



Youths' Reproductive Health and Risk Perception to Sexually Transmitted Infections in Communities in Bayelsa State, Nigeria: A Qualitative Study

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Authors' contributions

This work was carried out in collaboration between both authors. Author FOA designed the study, supervised data collection and transcribing of data, wrote the protocol and the first draft of the manuscript. Author NB assisted with advocacy, conducted of FGDs and wrote the report. Both authors read and approved the final manuscript.

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ABSTRACT

Aims: Young people especially in sub-Saharan Africa are at great risk of contracting HIV. Studies have shown that young people aged 15–24 account for an estimated 45% of new HIV infections worldwide while less than half could demonstrate accurate and comprehensive knowledge about HIV/AIDS. Similarly they lack access to appropriate reproductive health information and treatment. This study aimed to identify the beliefs, values and attitudes of the youths and gatekeepers in the community to STIs including HIV/AIDS and socio-economic factors promoting their spread.

Place and Duration of Study: This study was carried out in Bayelsa State between January and April 2007.

Methodology: Four focus group discussions among youths and five in-depth interviews among opinion leaders were conducted in a rural and urban area of Bayelsa state. The participants were homogenous groups in terms of age and sex and comprised of an average of ten youths per group

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Opinion leaders were made up of media practitioners, youth leaders and religious leaders of both sexes.

Results: The FGD revealed that youths in both the urban and rural areas had limited access to reproductive health information, contraceptive advice and treatment. This resulted in wide spread use of herbal medicine and high doses of quinine among youths as contraceptives with an early age of sexual debut. Cost of procuring an abortion varied from 17 to 25 USD. Socio-cultural and economic factors contributing to the spread of HIV/AIDS among youths identified by opinion leaders were deterioration of traditional social discipline and norms of behavior, multiple sexual partners, poverty, non-acceptance by religious groups of all proven HIV preventive methods such as condom use among youths, and on-going harmful cultural practices such as female genital mutilation and socio-cultural events such as 'owigiri night'.

Conclusion: There is a need for health programmes and mass media interventions that will improve access to reproductive health information and services, among youths in this region so as to help check the spread of STIs.

Keywords: HIV/ AIDS; youths; sexual; infections.

1. INTRODUCTION

It is sobering to note that Sub-Saharan Africa continues to bear the highest burden of the number of people living with HIV (Human immunodeficiency Virus) as well as the number of deaths from AIDS (Acquired Immune Deficiency Syndrome). A majority, 24.7 million out of the 35 million people living with HIV globally, can be found in this region [1]. In many parts of the world, new cases of the virus are appreciably higher among youths between the ages of 15-24 years of age [2]. While the percentage of people living with HIV has stabilized since 2000, the overall number of people living with HIV has steadily increased as new infections occur each year [3]. In the year 2014, the UNAIDS (Joint United Nations Programme on HIV/AIDS) reported 2.1 million new HIV globally, whereas in 2009, an estimated 2.6 million people became newly infected with HIV [4], in 2007, 2.7 million, and in 2005, 3 million new cases were reported respectively [3]. The national HIV sero-prevalence level in Nigeria has shown a steady decline since 2008, (4.4% in 2005, 4.6% in 2008, 4.1% in 2010, 3.4% in 2012 and 3.1% in 2015) [5]. The National Agency for the Control of AIDS reported that 3 500 000 [2 600 000 - 4 500 000] people are currently living with HIV in Nigeria while an estimated 227,518 new HIV infections occurred in 2014 [5].

Young people aged 15–24 account for an estimated 45% of new HIV infections worldwide [3], and in Nigeria the proportion of youths affected by the infection remains high at 24.8%. [6]. Though HIV affects all age groups, in Nigeria, the young adults (20 – 29 years) are

more affected [7]. In some regions there is also an alarmingly high prevalence in the 15–19 year group. There is an almost equal HIV prevalence in major urban and rural communities [7]. Amongst adolescents, girls are about 5 times more vulnerable than boys [8]. According to the National AIDS and STI Control Programme (NASCP) in Nigeria there are about 3 million reported annual cases of STIs (Sexually Transmitted Infections) mainly caused by Chlamydia, Neisseria Gonorrhoeae and Trichomonas [9,10]. STIs are known to increase the chances of contracting HIV.

Among young people in Nigeria there is an unmet need for reproductive health, including access to basic knowledge needed to prevent sexually transmitted infections including HIV [11]. According to the UNAIDS; only 40% of young people between the ages of 15 and 24 could demonstrate accurate and comprehensive knowledge about HIV/AIDS [12]. Knowledge is thus very crucial in the struggle to check the spread of HIV infection. Worldwide youths generally do not view themselves as vulnerable to STIs including HIV hence they tend to underestimate their risk [13-16] as well as that of their partners [17-18]. They tend to therefore engage in behaviours that increases their chances of contracting STIs. Hence it is important to identify the beliefs, values and attitudes of the youths, community and gatekeepers to youths in the area of HIV/AIDS and STIs. In addition this study aims to identify socio-economic and cultural factors which are constraints as well as the enablers of behavioural change and to use the findings to develop a behavioural change communication programme for youths.

2. MATERIALS AND METHODS

2.1 Setting

This study was conducted in Yenagoa (urban) and Polaku (rural) both situated in Bayelsa state. It is one of the oil rich states of the Niger Delta Region and is made up of numerous villages and rural settlements, many of which are 'floating hamlets' scattered and isolated from each other and distant from the few urban centers with health facilities. The major ethnic group is the 'Ijaws' who are mainly farmers and fishermen.

2.2 Study Method

Study methodology employed was qualitative involving a combination of focus group discussion for youths and in-depth interviews for opinion leaders. A total of four Focus Group Discussion (FGD) sessions (2 female and 2 male groups) and five in-depth interviews were held in both the urban and rural areas. The participants for the FGD were homogenous in terms of sex. Each group was made up of an average of ten youths between the age of 15 and 29 years old. The participants were recruited by the health workers working in the Local Government Area (LGA), based on the criteria of age between 15 and 29 years and willingness to participate in the study for the youths and the criteria of position in the society for the opinion leaders. They were made up of secondary school students, University undergraduates, graduate workers, unemployed youths, out-of-school youths involved in petty trading, farming, fishing and commercial 'okada' (motor bike) drivers. Opinion leaders included youth leaders, a religious leader, a journalist, and CDC (community development committee) leaders. Each FGD and in-depth interview sessions were conducted by a moderator of the same sex using a structured interview guide and lasted for an hour. The guide comprised of open ended questions such as 'where did you hear about HIV/AIDS?' 'What is your attitude to sex before marriage?'. The discussions and interviews were recorded on tape with back-up notes taken by a transcriber.

The recorded data were transcribed, coded and thematic headings were gotten based on responses from the participants.

3. RESULTS AND DISCUSSION

3.1 Knowledge (STIs including HIV/ AIDS)

Youths in both areas (i.e. rural and urban) reported that they heard about HIV/ AIDS, for the first time mainly through the mass media such as the radio, and television. They were well versed in the various ways in which one could contract the virus and gave responses such as by 'sexual route' and 'unsterilized object'. Participants reported that 'unprotected sex' and 'casual sex' all contribute to the transmission of sexually transmitted infections' (STIs).

3.2 Reproductive Health, Sexual and Health Seeking Behavior

The age at first sexual activity among youths were reported as being between ten (urban) and eleven (rural) years. Their partners initially were mainly their peers (classmates, playmates) and later older men and women commonly termed 'sugar daddy' and 'sugar mummy'.

Reasons given for engaging in early sexual activities included bad peer group, for pleasure, frustration and anger, for material or financial needs, watching of videos and actually seeing their parents or adults engaging in sexual activity.

Contraceptives used vary from modern methods for example condoms and oral contraceptive pills to traditional methods such as local herbs mixed with *kaikai* (local gin) to abuse of drugs such as high doses of quinine and Andrew liver salt. Some of these herbs were inserted into the reproductive tract and others available commercially as local mixture called 'dongoyaro' which is high in quinine.

To protect themselves against STIs and HIV, participants reported using condoms, masturbating, being faithful to one partner and abstaining from sex. Participants were more likely to use condom with casual than regular partners. Even though participants reported hearing about the female condom none of them had ever used one. To treat sexually transmitted infections, youths prefer to go to the chemist first (usually manned by patent medicine vendors), who were described as discreet to consulting their friends and native doctors who use herbs before consulting medical doctors.

The youths were very conversant with the changes at puberty. The source of information was mainly the school and in some cases parents. Over half of the youths i.e. the male opted to have an abortion if their partners got pregnant, while others said they will keep the pregnancy based on religious reasons and the fact that abortion kills. A 23 year old female undergraduate reported that the cost of terminating a pregnancy varied with the 'gestational age' (2 to 3 thousand naira i.e. 17 to 25 USD per month) and 'professionalism' of the person carrying it out. Payment was said to be in cash or in kind i.e. the girl exchanges sex for abortion. Since abortion in Nigeria is illegal, it was done in private clinics, back rooms at the chemists, offices of local traditional practitioners and sometimes at home by the youth through use of herbal concoction and high doses of quinine. Chemists were also reported to use quinine to induce abortion.

In Bayelsa state, a man has to pay 'damage fee' to the family of the girl he has impregnated. These fees were deemed as being quite high and make abortion a cheaper and therefore preferred option for the youths especially the men. In addition to this the females were often treated as an outcast and thrown out onto the street by their parents and were also sent out of school.

3.3 Attitude and Perception in Relation to Condom Use, Premarital Sex and Multiple Sexual Partners

Participants procure condoms, from the pharmacy, chemist, friends and roadside 'mallam' (male petty trader). The price of condom according to a twenty year old male undergraduate student was said to vary from 'twenty naira to five hundred'. Condoms were used mainly to prevent unwanted pregnancies, other reasons for use were to protect against HIV and other sexually transmitted infections. A 23 year old male unemployed graduate said 'we use condom mainly to prevent unwanted pregnancy and also to protect ourselves from all these sexually transmitted disease'.

Reasons given for lack of condom use include fear of the condom tearing, reduction in the level of sexual satisfaction. ('If you use condom e no go sweet'), non availability of condom at the time of sexual activities, pain during sexual intercourse, the expectation that regular

partners will be mutually faithful and the fact that some youths do not belief in the existence of HIV/AIDS.

Reasons given for having sex before marriage includes myths such as 'sex is a sign of maturity', peer pressure, failure of parents to train their children, incentives especially in the case of the females such as financial gains, poverty, and the need to ensure sexual compatibility.

Among the youths, most of the females reported being content with only one partner as that was what the society expected of them; however the males especially at this young age were expected to have multiple partners. In addition there were socio-cultural factors that encourage men to have multiple partners. A 21 year old male Okada driver reported that 'For example if you want to become a chief you must marry more than one wife'.

3.4 Opinion Leaders' and Communities' Attitude and Practice

Among the opinion leaders interviewed, most felt that 'the issue of STIs and HIV/AIDS was a serious problem' among the youths in the community while only one of the leaders did not. The leaders do not support sex before marriage, while sex education was described as 'necessary' for youths by the leaders but some parents shy away from giving their children sex education because they belief that this would make them want to experiment. Opinion leaders were unanimously against promoting condoms among youths. An opinion leader, a fifty year old female journalist said 'I condemn condom use'.

In the communities, according to the leaders 'the value of the community is wrongly placed' and it is not against pre-marital sex. Parents do not train their children and give them sex education rather the females are encouraged to trade sex for financial incentives, these were the summation of a middle aged male pastor.

3.5 Religious Bodies

The Church is not in support of sex before marriage, while some churches encourage sex education others don't. The clergyman said 'religious bodies are not in support of condom use amongst youths'. Churches that support condom use do so for married couples only.

3.6 Socio-cultural and Economic Factors

The socio-cultural and economic factors contributing to the spread of HIV/AIDS among youths identified include failure of parents to give reproductive health advice to their children, deterioration of traditional social discipline and norms of behavior, polygamy which promotes multiple sexual partners, lack of an effective system to check molestation of females and the girl child, poverty and financial constraints, harmful cultural practices such as female genital mutilation (some carried out discreetly by health workers), social events such as the 'owigiri night' (held during burial ceremonies) and 'parema night' which is characterized by alcohol and casual sex.

3.7 Mass Media

Most of the youths have access to a radio. Preferred time to listen to the radio was the morning time between 6.00 and 9.00 am and later on in the evening from 4.00 pm.

3.8 Discussion

Youths in this study heard about HIV/AIDS mainly through the mass media, this is comparable to findings from several studies where the mass media have been cited as the key source of information about HIV/AIDS [2,19]. Findings from an evaluation of mass media intervention in 15 countries support the effectiveness of mass media interventions to increase knowledge of HIV transmission, improve self-efficacy in condom use, influence some social norms, increase the amount of interpersonal communication, and boost awareness of health services [19]. The National policy on HIV/AIDS, reported that youths in the urban area had more access to information when compared to the youths in the rural area [7]. This difference was however not observed in this study and may be due to the fact that the State generally lacked sources of reproductive health information such as Youth Friendly Centers. The survey results from sub-Saharan Africa indicate that young people possess some basic information about STIs, HIV/AIDS and pregnancy prevention, yet overall they receive much inaccurate information from rumors and myths [20] as was observed in this study.

Knowledge of where to purchase condom does not necessary translate to increase condom use,

a survey among youths in Cameroun showed that only 62% of sexually active females reported knowing a condom source within 10 minutes walking distance, compared to 83% of males. However, only 45% of males and 34% of the females reported condom use in their last sex act with a regular partner [21]. Reasons given for condom use in this study were similar to that of other studies; one important factor related to consistent condom use among young females in this study was equating condom use with lack of trust. This belief was associated with a significantly reduced likelihood of condom use. Corroborative evidence for both sexes with respect to trust and condom use was reported in qualitative studies in Nigeria [20, 21]. Likewise, identified barriers to condom use in this study were the same as in another study in Nigeria, where 59% of males believe that condoms reduce sexual pleasure for men, as opposed to only 39% of females [21].

Other studies have also reported early age at first sexual act. A mean age of between 12-20 years was reported among youths in South west Nigeria [22]. Another Nigerian study among University and secondary school students revealed 9.3% of male had sexual exposure at less than 10 years of age, 2.4% at 10 years, and 4.9% at 11 years [23].

The family background had also been found to have significant influence on young people's sexual behaviour. In many countries, young women lacking opportunities and from poor family background to tend seek support from men by trading sex and thus risk HIV infection and other STI's for security [24,22].

In the treatment of STIs, findings of self medication and use of traditional healers are consistent with similar reports by the National policy on HIV/AIDS and these have been identified as sources of ineffective treatment of sexually transmitted diseases in Nigeria [7]. In a FGD conducted in Nigeria among adolescents medications discussed as being used for contraceptives included aspirin, quinine, paracetamol, tetracycline, indocid and ampicillin [25]. We did not come across any study which reported use of high doses of quinine as we have reported as high doses of quinine has other toxic side effects. In addition the study described a premarital pregnancy as the major threat to a young woman's well-being.

Socio-economic barriers reported in this study were similar to reports from other studies the

UNDP has reported that there is a down play of the magnitude of the problem of HIV/AIDS among opinion leaders, in the Niger Delta region where this study was carried out and in some cases it has been viewed as a punishment from God [26]. Also the National policy on HIV/AIDS reported that religious bodies have refused identified methods of HIV/AIDS prevention such as condom use [7]. The UNDP reported that in Nigeria, harmful traditional practices add an extra dimension of risk in contracting HIV. These include Female Genital Mutilation (FGM), widowhood rites and body scarification [26]. We however did not come across any study reporting social events such as the 'owigiri nights' which promote casual sex and the risk of contracting HIV as in our study.

Finally the transcripts and reports of this study have been developed into a radio drama series, 'when breeze blow' (26 episodes lasting 30 minutes) by an NGO the African and Radio Drama Association.

4. CONCLUSION

The FGD revealed that youths in both the urban and rural areas had limited access to reproductive health information and contraceptive advice hence they engaged in sexual activities at an early age. There is also a wide spread use of herbal medicine, and high doses of quinine among youths as contraceptives. They also did not have access to proper treatment of sexually transmitted infections, as they usually consulted with patent medicine vendors first. Socio-cultural and economic factors contributing to the spread of HIV/AIDS among youths identified by opinion leaders were deterioration of traditional social discipline and norms of behavior, multiple sexual partners, poverty, non-acceptance by religious groups of all proven HIV preventive methods such as condom use among youths, and on-going harmful cultural practices such as female genital mutilation and socio-cultural events such as 'owigiri night'.

The youths in the state will therefore benefit from a behavioural change communication programme addressing these gaps.

CONSENT

Permission to carry out this study was obtained from the State Agency for the Control of AIDS.

Informed consent was obtained from each of the Focus Group Discussion and In- Dept Interview participants before commencement of the study.

ETHICAL APPROVAL

Ethical consent was obtained from the State Ethical Review Committee.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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