ORIGINAL RESEARCH ARTICLE

Unmet Reproductive Health Needs and Health-Seeking Behaviour of Adolescents in Owerri, Nigeria

Chukwunenye I Okereke
Department of Sociology, Faculty of Social Sciences, University of PortHarcourt, PortHarcourt, Nigeria.
Tel: 234 803-702-6486 *Email:* chuokereke@yahoo.com

ABSTRACT

The study examined unmet reproductive health needs and health-seeking behaviour of adolescents in Owerri, Nigeria. Primary information was obtained through questionnaire, FGDs and in-depth interviews. The adolescents were mostly Christians (99.6%) and Catholics (78.6%), with 66.4% living with their parents. Half (50.8%) of the adolescents have had sex. Contraceptive use was low, due to culture. Data showed that 27.2% of the ever had sex have had STIs, mostly gonorrhea and syphilis; 30.2% of the female adolescents have had unintended pregnancies, amongst who 73.3% had recurrent pregnancies and 19.6% of all the females have had abortion. The primary contact for health-care was patent medicine operators. In conclusion, more accessible and cost-effective method of disseminating STI/HIV information involving the use of vernacular and traditional/ local opinion leaders should be used (Afr J Reprod Health 2010; 14[1]:43-54).

RÉSUMÉ

Les besoins par rapport a la sante de la reproduction qui ne sont pas satisfaits et le comportement destine a la recherche de la sante chez les adolescents a Owerri, Nigeria. L'étude a examiné les besoins relatifs à la santé de la reproduction qui ne sont pas satisfaits et le comportement destiné à la recherche de la santé chez les adolescents à Owerri, Nigéria. L'information de base a été obtenue à l'aide des questionnaires, des DGFs et des interviews en profondeur. Les adolescents étaient en majorité des chrétiens (99,6%) et des Catholiques (78,6%), dont 66,4% vivaient chez leurs parents. La moitié (50,8%) des adolescents ont eu des rapports sexuels. L'emploi des contraceptifs était faible à cause de la culture. Les données ont montré que 27,2% des adolescents qui ont jamais eu des rapports sexuels ont eu des IST's surtout la gonorrhée et la syphilis ; 30,2% des adolescentes ont eu des grossesses non voulues, dont 73,3% ont eu des grossesses repétées et 19,6% de toutes les femelles ont eu un avortement. Le contact primaire pour les services médicaux ceux qui travaillent dans le domaine de la spécialité pharmaceutique. En conclusion, il faut utiliser des méthodes qui sont plus accessibles et rentables pour le diffusion de l'information sur les ISTs/VIH à travers la langue locale et les dirigeants l'opinion (Afr J Reprod Health 2010; 14[1]:43-54).

KEYWORDS: Reproductive, Need, Sex, Health-seeking, Contraceptives, Information.

Introduction

It has been observed that a considerable population of adolescents, aged 15-19 years are sexually-active. This has become more worrisome in light of the unprotected sexual activities in which they are involved, arising mostly from a poor knowledge of reproductive health and sexuality education that have unarguably exposed them to reproductive health problems.

Most parents in Owerri scarcely disseminate sexuality education to their children, they rather obligate it to the school, where reproductive health and sexuality education have not been introduced into the curriculum, in spite of several recommendations. Consequently, adolescents seek reproductive information and care from a variety of non-formal sources that include peers, pornography and magazines. The unguided youths usually experiment with the information received and often become exposed to sexually transmitted infections (STIs) and unintended pregnancy, among others.

Reproductive tract infections (RTIs) and sexually transmitted infections (STIs) are critical health issues among adolescents in Nigeria[1], which are complicated by multiple partnerships, with implications for HIV/AIDS, acute and recurrent pelvic inflammatory diseases (PID), chronic pelvic pain, ectopic pregnancy and infertility[2]. Also, it has been found[3] that unintended pregnancy had been a major cause of dropping out of school for girls in Nigeria, thereby limiting their education, economic opportunities and career choices. In spite of campaigns on contraceptive awareness, there does not appear to exist any remarkable improvement in contraceptive use. In contrast to orchestrated arguments on inaccessibility to reproductive health facilities[4], the author argues that contraceptives, particularly condom and pills are affordable and widely available on shelves of even provision shops in Owerri and other urban centres in Nigeria. The worrisome issue rather is on usage, which has at least three dimensions. First, sexual activities are still perceived as preserve of the married, and pre-marital sex a sub-culture of deviants, with sexual tools especially condoms amongst adolescents construed as taboo. Second, the artificiality of condom masks sexual ecstasy and, therefore, individuals that want the naturalness of coitus might ignore using condom in spite of its availability. Third, *'transactional sex'*, deriving from gender-inequality and patriarchal structures could result to poor contraceptive usage in order to secure material benefits (money, physical assets etc), to enhance trust and or to secure a marital relationship. For this, it is relatively difficult for the adolescents to address their reproductive health need without adequate information.

The importance of using the different media properly and wisely to strengthen communication support to health projects has been identified in Ethiopia[5]. Similarly, the use of such communication channels as conversation, the town crier, the market place churches, schools, health officers and radio very useful in creating and sustaining awareness of the health needs and health care delivery has been found in Ghana[6]. In Nigeria, a number of mass enlightenment programmes have been initiated by various governments to create awareness about the sexually transmitted infections (STIs), including HIV/AIDS, through the media (especially radio, television and print). However, the results have not been far-reaching. The focus of this study, therefore, is to examine the unmet reproductive health needs of adolescents in Owerri – Nigeria and their health-seeking behaviour. There is dearth of documented evidence on adolescents' reproductive health needs in Owerri, a notable city in Nigeria. It is the need to extend frontiers in knowledge that this study is directed.

Methods

Study Area

This study was carried out in Owerri in the Southeastern Nigeria which came into focus in the colonial era as an administrative capital of Old Owerri Province that stretched further to Umuahia and PortHarcourt in the region. At present, Owerri is the capital of Imo State, one of the five predominant Igbo-speaking Southeastern

States of Nigeria. It was mapped and planned immediately after creation of Imo State in 1976 by a firm of planners from Switzerland and is a transit town enroute other parts Nigeria for the South- south States (Rivers, Cross Rivers and Bayelsa States). Owerri is a built-up area with basic infrastructures. It is bounded in the East by Naze; in the West by Amakohia and Irete; in the North by Orji and Egbu and in the South by Obinze. It has a plain topography and most of its inhabitants are non-indigenes who work in public and private organizations in the area. It is greatly perceived as a *'civil service town',* with Christianity as the predominant religion, particularly the Catholic denomination. The notable landmark include Imo State University(IMSU), Alvan Ikoku College of Education(AICE), Garden Park Business Centre, Ama J K Recreation Park, Modotel Hotel, Imo Hotels, Concorde Hotels, World Bank Housing Estate, Aladinma, Ikenegbu and Federal Housing Estates and Courts (Magistrate and High Courts). Recently, there is proliferation of banks, hotels and Eating Houses(Mr Biggs, Crunchies, Mr Fans, Rennies, Chicken Republic, De St Simeon with some of them having 2 – 3 branches within the area).

Population

The population of this study consisted of both in-school and out-of-school adolescents of both genders, aged 10 – 19 years in Owerri.

Sample and sampling technique

A sampling frame consisting of 15 secondary schools in Owerri was obtained from the Ministry of Education, Imo State out of which are 5 'all Boys', 3 'all Girls' and 7 'co-educational(mixed) schools. Attempts were made to ensure equitable representation of students of each gender. For this, simple random sampling was used to select 3 out of the 5 'all Boys'; the 3 'all Girls' schools were drawn into the survey population.

Students were stratified into classes (JS 1,2,3, SS 1, 2,3) and a sub-class (eg JS 1A) was randomly selected in spite of other existing sub-classes(eg JS 1B, JS 1C), in the hope that the sub-class has characteristics representative enough of that of other sub-classes. From most of the Class Registers, the average population of students in each sub-class was 30. A quasi-random sampling typified in systematic sampling technique was used to establish the ratio (k) of the population of students in a sub-class (N) to the survey population (n) – (which is 6 students from each sub-class in each of the selected 13 secondary schools). Thereafter, a number was selected randomly from 1 – 5 inclusive (j) inclusive to get the first person in the survey population (using the serial number in the class register), with subsequent members selected by additions to the number k. In terms of the co-educational schools, the method is the same, except that males and females were in different sub-populations listed serially with the cooperation of the Class Teachers and 3 students selected from each of the sub-populations. In all, 36 students were selected from each of the 13 schools, making a total of 468 students (consisting of 234 males and 234 females) primarily using their class registers and without recourse to their ethno/tribal and religious background and without consideration for their place of residence.

From each of the localities where 13 schools were selected, 36 adolescents who were out-of-school were selected, through Convenience non-random sampling in the light of paucity of sampling frame that contains list of such adolescents. Out –of –school, in this context, refers to persons that were not in secondary school or in any tertiary educational institution. They either dropped out of secondary school, did not enter into secondary school(but exclude primary school pupils), have completed secondary school and waiting for admission into tertiary educational institution, learning a craft or trade or unemployed.

Research instrument

A pre-coded questionnaire was used to obtain information from 896 adolescents on their sexual and reproductive health. Other information sought included demographic characteristics of the respondents (age, sex, educational category, the person they live with and religion/denomination).

The instrument was pre-tested before the fieldwork on a randomly selected 45 adolescents comprising 30 in-school and 15 out-of-school adolescents. This was to ascertain the explanatory potentials of the questionnaire, particularly in terms of its validity and reliability. This enhanced clarification of whatever ambiguities the respondents might have and ensured that they understood the questions. All necessary corrections were effected in the process before administration to the population. In addition, 4 Focus Group Discussions (FGDs) were held with adolescents (2 for each of the genders) in selected localities where the researcher had easy access to the adolescents. The FGDs aimed to capture the local context of sexual and reproductive health of the adolescents and, in essence, enabled a true picture of social reality.

Each of the FGDs consisted 8 – 12 adolescents (involving those in secondary school and those not in secondary school). The out-of-school adolescents were identified where they were working or practicing their craft/trade and invited to a rendezvous. They eventually assisted to get some students. The researcher introduced the topic to them and gave them leeway to express themselves. Their responses gave fillips to probes and relevant responses were recorded verbatim. In-depth interviews were held with 15 key informants who are reproductive health service providers in Owerri (consisting of 5 medical doctors and 10 paramedical personnel) and the Coordinator of Forward Africa (a non-governmental Organisation based in Owerri). Forward Africa was purposively selected as it deals on adolescents' reproductive health. A list of Hospitals/Clinics in Owerri was obtained from the Owerri Municipal Secretariat, from where 5 Hospitals/Clinics were randomly selected. There is dearth of records on paramedical facilities in Owerri, just as in most urban areas in Nigeria. For this, convenience (accidental) sampling was employed to obtain information from 10 paramedical personnel (involving pharmacists, patent chemist operators and herbal doctors). The researcher believed that interview with the health-care providers would effectively enable obtaining of facts about adolescent's reproductive health, as the health-care providers constantly interact with adolescents during provision of health care and, therefore, would provide valuable information on adolescents' reproductive health.

The information obtained from the questionnaire, the FGD and in-depth interviews formed a single report.

Results and Discussion

Socio-economic characteristics

Table 1 shows that out of the total population of adolescent respondents in Owerri, with mean age 15.7 years, 74.9 percent are aged 15-19 years, with 25.1 percent aged 10-14 years. Equal population of adolescents of both gender (male and female) were interviewed, with 52.2 percent of them as students (those in Secondary Schools) and 47.8 percent as out-of-school (that is, not in secondary school, but either learning a trade/vocation, awaiting admission into higher tertiary educational institution, engaged in labour services or unemployed). Most of the adolescents are Christian (99.6%), with a considerable population as Catholics (78.6%), and a preponderant percentage (66.4%) living with their parents.

Accessibility to Reproductive Health Centre(s)

Statistics in Table 2 show that close to three-quarters (71.5%) of the adolescents affirmed availability of reproductive health centre(s) within their residential neighbourhood out of which only 26.4 percent are willing to purchase contraceptives offered at the centre(s). The contraceptives offered at the reproductive health centres range from pills (especially family planning pills), condoms (particularly Gold Circle), intra-uterine device (IUD), cervical caps and gels, vaginal suppositories and foams to masectomy (tubal ligation). The unwillingness to buy the contraceptives by the adolescents in Owerri is puzzling, albeit it corroborates findings[7] that adolescents in Africa are less likely to use contraceptives, the unwillingness of adolescents in Owerri to purchase contraceptives at the health centre(s) is not directly related to poverty. The cost of contraceptives offered at the health

Table 1: Socioeconomic characteristics of the adolescent respondents in Owerri (N=896)

Variable	Frequency	Percentage (%)
Age		
10-14	225	25.1
15-19	671	74.9
Average (yr)	15.7	
Gender		
Male	448	50.0
Female	448	50.0
Current School Attendance		
In-School	468	52.2
Out-of-School	428	47.8
Work Status		
Student	468	52.2
Civil Service	2	0.2
Technical Job	85	9.5
Trading	93	10.4
Services (Hair dressing, barbing salon, house-help, shop assistant; assistant in restaurant etc)	158	17.6
Doing Nothing	90	10.1
Person with whom the Adolescent Respondent Lives		
Parent(s)	596	66.5
Alone	60	6.7
Brother/Sister	99	11.1
Other Relation	63	7.0
Someone not related to me	78	8.7
Religion/Denomination		
Christianity	892	(99.6%)
Catholic	704	78.6
Protestants (Anglicans, Methodists etc)	129	14.4
Protestants	42	4.7
Aladura, Celestial	17	1.9
Others	4	0.4

Table 2: Accessibility of adolescents in owerri to reproductive health centre(s)

Variable	Frequency	Percentage (%)
Reproductive health centre(s) availability within residential neighbourhood (N = 896)	641	71.5
Willing to buy contraceptives at the health centre(s) (N = 641)	169	26.4

centre(s) is subsidized (comparatively cheaper than what obtains in the open market). At the Centres, family planning pills are ₦100 per Card of 29 tablets, masectomy (tubal ligation) is ₦300 and condoms (which are mostly Gold Circle) are ₦20 per pack of 4. It is rather a function of poor disseminating of a fossilized suspicion about contraceptives and poor dissemination of information about sexually transmitted infections (STIs), including HIV/AIDS in the area.

Concerns about side-effects of contraceptive methods are widespread and significant[8] even among women in Owerri. Hormonal and barrier method, as well as IUD are seen as invasive,

disruptive of the body's natural rhythm and deadly[9]. In an earlier study[10], it was reported that women reported that condoms can come off and get stuck in a woman's body, shutting off her reproductive system or clogging the valves of her heart. Specifically, it was noted that IUD could make one bleed uncontrollably, and that pills could damage the skin, causing it to peel and turn white[11]. These findings correspond with those[12] on West African societies as well as general beliefs and conversations on contraceptives among women in Owerri–Nigeria.

Emphasis[13] had been made on the inaccessibility of adolescents to family planning services, due to the target of maternal and child health / family planning being mainly on older married women. This is not correct of contemporaneous events, family planning services in Owerri and in some other urban centres in Nigeria do not discriminate against the unmarried youth. The worrisome issue is that the adolescents scarcely go to the centres for reproductive health services, due partly to an element of culture that they could not repudiate openly.

Sexual activities are greatly perceived as a preserve for the married, while premarital sex a sub-culture of deviants. This fossilized idea haunts adolescents and thus, prevents them from going to the centres. There is no established documentary evidence on adolescents being refused reproductive health – care services, except for criminal abortion. Also, Catholicism is predominant in Owerri and in tandem them with argument[14] that Catholic countries are in most instances laggards in the demographic transition, especially when religious institutions have the means to communicate values to their members and to institute mechanisms to promote compliance and punish non – conformity, it is not implausible that adolescents in Owerri who are Catholics would refrain from contraceptive use.

In spite of the numerous programmes and action plans initiated by various governments in Nigeria to create awareness about the catastrophic consequences of sexually transmitted infections (STIs), including HIV/AIDS through the media (radio, television and the print), there exists clear evidence that the sensitization did not achieve the desired impact. Table 2 reveals that 73.6 percent of the sub-population that affirmed existence of reproductive health centre(s) in their neighbourhood are unwilling to buy contraceptives at the centre(s). The explainable reason for the foregoing appears to be the use of inappropriate channels of information dissemination that do not ensure accessibility to STIs information. Due, however, to poverty and illiteracy, both of which are high in Owerri there is need for a more accessible, convenient, familiar and cost-effective method of information dissemination that could enhance understanding of the consequences of sexually transmitted infections (STIs), including HIV/AIDS. The use of local vernacular and institutional framework, involving traditional/local opinion leaders that are readily available and accessible might be a panacea.

The unwillingness of the adolescents in Owerri to buy contraceptives offered at the reproductive health centre(s) prima facie suggests the presence of an issue that is deep-seated within their memory that inhibits their demand for contraceptives. There is need, therefore, to re-orientate the adolescents to erase the fossilized belief they have against contraceptive use as the adolescents who have ever had sex would obviously become susceptible to reproductive health problems that include STIs and unintended pregnancies.

Perceived Reproductive Health Problems

Table 3 below shows that half (50.8%) of the adolescents has ever had sex. In the words of a key informant:

> *…So many of the female adolescents in Owerri start early to have sexual sensations. They accommodate any person they feel they can move with. (In-depth Interview, Medical Doctor, Owerri).*

This supports the argument that recent studies indicated that sexual activity in Nigeria was particularly high among unmarried youth[15]. This contrasts with tradition. Most anthropo-logical and historical records on culture areas in Nigeria[16] showed that premarital sexual activities were at an abysma-

Table 3: Perceived reproductive health problems of adolescents in Owerri

Variable	Frequency	Percentage (%)
Ever had sexual intercourse (N = 896)	455	50.8
Ever had STI (N=455)	124	27.2
Nature of STI Contracted (N = 124)		
Trichomonas	4	3.1
Painful Urination	7	5.5
Itching Vaginal Discharge	8	6.3
Genital Rashes	10	7.9
Candidiasis (though not strictly an STI)	15	11.8
Syphilis	28	22.8
Staphylococcus Aureus	20	16.5
Gonorrhea	42	33.9
Contracted STI while using contraception (N = 124)	21	17.3
Where Treatment Was Obtained (N = 124)		
Health Centre/Hospital	29	23.6
Patent Chemist	81	65.4
Traditional Medical Practitioner (Herbal Doctor)	12	9.4
Nowhere	2	1.6
Ever had unintended pregnancy (N = 448)	135	30.2
Frequency of Unintended Pregnancy (N = 135)		
Once	28	20.9
Twice	97	71.9
More than Twice	2	1.4
No Response	8	5.8
Did you bear the child? (N=135)	46	33.8
Ever had abortion (N = 448)	88	19.6
Frequency of Abortion (N = 88)		
Once	54	61.1
Twice	22	25.6
More than twice	12	13.3
Major Reason for Terminating Pregnancy (N = 88)		
Fear of Parental Disapproval	36	41.0
Boyfriend's refusal to take responsibility	24	27.0
Fear of not getting a husband in future	13	15.0
Fear of Expulsion from School	10	11.0
Others	5	6.0
Place where Abortion Services were obtained (N = 88)		
Patent Medicine Store	43	49.0
In the Bush	4	5.0
A Friend's House	17	19.0
Others	20	22.0
No Response	4	5.0
Had any post-abortion problem (N = 88)	63	71.1
Received treatment for the post-abortion problem (N = 63)	20	31.2

lly low level, as marriage loomed upon the horizon of the maids as an indispensable function to be fulfilled with as little delay as possible immediately after reaching puberty. Sexual activities were negotiated within marriage and the concept of *"virgo intacta"* (remaining a virgin until marriage) was a cherished norm. Of recent, however, the value on virginity is disregarded especially by young persons. They perceive a woman who has reached between 18 and 24 years that is still a virgin as an uncivilized person who is either ugly or possesses repulsive characteristic

that nauseates men. Sexual-activeness is construed as an eloquent portrayal of civilization and an indication of being adequately socialized. Delay in marriage arising from demands for formal education in the modern economy is partly responsible for the prevalent premarital sexual activities, especially when associated with relaxation in social mores.

The sexual behaviour of the adolescents appears to have affinity with the existing socio-economic context of Owerri. The total fertility rate (TFR) for Imo State where Owerri is the capital was 6.7 children per woman in 1991 Census exercise [17] and in the absence of any specific current official information on Imo State the TFR might not have varied remarkably. Apparently, this tasks capacity to save and invest, thereby resulting to low economic productivity and low income that invigorate a *"vicious cycle"* of poverty. As summarized by a key informant:

> *By the very nature of the economic environment of Owerri, a lot of the inhabitants are poor. The marginal propensity to indulge in illicit sex is heightened by low socio-economic status. Some of the female adolescents use sexual practice as means of acquiring certain materials assets. Unfortunately, the sexual practices are unprotecte (In-depth Interview, Medical Doctor, Owerri).*

The low contraceptive use of the adolescents in Owerri is subsumed in their unwillingness to buy contraceptives in the reproductive health centre(s) within their neighbourhood, indicated in Table 2 above. Generally, sexual activities are perceived traditionally in Owerri as exclusive preserve of married persons and contraceptives, particularly, condom is seen as a tool used by immoral persons who have no control over their sexual appetite. For this, it is strange to see a young woman purchasing a condom as she is apprehensive of being described as a prostitute who buys condom for a sexual activity with men. Men themselves both married and unmarried, irrespective of their education, occupation and social status are usually shy to demand for condom over the counter in patent medicine stores and pharmacy shops in Owerri.

This is especially so when the seller is someone of the opposite sex and of comparable age with their mother. Also, they have difficulty demanding for condom when there are other persons present in the shop. Coincidentally, the premarital sexual activities to which the adolescents are engaged contradict their religious doctrine and the associated rejection of modern contraceptives. Howbeit, it visibly exposes the adolescents to sexually transmitted infections (STIs) and unintended pregnancy.

Amongst the adolescents that reported having had sex, 27.2 percent have had STIs, mostly gonorrhea (33.9%) and Syphilis (22.8%). In support, a discussant reported as thus:

> *I have contracted sexually transmitted infections several times. Notable among the infections are gonorrhea, syphilis, candidiases (just once and recently) and staphylococcus (it seems thrice) (FGD, Female, 15 – 19 years, Owerri)*

Consistently, a Key informant surmised as thus:

> *…There is evidence that STIs are caused by unprotected sex behaviour. An appreciable percentage of adolescents that agreed to have contracted STIs mentioned mainly gonorrhea and syphilis as the STIs they suffered (In-depth Interview, Coordinator of Forward Africa, Owerri).*

Although the foregoing supports and amplifies scholarly findings [18] on the inverse relationship between contraceptive use and exposure to STIs, the 17.3 percent of the adolescents who had infection even when they used contraceptives is quite heuristic.

Could it be that some of the condoms were used after their expiry date or that the sexually-active adolescents did not wear the condoms well or that they engaged in hyper-active sex game that eventually burst the condoms? Whichever the case, this is a pointer to the need for appropriate information dissemination on contraceptive use.

Table 3 below reveals that most (65.4%) STIs patients go to patent medicine operators for treatment. In the words of a key informant:

> *…in lot of cases, the adolescent victims of STDs prefer going to patent medicine*

operators where they would pay N50 for a capsule of terramycine or ampiclox, which is under-dosage for treatment of the STD or to herbal doctors. So many of the adolescents come to clinics as a last resort, that is, when they were unable to obtain cure from patent chemist operators and herbal doctors (In-depth interview, Medical Doctor, Owerri).

In support, another key informant summarized as thus:

Some of the STI victims come to patent chemist operators as their primary contact. They do not often go to hospitals due to the huge financial cost it entails. They believe it would cost them about N2, 000 to obtain an adequate treatment in the hospital. They prefer dropping N100 or N200 for treatment, to spending about N1,650 to buy Tarivid, Ciproxin, Peflacin, Oxflacin etc that can cure the infection.

Most of the male adolescents prefer using preventive measures, such as asking for an STI preventive drug immediately after premarital sex. They often request for one capsule of Ampiclox. They do not even wait for the infection to manifest and or the clinical manifestation of the pathogen *(In-depth Interview, Pharmacist, Owerri).*

The foregoing suggests interplay of ignorance, poverty and confidentiality of a health problem. The patent medicine operators are not trained in medicine and drug administration. Most of them are traders, who learnt to sell medicine from apprenticeship. However, most of the STI patients in Owerri trust on the credibility of the medicine operators and confide in them sometimes through whispers in the hope to get adequate treatment from them. In some cases, the STI patient instructs the patent medicine operator on which medicine to give him, on what dosage he wants based on the amount of money he has. This health-seeking behaviour might rather complicate the health problem of the STI patient. Data in Table 3 show that 23.6 percent of the STI patients went to government health centre(s)/hospitals for treatment, 9.4 percent went to traditional medical practitioners (herbal doctors), while 1.6 percent did not treat their infection(s).

Table 3 shows that one-third (30.2%) of the female adolescents in Owerri have had an unwanted pregnancy, amongst who 73.3 percent had recurrent pregnancies. As summarized by a key informant:

Female adolescents in Owerri are constantly having unwanted pregnancies. This is commonly seen within January and February each year and also few weeks after major festivals (In-depth Interview, Medical Doctors, Owerri).

It is expediently necessary to note that the yearly celebration of Christmas in December and the notable festivals in Owerri such as Oru Owerre, Ita Oka, Ita Ukazi etc are usually associated with displays of wealth by the rich to the astonishment of impoverished persons. The poor young women are easily wooed to sex by the rich who lavish or promise to lavish money on them if they accept their sexual overtures. In the context of low contraceptive use, earlier indicated in Table 2, unintended pregnancy is not strange. A notable consequence of rise in pre-marital sex is increase in unintended pregnancy [19] and increase in induced abortion [20] that is illegal and unsafe in Owerri-Nigeria. However, Table 3 further reveals that only 33.8 percent of those with unintended pregnancy bore their child, as against 66.2 percent that, perhaps, aborted their baby. Furthermore, about one-fifth (19.6%) of the total population of female adolescents in Owerri have had abortion, amongst who half (49.9%) have had recurrent abortion. In the words of a discussant:

I have had four unwanted pregnancies. When I missed my period it occurred to me that it could be pregnancy. I went to a patent chemist dealer and was given white quinine injection. On two occasions, I went for a D & C in a Clinic. This was after I went to a chemist and the pregnancy did not abort (FGD, Female 15-19 years, Owerri).

Also, another discussant surmised as thus:

I have had three unwanted pregnancies. Whenever I suspect pregnancy after the first month I go to the patent chemist for white quinine and from two months D & C in a

clinic. Well, I wish I could stop this. Abortion is not good, but I have to do it since I am not married (FGD, Female 15-19 years, Owerri)

There is consensus amongst key informants about the high rate of involvement of female adolescents in Owerri in abortion practices. Their views are summarized by a Key informant.

…an appreciable percentage of the premarital pregnancies end in abortion. Abortion procurement is most common among adolescents aged 15-19 years. They become pregnant during major festivals such as Christmas and Easter periods. Most of the times, they are accompanied by friends and sexual partners for the procurement of abortion (In-depth Interview, Medical Doctor, Owerri).

The preponderant reason (41%) for the abortion was the fear of parental disapproval of the pregnancy and a possible humiliation, followed by lack of established paternity over the foetus (27%), apprehension that the pregnancy would hinder prospects of getting a husband (15%) and least was fear of expulsion from school (11%). In the words of a Key informant:

In some cases where we have recurrent abortions the female adolescents often plead for their parents, brothers and sisters not to know about it, to avoid punishment for it (In-depth Interview, Patent Chemist Operator, Owerri).

Consistently and more explicitly, another Key informant summarized as thus:

Unwanted pregnancy among female adolescents in Owerri is not strange. In some cases, one observes that about 85.5% of the patients at a given day are abortion seekers. The abortion seekers come with their female friend or their sex partner and in some cases, they come with their mother. The reason for procurement of abortion is to avoid interference with their studentship, lack of established paternity over the pregnancy, parental disapproval of the pregnancy etc (In-depth Interview, Medical Doctor, Owerri).

According to Table 3, almost half (49.0%) of the abortion seekers in Owerri obtained abortion services from patent medicine operators, with three-quarters (71.1%) of them having had post-abortion problem. Amongst those that had post-abortion problem, more than three-fifth (68.8%) did not receive treatment.

Conclusion

Most of the adolescents in Owerri are Catholics, which is a Christian religious denomination that conspicuously denounces contraceptive use in order to discourage immoral practice. But, premarital sexual activities are common among the adolescents. The contradiction between the religious doctrine and sexual practices of the adolescents is the Achilles Heel – the missing link in adequately meeting the reproductive health needs and choices of the adolescents.

The interaction of the premarital sexual activities of the adolescents with a deep-seated religious doctrine and, perhaps, socio-cultural value exposed them to reproductive health problems particularly sexually transmitted infections (STIs), unintended pregnancy and abortion. These, together with co-existing socio-economic circumstance (poverty) of the adolescents, by which they often seek health-care services from patent medicine operators, further complicate their reproductive health problem.

For the fact that a considerable percentage (66.4%) of the adolescents live with their parents and yet are highly exposed to reproductive health problems prima facia suggests that the parents might not be oblivious of the sexual behaviour and sexual outcome of their children. What have they done in the circumstance to discourage the sexual behaviour of their children? As most of the female adolescents engage in sex for material benefits, do the parents by any means encourage them in the act in order to benefit from the sexual reward? These require further investigation.

The issue of recurrent pregnancy and abortion and the inability to seek or receive treatment for a post-abortion problem is a vivid indication of absence of proper counseling or education about sex and reproductive health. It clearly shows the failure of the numerous enlightenment programmes and action plans initiated to create awareness about STIs,

(including HIV) to meet the desired target. Due to poverty and illiteracy, both of which are high in Owerri, it is expediently necessary to use a more accessible, more acceptable convenient, familiar and yet cost-effective method of information dissemination that could enhance understanding of STIs and their catastrophic consequences on reproductive health. It is, therefore, suggested that the use of local vernacular through town crier, the use of institutional framework involving Traditional/ Opinion Leaders in the communities be explored.

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