EDUCATIONAL BACKGROUND AND SEX AS CORRELATES OF REPRODUCTIVE HEALTH SERVICES AMONG UNMARRIED ADOLESCENTS IN EKITI STATE

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ABSTRACT

The study examined the educational background and sex as correlates of reproductive health services among unmarried adolescents in Ekiti State. The problem of the study arose from observed reproductive health issues faced by unmarried adolescents in Ekiti State. Descriptive research of the survey type and correlational design was employed. The population for the study was all the unmarried adolescents in the sixteen local government areas of Ekiti State. The instrument used was a questionnaire designed by the researcher titled "Unmarried Adolescents' Reproductive Health Questionnaire" (UARHQ). The data generated was analysed using descriptive and inferential statistics. It was found that many unmarried adolescents in Ekiti State are sexually active and that the status of reproductive health services influences them. The factors which affect the status of reproductive health of unmarried adolescents in Ekiti state include their educational background and sex. The findings of this study led to the conclusion that unmarried adolescents in Ekiti State have poor status of reproductive health. It was recommended that donors, governments, humanitarian organizations and development agencies need to urgently address adolescents' sexual and reproductive health issues.

Keywords: Educational Background, Sex, Unmarried Adolescent.

INTRODUCTION

Nearly one third of Nigeria's total population is between the ages of 10 and 24 (Population Reference Bureau, 2008). Nigerian adolescents' sizeable share of the population makes them integral to the country's social, political and economic development. Inadequacy of sexual health information and services appear to make young people vulnerable to sexually transmitted infections (STIs) and unwanted pregnancy. However, many organizations are working to improve adolescents' reproductive and sexual health through advocacy and prevention programmes.

In fact, in many countries in Africa, especially Nigeria and particularly in Ekiti State, adolescents constitute approximately thirty-three per cent of the population. Adolescence is the transition from the world of childhood to the world of adulthood. It is a period of physical and emotional development almost as rapid as the first decade of life. At this time, the body matures and the mind becomes more questioning and independent.

It seems the physiological changes which take place during this period of transition from childhood to adulthood result in the formation of sexuality and present the first challenge to healthy adolescent growth. During this period, adolescents often engage in sexual exploration and experimentation without adequate knowledge of reproductive health issues and credible information sources.

In most parts of the world and in Nigeria in particular, more than 90 percent of young people know at least one contraceptive method, but usage rates seem to remain low, especially in rural areas. This is probably due, in part, to the lack of youth-friendly services, myths about sexuality and reproductive health, lack of knowledge about sexual and reproductive rights, as well as gender inequality (Osakinle, Babatunde and Alade, 2013). It seems that one of the largest obstacles that young people face today is the lack of health services that work with their priorities and needs.

Ola (2004) in her findings revealed that Ekiti State did not have specific adolescent friendly preventive reproductive health services while adolescents in the State had unmet need for contraception, abortion, access to health information and preventing sexually transmitted diseases including HIV/AIDS. The level of access and utilization of preventive reproductive health services by adolescents seems to be low. This may be due to the following factors: lack of adolescent-friendly services, lack of relevant and appropriate service delivery-centered approaches which can improve access to family planning services for adolescents.

Traditionally, Nigerian masculinity is defined by strength, a desire for sex and not allowing oneself "to be dominated by a woman." This traditional model of masculinity encourages men, young and old, to dominate women. In male-dominated relationships, men may be less likely to accept a woman's request to use a condom or her desire to abstain from sexual engagement entirely, thereby increasing sexual and reproductive health risks for both partners. The influence of masculinity and perceived "machismo" (a strong sense of masculine pride) appears to limit the use of sexual and reproductive health services by young men. Young men, often, believe that use of health services and other positive-seeking behaviours signifies a sign of weakness. The role of gender norms and values in determining Adolescents Sexual and Reproductive Health (ASRH) behaviour has not been systematically documented. With the increasing importance of analysing reproductive health issues from a gender perspective world-wide, it has become obvious that gender norms and values make significant contributions to adolescent sexual behaviour and Reproductive Health (RH). Many cultures show preference for the male child and accord him privileges often to the exclusion of the female child. This leaves the female with little or no education and at a low socio-economic stratum with sex as the only bargaining tool.

The educational background of adolescents is another major area of concern in dealing with adolescents' sexual and reproductive health. There is no study that has looked into the effect of formal education on ASRH while controlling for such confounders as age and socio-economic background. However, the few studies that disaggregated their data according to educational characteristics showed that adolescents with little or no formal education appear to be more likely to have had sex and would have initiated sex earlier. Analysis of the NDHS data according to years of education showed that among adolescents aged 15 -19 years who had less than 7 years of education, the percentage that had given birth was 32.8% compared to 7.7% among adolescents that had at least 7 years of education (Singh, Audan and Wulf, 2004).

Statement of the Problem

Although adolescents share many characteristics with adults, their health related problems and needs are different. Adolescent sexuality remains a global challenge particularly in developing countries. Although most adolescents become sexually active before the age of 20, the sexual contacts are generally unprotected. Every day, more than a quarter of a million

young people become infected with an STD, and more than half of all new HIV infections occur in young people.

Sexual activity among young people is not always consented and this exposes them to greater risks. Thus, adolescents are more vulnerable to rape, harassment, sexual exploitation, physical and verbal abuse because they are less able to prevent or stop such manifestations of power. Providing information and services to adolescents may likely improve their health. Despite this recognition, socio-cultural and policy barriers, as well as lack of adolescent-specific services appear to make it difficult for adolescents to access and utilise reproductive health services.

The religious belief of some parents and unmarried adolescents appears to negate the preaching of reproductive health workers on the utilization of reproductive health services. Religions differ in their stand on fertility regulation and among the major world religions, Catholicism and Islam are widely regarded as pronatalist in their ideology. However, the relationship between religion and contraceptive use is much more complex than expected. It has also been hypothesized that there is a positive correlation between reproductive health knowledge and level of education. Other things being equal the higher the level of education the higher the knowledge of reproductive health is expected to be.

The present study is designed to examine the psychosocial variables as correlates of reproductive health services among unmarried adolescents in Ekiti State. The specific purpose of the study is to investigate the status of reproductive health services available in the state, investigate the influence of educational background, belief system, religion, age, sex, location and social-economic status on unmarried adolescents` status of reproductive health.

It is also to determine the level of the unmarried adolescent access to reproductive health services, determine the frequency of use of reproductive health services by the unmarried adolescents, and ascertain constraints to access and use of reproductive health services among the unmarried adolescents. To achieve this, the study sought to answer the following general question:

What is the status of reproductive health of unmarried adolescents in Ekiti State?

Research Questions

1. Will sex of unmarried adolescents influence their status of reproductive health?
2. Will educational background of unmarried adolescents influence their status of reproductive health?

Research Hypotheses

1. There is no significant relationship between the sex of unmarried adolescents and their status of reproductive health.
2. There is no significant relationship between the educational background of unmarried adolescents and their status of reproductive health.

LITERATURE REVIEW

The constructions of adolescence and adolescent sexual health are central to the discourse of ASRH services. The meanings of adolescence and ASRH vary across cultures and ethnic groups. Due to these variations, "the lives and sexual and reproductive health needs of adolescents may vary considerably across these different groups, and programmes and interventions need to be designed to take that diversity into account" (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction [HRP] 2002). As such, understanding the conceptualisations of adolescence and sexual health in specific cultural context is necessary for effective ASRH programming.

Generally, adolescence is considered a time of transition from childhood to adulthood during which there are physical changes associated with puberty (Adamchak, 2000). From this biological perspective, adolescence is defined as a period of lifespan of between the ages 10 to 19 years (WHO 2003). The period of adolescence is characterised by a number of changes including physical and emotional changes, the search for identity and greater maturity in reasoning. It is considered as the period during which the individual progresses from the initial appearance of secondary sexual characteristics to that of sexual maturity, whereby individual's psychological processes and patterns of identification develop from those of a child to an adult (WHO 2003). Thus, adolescence is considered as a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood (Caldwell, 1998).

However, defining 'adolescence' from the biological perspectives is problematic. The fall in the age of menarche from sixteen and seventeen in the mid nineteenth century to just under thirteen in 1960 can make definition of adolescents varying according to contexts (Cameron, Kgamphe and Levin, 1991). Socially, the notion of adolescence is not the same everywhere. Although the utilization of the concept of adolescence is so widespread in SRH literature, the term usually alludes to different phenomena. Because it is a culturally defined phenomenon, adolescence is a term whose meaning is variously defined in the literature (Schlegel 1995; Caldwell., 1998). Furthermore because adolescence is experienced differently in every society; and even within societies there may be vast differences in how some youth experience adolescence as compared to others (Schlegel 1995; Caldwell, 1998).

Adolescence as a biological concept may be misleading due to the variations in the social responsibility and cultural constructions in various contexts. Therefore, defining adolescence simply in terms of biological and chronological age is atheoretical and limits the potential for understanding underlying processes associated with adolescence for the production of sexual risk-taking behaviours. As such, Van and Wells (2003) states that adolescence should be considered a phase rather than a fixed age group, with physical, psychological, social and cultural dimensions perceived differently by different cultures.

However, as the notion of adolescence varies from society to society, this makes it increasingly difficult to provide any meaningful definition of adolescence and this explains why, for the most part, adolescents are defined as all those belonging to a defined age group (Family Health International, 2000).

Educational Background and Reproductive Health

The educational background of adolescents is another major area of concern in dealing with adolescents' sexual and reproductive health. There is no study that has looked into the effect of formal education on ASRH while controlling for such confounders as age and socio-economic background. However, the few studies that disaggregated their data according to educational characteristics showed that adolescents with little or no formal education appear to be more likely to have had sex and would have initiated sex earlier. Analysis of the NDHS data according to years of education showed that among adolescents aged 15 -19 years who had less than 7 years of education, the percentage that had given birth was 32.8% compared to 7.7% among adolescents that had at least 7 years of education (Singh, Audan and Wulf, 2004).

Educational background is very important in enhancing positive knowledge, attitudes and behavioral change in adolescents towards their sexual and reproductive health. School, health facility, and community based adolescent sexual and reproductive health education programs showed positive outcomes in changing knowledge, attitudes and behavior related to adolescent sexual and reproductive health outcomes (Cupples, Zukoski and Dierwechter, 2010).

The college environment should have been the safest place for adolescents but on the contrary, it offers great opportunity for HIV high-risk behaviors, including unsafe sex and multiple partnerships. While the overall incidence of HIV infection has seen some decline in recent years, rates of HIV infection among young adults have not seen a proportionate decline. (Adefuye, Abiona, Balogun and Lukobo, 2009).

Gender and Reproductive Health

Reproductive health is a good starting point for addressing gender issues (MCSH, 2006). The HIV/AIDS epidemic has demonstrated that existing reproductive health programs are having limited impact in helping countries achieve overall reproductive health and development goals (Greene, Mehta, Pulerwitz, Wulf, Bankole and Singh, 2006). The International Conference on Population and Development (ICPD, Cairo, 1994) and the Fourth World Conference on Women (FWCW, Beijing, 1995) both clearly emphasized the need to promote gender equity and equality in reproductive health policies and programs, and to promote and protect human rights. More recently, these agreements were reinforced in the five-year reviews of both conferences, held in 1999 and 2000 respectively. Furthermore, the United Nations Population Fund (UNFPA) also supports a gender-and rights-based approach to reproductive and sexual health that empowers women throughout their lives. They recognize that reproductive rights become tangible only when reproductive health services offer a high quality of care and are made widely available (UNFPA, 2006).

In particular, sexual and reproductive health (SRH) was given an international consensus definition at the International Conference on Population and Development (ICPD) earlier in 1994. Since then, international family planning has expanded from its emphasis on the delivery of clinical services to married women of reproductive age. This emphasis has made important contributions to the health and well being of women and their families (Greene *et al*, 2006). Recently, the ICPD adopted the goal of ensuring universal access to reproductive health by 2015 as part of its framework for a broad set of development objectives. The Millennium Declaration and the subsequent Millennium Development Goals (MDGs) have

also set priorities closely related to these objectives. It is understood that progress towards the MDGs depends on attaining the ICPD reproductive health goals (Bernstein and Hansen, 2006).

Sexuality and relationships education curricula in the schools as well as out-of-school health-promotion, life-skills and capacity-building programmes provide opportunities for young people to question the content of prevailing male and female gender scripts and adopt new ways of thinking and behaving (Haberland and Rogow 2007). The guidelines and activities of It's All One Curriculum are especially designed for this purpose (Haberland and Rogow 2009). Interventions may be gender neutral in treating boys and girls the same with respect to content and methods; gender sensitive in attempting to meet the different existing needs and interests of boys and girls; or gender transformative in their goal of empowering girls to know and assert their rights, and conscientizing boys to respect the equal rights of women without coercion or violence and to clarify and fulfil their responsibilities (Barker, 2007).

Research could help to identify the main features of gendered beliefs and behaviours among girls and boys in different populations, their sources, and their flexibility, including tolerance of sexual and gender diversity; the ages and stages at which adolescents are most receptive to questioning gender roles and considering alternative views; and the effectiveness of initiatives aimed at transforming their attitudes and behaviours. Gender roles are acted out in the context of specific sexual cultures. A prohibitive sexual culture disapproves strongly of all sexual relations outside of marriage, for example, whereas a restrictive or conservative culture might tolerate premarital intercourse with an intended spouse but not with other partners. A moderate sexual culture would tolerate non-marital sexual relations with a regular partner – a steady girlfriend or boyfriend, perhaps – and with more than one partner; a permissive one would also tolerate multiple casual relationships, even to the point of exchanging sexual intercourse for money or gifts and having sexual intercourse with strangers. These are among the sex–gender rules that young adolescents are expected to learn from their parents, peers and other sources. Degrees of tolerance differ for males and females within these rule sets, of course (and for persons with alternative gender identities or sexual orientations), and intersect with age, class, race, ethnicity and other personal and social characteristics to determine what is permitted and what is not.

Research Method

Descriptive research of the survey type and correlational design was used. Descriptive design was considered appropriate because observations and perception of existing situation was described and interpreted. This was done in relation to issues, conditions practices or relations existing already. Also status, belief, attitude held and practices that is going on among the respondents was observed. The correlational design method was also considered appropriate because it entails systematic investigation into the relationships that existed between the psychosocial variables and the status of unmarried adolescents reproductive health.

The population for the study includes all the unmarried adolescents in the sixteen local government areas of Ekiti State. Which involved those in the market places, churches, mosques, rural and urban areas, schools and hospitals take part in the study. The total number of adolescents in Ekiti State was approximately seven hundred and eighty six thousand, seven hundred and eighty nine (786, 789) as of the time this study was conducted based on census of 2006.

The sample used for the study was 696 respondents chosen from sixteen local government areas of Ekiti State. Simple and multistage sampling technique was used. Balloting technique was used to select the 6 local government areas out of the 16 local government areas. This was done by writing each local government in a sheet of paper, squeezing the paper and after thorough mixing one was picked at a time until the total of six was picked from the total of 16 local governments. Simple random sampling technique was used to select four towns and villages from each of the six selected local government area selected. Simple and stratified random sampling technique was used to select unmarried adolescents based on sex, location, religion, socio-economic status and educational status.

The data generated was analysed using descriptive and inferential statistics. Descriptive statistics of frequency counts and percentages was used to answer the general questions. The hypotheses were tested using inferential statistics. Hypotheses one to seven were tested using correlation while hypothesis eight was tested using regression analysis. All the hypotheses were tested at 0.05 level of significance. Regression analysis was used to predict the variable that has the greatest impact on adolescents' reproductive health.

RESULTS

Question 1: What is the status of reproductive health of unmarried adolescents in Ekiti State? In other to answer the question, responses on items relating to status of reproductive health of unmarried adolescents in Ekiti State were subjected to frequency counts and percentages. The result is presented in Table 1.

Table 1: Status of Reproductive Health of Unmarried Adolescents in Ekiti State

S/N	ITEMS	YES	NO
1	Have you ever had a boyfriend/girlfriend/partner	480(69.0)	216(31.0)
2	Have you ever lived with a boyfriend/girlfriend/partner	142(20.4)	554(79.6)
3	Have you had sexual intercourse recently	198(28.4)	498(71.6)
4	Did your partner agree to use a condom the last time you had intercourse with him/her	304(43.7)	392(56.3)
5	Have you ever had any kind of sexual experience (kissing, petting or penetrative intercourse)	436(62.6)	260(37.4)
6	The first time you had intercourse, were you forced into it against your will?	192(27.6)	504(72.4)

Percentage are enclosed in parentheses

Table 1 shows that 69% of the total sample had boyfriend/girlfriend /partner, 20.4% had lived with a boyfriend/girlfriend/partner, 28.4% have had sexual intercourse recently, 43.7% report that their partners agreed to use a condom during sexual intercourse, 62.6% exhibit one form of sexual experience ranging from kissing, petting to penetrative intercourse while 27.6% were forced into sexual intercourse against their will during the first time they had intercourse. Table 1 further depicts the adolescents' status of reproductive health.

Hypothesis 1: There is no significant relationship between the sex of unmarried adolescents and their status of reproductive health.

Table 2: Pearson Product Moment Correlation Showing the Relationship between the Educational Background of Unmarried Adolescents and their STATUS of Reproductive Health.

Variables	N	Mean	S.D	r_{cal}	r_{tab}
Educational background	696	17.35	2.528		
Reproductive health status	696	9.48	1.619	0.539*	0.195

P<0.05

Table 2 reveals that r_{cal} (0.539) is greater than r_{tab} (0.195) at 0.05 level of significance. The null hypothesis is rejected. This implies that there is significant relationship between the educational background of unmarried adolescents and their status of reproductive health.

Hypothesis 2: There is no significant relationship between the religion and unmarried adolescents` status of reproductive health.

Scores relating to the religion of unmarried adolescents and their status of reproductive health were computed for statistical significance using Pearson Product Moment Correlation at 0.05 level of significance. The result is presented in Table 7.

Table 3: Pearson Product Moment Correlation Showing the Relationship between the Sex of Unmarried Adolescents and their Status of Reproductive health

Variables	N	Mean	S.D	r_{cal}	r_{tab}
Sex of unmarried adolescents	696	17.30	2.265		
Reproductive health status	696	9.48	1.619	0.594*	0.195

P<0.05

Table 3 shows that there is significant relationship between the sex of unmarried adolescents and their status of reproductive health. This is because r_{cal} (0.594) is greater than r_{tab} (0.195) at 0.05 level of significance. The null hypothesis is therefore rejected.

DISCUSSION

The result shows generally a poor status of reproductive health of unmarried adolescents in Ekiti state. Many unmarried adolescents in Ekiti State are sexually active at their early age and have practice one form of sexual activity or the other. Substantial part of them has had boyfriend/girlfriend/ partner. Unmarried adolescents in Ekiti State have poor knowledge of contraceptives. Majority of them have never visited health centers, private doctor, chemist or even government clinic for prevention, treatment or information on sexually transmitted diseases.

The result shows a significant relationship between educational background of unmarried adolescents and their status of reproductive health. Unmarried adolescents with little or no formal education are more likely to have had sex and would have initiated sex earlier. Analysis of the NDHS data according to years of education showed that among adolescents aged 15 -19 years who had less than 7 years of education, the percentage that had given birth was higher compared to adolescents that had at least 7 years of education (Singh, Audan and Wulf, 2004). Education has been a very important determinant of unmarried adolescents' sexual activities in the developing world according to the demographic and health surveys that have been conducted worldwide in the 1990s (World Population Monitoring, 2002).

From the result, unmarried adolescents who have attained secondary education know more about reproductive health than those who have not. They have better idea where reproductive health services can be obtained and at the same time have information on supply sources for specific contraceptive method. This was further confirmed by a personal visit made by the researcher to a community health center in Efon Alaaye Local Government Area of Ekiti State. One of the health provider confirmed that unmarried adolescents who have attained or in the process of attaining secondary education seek reproductive health information from the health center more than those who only have primary education or no education at all.

Similarly, there is significant relationship between the sex of unmarried adolescents and their status of reproductive health. The study revealed that unmarried adolescents still belief that contraception is girls' responsibility. Nevertheless, the fact that a majority of respondents did not agree suggests that such belief are malleable and that at least many unmarried adolescents are receptive to other points of view. To support this result, among a sample of unaffiliated, apprenticed and in-school young people aged 12–24 years in Ghana, for example, higher number of adolescents believed that a man may justifiably beat his girlfriend (Glover, 2003). Such masculine power has led so many male to forcefully have canal knowledge of their female counterparts. For example, some unmarried adolescents agree that they were forced into having sex the first time they had sex.

CONCLUSION

The findings of this study led to the conclusion that unmarried adolescents in Ekiti State have poor reproductive health status. Unmarried adolescents in Ekiti State have poor knowledge of contraceptives even though many of them are aware of condom and its use but they are not well informed about many other contraceptive methods available. The status of reproductive health services is poor and it influences unmarried adolescents in Ekiti state. There is significant relationship between socioeconomic status, belief, educational background, religion, age, sex and location and unmarried adolescents' status of reproductive health. The single best predictor of unmarried adolescents' status of reproductive health is sex.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

For improved access to sexual and reproductive health services for unmarried adolescents, donors, governments, humanitarian organizations and development agencies need to urgently address adolescents' sexual and reproductive health from the onset of an emergency through protracted crisis and recovery.

Community sensitization programs should be implemented through the local administration, folk theatre, cultural groups, youth and women`s organizations, schools and extension services. Trained health workers should be mobilized to transmit health messages to unmarried adolescents and serve as agents of change in their respective communities.

International non-governmental organizations concerned with protecting the health of unmarried adolescents should extend their financial and material support to national non-governmental organizations to ensure the success of their activities.

Non-governmental organizations already positively engaged in activities for the dissemination of reproductive health information to unmarried adolescents should intensify those activities.

Health workers should be required to dissociate themselves completely from harmful traditional practices.

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