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Youth Welfare and Health Seeking Behavior in Edo Central, Nigeria

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ABSTRACT This study is an examination of youth welfare in relation to health seeking behavior. Data were derived from 783 randomly selected youth ages 10 – 24 years and standardized using percentages to cushion the effect of the variation in the sample sub-totals. Among the respondents, 46.4% had experienced penetrated sex previously and 53.6% had not. 87.1% of them had known of a type of sexually transmitted infections (STIs). In other words, 12.9% was not familiar with STIs at the time of survey. Consequently, respondents' health seeking behavior, after contract with STIs, was investigated. It was observed that 57.5% and 45.1% of youth and sex partners respectively went to hospital or clinics for treatment after contract with STIs. Since, this was not quite encouraging or good enough to stop the perpetuation or prevalence of STIs, proper counseling by stakeholders is recommended to improve the functional health and treatment literacy among youth.

It has been suggested by Boyd et al. (2000) that the recent trends in mass media activities, breakdown of traditional families and morals, urbanization and materialism have posed fundamental concerns about the welfare of youth. These have contributed immensely to increase the opportunities and desires of youth, for instance, in sexual activities. Consequently, more young people have faced serious health risks as they mature and become sexually active. This is partly the reason that this study was devoted to providing some basic information we needed about youth (ages 10 – 24 years) and its well being. These included the number that was sexually active or not, the number that was aware or not of the types of sexually transmitted infections (STIs) as well as youth and sex partners that had gone for treatment or not after contract with STIs.

Also, Nigeria is one of the few sub-Sahara African countries said to be on course to achieve the Millennium Development Goals in education and gender (Goals 2 & 3). The country should take leadership or excel in combating HIV/AIDS, malaria and other diseases (Goal 6). Besides, the future of this country and, indeed the world is said to be rested on youth. Furthermore, research efforts targeting the youth would help enlighten health planners and demographers about health needs and necessities in order to reduce the associated health risks for the future. Hence, this study was designed to confirm how far disease conditions were managed to reduce the incidence of morbidity and mortality.

Accordingly, this study is separated into a number of sessions. Section 1, starts with the introduction and includes the conceptual framework. Section 2, discusses the methodology. Section 3, presents results and brings the discussion to a close with concluding remarks.

Conceptual Framework

The phenomenon or focus of attention in this study was youth welfare as related to behavior. As is typical of the behavioral sciences, youth health seeking behavior may be analyzed using the objective and subjective approaches. Cohen (1968) had observed that from the point of view of the subjective approach, man is the active participant in his environment. This is to the extent that the behavior is typical for multiple individuals, in a given situation, according to Adam and Sydie (2002). Man has self and engages in reflexive processes. Sentiments, goals, aims, wishes and aspirations are derived from the actors. In other words, actions are influenced by personal, individual or population characteristics or composition.

Furthermore, Adam and Sydie (2002) are associated with the view that Max Weber, Blumer, Mead and Parsons were proponents of such theoretical perspective that 'the sociologist can formulate generalizations that provide bases for

causal linkages'. Hence, it was contended in this study that the subjective approach of the behavioral sciences would be supportive of eliciting information from the youth on their sexuality, awareness of sexually transmitted infections (STIs) and consequently, health seeking behavior of self and partners.

From the point of view of the objective approach, structures and institutions come first in the explanation of social reality. This was typical of Emile Durkheim that social facts and not individuals should form the data in sociology (Adam and Sydie 2002; Coser and Rosenberg 1976). As it pertains to this study and as noted by Braude (1981), the social structure may influence or shape reproductive health, that is, from the point of view of sexuality and sexual behavior of youth. These included several traditional beliefs, as observed by Okolocha and Chiwuzie (1999) that have hampered the application of modern medical care in reducing maternal mortality in Africa. Hence, an examination of youth welfare as it relates to health seeking behavior in this study.

Youth Welfare

Welfare is defined by the Oxford English Dictionary as good health condition, comfortable living and working condition. Generally, welfare refers to government or public assistance that provides money, medical care, food, shelter (housing) and other necessities for needing people. It is youth welfare, according to Odaman (2006), when such organized forms of assistance are directed towards the needy people, ages 10 – 24 years. Regarding health care, there is provision in Nigeria for the infants and children before they become adolescents/youth. This include, the national programmes on immunization (NPI) aimed at eradicating the six deadly diseases, deworming, free health care for cancer patients, etc., by government.

Generally it is known that in societies where welfare programmes on health are fully implemented, people who may not afford large medical bills have qualified for medical aids. Some of the services paid for included doctor's visit, hospital treatment and nursing home call. Such welfare may cover the cost of drugs, eyeglasses, hearing aids and other medical items such as family planning services. Most medical funding presently comes from the Federal Government in the form of medical bills paid to public and civil servants. The rest may come from the state and local Government with funds mainly from the Federal Government. In all, the Federal Government of Nigeria (2004) had included the provision of adequate health care for the entire population, by the year 2010, in its developments.

Youth Health Seeking Behavior

Nigeria's population is young and youthful. Youth, ages 10 – 24 years, comprised 32 percent of the nation's total (National Population Commission 1998; Federal Government of Nigeria 2007). Youth have experienced a number of reproductive and development challenges. For instance, due to early exposure to sex and high level of childbearing, adolescents (ages 9 – 19 years) comprising 23% of the nation's population were accounting for about 11% of all births and high proportion of maternal deaths. According to Overby and Kegeles (1994), youth have a desire to experiment, seek more of peer approval and get involve in relatively short-term relationship. As observed by Alan Guttmacker Institute (1994), adolescents delay seeking prescription contraception for an average of one year after initiating sexual activity. In addition, younger ages are strong risk factors for sexually transmitted infections (STIs) like Chlamydia trachomatis (Han et al. 1997; Burstein et al. 1998; Hilger 2001).

Youths are vulnerable and risk their lives through sexual behaviors. According to Ejikeme (2003), some young male and female virgins were forced into ritual sexual abuses by older partners apparently seeking quick wealth, power, longevity, protection and cure from diseases. Such was arising from beliefs in some parts of the Eastern and Northern Nigeria that sex with virgins and certain ritual activities could bring advantages. Consequently, youth or victims suffered trauma, destabilization, sexual abuse and were prone to suicide, loss of self worth as well as poor mental health.

Izugbara (2001) has it that, in Senegal and Ghana, a variety of partners at initial sexual encounters of youth included prostitutes, sugar dads, relatives, caretakers, teachers, older women and housemaids. Circumstances of first sexual encounters included being drugged, raped, coerced, enticed and mutual consent. The outcomes of initial sexual encounters produced identifiable consequences such as penile and

vaginal lacerations, wounds, sexually transmitted infections (STIs) and unwanted pregnancies. It is in the light of the foregoing that we have investigated the health seeking behavior of youths. That is, to optimize their physical health, economic and social opportunities available to the youths.

Method of Study

This study has its genesis on "Youth Sexuality and Sexually Transmitted Infections (STIs) in Edo Central District, Edo State, Nigeria" – by these authors. Consequently, a sample size of 800 youth ages 10 – 24 years was chosen (see Table 1 for the population size of the LGAs and the estimated sample size of the respondents in each locality/ town). A total of 783 questionnaires were fully completed in that study between September and October 2007. Ekpoma, Irrua and Uromi communities were selected to represent Edo State in that study. These were chosen because they were the main abodes of the youth in this part of the state and country. Each of the towns was oriented to quarters and streets. In each, five quarters were randomly selected. Also in each quarter, five streets were randomly selected. The houses in each of the selected streets were listed and numbered where numbering did not exist. In each street, the systematic random sampling was adopted to select every fifth building, beginning from the home numbered 1. Within each of the selected buildings, a household was chosen and the interviewers collected data by administering questionnaires to the youth ages 10 to 24 years resident in the households.

Edo Central comprises more males (178,053) than females (172,445). It is the traditional abode of the Esan speaking people and received inmigrants from the entire state, the country and beyond. The high influx of youths has been on the account of the presence of Ambrose Alli University in Ekpoma and occupational activities at the headquarters. Apart from accommodating the local government secretariats, the High Court of Justice and General Post Offices, the towns have banking institutions, ministries, health, educational and Agricultural institutions and related industrial establishments. Residents find employment in these organizations including hotels, guesthouses, libraries and bookshops that service the towns. The areas are supported by self-employed craftsmen, tradesmen, artisans and traders, with agriculture being the main activity of the indigenous people. Finally, Edo Central is on the Ishan Plateau and varies in elevation between 350 and 450 meters above sea levels, as noted by Akinbode (1983). Irrua and Uromi are about 3 kilometers and 8 kilometers from Ekpoma respectively, while Ekpoma is about 84 kilometers from Benin City, the Capital of Edo State Nigeria.

Table 1: Population size of LGAs and the estimated sample size of respondents

LGA	*Selected locality/Town*	*Population size of LGA*	*Estimated sample size*
Esan West	Ekpoma	125,842	400
Esan Central	Irrua	105,310	150
Esan N.E.	Uromi	119,346	250
Total		350,498	800

Source: Field Survey, September – October 2007.

RESULTS AND DISCUSSION

Social and Economic Characteristics of the Respondents

Youth age, sex, marital status, schooling status and religion were examined in this study. The population of the youth increases with age. As in table 2, the adolescents aged 10 – 19 years (50.4%) comprising pre-teens and teenagers were slightly in excess of young adults, ages 20 – 24

Table 2: Selected characteristics of youth

Characteristics	*Respondents*	
	(N)	*(%)*
(a) Age		
Pre teens (10 –12 years)	80	10.2
Teenagers (13 – 19 years)	315	40.2
Young Adults (20 – 24 years)	388	49.6
(b) Sex		
Male	399	51.0
Female	384	49.0
(c) Marital Statue		
Never Married	662	84.6
Married	109	13.9
Divorced	4	0.5
Widowed	8	1.0
(d) Schooling Status		
Attended before	39	5.0
Attending Primary	144	18.4
Attending Secondary	313	40.0
Attending Post Secondary	287	36.7
(e) Religion		
Christianity	605	77.5
Islam	150	19.2
Traditional	28	3.6

Source: Field Survey, September – October 2007

years (49.6%). On Sex, data (Table 2) revealed that the males were also slightly in excess of the females among the respondents. This was consistent with the findings of the previous population censuses in Nigeria that there were more males (44,529,608) than females (44,462,612) in the country (National Population Commission 1998; Federal Government of Nigeria 2007). Regarding marital status, data (Table 2) indicated that the bulk of the respondents was never married (84.6%), 13.9% was married and the number that was widowed was very negligible. As for education or schooling status of the respondents, data (Table 2) revealed that the bulk of youth (76.7%) were attending secondary and post secondary while 18.4% was attending primary. Only 5.0% belonged to the category of those who 'attended before'. This implied that majority of youth in Edo Central, Nigeria were engaged in educational activities, that is, as students. In terms of religious belief, 77% of the respondents were Christians, 19.2% were Moslems while 3.6% revealed that they were practicing African traditional religion (Table 2).

Youth Sexuality

The numbers that were sexually active or had penetrated sex and youth awareness of sexually transmitted infections (STIs) were sought with a view to appreciating the young people's health seeking behavior. Consequently, it was confirmed, as in table 3, that more youth (53.6%) had not had penetrated sex, as at the time of enquiry. A lesser number (46.4%) reported it had. This could be explained, partly, by the inclusion of pre-teens (ages 10 – 24 years) in the sample. Nevertheless, considering the deleterious effects of pre-marital or early sex, such proportion was significant of youth population. For instance, as observed by Opaneye and Ashton (2000), the accompanying infections have considerable health, social and economic consequences, particularly, when they are repeated. Also, ascending infections are the main causes of pelvic inflammatory disease (Opaneye and Surtees 1998) and adolescents are at greater risk of this complication with attendant legal implications where they are sexually abused (Hammerschlag 1998). When the pelvic inflammatory disease (PID) is not properly handled, it may lead to tubal blockade, chronic pelvic pain and ectopic pregnancy. This causes substantial drains on private funds during adult years and a potentially strong cause of marital disharmony and marriage failures.

Table 3: Youth sexuality

Have you had penetrated sex previously?	*Respondents*	
	N	*%*
Yes	363	46.4
No	420	53.6
Total	783	100.0

Source: Field Survey, September- October 2007

Health Seeking Behavior of Youth and Sex Partners

Youth Knowledge of Types of Sexually Transmitted Infections (STIs) was first examined. The sexually transmitted infections (STIs) were enumerated according to their types, viz: gonorrhea, herpes simplex, chlamydia tracho-matis, genital warts, syphilis, staph aureus and HIV/AIDS. Each respondent was earlier asked if s/he had heard or known of the types. The responses they gave (Table 4) tended to suggest that all types of STIs were known. However, such knowledge or awareness varied with the types. For instance, 87.1% of the respondents had known a type of STI such as HIV/AIDS. In other words, about 12.9% was not familiar with STIs, as at the time of survey. Apart from HIV/AIDS, gonorrhea appeared to be very well known. This was followed by syphilis, genital warts, staph aureus, herpes simplex and chlamydia trachomatis.

What was examined next was the health seeking behavior of youth. The first question was: did you go for treatment in hospitals/clinics after contract with sexually transmitted infections (STIs)? As in table 5, it was observed that 57.5% of youth with such cases went to hospitals or clinics while 42.5% did not but resorted to

Table 4: Youth knowledge of types of sexually transmitted infections (STIs)

Sexually Transmitted Infections (STIs)	*Respondents*			
	Yes		*No*	
	N	*%*	*N*	*%*
Gonorrhea	552	70.5	231	29.5
Herpes Simplex	112	14.3	671	85.7
Chlamydia Trachomatis	99	12.6	684	87.4
Genital Warts	116	21.2	61	78.8
Syphilis	369	47.1	414	52.9
Staph Aureus	140	17.9	643	82.1
HIV/AIDS	682	87.1	101	12.9

Source: Field Survey, September- October 2007

Table 5: Youth health seeking behavior

Did you go for treatment in hospitals/clinics after contract with STIs?	*Respondents*	
	N	*%*
Yes	65	57.5
No	48	42.5
Total	113	100.0

Source: Field Survey, September- October 2007

Table 6: Health seeking behavior of youth sex partners

Did your sex partners go for treatment in hospitals/clinics after contract with STIs?	*Respondents*	
	N	*%*
Yes	51	45.1
No	62	54.9
Total	113	100.0

Source: Field Survey, September- October 2007

alternative health care providers such as chemist shops, traditional herbalists and midwives. This tends to bother on ignorance as well as buttresses the assertion of Condon et al. (2000) that youth have unrealistic expectations on the likelihood and consequences of early, adolescent and premarital sex.

The next question was: did your sex partner(s) go to hospitals/clinics for treatment after contract with sexually transmitted infections (STIs)? In the same vein, the responses of youth, as in table 6, clearly suggested that the majority (54.9%) of sex partners did not go for screening and treatment in hospitals or clinics. In other words, 45.1% had their sex partners showed up in clinics or hospitals for treatment after them. Such behavior has tended to agree first, with the observations of Moon et al. (1999) that the period of adolescence is characterized by youth's belief in his or her 'immortality'. Secondly, it buttresses the observation of Alan Guttmacker Institute (1994) that adolescents delay seeking prescription contraception for an average of one year after initiating sexual activity. Consequently, emphasis should be placed on the need for partners' treatment in order to reduce the spread of sexually transmitted infections (STIs) because younger ages are strong risk factors for sexually transmitted infections (STIs) like Chlamydia trachomatis (Han et al. 1997; Burstein et al. 1998; Hilger 2001).

CONCLUSION

This study has attempted to examine youth welfare and youth health seeking behavior after contract with STIs in Edo Central, Nigeria. It was observed that 46.5% of youth were sexually active or had penetrated sex, previously. This is problematic because at teenage ages, youth are hugely vulnerable. It is also significant because given such proportion that have tasted active sex, the observations of Ejikeme (2003), Izugbara (2001), Overby and Kegeless (1994) have gained support in this study. That is, that peer group influence, coercion and youth adventurism among others have led youth into premarital sex.

As it relates to short or long term relationship, the observation in this study that youth were more engaged at school tended to indicate rising age at marriage. This is also a significant development because a reduction in early marriages and full embrace of education by youth would be of benefit to the individuals as well as to the nation in thence of skilled manpower development. This means that adequate funds should be duly and sincerely committed to education so as to encourage the youth and keep them highly engaged in meaningful and productive ventures.

With respect to the religion of respondents, it is tempting to conclude that religious belief alone might not be enough to control risky sexual indulgence of youth. Consequently religious leaders and organizations as well as notable community leaders, opinion leaders, traditional rulers, politicians and policy makers should be encouraged to play active roles in youth restiveness and unhealthy indulgence in sexual acts that are capable of jeopardizing their future.

On youth awareness of sexually transmitted infections (STIs), it was found that 87.1% of the respondents had known or heard of a type such as HIV/AIDS. In other words, 12.9% was not as familiar with STIs, at the time of survey. The results generally showed very poor level of awareness of Herpes simplex, Chlamydia tranchomatis, genital warts and staph aureus as sexually transmissible infections. Level of awareness of syphilis as sexually transmissible was relatively appreciable. Therefore, sex education should be more emphatically embraced both in schools and at home in Nigeria. It should be gravely embedded into our academic curriculum in the primary, secondary and at post secondary levels.

Finally, it was observed that youth (57.5%) and sex partners (45.1%) went to clinics or hospitals for treatment after contract with STIs. In other words, 42.5% of youth and 59.9% of their

sex partner never did but resorted to alternative health care providers. Such was capable of perpetuating prevalence of sexually transmitted infections (STIs) due to poor management. It is therefore, strongly recommended that the health system in the country should generally be improved upon to meet international standards. Database should be upgraded. All forms of quackery and illicit practices should be sanctioned. Alternative sources of medical remedy should be standardized and restricted to respect its limits. This will go a long way to give our health system a new outlook, ensure proper service delivery and make the millennium development goal realistic.

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