

## **SEXUAL BEHAVIOUR AND REPRODUCTIVE HEALTH AMONG FEMALE SENIOR SECONDARY SCHOOL STUDENTS IN ABAKALIKI LGA, EBONYI STATE**

BY

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### **SUMMARY**

#### **Objective:**

To investigate the sexual behaviour and reproductive health amongst female senior secondary school students.

#### **Methods:**

Using cross-sectional descriptive study 374 students were studied. Information was collected on their sexual behaviours, knowledge of sexually transmitted infections (STIs), prevalence of induced abortion and knowledge of health consequences of these practices.

#### **Results:**

Of the 81 (21.7%) sexually active students, pressure from friends in 24.7%, and desire for sex in 23.5% were the commonest reasons for having sex. The modal age at debut sexual encounter was 15 - 19 years. Condom use was reported in 58%: this was neither associated with age, class nor knowledge of STIs. Knowledge of sexually transmitted infections, including HIV was reported by 43.9%: this was not influenced by age or class. There was also no association between ever having had sex and knowledge of STIs. However, there was a statistically significant association between knowledge of STIs and both mother's ( $p < 0.0129$ ) and father's education ( $p < 0.0001$ ). There was a 12% prevalence of induced abortion among the respondent, constituting 51% of the sexually active students: 26.8% of these had had more than three induced abortion.

#### **CONCLUSION:**

The high percentage of sexually active female secondary school students and the high prevalence of induced abortion among them reflect the poor adolescent sexual behaviour in the area of this study. Sex education and counselling services should begin at home, and be compulsorily included in secondary school curricula. Intervention programs to provide life skills for adolescents should include peer educators, parents, school authorities and religious organizations.

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## **INTRODUCTION:**

The overall sexual and reproductive health status of adolescents in Nigeria is poor. The evidence for this is the increasing rates of early initiation of sex, unprotected sex, early marriage, unsafe abortions and sexually transmitted infections (STIs) including HIV<sup>1</sup>. Late adolescence and early adulthood is the trap period for sexually transmitted infections (STIs) in both males and females but until the high mortality associated with HIV infection became apparent, STIs were only considered an inconvenience. The reports of the national HIV sero-prevalence studies show that adolescents have one of the highest rates of HIV and STIs in the country<sup>2</sup>. Teenagers account for over 60% of the complications of unsafe abortion referred for care in Nigeria, and 50% of Nigeria's high maternal mortality rate are in adolescent girls, most due to illegal abortions<sup>2</sup>. Studies on female adolescent sexual behaviour and reproductive health in various areas are therefore needed as part of efforts to improve adolescent sexual and reproductive health.

The aim of this study is to assess the factors associated with the sexual behaviour of female adolescents and the health complications of this behaviour in Abakaliki LGA of Ebonyi State. The findings of this study will enable reproductive health program managers to develop specific and effective interventions to promote and protect adolescent female sexual and reproductive health in the study area.

## **MATERIALS AND METHODS**

### **BACKGROUND OF THE STUDY AREA:**

Abakaliki LGA of Ebonyi State is a predominately urban area. The inhabitants are predominantly Igbos: mainly civil servants, farmers, traders, artisans and businessmen. At the time of this study in July 2006, the total secondary school population in the area was 24, 178 students: made up of 18,426 students in thirteen government secondary schools; and 5,752 students in five registered private schools.

## **STUDY DESIGN:**

A cross sectional descriptive survey was done. In a multi-stage random sampling technique, a sample size of 400 female students was drawn from the schools. The sample size was determined using a formula for computation of sample size for populations greater than 10,000.

In the first stage of the sampling procedure 8 schools were selected from the list of 18 secondary schools using simple random sampling. In each of the sampled schools, the study was restricted to senior secondary 1 and 2 female students (SS1 and SS2) because the SS3 students had left school, having completed their final examination by the time of the study. In the second stage of the sampling procedure, using proportionate allocation, the number of students to be sampled in each selected school was determined and recruited from the classes using systematic random sampling. Where the classrooms were more than one, the required number of students was distributed among the classrooms equally.

Structured close ended self administered questionnaires were used to collect information on socio-demographic characteristics, age at sexual debut, sexual history, and reasons for engaging in sex, knowledge of STIs, prevalence of abortion and knowledge of complications of abortions. The data were entered into the computer and analyzed using EPI info version 6. The chi-square test was used in assessing the significance of associations between categorical groups with P-value of less than 0.05 considered statistically significant.

Permission for the study was obtained from the management of the schools and informed consent was obtained from each student. Distribution of the questionnaires and supervision of data collection was done by the research team. The students were assured of confidentiality and encouraged to write only the truth. Anonymity was ensured as names were not required from the respondents. To ensure confidentiality and to encourage honesty, only the consenting and participating students were allowed to remain in the

classroom with the research team during the completion of the questionnaires.

## RESULTS

A total of 392 questionnaires out of the 400 administered were retrieved giving a response rate of 98%. However only 374 questionnaires were analyzed as this constituted the number of unmarried respondents.

### Socio-demographic characteristics of respondents

Table 1 shows that majority of the respondents were aged 15 – 19 years (79.1%), Christians (97.1%) and mostly of the Igbo ethnic group (94.7%). Students in SS2 made up 68.4% of the respondents.

**Table 1**  
Socio demographic characteristics of respondent (n=374)

Age		
Characteristic	Frequency	%
Age		
10 – 14	51	13.7
15 - 19	296	79.1
20 - 24	25	6.7
25 - 29	2	0.5
Ethnicity		
Ibo	354	94.7
Yoruba	8	2.1
Hausa	7	1.8
Efik	4	1.1
Ijaw	1	0.3
Religion		
Christianity	363	97.1
Islam	8	2.1
Traditional	3	0.8

### Source of information

Data on sources of information about sexual and reproductive health shows that 48.7% received this information from occasional school talks, 23.8% from parents, 15.5% from

friends, 8.8% from the mass media, and 3.2% from health staff.

### Sexual behaviour

Table 2 gives the number of respondents who reported ever having had sex to be 81 (21.7%). The modal age category at debut sexual encounter was 15–19 years. Pressure from friends in 24.7%, and desire for sex in 23.5%, were key motivators of first sexual encounter.

**Table 2** Reasons for engaging in sex

Reasons	Frequency	%
Pressure from my friends	20	24.7
Desire for sex	19	23.5
Inability to resist	13	16.1
Pressure from partner	12	14.8
To be considered for marriage	12	14.8
Offered money/Gifts	4	4.9
Under influence drug/alcohol	1	1.2
Total	81	100

### Knowledge of STIs

**Table 3**

Association between (a) Father's educational level and knowledge of STIs (b) Mother's educational level and knowledge of STIs

(a)	Knowledge of STIs		
	Yes	No.	Total
Father's educational level			
None	22	27	49
Primary	24	40	64
Secondary	45	110	155
Tertiary	73	33	106
Total	164	210	374

$$X^2 = 41.84; \text{ df} = 3; \text{ p} < 0.0001$$

(b)	Knowledge of STIs		
	Yes	No.	Total
<b>Mother's educational level</b>			
None	23	34	57
Primary	26	52	78
Secondary	48	70	118
Tertiary	67	54	121
Total	164	210	374

$X^2 = 10.79$ ;  $df = 3$ ;  $p = 0.0129$

Knowledge that infections were transmissible through sexual intercourse was found in 164 respondents (43.9%). Table 3 shows that knowledge of STIs was significantly associated with father's and mother's education ( $p = <0.0001$  and  $p = 0.0129$  respectively); while tables 4, 4 and 6 show that knowledge of STIs was not associated with age ( $p = 0.2357$ ), class ( $p = 0.1606$ ) or ever had sex ( $p = 0.5240$ ) respectively.

**Table 4**  
Influence of age on knowledge of STIs and condom use

Knowledge of STIs	Age				Total
	10 – 15 yrs	15 – 19 yrs	20 – 24 yrs	25 – 29 yrs	
Yes	25	124	13	2	164
No.	26	172	12	0	210
Total	51	296	25	2	374

$X^2 = 4.25$ ;  $p = 0.2357$

Condom use	Age				Total
	10 – 15 yrs	15 – 19 yrs	20 – 24 yrs	25 – 29 yrs	
Yes	2	37	7	1	47
No.	4	28	2	0	34
Total	6	65	9	1	81

$X^2 = 3.7$ ;  $p = 0.2958$

**Condom use**

Out of the 81 respondents who had ever had sex before, 47 (58%) reported ever having used condom on the male partner. Tables 4 to 6 show that the association of use of condom with age ( $p = 0.2958$ ), class ( $p = 0.8089$ ) or knowledge of STIs ( $p = 0.6963$ ) were not statistically significant.

**Table 5**  
Influence of class on knowledge of STIs and on condom use

Knowledge of STIs	Class		
	SS1	SS2	Total
Yes	58	106	164
No.	60	150	210
Total	118	256	374

$X^2 = 1.97$ ;  $p = 0.1606$

Condom use	Class		
	SS1	SS2	Total
Yes	10	37	47
No.	8	26	34
Total	18	63	81

$X^2 = 0.06$ ;  $p = 0.8089$ ; not significant.

**Abortion**

Of the sexually active respondents, 41 (51.0%) have had induced abortion. Of this number 16 (39%), had had one abortion while 11 (26.8%) had had more than three abortions. The respondents' knowledge of the complications of abortion show that 29.6% identified destruction of womb, 25.5% identified bareness, 21.3% identified death, 10.6% identified bleeding, 7.4% identified shame for parents, while 6.5% identified that abortion could lead to HIV infection.

**Table 6**  
Association between knowledge of STIs and (a) ever had sex (b) condom use

$X^2 = 0.41$ ;  $p = 0.5240$

(a)	Ever had sex		
Knowledge of STIs	Yes	No.	Total
Yes	33	131	164
No.	48	162	210
Total	81	293	374

(b)	Condom use		
Knowledge of STIs	Yes	No.	Total
Yes	20	13	33
No.	27	21	48
Total	47	34	81

$$X^2 = 0.15; p = 0.6963$$

## DISCUSSION

This study examined the sexual behaviour and reproductive health of female adolescents in the study area.

The sexually active female adolescents make up 21.7% of the respondents in this study. This compares with the 25.7% found in studies in PortHarcourt<sup>4</sup>, the 29.9% in Lagos<sup>5</sup>, and the 26.3% in Nnewi<sup>4</sup>. It is, however, lower than the 37.4% found in Calabar<sup>6</sup>. The difference between our findings in Abakaliki and those of the study in Calabar may be due to under reporting and tighter parental / religious control in Abakaliki or greater exposure in Calabar due to the more international nature of the city as a result of the seaport. This study found the modal age at first sexual intercourse to be 15-19 years. This again is also later than the age at first sexual intercourse in the Calabar<sup>6</sup> study (11-16 years). This suggests earlier and increased sexual activity among adolescent girls in Calabar than their peers in Abakaliki. Other studies<sup>2</sup> have also found that 15% of

adolescents in Africa have regular (often unprotected) premarital sex by the age of 15 years.

Our finding that desire for sex was the second commonest reason for engaging in sex agrees with a similar study in Abia<sup>7</sup> where the urge to have sex and curiosity were key motivators to have sex. In Calabar<sup>6</sup>, 84% were interested in sex for fun, intimacy and friendship. Adolescence is well known as a time of adventure, and letting go of inhibitions and extreme peer pressure. The latter can be seen in the fact that pressure from friends was the commonest reason for engaging in sex in our study.

The need to introduce sexuality, and reproductive health education and counselling services into secondary school curricula cannot be more emphasized. Support from peer educators and counsellors will assist the adolescents to learn to cope with sexual urges and peer pressure and enable them go through this period safely till they are physically and socially mature to make well informed choices and take responsibility for their actions.

The male condom use reported by 58% of the sexually active females in our study is higher than reports of any contraceptive use in the Calabar<sup>6</sup> (6%), and the Abia<sup>7</sup> study (1.2%). Use of other contraceptive methods was not examined in this study. It has been reported that the use of condoms among young persons in sub Saharan Africa is low<sup>8</sup>. The high figure here may be due to the fact that an organization had been distributing free condoms in the study area in response to the HIV/AIDS pandemic. However, it may also be due to over reporting. To reinforce the emphasis now placed on formal education in the state, education is free up to SS3 level. Therefore the students may feel that condom use will solve the problem of unwanted pregnancy, allowing them pursue their education without interrupting their sexual activities. Reasons for non use of condom by those who did not use it were not elicited. Qualitative data is needed to elicit attitudes which may influence their sexual behaviour.

The low level of sex education in homes is revealed by the finding that only 23.8% of the

respondents received their information on sexual and reproductive health from their parents. This implies that adolescents become sexually active without adequate preparation about sexuality from their home or from school. This is also buttressed by the fact that their knowledge of STIs did not significantly influence either condom use or ever having had sex. The knowledge they had of STIs is obviously inadequate as it did not produce the desired behavioural change. That the knowledge of STIs was not significantly associated with age of respondents or class in school but was significantly associated with both parents' educational level may be because education is likely to influence parental attitude to sexuality and issues concerning sex. Also the children are exposed to books read by the parents at an early age. Communication between parents and adolescents is more when parents spend more time at home with them. Strong relationships with good communication between adolescents and their parents should be encouraged with parents learning to spend more time with their children and start them on sex education correctly to prevent their imbibing the wrong information from peers in school. Often, parents, school authorities, and public opinion leaders believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active<sup>2</sup>. Good quality sex education does not lead to earlier or increased sexual activity among adolescents. Rather it would create awareness of pitfalls and should influence the desired behaviour change. Young persons need life skills in order to pass through adolescence without adverse social and health implications<sup>2</sup>. Moreover, withholding information has not made them less sexually active as can be seen from ages at sexual debut across the country. However, it is recommended that as part of sex education, abstinence as the safest option for preventing risks of STIs, including HIV/AIDS and unwanted pregnancy with its complications among adolescents should be emphasized,

while the drawbacks of relying on 'safe sex' at this period should be pointed out.

The percentage of sexually active respondents who had ever had an induced abortion (51%) is worrisome and even more so is the finding that 27% of these ones had had more than three induced abortions. A similar study in Port-Harcourt<sup>4</sup> reported 24.8% of sexually active having ever had an abortion. A greater stigma attached to unwanted pregnancy is a possible explanation for the disparity. It has been shown that abortions in adolescents is usually illegal and unsafe, procured from unskilled personnel and by dangerous methods, with resultant life threatening complications and death. More effort should be made to sanction health personnel and quacks found engaging in this.

#### **CONCLUSION AND RECOMMENDATIONS:**

We conclude that the high percentage of sexually active female secondary school students, their poor knowledge of STIs and the high rate of induced abortion amongst them in this study reflects a poor female adolescent sexual behaviour in the area.

Improving the quality of sexual and reproductive healthcare services and coverage of Family Life Education program among adolescents and young people is one of the objectives of the 2004 National Population Policy towards achieving improvement in the reproductive health of all Nigerians<sup>2</sup>. It is recommended that sexuality and life planning education be compulsorily included in secondary school curricula. Parents should be encouraged to pay more attention to their children and provide sex education at home the right way.

Intervention programs to provide life skills and healthy attitudes for adolescents should be undertaken at community levels targeting peers, peer educators, parents, school authorities and religious organizations.

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