

It could be seen that 16 of the respondents (3.7%) would seek for abortion in a chemist store or have it induced on their own, while just 7 (1.6%) of them opined that they had their pregnancies aborted by a medical practitioner. The health care workers interviewed stated that *"Abortion is not usually granted to adolescents except on health grounds because of its prohibition by the Nigerian law"*. Consequently, the researcher concluded that adolescents will always terminate pregnancy illegally and in an unsafe manner and place. More so, respondents were asked of ever contracted an STD. The responses are shown in table 23.

Table 21: Have you ever contracted an STD?

Responses	Frequency	Percent
Yes	91	21.0
No	342	79.0
Total	**433**	**100.0**

Table 21 shows that 342 (79.0%) of respondents said they have never contracted an STD, while only 91 (21.0%) of them agreed they have. Respondents were asked which STD and what method of treatment they used. The findings are shown in table 22.

Table 22: Responses on methods of treating STD.

Responses	Frequency	Percent

Staphylococcus: by injection	12	2.8
Itching; Drugs from Chemist store	48	11.0
Not known; treated in a hospital	16	3.7
Candidiasis: used tradition herbs	15	3.5
Total	91	21.0
Not Applicable	342	79.0
Total	**433**	**100.0**

It could be seen from table 22 that 48 (11.0%) of the respondents who contracted an STD had it treated in a chemist store, while 15 (3.5%) of them used traditional herbs and medicines. The FGD participants revealed, *"We girls do not usually tell people if we have an infection"*. One girl cautioned, *"I don't want to have a bad name and reputation"*. The rest of the girls chorally agreed this.

Test of Research Hypotheses

The two hypotheses postulated for this study were tested as follows:

Hypothesis 1: "There is a significant relationship between age of adolescent and their engagement in sexual intercourse in Enugu East Local Government Area".

Table 23: Relationship between age of adolescents and their engagement in sexual intercourse in Enugu East Local Government Area

Age of adolescents	Have you ever had sexual experience			X2(3,N=433) = 62.723 P<.000
	Yes	No	Total	
12-15	14	53	67	
16-19	87	69	156	
20-23	113	57	170	
24 and above	37	3	40	
Total	**251**	**182**	**433**	

The computed value of chi-square is 62.733 while the table value of chi-square at 0.05 level of significance with a degree of freedom (df) of 3 is 7.815. Since the computed chi square value is greater than the critical value, the researcher therefore accepted the alternative hypothesis. It follows therefore that there is a significant relationship between age of adolescents and their engagement in sexual intercourse in Enugu East Local Government Area.

Hypothesis 2: "There is a significant relationship between level of education of adolescents and use of contraceptives in Enugu East Local Government Area".

Table 24: Relationship between level of education of adolescents and use of contraceptives in Enugu East Local Government Area

Level of education	Do you know if female adolescents in your locality use contraceptives?		X2 (3, N=433) = 3.075 P<.380
	Yes	No	Total
FSLC	165	36	201
JSSC	128	36	164
SSCE/TCII	41	7	48
OND/Degree	14	6	20
Total	**348**	**85**	**433**

The computed value of chi-square is 3.075 while the table value of chi-square at 0.05 level of significance with a degree of freedom (df) of 3 is 7.815. Since the computed chi square value is less than the critical value, the researcher therefore rejected the alternative hypothesis. It implies that there is no significant relationship between level of education of adolescents and use of contraceptives in Enugu East Local Government Area.

Discussion of the Findings

This research work revealed a number of findings. First, it was found that most of the female adolescents of the L.G.A believe that the right age to have sex is between the ages of 17 and 20 years. This is because of particular events in their life setting, not necessarily as a matter of choice.

The study has shown that majority of the adolescents view early sexual intercourse as being morally wrong but paradoxically indulges in it probably because they see it as a way to express love to their partners in addition to financial rewards they derive from it.

Furthermore, the study found that condom is the most frequently used method of contraceptive. Young female adolescents are usually hesitant to use family planning services because if parents and friends learned of their contraceptive use, they would deduce their sexual activities. It therefore follows that culture of silence regarding adolescent sexuality contribute to non-use of family planning. These findings are synonymous with the third component of Ajzen and Madden (1986) theory of planned behaviour in which they observed anticipated obstacles such as barring health care providers from providing reproductive health services to individuals younger than 16 years old, except for married women.

More so, the study revealed that there is a wide communication gap between adolescents and their parents on the subject of sex. The low level of sex education in the family setting appears to result from the traditional norms and customs. Thus, adolescents are left to make decisions about their sexual activity and to cope with the emotional demands of sexual relationship. This finding agrees with Oyekanmi (2004) and Omoluabi (2004) who blamed socio-cultural and religious norms for seeing discussion of sex as a taboo. This approach has deepened suspicions, misunderstanding, confusion and uncertainty for adolescents and has invariably made them to lack the basic information on sexual and reproductive health matters.

Again, the study found that young people's sexual risk behaviours are influenced by both cultural and economic factors. As was observed, most of adolescents' sexual activities occurred when parents were away or when the students were studying. Female adolescents who live in poor households or have insufficient resources to meet their needs are at greater risk than their peers of having several sex partners and of engaging in casual sexual intercourse. This finding buttresses the findings of Orunbaloye and Caldwell (1994) in which they observed that the earnings and support from ones family determines whether the child is exposed to early sexual and reproductive behaviour and how long he/she will continue in the act. Orunbaloye and Caldwell (1994) further

argued that adolescent hawkers are dependent on selling goods and sex to survive because they receive very little support from their family.

It was observed also in this study that adolescent pregnancy is viewed as unintended and unwelcome. A teenager who is pregnant might seek for an abortion due to financial burdens of pregnancy (pre and post natal care), family disapproval, derision from her peers and community, and potential abandonment by the baby's father. Further to this, it was also found that the occurrence of an STD is usually hidden and not talked about. This increases the spread of sexually transmitted diseases as well as the resultant risk of infertility from untreated STD. It was also revealed that an unqualified' medical merchant mostly does the treatment of an STD in a patent medicine store. The negative aspect of this is that it leads to damage of a reproductive organ, which invariably can bring about infertility in a society where childbearing is accorded cultural meaning.

In the test of hypotheses, this study found significant relationship between age of adolescents and their engagement in sexual intercourse in Enugu East Local Government Area. It implies that engagement in sexual intercourse of adolescents has to do with a particular age bracket. It follows that most adolescents indulge in sexual intercourse on attainment of the age of maturity i.e. between 17-20 years.

This study also found no significant relationship between levels of education of adolescents and use of contraceptives in Enugu East Local Government Area. This shows that the non-use or use of contraceptives by adolescents has no bearing with their level of education. That is, anybody that has the intention and opportunity to use contraceptives can do so irrespective of his/her level of education.

Summary of the Findings

The findings of this study can be summarized as follows:

(i) Most female adolescents in Enugu East Local Government Area have engaged in sexual intercourse. The engagement of female adolescents in sexual intercourse was between ages 17-20 (age of maturity). This study also found that wrong notion of sex as expression of

love and financial benefits derived from sexual intercourse are the major reasons why adolescents go into it.

(ii) There is a wide communication gap between adolescents and their parents when it comes to sex and contraceptives. Although a few parents are supportive of their girl child exposure to sex on grounds of financial gains, many parents do not hold discussions on sex and contraceptives with their children due to their traditional norms and customs.

(iii) Many female adolescents have accurate knowledge on the subject of sex and contraceptives. However, such knowledge has not fully translated to safe sex and reproductive health practices. Consequently, some of the adolescents engage in behaviours that pose a lot of danger to their sexual health and future lives such as keeping more than one sexual partner. Some others ignore the use of contraceptives during sexual intercourse.

(iv) This study also found unwanted pregnancy, contracting and spreading of STDs as well as emotional and psychological damage to the adolescents' welfare as the adverse consequences of unsafe sexual behaviour of the female adolescents. It was found that to avoid social stigma, pregnant adolescents seek for abortion, which are usually self-induced. More so, female adolescents are less inclined to disclose their STD infection to people. Infected female, adolescents subscribe to self-medication and traditional herbs for treatment.

(v) Early sexual intercourse has relevance with age and level of education. It usually occurs when a girl has limited powers and control over what happens to her as well as to negotiate the "terms of trade" of a particular sexual relationship.

Conclusion

This study has shown that as adolescents enter the teenage years, their sexual attitudes and behaviours are significantly stimulated and shaped by socio-cultural norms giving rise to early sexual exposure. The paucity of sex education and limited access to health care and family planning to adolescents has done more harm than good. It has negatively affected the process creating positive sexual behavior and safe reproductive health practices among adolescents in the study area. This situation must be controlled to positively influence sexual, reproductive and health behaviour of the adolescents.

Recommendations

The following recommendations are based on the findings of this study,

(i) Family life education should be introduced in families and religious groups for younger children. Such programs help adolescents develop the skills to make informed decisions about engaging in sexual intercourse and contraceptive use.

(ii) Parents should educate the daughters at home on safe sex and contraceptive use. Programs and advertisements, which promote the knowledge of contraceptives use by adolescents, should be encouraged and sponsored in the media. Girl child enlightenment on the dangers of STDs and AIDs should not be ignored as well.

(iii) The federal government should lift the ban on passage of health care and family planning information to adolescents. Adolescents should be accorded basic reproductive health service irrespective of their age and marital status.

(iv) The government, non-governmental organizations (NGOs) and private sector should provide gainful employment for adolescents in and out of school.

(v) The federal government should also enforce the law on girl-child education to a certain level before marriage so as to empower them.

(vi) It is necessary to establish counseling and rehabilitation services to assist female adolescents who had problems such as abortion and teenage pregnancy to recover from the psychological shock of those experiences.

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