

## **Unmet reproductive health needs of adolescents: implications for HIV/AIDS prevention in Africa**

**Iwalola Onifade**

*Youth Empowerment Foundation, Ijapo Housing Estate, Akure*

The foundations for sexuality, reproductive health and gender relations are laid very early in life and these are influenced by the interplay of socio-cultural and economic factors, peer-pressures, mass media influences and familial forces which impinge on the lives of adolescents in the society.

Adolescents of today constitute one of the most dynamic human resource bases. Unfortunately, they are missing out in the area of education about sexual and reproductive health. This is despite their strong desire to participate in activities geared towards their reproductive health and social development needs.

Adolescence according to WHO is the period of progression from the appearance of secondary sexual characteristics (puberty) to sexual and reproductive maturity, the development of adult mental processes and adult identity as well as the transition from total socio-economic dependence to relative independence. Adolescents are aged 10 to 19 years and they constitute 20 per cent of the world's population. This sheer size of the adolescent population should justify seriously addressing adolescent health issues, but this is not the case in developing countries.

In Nigeria for many years, the health of adolescents has been neglected. This is because they are believed to be less vulnerable to diseases than children and the very old. However, young people are highly vulnerable to social changes. In recent times, in many societies, changes in sexual and social mores have increased the risks of unwanted pregnancy and sexually transmitted diseases including AIDS. Also, the propensity of youth to experiment with drugs such as marijuana is now increasing (WHO 1993; Akinyele and Onifade 1996).

In developing countries, Nigeria included, it is estimated that as many as 60 per cent of all adolescent pregnancies and births are unintended. Early pregnancy can compromise young women's health through childbearing or unsafe abortion. Early parenthood can also interrupt schooling, which can lead to fewer job opportunities and lower income (McCauley *et al.* 1995). Every year, millions of young people contract a sexually transmitted disease (STD) (Population Reference Bureau 1994). It has been established that the presence of an STD leads to a decline in health and possible infertility as well as an increase in the likelihood of HIV transmission (Elias and Heise 1993). It has also been well documented that approximately half of all HIV infections thus far have occurred in men and women under the age of 25, and in many developing countries recent data indicate that up to 60 per cent of all new HIV infections are among 15-24-year-olds, with females outnumbering males by a ratio of 2 to 1 (Family Care International 1995; WHO 1995).

### **The unmet needs**

In the 1990s, family planning programs have faced the challenges of finding better ways to deliver services to millions of people who would use family planning if they could. One indicator of the size of this challenge is unmet need for family planning. This concept of

unmet need describes married women who are able to bear children but are not using contraception despite their statements that they either do not want to have any more children or want to wait at least two more years before having another child (Westoff and Ochoa 1991).

By this definition, in the developing world as a whole, about 120 million married women – about one in every five – have unmet needs for family planning, either for limiting or spacing births (Robey *et al.* 1992). In most countries surveyed by the Demographic and Health Surveys (DHS), between 20 and 30 per cent of all married women of reproductive age have an unmet need for family planning. Outside sub-Saharan Africa, most women with an unmet need do not want to have any more children, whereas in sub-Saharan countries, most unmet need is for spacing births.

Another indicator of the challenges facing family planning programs described as ‘the ultimate unmet need for family planning’ (Coeytaux 1993) is that more than 50 million women each year terminate their pregnancies with abortions, most of them illegal and dangerous; unmet need for family planning has a highly significant relationship with the increasing incidence of abortion.

The concept of unmet needs has been expanded to other groups. This is significant in view of the degree to which unmet needs contribute to persistently high mortality and morbidity rates. Groups that must be included are young people, husbands and unmarried adults of both sexes. The issue of unmet needs must therefore cover all groups of people that have a significant role to play in the reproductive cycle of women.

In African countries, access to family planning and reproductive health service is highly limited. The highest level of access is found in Mauritius (75%) but in Nigeria, Sudan, Tanzania and Zambia, only 7-24 per cent of the demand for family planning services for adolescents (15-19 years) is satisfied. Of married women aged 15-49 years, only 18-26 per cent have access to family planning services.

The concept of ‘unmet needs’ considered in this paper encompasses adolescents’ access to family planning services and information on reproductive health issues. This paper also presents a summary of relevant results of a three-year project conducted in Ondo and Ekiti states in South-Western Nigeria.

## **The study**

An initial baseline was established through a questionnaire, focus-group discussion sessions and in-depth interviews. The study areas were Akure, Ado-Ekiti, Igbokoda, Igbekobo and Aiyetoro. Both in-school and out-of-school adolescents took part in the study. A sample of 1758 adolescents comprising 829 males and 929 females were studied. A total of 17 schools participated in the study, eight in Akure, six in Ado-Ekiti and three in the old Ilaje-Eseodo Local Government Area. A total of 36 vocational training institutions were also studied, 18 in Akure, nine in Ado-Ekiti and nine in Ilaje. The respondents who participated in the study were between the ages of 11 and 25 years.

### ***The study instruments***

The instruments used were for both qualitative and quantitative research. A questionnaire was used to collect quantitative data sets while focus-group discussions and in-depth interviews were used to complement information from the questionnaires. Focus-group discussions and

in-depth interviews were used to collect qualitative information from respondents. The questionnaire was divided into six sections: (1) demographic information; (2) current social behaviour; (3) current sexual relationships; (4) contraceptive use and knowledge; (5) knowledge of sexually transmitted diseases and (6) reproductive health needs.

## Results

Findings from this study indicate the urgency of addressing the unmet needs of adolescents. This is considered under specific topics and compared with studies from outside the country to emphasize key points.

### *Current sexual relationship*

Age at first intercourse varies among countries and regions. Although many assume that most adolescents start having sexual intercourse at earlier ages than previous generations, this is not the case (UN 1994). In fact age at first intercourse is the same for women between the ages of 20 and 24 and those between the ages of 45 and 50.

From this study at least 37 per cent of male and 22 per cent of female adolescents had had sexual intercourse; 23 per cent of the males and 15 per cent of the females were currently having sexual intercourse. Most of these sexual activities occur outside marital unions.

In all societies a larger percentage of boys than girls report being sexually active at early ages. For example, in Latin America age at first intercourse for boys is between 13 and 16 years and it is from 16 to 18 for girls. This study obtained similar results with ages 11 to 15 years for boys and 16 to 20 years for girls (see Table 2). Contrary to what occurs in some countries, the majority of respondents in this study had their first sexual intercourse with their boyfriends and girlfriends. Most of the respondents who had their sexual initiation with relatives had been abused.

**Table 1**  
**Occupation of respondents**

	Males		Females	
	Number	Percentage	Number	Percentage
Sex	829	47.2	929	52.8
Occupation				
Student	725	87.5	756	81.4
Apprentice	63	7.6	144	15.2
Artisan	7	0.8	2	0.2
Trading	12	1.4	19	1.2
Other	22	2.7	8	1.2

**Table 2**  
**Current sexual relationship**

	Male		Female	
	Number	Percentage	Number	Percentage
Have girlfriend/boyfriend				
Yes	374	45.1	351	37.8
No	454	54.8	559	60.2
No response	1	0.1	19	2.0
Have had sexual intercourse before	311	37.5	211	22.7
Age at first intercourse				
1-5 years	3	0.3	2	0.2
6-10 years	21	1.5	1	0.1
11-15 years	134	16.1	32	3.4
16-20 years	122	14.7	149	16.0
No response	31	3.7	27	2.9
First sexual partner				
Girlfriend	257	31.0	2	0.2
Boyfriend	3	0.4	185	19.9
Relative	17	2.1	16	1.7
Prostitute	9	1.1	3	0.3
Others	12	1.4	-	-
Currently having sexual intercourse	194	23.4	143	15.4
No response	13	1.6	5	0.5
Number of current partners				
1	132	15.9	132	14.2
2-5	36	4.5	5	0.5
6 or more	14	0.2	-	-
Have had sexual intercourse against will	53	6.4	25	2.7
Have had sexual intercourse with same sex	50	6.0	21	2.3

Young male adolescents often report multiple partners while the females more commonly report having sexual relations with only one person. This, however, is not the case here. Although most have only had one partner, 36 males reported having had two to five sexual partners, while only five females reported the same. The need for urgent action is crucial as 14 of the male respondents claimed to have had more than six partners.

One issue that is often not given the necessary attention is sexual violence and coercion. World-wide, young adults and children suffer the physical and emotional traumas of sexual assault and rape. This is very difficult to quantify because a lot of it goes unreported. It is known that many young people suffer from sexual abuse, sexual coercion, incest and violence and in fact most of the perpetrators are not strangers but relatives, neighbours and acquaintances (Nyonyintono and Yiga 1994).

**Table 3**  
**Knowledge and use of contraceptives**

	Males		Females	
Have heard about contraceptives	502	60.6	623	67.1
Source of information on contraceptives				
Peers	131	15.8	140	15.1
Parents	49	5.9	89	9.6
Teacher	35	4.2	54	5.8
Boy/girlfriend	31	3.7	29	3.1
Books	94	11.3	130	14.0
Media	162	19.5	181	19.4
Have used contraceptives	111	13.4	70	7.5
Contraceptives used				
Condoms	85	10.3	20	2.2
Pills	5	0.6	10	1.1
Diaphragm	3	0.4	4	0.4
Withdrawal	n.a.	n.a.	n.a.	n.a.
Rhythm	8	1.0	25	2.7
Foaming tablet	9	1.1	8	0.9
Douche	-	-	2	0.2
IUD	1	0.1	-	-

n.a.: data not available.

The younger a female is when she first experiences sexual intercourse, the higher the chances that the sexual activity is coercive. Two major points are of relevance in this study. Apart from the fact that a significant number of respondents (53 males and 25 females) have had coercive sex, a significant number also had sex for the first time with their relatives (17 males and 16 females). In addition, 21 males and three females had sex before or at 10 years of age. These key points certainly indicate that we may be addressing the wrong people when it comes to sexual violence. This study shows that more males than females were sexually abused. We may therefore have to focus our attention on this group of male adolescents to get an overall picture of sexual coercion in adolescence.

Sexual abuse early in life can lead to high-risk behaviour in later life, which includes early onset of consensual union (Boyer and Fine 1992). All these issues (sexual coercion, multiple sexual partners, early initiation to sex) are factors which predispose the adolescents to HIV/AIDS transmission. A lot of research is still needed in the area of sexual violence and coercion.

#### ***Knowledge and use of contraceptives***

The results of this study confirm that respondents are aware of the existence of devices and methods for preventing conception. Major sources of information on contraception are the media and peers.

**Table 4**  
**Knowledge of sexually transmitted diseases (STDs)**

	Male		Female	
Have heard of STDs	652	78.6	750	80.7
STDs known				
Gonorrhoea	502	60.6	522	56.2
Syphilis	121	14.6	116	12.5
Herpes	37	4.5	27	5.1
Genital warts	53	6.4	47	5.1
Pubic lice	104	12.5	133	14.3
AIDS	582	70.2	692	74.5
Others	4	0.5	5	0.5
Knowledge about STDs				
Antibiotics prevent STDs				
True	-	-	135	14.5
False	94	11.3	57	6.1
Don't know	413	49.8	549	59.1
Women can have STDs without feeling symptoms				
True	176	21.2	143	15.4
False	85	10.3	117	12.6
Don't know	384	46.3	471	50.7
STDs can be caught from toilets				
True	257	31.0	339	36.5
False	85	10.3	89	9.6
Don't know	30	36.3	305	32.8
STDs can cause sterility				
True	247	29.8	337	36.3
False	52	6.3	42	4.5
Don't know	344	41.5	357	38.4
Knowledge of HIV/AIDS				
Having many partners increases risk of contracting HIV/AIDS				
True	474	57.2	544	58.6
False	51	6.2	43	4.6
Don't know	127	15.3	156	16.8
HIV/AIDS can be contracted through kisses and mosquito bites				
True	303	36.6	341	36.7
False	185	22.3	191	20.6
Don't know	162	19.5	207	22.3
HIV/AIDS can be contracted through sharing needles				
True	436	52.6	470	50.6
False	58	7.0	61	6.6
Don't know	156	18.8	208	22.4
A healthy looking person can have HIV/AIDS				
True	265	32.0	240	25.8
False	173	20.9	232	25.0
Don't know	210	25.3	269	29.0

**Table 4 (cont.)**

	Male		Female	
HIV/AIDS can be cured if detected early				
True	136	16.4	157	16.9
False	238	28.7	229	24.7
Don't know	275	33.2	354	38.1
Adolescents who have contracted STDs				
Gonorrhoea	26	3.1	17	1.8
Syphilis	6	0.7	-	-
Not sure of type	17	2.1	18	1.9

The use of contraceptives is poor; only 13 per cent of males and seven per cent of females use them despite the fact that 23 per cent and 15 per cent are sexually active. This difference is an indicator of the unmet need for contraception, because none of the adolescents want to have babies at this time in their lives.

The failure to use contraceptives has been linked to the fact that adolescents do not expect to have sexual intercourse and thus are unprepared. Another reason is that most do not know about contraceptives and even if they do, they do not know how to obtain such services. Therefore, adolescents have an unmet need for information and services on contraception. They do not know where to obtain contraceptives and what to expect from service providers. Even when adolescents have information about contraceptives and access to services, many contextual factors affect the final decision to use them. These factors include attitudes about social and sexual roles, extent of communication between partners and the secrecy surrounding sexual activities of young people (Billy, Brewster and Grady 1994).

Many unmarried adolescents see contraception as something for married people, while some people disapprove of it because they believe that it encourages promiscuity. Some young girls who are involved with older men may even find it very difficult to discuss contraception with their partners. Some people cannot use contraceptives because sexual intercourse is unwanted and forced. All these issues increase adolescents' vulnerability to sexually transmitted diseases and unwanted pregnancies.

In this study, the most commonly used contraception for the males was the condom, while females use the rhythm method more. The second most common for males was foaming tablets and, for females, condoms. It should, however, be noted that the type of contraceptive used was considered between sexual partners on the basis of the most commonly used contraceptive: if the girl and her partner mostly use condoms, then this is the only form of contraception they report.

#### ***Knowledge of sexually transmitted diseases***

It is well documented that young people are particularly vulnerable to sexually transmitted diseases (STDs) because they know little about them. For example, 79 per cent of males and 81 per cent of females have actually heard about STDs. AIDS was the best-known (70% of males and 74% of females) and this was followed by gonorrhoea (60% of males and 56% of females). Even though adolescents are aware of the existence of STDs, their information is not necessarily accurate. For example, in the study only 10 per cent of both male and female

respondents believe that STDs cannot be caught from toilet seats; only 11 per cent of males and six per cent of females know that antibiotics cannot prevent STDs. This shows the highly erroneous information adolescents have about these types of disease.

Knowledge about HIV/AIDS is greater than about other STDs. For example, at least 57 per cent of males and 58 per cent of females know that having multiple sexual partners increases one's risk of getting HIV/AIDS; approximately 53 per cent of males and 51 per cent of females believe that sharing needles also increases the risk of getting HIV/AIDS. A significant number of respondents believe that HIV/AIDS can be contracted through kisses and mosquito bites (37% in both sexes). The view with respect to mosquitoes stems from the belief that since they can transmit malaria through infected blood, why not HIV/AIDS?

The debilitating effects of STDs and HIV/AIDS are far-reaching and have been documented extensively. It should, however, be emphasized that young people can be forced into sex and may have little power in sexual relationships to negotiate condom use, particularly if the sexual partner is older (Meursing and Sidindi 1995), a double risk since older men are more likely to be infected.

Incidence of STDs among respondents was not high but might be underestimated because information was obtained directly from the questionnaire and in-depth interviews. However, 26 (3%) males and 17 (2%) females reported having contracted gonorrhoea, while six males reported having contracted syphilis. Some of the respondents also said they had contracted some disease from sex and at least two per cent of respondents were sure of this although they were not sure of the type of STD.

### **Conclusions and recommendations**

The needs of young people vary according to age, sex, class, religion and culture, urban or rural residence and whether they are in school or out of school, married or unmarried, sexually active or not. Likewise, programs designed to meet diverse needs are clearly shaped by social and economic factors. While no program model would possibly suit all contexts, some basic principles can be derived from other program experiences to date. The starting point for any program is to listen to the young people's concerns and understand how they perceive their own needs. Many programs increase young adults' knowledge about reproductive health, a necessary first step, but information does not necessarily lead to behaviour change.

In a recent review of successful reproductive health programs which effected safe sexual behaviour in adolescents, nine key points were identified. Programs focused narrowly on reducing sexual risk-taking; were at least 14 hours long or involved intense small-group exercises; were based on the theory of behaviour change; used teaching methods that involved students; provided basic accurate information about the risks of unprotected intercourse and ways to protect oneself; addressed social pressures to be sexually active; reinforced clear values and presented messages that strengthened individual values and group norms against unprotected sex; modelled and practised communication and negotiation skills; and trained the individuals who conducted the training.

It is important to note the issues involved in the theory of behaviour change. The theory is based on the social learning theory, social influencing theory and theory of reasoned action. The social learning theory posits that people learn behaviour by observing and imitating others as well as through formal education. The social influence theory suggests that behaviour is shaped by group and individual norms and attitudes. Thus it is helpful for

people to identify social pressures and then to develop individual and group values that support healthy and appropriate behaviour. The theory of reasoned action asserts that people's intention to adopt new behaviour reflects their own beliefs, expectations and perceived norms. It is necessary to take note of all these crucial points when organizing intervention activities for young people.

Other important points include the fact that it is necessary to build community support by working with parents and community leaders. Programs should be based on needs assessment to serve as a baseline for future evaluation. Such programs must be attractive and interesting, so must use communication materials that engage the participants. They must reach out to youth wherever they are, particularly those out of school. And it is crucial to link communication programs with health services.

Meeting the needs of youth should also involve changing the messages portrayed by the mass media and by social and educational systems so as to develop caring, responsible and well-adjusted adults. In the long term, poverty must be addressed, so education, employment and other basic opportunities should be provided to give young people hope for the future.

## References

- Akinyele, I.O and I.O. Onifade. 1996. Trends in social behaviour among secondary school adolescents in Ibadan. Occasional Publication No. 5. Institut Français de Recherche en Afrique (IFRA).
- Billy, J.O., K.L. Brewster and W.R. Grady. 1994. Contextual effects on the sexual behavior of adolescent women. *Journal of Marriage and the Family* 56,2:387-404.
- Boyer, D. and D. Fine. 1992. Sexual abuse as a factor in adolescent pregnancy and child maltreatment. *Family Planning Perspectives* 24,1:4-11, 19.
- Coeytaux, F. 1993. Abortion: the ultimate unmet need. Pp. 701-708 in *Family Planning: Meeting Challenges, Promoting Choices. The Proceedings of the IPPF Family Planning Congress, New Delhi*, ed. P. Senanayake and R.L. Kleinman. New York: Parthenon Publishing.
- Elias, C. and L. Heise. 1993. The development of microbicides: a new method of HIV prevention for women. *Population Council Programs Division Working Paper* No 6. New York: The Population Council.
- Family Care International. 1995. *Commitment to Sexual and Reproductive Health and Rights for All Framework for Action*. New York.
- McCauley, A.P., C. Salter, K. Kiragu and J. Senderowitz. 1995. Meeting the needs of young adults. *Population Reports. Series J. Family Planning Programmes* 41:1-43.
- Nyonyintono, R. and D. Yiga. 1994. Sex abuse. *Women and Health* 2,2:30-35.
- Population Reference Bureau (PRB) and Center for Population Options(CPO). 1994. A special focus on reproductive health. *PRB and CPO Fact Sheets*.
- Robey, B., S.O. Rutstein, L. Morris and R. Blackburn. 1992. The reproductive revolution: new survey findings. *Population Reports, Series M: Special Topics* No. 11. Baltimore MD: Johns Hopkins University, Center for Communication Programs, Population Information Program [PIP].
- United Nations. 1994. *Report of the International Conference on Population and Development (ICPD), Cairo, 5 - 13 September 1994*. New York.

Westoff, C.F. and L.H. Ochoa. 1991. Unmet need and the demand for family planning. *Demographic and Health Surveys Comparative Studies* No. 5. Columbia MD: Institute for Resource Development / Macro International.

World Health Organization (WHO). 1993. *The Health of Young People: A Challenge and a Promise*. Geneva.

World Health Organization (WHO). 1995. *Women and AIDS: Agenda for Action*. Geneva.