SURVEY OF THE PROBLEMS OF GIRL CHILD IN EKITI STATE, NIGERIA.

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ABSTRACT

Objectives: To determine the prevalence of teenage pregnancy and knowledge of reproductive health problems among adolescent girls in Ekiti State, Southwest Nigeria.

Methods: A cross-sectional community based study was conducted. Using convenient random sampling technique, four local government areas were selected. Eligible participants were both in and out of school children between the ages of 13 -18 years. A hundred respondents were sampled from each selected local government, making a total sample size of 400. Consenting participants were administered questionnaire in their homes by trained LGA enumerators. It elicited information on socio-demographic and reproductive health issues. Data collected were subsequently collated and analyzed.

Results: Majority of the girls (78%) were still in-school. All were already menstruating, mostly attaining menarche between the age 15-16years. Only 212 (53%) could remember their last menstrual period. Sexual derby mainly occurred around age 15-16years; 53.3% were already sexually exposed. A quarter of respondents had been pregnant before. Only 187 (46.8%) were aware of modern contraception. The girls had a fair knowledge of implication of early sexual derby and unprotected intercourse, though it did not translate to behavioural change.

Conclusion: There is a high prevalence of teenage pregnancy and poor reproductive health knowledge among teenagers in Ekiti State. More collective efforts involving parents, community heads, opinion leaders, civil societies and the state are needed to help our girls attain and sustain healthy reproductive behaviours.

INTRODUCTION

Adolescents' reproductive health needs and problems have become contemporary concerns globally [1]. Adolescent period is characterized by physical, emotional and psychological transition from childhood to adulthood. Prominently, physical potential for reproduction (puberty) is attained, social identity is formed and there is high level of sexual experimentation. It is a delicate stage that needs careful handling by both the adolescents and all those who have influence over them especially parents, government and other policy makers [2].

The vulnerability of the adolescent girls is profound. The girl-child often faces

discrimination from the earliest stages of life, through childhood and into adulthood. Her perceived low status is reflected in the denial of fundamental needs and rights coupled with harmful attitudes and practices such as a preference for sons, early marriage, female genital mutilation, domestic abuse, sexual exploitation, less access to education and a host of other reproductive health challenges [3].

The fourth world conference on women in Beijing 1995, identified the persistent discrimination against the girl-child and the violation of her rights as one of the 12 critical areas of concerns requiring urgent attention by government and the international community [4]. There has been an alarming increase in the number of girls having sexual intercourse in their teens with consequent unwanted pregnancies, increasing sexually transmitted diseases, vaginal discharge and chronic pelvic pain. In addition to this is the increasing incidence of HIV infections among both in-school and out of school adolescent girls [5].

The adolescents of today constitute the leaders of tomorrow. It may be a disservice to them if their plights are not well handled as their potential for greatness will be compromised. In Ekiti State, the NDHS 2008 put the adolescent pregnancy rate at 8% and contraceptive uptakes among the adolescents as 4.5% and life time risk of death from pregnancy related problems at 1 in 13 [6]. The recent Ekiti State Free Health Mission conducted in 2012 revealed that a sizeable number of our girls are multiparous at eighteen years with significant number of them being HIV positive.

Obviously, this is worrisome and a cause for great concern necessitating the Governor of Ekiti State, Dr John Kayode Fayemi to direct the Commissioner for Health, Education, Women Affairs, Social Development and Gender Empowerment to conduct a study appraising the girl-child in the State, focusing on teenage pregnancy with a view to knowing the prevalence and knowledge of reproductive problems common to this cohort of female population. The findings of the survey will be crucial to informing state policies in the areas of Health, Education and Gender Empowerment.

METHODOLOGY

This is a qualitative and quantitative questionnaire-based study conducted from September - December, 2012 in Ekiti State, South-west Nigeria.

Ekiti State lies between latitude $7^{o}15^{1}$ and $8^{0}5^{1}$N and longitude $4^{o}45^{1}$E. It covers a land area of 5,435 square kilometers and has a population of 2,364,212 based on the 2006 census. The state comprise of 16 local government areas group into three senatorial districts. The state is endowed with agricultural and mineral resources. Predominantly, inhabitants are farmers.

A convenient random sampling technique was employed to select four local governments in the State - Ekiti East, Ado Ekiti, Ikere and Efon Alaaye LGA. Eligible participants were both in and out of school children between the ages of 13 -18 years. A hundred eligible respondents were sampled from each selected local government, making a total sample size of 400. Informed consent to participate in the survey was obtained from respondents before administration of questionnaires.

The questionnaire instrument was designed to obtain information on socio-demographic variables of the respondents as well as their knowledge of normal and abnormal menstruations; sexual experiences,

contraception, HIV prevention and current health challenges. The questionnaire was administered to eligible participants in their homes by trained LGA enumerators in these LGAs. The data collected was collated and analyzed using a computer statistical package for the social sciences [SPSS] version 16 (IBM, Armonk, NY, USA). Appropriate interpretations were subsequently made.

RESULTS

A total of four hundred girls (100 from each selected local government) who were between the ages of 13-18years were interviewed during the survey. Out of the respondents, 89 (22.2%) had already dropped out of school, 83 (20.8%) were in junior secondary school while 228 (57.0%) were in senior secondary school [Table1]. Mostly their parents were self-employed, engaged in farming and petty trading. Only 101 (25.2%) had their fathers in the Civil service and 96 (24.0%) also had their mothers as Civil servants.

Table 2 shows the menstrual history and knowledge of ovulation period among respondents. The survey demonstrated that most of the girls attained menarche in all the selected four LGAs between the ages of 15-16years. The next likely age bracket for menarche was between ages13-14 years, except in Efon-Alaaye where it was between the ages of 17-18years.

Reliably, 212 (53.0%) could remember the date of their last menstrual period while 188 (47.0%) could not. Menstrual blood loss was scanty in 54 (13.4%), moderate in 299 (74.8%) but heavy in 47 (11.8%). More than half of respondents (66.2%) have duration of menstrual bleeding spanning from 2-5 days; 80 (20%) bleeds for 6 days or more.

Painful menstruation (Dysmenorrhea) was considered moderate by 210 (52.3%) of the girls while it was severe i.e. sufficient enough to disrupt conduct of daily activities in 117 (29.4%). Most of the girls had regular menstrual cycle. However, 198 (49.5%) are not acquainted with the term ovulation while 162 (40.5%) do not know about 'safe' period.

Table 3 summarizes history of sexual exposure in the respondents. Of the four hundred sampled, 213 (53.3%) have had sexual intercourse before. Sexual exposure was more predominant in Ikere LGA where 67% of the girls were already sexually exposed. From the four LGAs, a majority 92 (43.2%) first became sexually exposed at the age of 15-16 years. A quarter of respondents have been pregnant before.

Knowledge of contraception was generally below average - only 187 (46.8%) were aware of modern methods. But in Omuo LGA, awareness was fairly good as 72% of respondent were aware of modern methods. Major source of information on contraception was from friends in 201 (50.2%) of the respondents. This was followed by jingles/adverts from radio stations. Television and Newspapers played least role.

Questions on implication of early sexual derby in the respondents showed that 292 (73.0%) were aware that they could be pregnant from their early sexual exploration [Table 4]. Only a little above a third (157; 39.2%) did not know that they could contact HIV/AIDS as a result of their early sexual exposure. Of the 400 interviewed, 334 (83.5%) knew that infection from sexual intercourse could be the cause of abnormal vaginal discharge. Majority (340; 85.0%) were also aware that early sexual derbies could ultimately lead to school drop-out. Most of the girls (344; 86.0%) knew there may be need for operative intervention for delivery of

pregnancies resulting from early sexual intercourse. A sizeable proportion of respondents (326; 81.5%) equally knew that there is possibility of maternal and/or child's death occurring as a complication from teenage pregnancy.

Table 5 shows the knowledge of HIV/AIDS infection and transmission among the respondents. The survey showed that only 193 (48.3%) know the cause of HIV/AIDS. Most of the respondents knew that HIV/AIDS is not transmitted by condom while 112 (28.0%) differed. Transmission of HIV/AIDS by hugging and/or shaking of hands were affirmed as possible by 160 (40.0%) of the girls while 131 (32.8%) also stated that transmission is possible through kissing. Majority (347; 86.8%) were aware that transmission of HIV/AIDS could occur through sharing of syringe and needles. Also, 344 (86.0%) knew that unsafe sexual practices could lead to HIV/AIDS infection. Only 70 (17.5%) were ill as at the time of filling the survey questionnaire.

Table 1: Socio-Demographic Variables Of The Respondents

Variables		Ado	Ikere	Omuo	Efon	Total [n (%)]
Age	13 -14yrs	36	17	10	3	66(16.5)
	15 -16yrs	15	43	34	53	145(36.3)
	17-18yrs	49	40	56	44	189(47.2)
Level of Education	Out-of-school	42	21	8	18	89(22.2)
	JSS	27	8	18	30	83(20.8)
	SSS	31	71	74	52	228(57.0)
Mother's Occupation	Civil servant	19	33	24	20	96(24)
	Self-employed	35	53	67	76	231((57.8)
	Unemployed	46	14	9	4	73(18.2)
Father's Occupation	Civil servant	28	26	20	27	101(25.2)
	Self-employed	19	49	74	70	212(53.0)
	Unemployed	53	25	6	3	87(21.8)
Religion	Christianity	70	50	80	49	249(62.2)
	Muslim	20	37	19	39	115(28.8)
	Traditional	10	13	1	12	36(9.0)

Table 2: Menstrual history and knowledge of ovulation period among respondents

Variables		Ado	Ikere	Omuo	Efon	Total [n (%)]
Age of first menstruation	13 -14yrs	38	44	33	10	125(31.2)
	15 -16yrs	51	31	47	50	179(44.8)
	17-18yrs	11	25	20	40	96(24.0)
Date of last menstruation	Yes	64	69	23	56	212(53.0)
	No	36	31	77	44	188(47.0)
Menstrual period blood loss	Heavy	21	2	5	19	47(11.8)
	Moderate	56	80	91	91	299(74.8)
	Scanty	23	18	4	4	54(13.4)
Duration of menstrual blood loss	1 day	14	16	9	16	55(13.8)
	2-5 days	50	71	82	62	265(66.2)
	6+ days	36	13	9	22	80(20.0)
Pain during menstruation	Mild	19	16	16	22	73(18.3)
	Moderate	15	67	66	62	210(52.3)
	Severe	66	17	18	16	117(29.4)
Regularity of Menstruation	? 21 days	24	14	18	31	87(21.8)
	21-28 days	56	64	78	62	260(65.0)
	>28 days	20	22	4	7	53(13.2)
Knowledge of menstrual period	Yes	40	66	70	80	256(64.0)
	No	60	34	30	20	144(36.0)
Do you know when is 'safe' period	Yes	38	38	33	31	140(35.0)
	No	18	42	43	59	162(40.5)
	Don't know	44	20	24	10	98(24.5)
Have you heard the term ovulation before	Yes	34	48	32	38	152(38)
	No					198(49.5)
	Don't know	15	17	10	80	80(12.5)
Can pregnancy occur during ovulation	Yes	24	60	29	3	166(41.5)
	No					141(35.2)
	Don't know	45	12	24	2	93(23.3)

Table 3: The Sexual History of Respondents

Variables		Ado	Ikere	Omuo	Efon	Total [n (%)]
Have you had intercourse before	Yes	43	67	58	45	213(53.3)
	No	57	33	42	55	187(46.8)
Age at first intercourse	13 -14yrs	12	13	18	11	54(25.4)
	15 -16yrs	27	11	29	25	92(43.2)
	17-18yrs	4	43	11	9	67(31.4)
Have you been pregnant before	Yes	41	5	30	24	100(25.0)
	No	59	95	70	76	300(75.0)
Knowledge of modern contraception	Yes	39	32	72	44	187(46.8)
	No	61	68	28	56	213(53.2)
Methods used to prevent pregnancy	Calendar	34	44	31	27	136(34.0)
	Pills	58	20	43	30	151(37.8)
	Traditional	4	8	10	3	25(6.2)
	Condom	4	28	16	40	88(22.0)
How you knew of contraception	Friend	36	26	75	64	201(50.2)
	Radio	54	60	14	13	141(35.2)
	Television	4	10	4	11	29(7.3)
	Newspaper	6	4	7	12	29(7.3)

Table 4: Knowledge of implication of early sexual exposure among respondents

Variable		Ado	Ikere	Omuo	Efon	Total [n (%)]
Do you know early sex can result in pregnancy	Yes	50	70	92	80	292(73.0)
	No	50	30	8	20	108(27.0)
Do you know early sex can result in HIV/AIDS	Yes	74	10	93	66	243(60.8)
	No	26	90	7	34	157(39.2)
Do you know early sex can cause chronic abdominal pain	Yes	51	60	85	94	290(72.5)
	No	49	40	15	6	110(27.5)
Do you know early sex can cause vaginal discharge	Yes	75	87	85	87	334(83.5)
	No	25	13	15	13	66(16.5)
Do y ou know early sex can result in drop out of school	Yes	72	90	89	89	340(85.0)
	No	28	10	11	11	60(15.0)
Do you know early sex can result in early child bearing	Yes	81	91	97	89	358(89.5)
	No	19	9	3	11	42(10.5)
Do you know early sex can result in delivery by operation	Yes	62	95	93	94	344(86.0)
	No	38	5	7	6	56(14.0)
Do you know early sex can result in physiological problems	Yes	80	77	93	87	337(84.2)
	No	20	23	7	13	63(15.8)
Do you know pregnancy from early sex can lead to m other	Yes	63	79	88	96	326(81.5)
	No	37	21	12	4	74(18.5)

Table 5: Knowledge of HIV/AIDS infection and transmission among respondents

Variable		Ado	Ikere	Omuo	Efon	Total [n (%)]
Have heard about HIV/AIDS	Yes	42	67	22	48	179(44.8)
	No	58	33	78	52	221(55.2)
Do you know the cause of HIV/AIDS	Yes	56	61	48	28	193(48.3)
	No	44	39	52	72	207(51.7)
Is HIV/AIDS acquired through use of Condom	Yes	42	29	33	8	112(28.0)
	No	58	71	67	92	288(72.0)
Is HIV/AIDS acqu ired through hugging / shaking hands	Yes	40	95	23	2	160(40.0)
	No	60	5	77	98	240(60.0)
Is HIV/AIDS acquired through kissing	Yes	45	30	31	25	131(32.8)
	No	55	70	69	75	269(67.2)
Is HIV/AIDS acquired through shared syringe/needles	Yes	59	98	91	99	347(86.8)
	No	41	2	9	1	53(13.2)
Is HIV/AIDS acquired through unsafe sexual practices	Yes	67	93	91	93	344(86.0)
	No	33	7	9	7	56(14.0)
Is HIV/AIDS acquired through abstinence	Yes	58	70	21	21	170(42.5)
	No	42	30	79	79	230(57.5)
Is HIV/AIDS acquired through use of other contraceptives	Yes	58	40	35	49	182(45.5)
	No	42	60	65	51	218(54.5)
Do you have any illness at the time of filling this form	Yes	55	1	12	2	70(17.5)
	No	45	99	88	98	330(82.5)

DISCUSSION

Developing strategies to address the reproductive health needs and concerns of the adolescent girls in Ekiti State and Nigeria at large is paramount since this sub-set of the population constitutes a significant percentage [7].

Out of the studied population of girls aged 13-18years, 78% were in-school while 22% were out of school. This percentage of female secondary school enrollment is higher than the national average of 45.6% [8]. It is much higher than what is obtainable in the Northern part of the country where only 20% of women in the North West and North East are literate and have attended school [9].

It is important to sustain and possibly increase the current percentage of female secondary school enrollment in Ekiti State as it will not only confer immediate benefit of empowering the girls but on the long-term enhance the State's development. When girls are educated, it affords them opportunity to develop essential skills, they are self-confident, they are able to participate effectively in society and protect themselves from sexual exploitation and HIV/AIDS [9].

Most of the girls attained menarche between the ages of 15-16years. The finding is comparable to a recent observation by Tunau *et al* in Sokoto, Northwest Nigeria where the mean age at menarche was put at 15.26 years [10]. It is also consistent with the findings in Southeast Nigeria by Umeora and Egwuatu where mean age at menarche was 15years [11].

Enquiry into knowledge of the girls about their menstrual history and fertility period showed that close to half of them (47.0%) could not remember their last menstrual period. Another 40.5% are not aware of their ovulation period. This has a grave consequence as it precludes the girls from taking necessary precautions to avoid unwanted pregnancies. Surprisingly, sexual debut occurred mostly between the ages of 15-16 years with a quarter of the respondent stating that they have been pregnant before. It raises reproductive health concern and brings to bare need for sex education in our schools.

Studies emanating from Africa including Nigeria have shown increasing rate of premarital sex and decline in age of sexual debut among adolescents which contravenes our esteemed moral and cultural values [12,13,14]. For example in Portharcourt, 70% of adolescents have had sexual exposure [15] and other local studies have reported similar figures [16,17].

Evidence has shown that often the first sexual exposures were unplanned [18] and that early sexual debut ultimately predisposes the adolescent to having more than one sexual partner per unit time [18,19]. Consequently, aside having unwanted pregnancies, they also have increased tendency of contracting sexually transmitted infections (including HIV/AIDS) and developing cervical cancers [18].

Many reasons have been adduced to rising incidence of early sexual debut in our environment. These include high poverty level, adoption of western norm of sexual liberty, gradual erosion of our traditional norms/values, lack of parental control, mass media, urbanization and tourism [15,20,21]. To intercept the menace, parents and the government will have to be proactive and arise to responsibilities. Policy formulations that promote our ideals are necessary.

Knowledge of contraception was below average among the respondents (46.8%). Majorly, source of information was from friends (50.2%); it was followed by radio jingles on family planning (35.2%). This observation is in tandem with the findings in Ibadan where most in-school adolescents first learn about sexual issues from their school mates/friends [18]. It is however different from the observation in Enugu where information via mass media was dominant [22]. There is a need to alter the trend in Ekiti State as contraceptive information from friends may be grossly deficient, incorrect and disjointed.

Sex education has been referred to as a planned process of education that fosters the acquisition of factual information, formation of positive attitude, beliefs and values as well as the development of skills to cope with the biological, socio-cultural and spiritual aspects of human sexuality [23]. Distorted, unorganized source of information on human sexuality will be bait for unwanted pregnancies. If there will be a fruitful outcome at preventing unwanted pregnancies and curbing infections amidst our girls, then education on sexual issues will have to be purposefully, intelligently and precisely delivered.

Overtime, it has been recommended that sex education be introduced into school programmes at all levels of education – primary, secondary and tertiary [24-26]. Till date, this has been poorly implemented. In order to salvage our most vulnerable adolescent girls, there will be need for the government to re-appraise incorporation and enforcement of sex education in our school curriculum.

Earlier there were concerns on channel of sex information delivery in the schools. However, emerging evidences now show that both teachers and peers can be used to deliver sex education in the schools if given appropriate training [22,27,28]. There should be capacity building of Guidance and Counsellors on issues of sexuality. Supply of audio-visual materials that enhances understanding of reproductive physiology is essential. And, trained peer educators will be able to sub-serve both in-school and out-of-school girls. Trained students can inform, counsel and distribute non-prescriptive contraceptives to their colleagues [28,29]. In the same vein, employment of diversionary activities like sport competition, debates, etc can positively engage the minds of the youths.

Most of the respondents fairly had a good knowledge of the implication of early sexual derby. Seventy three percent (73%) knew early sexual intercourse could result in pregnancy, 60.8% are aware they could contract HIV/AIDS while 85% knew that early sexual experimentation could lead to school drop-out. Despite this, early sexual derby was rampant. It shows that although acquisition of knowledge is usually the first stage in the process of behavioural change, knowledge alone is often not sufficient to produce change in sexual behaviour in most people [30]. Our values equally play a role in our choices.

Parents have a critical role of inculcating right values in their children, not delegating to government. Studies in Nigeria have reported high rate of parental aversion in discussing sexuality issues with their children [31]. This ought not to be. Basic unit of the society is the family and charity will begin at home. Sensitization efforts should be deployed to awake parents to their responsibilities. Involvement of community leaders- Obas,

Chiefs; Opinion leaders, Iyalojas/Iyalajes and religious leaders in the advocacy at promoting our rich moral values within the family unit may yield resounding dividend.

This survey showed that the general knowledge of HIV/AIDS infection was below average. Only 48.3% know the cause of the infection. Although 86% knew that HIV/AIDS could be acquired through unsafe sexual practices, 42.5% still felt abstinence could be a cause of the infection. Forty percent (40%) were of the opinion that transmission is possible through handshake while 28% said infection could occur through the use of condom. This finding compares well with previous local studies where poor knowledge of HIV/AIDS infection has been demonstrated among the adolescents [32,33].

It will therefore be important to improve enlightenment campaign on HIV/AIDS infection among our youths in the State. They should have no ambiguity on preventive measures to avoid infections. The campaign should also be directed to correct myths and misconceptions about HIV/AIDS.

As at the time of survey, 17.5% of the girls were sick. Our youths need information on healthy habits that promote wellbeing and they need to be taught on health-seeking behaviours. Our schools should have sick bays where students are promptly attended to so that they can quickly recover and resume classes.

CONCLUSION AND RECOMMENDATION

This survey of the girl child in Ekiti State showed a female secondary school enrollment that is higher than the National average. Age of menarche in Ekiti State was comparable with other regions in the country.

Knowledge of menstrual history and fertility was poor as less than half of respondents could remember their last menstrual period or know how to predict ovulation period. Majority had early sexual derby with a quarter previously pregnant.

Knowledge of contraception was below average. Mostly, information on contraception was obtained from friends followed by radio jingles. The girls had a fair knowledge of implication of early sexual derby, though it did not translate to behavioural change. Knowledge of HIV/AIDS infection and transmission was equally poor as a sizeable portion of respondents felt HIV/AIDS could be caused by abstinence, handshake or use of condom.

With the observations from this survey, the following actions/steps are needful to improve the situation of the girl child in Ekiti State:

1. Elimination of all forms of gender discrimination. Campaigns directed towards eschewing all vices against the girl child and abusive cultural practices should be intensified across the state.
2. Extreme poverty and hunger should be eradicated. Our females should be empowered to make them less vulnerable to sexual exploitation due to imbalance in power relations.
3. Efforts should be deployed to increase current level of girl child education in Ekiti state. We should have a bench mark of achieving 100% school enrollment till secondary level for the girls.
4. Legislation that enforces compulsory girl child education should be enacted and fully implemented.
5. Sex education should be introduced to our school curriculum and taught.

6. State should deploy resources to train personnel – teachers, peers, community volunteers, etc, in sex education to ensure appropriate, correct and precise information dissemination on sexual matters.
7. Since family is the fulcrum of the society, the government should step up awareness campaign on need for parents to rise up to the responsibility of teaching good ideals and moral values at homes.
8. The State should involve community leaders- Obas, Chiefs; Opinion leaders, Iyalojas/Iyalajes, market women and religious leaders in the advocacy at promoting our rich moral values within the family unit.
9. More Non-governmental Organizations and Civil Societies should make issues of girl child priority actions in their projects.
10. The State should establish Youth Friendly Centres where youths will have access to Reproductive Health services within the Community. At least each Local Government should have such centre.

With the above recommendations and more, it is hopeful that the situation of the girl child will improve in Ekiti State.

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