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SEXUAL BEHAVIOUR AND THE RISKS OF HIV/AIDS AND OTHER STDs AMONG YOUNG PEOPLE IN SUB-SAHARAN AFRICA: A REVIEW

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Abstract

Reproductive health problems present one of the greatest threats facing youth in sub-Saharan Africa today, in addition to political and economic insecurity. Although premarital sex is condemned in many African societies, and young, unmarried people, especially young women, are not expected to be sexually active, the gap between expected and actual behaviour is enormous. In particular, there is almost a universal gap between age at first sexual intercourse and age at first marriage across sub-Saharan Africa. A substantial proportion of young girls are sexually active, sometimes with multiple partners. Available evidence indicates more than 50 percent of all mothers in sub-Saharan Africa are in the age group 15-19 years, and in some settings, the youth are initiated into sexual activity as early as age 12 (girls) and 13 (boys). All these have a direct correlation with reproductive health problems, including HIV infection and other sexually transmitted diseases. Governments in the region should play a leading role in putting the reality of youth sexuality into public consciousness and political agenda.

Key Words: Sexual behaviour, activity, sex, HIV, AIDS, young people, sub-Saharan Africa.

Introduction

The stage of life during which individuals reach sexual maturity is known as adolescence. It is the period of transition from childhood to adulthood. Although the change is biological, the duration and nature of adolescence are primarily a social construct and thus vary greatly from culture to culture (Abraham and Kumah 1999; Senderowitz 1995; Bledsoe and Cohen 1993; Wulf and Lincoln 1985). In some cultures, adolescence may not exist at all: the child moves directly into what is considered adulthood. World Health Organization (WHO) identifies the age range 10-19 years as the period of adolescence, while the term "youth" denotes the age group 15-24 (WHO, 1986). The WHO definitions have been widely adopted, while in some studies, the terms "adolescence" and "youth" are used interchangeably (Bradner et al., 2000; Santow and Bracher, 1999; Darroch and Singh, 1999). This paper refers to the combined age range 10-24 years, which WHO refers to as encompassing "young people", but focuses mostly on the age group 15-24 because this age span incorporates much of the variation seen between countries and population sub-groups in the events that define the beginning of sexual and reproductive life.

Among demographers and other social scientists, there is growing attention towards young people because this period of development is increasingly recognized both as an important determinant of future health, and as a specially vulnerable period of life. In particular, increasing concern has been expressed about sexual risk-taking among young people, and the consequences of such behaviour, including teenage pregnancy (Senderowitz 1995; Gage and Meekers 1994). This concern, as well as the fact that young people aged 15-24 years constitute about 20 percent of sub-Saharan Africa's population and will, therefore, have a substantial impact on future population growth, make an understanding of the patterns of sexual behaviour of young men and women a significant issue for research and policy (United Nations 2001).

However, relatively little is known about young people in sub-Saharan Africa, especially about male adolescents and the unmarried ones (McDevitt 1996; United Nations 1995a).

The present article offers an overview of sexual behaviour and the risks of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) among young people in some parts of sub-Saharan Africa. It utilises some quantitative and qualitative information on young people's sexual behaviour, emanating from national and international organizations, as well as individuals.

Sexual Behaviour

Initiation of sexual and reproductive capability generally occurs in the second decade of life. The events that define entry into sexual and reproductive life among sub-Saharan youth, and their timing, are important determinants of sexual and reproductive health and have important implications for the future life course of these young men and women. At the same time, the factors that motivate young people to initiate and continue sexual activities are not well understood (Mba 2001).

The timing and circumstances of first sexual intercourse before marriage are of interest for a number of reasons. The timing marks the onset of the risk of childbearing and exposure to health hazards, while the circumstances may have implications for future sexual behaviour. The growing body of survey data reveals that sexual behaviour among young people varies widely (Pillai and Benefo 1995; Gage and Meekers 1994; Youri 1994; Zabin 1994). In some areas of the world intercourse begins early and is frequently premarital, while in others it is dictated by strong social sanctions and commonly coincides with marriage, although marriage may occur at a very early age.

Defined as any sexual activity before legally or traditionally sanctioned marriage, premarital sex is frowned at in many traditional African societies. However, several studies indicate a discrepancy between a persistent ideal of virginity before marriage and actual levels of premarital activity. In his study of sexuality, migration and AIDS in Ghana, Anarfi (1993) found that three-quarters of both men and women said that they believed women should be virgins at marriage, but barely 1 in 10 of either sex maintained that he or she was a virgin. He further found that two-thirds of ever-married men and one-half of ever-married women reported having had two or more premarital partners. Similarly, Ogbuagu and Charles (1993) in their study found that 40 percent of the respondents in Calabar city, Nigeria, said that they hold virginity at marriage as an ideal, but fewer than half that proportion could report that they had no sexual activity before marriage. Also, Meekers (1994), using several demographic and health survey data shows that Botswana and Kenya display strong evidence of a rise in premarital sex. Furthermore, Cleland and Ferry (1995) found that between 45 and 60 percent of both sexes are sexually active by the age of 15 in Cote d'Ivoire and the Central African Republic. Carael (1995) reports that in Kenya and Guinea-Bissau, over one-half of all those aged 15-19 years are already sexually experienced. Anarfi and Awusabo-Asare (1993) also found that in Ghana some young people recall that they first had sex when as young as 8 or 10. This young age at first sexual intercourse is important when targeting populations for interventions, particularly in light of the work by Konings et al. (1994) which shows a correlation between early sexual debut and large number of partners.

A vital source of empirical information on young people's sexual behaviour in sub-Saharan Africa is the series of national surveys conducted by ORC Macro (formerly Macro International), the Demographic and Health Surveys (DHS). Fieldwork for this series began in 1985 and continues to the present time. The current DHS evidence reveals that in Ethiopia, interestingly, the median age at first sexual intercourse for women (16.0 years) is the same as the median age at first marriage (Central Statistical Authority and ORC Macro, 2001). The

findings further show that although the median age at first sexual intercourse for men is about four years later than for women, men become sexually active well before first marriage. In Zimbabwe, the median age at first sexual intercourse is 18.7 years for women and 19.7 years for men (Central Statistical Office and Macro International Inc., 2000). Unlike in Ethiopia, although men marry on average five years later than women in the country, both women and men become sexually active before entering marital relationships.

The findings of the latest nationally representative survey in Ghana, the 1998 Ghana Demographic and Health Survey, indicate that the likelihood of the commencement of sexual activity among young people residing in urban areas is quite high, while their counterparts who are rural dwellers tend to delay their sexual debut (Ghana Statistical Service and Macro International Inc., 1999). The results further show that whereas 40 percent of women were sexually active in the four weeks preceding the survey, the corresponding values for Cameroon, Niger, and Senegal, were 58 percent, 57 percent, and 63 percent, respectively. This is noteworthy because teenagers who have an early sexual debut are more likely to have sex with high-risk partners or multiple partners and are less likely to use barrier methods of contraception. Indeed, as a result of early and unbridled sexual behaviour among young people, the countries of sub-Saharan Africa have the highest levels of adolescent childbearing in the developing world. United Nations (1995b) evidence suggests that the proportion of births to unmarried women is on the increase in some sub-Saharan African countries. In contrast, though, in Africa's most populous country, Nigeria, the level of teenage childbearing seems to have declined somewhat. The proportion of girls aged 15-19 who have either given birth or are pregnant with their first child dropped slightly from 28 percent in 1990 to 22 percent in 1999 (National Population Commission and ORC Macro, 2000). However, teenage childbearing is higher in rural than urban areas and for those with no education than those with some education. Available data show that unplanned pregnancies are still common in Tanzania. About one-fourth of the births in the three years preceding the survey were reported to be unplanned (Bureau of Statistics and Macro International Inc., 1997). Also, childbearing begins early in the country, with just under one-half of the women becoming mothers by the time they reach age 18, and more than two-thirds having had a child by the time they are 20 years old. About 26 percent of the young women aged 15-19 are already mothers or pregnant with their first child, with teenage childbearing more common among mainland women (26 percent) than Zanzibar women (17 percent).

In his study of early and premarital sexual behaviour among female Ghanaians, Mba (2001) found that modernization and geographic region of residence are associated with the propensity to engage in early and premarital sexual activity. Several researchers note that young women sometimes feel under pressure to engage in premarital sex in order to prove their love to their boy-friends (Preston-Whyte 1994; Anarfi 1993; Goldstein 1993). Other studies maintain that young women are pressurized to prove that they are fertile by getting pregnant in order to increase their chances of marriage (Obbo 1993a; Standing and Kisekka 1989). It should be remarked that in many countries, sexual activity and childbearing typically begin within marriage. In some cultural settings, premarital relationships are tolerated and occasionally encouraged as a form of trial marriage, and demonstrated fecundity often leads to the formalization of the relationship (Bledsoe and Cohen, 1993). In other cultures, pregnancy can precipitate marriage because social opprobrium for unmarried mothers is strong. However, in most settings, births to unmarried adolescents are often unplanned or unwanted.

In Ekiti, Nigeria, Orubuloye et al. (1992) report that two-thirds of men's extramarital partners are single, and disturbingly, one-third of them are schoolgirls. This pattern is confirmed by Hogsborg and Aaby (1992), who conclude that in Guinea-Bissau, single women under age 26 appear to constitute the pool of non-marital partners for men of all ages. Most of the qualitative studies in the literature suggest that extramarital sexual activity has a primarily economic underpinning, with young women accepting material support, gifts, or money from their lovers or sugar-daddies (Mba 2001; Meekers and Calves 1997; Schoepf 1994; Awusabo-

Asare et al. 1993; Orubuloye et al. 1991). It is widely held in sub-Saharan Africa that men have an insatiable need to have sex and that this need must be satisfied if they are to remain in good health. The idea that retained semen is somehow poisonous and dangerous to health is frequently expressed. Caldwell et al. (1993) state that African cultures hold frequent sex to be healthy and strengthening, while Anarfi (1993: 47) argues that there is "the repetitive and overpowering nature of the sexual appetite in males".

Despite the paucity of systematic data and the variability in sexual behaviour of young people, three broad patterns of their sexual and reproductive behaviour can be identified. The first pattern is common in Asia and is characterized by marriage at an early age, followed by early childbearing (McDevitt 1996; McCauley and Salter 1995). In this pattern, the proportion of adolescent mothers is high and premarital sexual activity is uncommon, as are premarital pregnancy and childbirth. Also, contraceptive use is increasing, while abortion is often illegal and available only by resort to unsafe procedures. Similarly, the incidence of sexually transmitted diseases is high in some areas, with subsequent infertility problems.

The second pattern is generally representative of the developed world (Bradner et al. 2000; Council of Europe 1998). Here, initiation of sexual activity is frequently premarital and occurs from the middle to the late teens, and age at marriage is generally high. According to this pattern, the incidence of premarital pregnancies is high and abortion is legal and common but not in all countries. Also, contraceptive use is high and fertility is low, while the transmission of sexually transmitted diseases is not negligible.

The third pattern is intermediate or transitional and is found particularly in urban settings in developing countries, where lifestyles are rapidly changing owing to socio-economic development (Darroch and Singh 1999; McDevitt 1996; Pillai and Benefo 1995; Gage and Meekers 1994). In this pattern, sexual initiation is increasingly premarital, as is pregnancy, while age at marriage and age at first birth are, in general, rising. Also, fertility is beginning to decline and contraceptive use is increasing.

These three models fail to account for the behaviour observed among young people in Africa. It can be argued that the first model is the best fit for patterns of sexual and reproductive behaviour in Africa barring an important difference, namely that premarital sexual activity is common in the region.

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and other Sexually Transmitted Diseases

Until recently, prevention and control of sexually transmitted diseases, especially among the youth, was a low priority for most countries and development agencies. Lack of awareness of the problem of sexually transmitted diseases (STDs) and their complications, competition for resources to control other important health problems and reluctance of public health policy makers to deal with diseases associated with sexual behaviour have all played a role in this neglect.

Similarly, most programmes for the prevention of STDs have, until recent past, focused on the prevention of complications (secondary prevention) (World Health Organisation, 1994). The prevention of transmission of infection (primary prevention) is at present receiving increased attention because of the global epidemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and the identification of several STDs as risk factors for the spread of HIV (UNAIDS, 2000; International Planned Parenthood Federation, 1995).

It should be noted that sexually transmitted infections, especially the HIV/AIDS epidemic, have always entailed suffering. In addition to the physical suffering caused by these infections, there is also considerable emotional pain. Shunning and stigmatization often afflict young

people with sexually transmitted diseases and HIV infection, as well as their families and friends. Unarguably, modern drugs can cure most of the bacterial sexually transmitted infections and help palliate the pain and discomfort caused by viral infection, including HIV. However, it is common knowledge that even simple drugs are unavailable in many sub-Saharan African communities (World Health Organization, 1995; 1986).

The HIV epidemic continues to grow with thousands of new infections occurring every day, and the primary means of transmission is heterosexual intercourse. Virtually no country is free of the virus and at the end of 1994, a cumulative total of 1,025,073 AIDS cases (adults and children) worldwide had been reported to the World Health Organization (WHO, 1995). The actual number of AIDS cases is not known because of under-diagnosis, incomplete reporting and reporting delays. However, young people are the hardest hit. The most recent empirical evidence suggests that out of the 36 million people living with HIV/AIDS, an overwhelming 95 percent live in developing countries, while 83 percent of all AIDS deaths are in Africa (Food and Agriculture Organization, 2001). The evidence further indicates that in nine sub-Saharan African countries, more than 10 percent of the adult population is HIV-positive. In Botswana, Namibia, Swaziland, and Zimbabwe, 20 to 26 percent of the population aged 15-49 is living with HIV/AIDS.

Gender and Age Dimensions of Vulnerability to STDs and HIV

Young women are more vulnerable than men to infection with a STD and to its complications (such as infertility, cancer and inflammatory diseases). Biologically, women are more susceptible to most STDs than men, partly because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse (World Health Organization, 1994). In addition, the risk of transmission of STDs, including HIV infection, is greater whenever the mucosa is damaged. As a result of such factors, most STDs, including HIV infection, are transmitted more readily from men to women than from women to men. The fact that young women with a STD are more likely to be asymptomatic and are therefore less likely to seek treatment results in their being subject to chronic infections with more long-term complications.

The factors that contribute to the higher rate of STDs, as well as HIV, in young women are also related to economic and gender inequalities. In sub-Saharan Africa and indeed many developing countries, the fact that men migrate to cities for work results in concentrations of men away from their families with a demand for sexual services from young unmarried women (Mba, 2001; Darroch and Singh, 1999; Meekers and Calves, 1997; Schoepf, 1994). Where cultures expect women to be passive and subservient to men, the young women have little or no control over decision-making relating to sexuality, nor do they have control over the sexual behaviour of their male partners, or over the use of condoms for the prevention of STD and HIV or pregnancy.

In Rakai, Uganda, and Nairobi, Kenya, unmarried women are found to be far more likely to be HIV-positive than the married ones (Hunter et al., 1994; Serwadda et al., 1992). The Nairobi study, in particular, shows that single sexually active women are twice as likely and formerly married women three times as likely as married women to be HIV-positive. In Tanzania, it has been found that single men and women have the highest rates of change of sexual partners (Rutenberg et al., 1994). Some women who report knowingly having sex with an STD-infected partner say they did so because of a belief that sex could cure venereal diseases (Awusabo-Asare et al., 1993). This belief apparently extends to HIV/AIDS. Blue-collar respondents in Ugandan focus group discussions report a belief that frequent sex can diminish the viral load of the HIV-infected and that young girls are safe to have sex, while adolescents themselves say that infected men bribed young girls for sex or raped them (Obbo, 1993b; Konde-Lule, 1993). Similarly, Awusabo-Asare and Anarfi (1997) report that people in Ghana see HIV/AIDS as a supernatural phenomenon that shapes attitude toward the infected person and the victim's health-seeking behaviour. Although their study sample is small to permit generalization, their

findings point to the need for health workers to be explicit in confronting traditional beliefs in prevention campaigns, especially among young people. Other small-scale studies also reveal that for both behavioural and biological reasons, STDs are more prevalent among young than old people. Nichols and his colleagues (1987) found that about 10-15 percent of female respondents aged 14-17 and 20 percent of those aged 18-21 reported having had an STD. Similarly, they found that 20 percent of male respondents aged 14-17 and 29-41 percent of those aged 18-21 reported having contracted an STD. Also, Mafany (1989) found that in Cameroon, one-third of the sexually active high-school males and one-fourth of their female counterparts reported having had an STD, while 50 percent of the girls and 38 percent of the boys had received no treatment for it. In Ethiopia, Duncan and his colleagues (1994) found that 92 percent of young girls who were in gynecological, postnatal, family planning and similar maternal health facilities were seropositive for at least one STD. In Kenya, studies have also reported elevated levels of STDs among younger than older adults (Lema et al., 1991; World Bank, 1989).

Educational Campaigns, Attitudes and Response

Where awareness of reproductive health problems and need for care is low, the symptoms of an STD may not be recognized as such. Stigmatization and various cultural norms impede appropriate health-care-seeking behaviour since most of these young women may be in school and are therefore unmarried. At the same time, acceptable and accessible services for diagnosis and treatment may not be available for those of them seeking health care.

Approaches using a variety of mass media channels of communication have been effective in increasing contraceptive usage rate. In some countries the level of condom use among young people has increased tremendously as a result of persistent communication efforts. Condom use for sexually experienced young men aged 20-24 years varies from under 20 percent in Lesotho, Tanzania, and Togo to over 50 percent in Guinea-Bissau and Zambia (Mehryar, 1995). Moreover, it can be said that the communication programmes resulted in an overall change in the social norms among young people in favour of condom use. There are many other examples of successful programmes and interventions in the prevention and care of HIV/AIDS and STDs. Communication and education programmes in schools and the workplace, peer education, service-based approaches to sexually transmitted diseases, voluntary counselling and testing programmes, condom social marketing and community distribution programmes, mass media programmes and a variety of others, have been successful in different countries (Messersmith et al. 2000; Nyamu 1999).

It should be stated, though, that despite these efforts, the fight against HIV/AIDS is yet to be won (Ghana News Agency 2001; Mbamaonyekwu 2001; 2000). It is true that some HIV/AIDS awareness and condom distribution campaigns have been launched in all parts of the region. Unfortunately the ugly tide of scourge does not seem to abate. In most parts of the world, most new HIV infections are among adolescents, particularly among females. Granted that the use of male and female condoms offers protection against STDs including HIV, yet the risks of condom slippage cannot be wished away and these risks increase with the prevalence of intercourse. Moreover, the probability of having sex without condom rises with the frequency of intercourse. Yet it does not take more than one sexual intercourse to contract or transmit the virus.

Although awareness that HIV/AIDS is sexually transmitted has penetrated many segments of young adults' population, misconceptions still abound to the extent that a significant number of young people have only superficial knowledge about STDs, including HIV/AIDS. A survey of secondary school students in Nigeria found that less than one-half of the respondents were aware that HIV is the virus that causes AIDS (Araoye and Adegoke 1996), while one-third of the respondents aged 15-19 years in another survey in Kenya believed that HIV/AIDS could be transmitted via mosquito bites (Kekovole et al. 1997).

It is noteworthy that in addition to the health risks of contracting STDs posed by early and premarital sexual behaviour among young people in the region, prevalence of sexual activity often increases the incidence of induced abortion, which often are performed under unhygienic circumstances with dire consequences to the young women (World Health Organization 1996; 1986). In the same vein, premarital childbearing are generally either unplanned or unwanted, and places the young single mothers in a precarious economic position. Both of these circumstances greatly increase the chance of poor outcomes in the short term, as well as in the long term. This is because both the mothers' and children's health and nutrition will likely be poor, and they may have to depend on their families or other relatives for support, with the attendant stigmatization, insult and abuse.

Discussion and Policy Considerations

Many sub-Saharan African societies that hitherto placed a high value on premarital virginity and which sought to guarantee this through constraints on the behaviour of unmarried young people and through a pattern of early marriage are now experiencing a weakening of social controls over behaviour. Moreover, in many of these settings, the customs that united young people in marriage before, at, or shortly after puberty are becoming less common. It should be noted that on one hand, early age at first marriage places young women at risk of early premarital exposure to sexual activity. On the other hand, due to increases in age at first marriage in parts of the region as a result of formal educational, both young women and men are at even greater risk of premarital sexual behaviour and the accompanying health hazards.

Increases in the proportion of young people engaged in premarital sexual activity raise concerns for a number of reasons. Although marriage does not alleviate all health problems associated with early sexual activity, it does mitigate them. Access to health-care services, including family planning and prenatal care, is often easier for married than unmarried women. The social and economic consequences of pregnancy and childbirth are also reduced through the process of marriage, which provides a legitimizing mechanism and support system.

As more young women are attending school and delaying marriage than ever before in sub-Saharan Africa, they are exposed to the risks of premarital sexual intercourse for longer periods of time, which places them to greater risks of unintended pregnancies, induced abortions and STDs, including HIV/AIDS. In fact, increases in pregnancy-related school drop-outs have been reported in some studies (Meeker et al., 1995; King and Hill, 1993). In most cases school girls who become pregnant have to resort to illegal (often unsafe) abortions or face expulsion from school. At the same time, young women who drop out of school due to pregnancy rarely return to complete their education. Consequently, their opportunities for socio-economic advancement in the youth are adversely affected significantly. It can be argued then that the net result of early and premarital sexual behaviour and reproduction reinforces the poverty of women because poor young mothers work more and earn less than do other mothers, and the timing of their childbearing is directly related to their children's nutritional status (World Health Organisation).

In responding to the challenge of unbridled sexual behaviour and the attendant risks of STDs, including HIV/AIDS, among young people in sub-Saharan Africa, there is the urgent need for the development of more relevant information, education and communication (IEC) programmes to build knowledge, motivation and skills. IEC programmes need to be developed based on a full understanding of the individual and the broader socio-economic factors that influence individual, institutional and group behaviour. They should focus on fostering health and responsible behaviour. IEC could also be used to promote ideas of equitable and mutually respectful and responsible gender relations, to increase male responsibility in pregnancy and the prevention of STDs and HIV, and to promote informed reproductive health choices, especially for young women. This is because biological and social factors make women and girls more vulnerable to HIV/AIDS than men and boys. Moreover, studies, some of which have been

highlighted in the preceding discussion, show that HIV infection rates in young women can be 3-5 times higher than among young men.

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Since the current health programmes in some settings are falling short of helping young people acquire appropriate behaviours, knowledge and skills, the establishment of a supportive, enabling environment is imperative. A supportive environment should include a number of actions to change the social, economic, cultural and political environment in a manner conducive to better sexual and reproductive health, as well as programmes addressing the problems of HIV/AIDS and STDs. This should include a variety of possible actions. There is a strong need for advocacy to promote interventions and action. Advocacy should be geared towards a greater understanding of the magnitude of the problem and the need for action internationally and nationally. The soliciting of international community support is needed, including that of agencies and non-governmental organizations, to increase resources, develop some common guiding principles and establish collaboration and partnerships for programme implementation. Advocacy should draw the attention of communities and decision makers to the issue of sexual behaviour and reproductive health among the youth, HIV and STDs, and point towards nationally relevant solutions. National advocacy should provide the rationale for greater allocation of national resources for action on STDs and HIV/AIDS.

Data availability and data quality concerns have long constrained the assessment of young people's sexual behaviour in many parts of sub-Saharan Africa. Large-scale demographic surveys, such as World Fertility Survey (WFS), the Contraceptive Prevalence Surveys (CPS), the Family Planning Surveys (FPS) and the Demographic and Health Survey (DHS), as well as regional, national, and geographically limited surveys, have brought about a much-needed improvement in the quantity, quality, availability and international comparability of information on sexual and reproductive behaviour, as well as health-related issues. Despite these significant improvements, there is still limited data on many countries and for many relevant issues, such as young people's actual access to health services and health results of programme interventions and community factors in the region. Meeting these needs for timely and reliable information remains a major challenge facing the initiatives being launched presently to improve sexual and reproductive health in sub-Saharan Africa.

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