# Challenges to Sexual Health Information Seeking Behaviour among Adolescents in Nigeria

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**Abstract**
This paper discusses the factors affecting the development of young people and their reproductive and sexual health. It reviews literature on the behaviour of young people vis a vis their reproductive and sexual risk behaviours such as low knowledge of contraception, high infection rate, early sexual initiation, early child bearing, unsafe abortion and lack of Information on STIs and HIV/AIDS. The health belief model was used as a basis to examine whether young people consider their health as important in their daily decision in relation to the issue of sexual activity. The paper also examines the relevance of Erikson's stages of psychosocial development which deals with how children socialize and how this affects their sense of self. The paper sums up documented studies on the poor health-seeking behaviours of young people which is the bases for their continuous risky behaviour. It finally argues that poor information seeking behaviour among young people could be based on cultural and traditional values that prevent information seeking on sexual issues. It then recommends that reliable information should be disseminated through public health campaigns, the media, and the educational system.

**Key Words**: Information, Reproductive Health, Sexual Health, Adolescents, Young People.

## Introduction

Young people's health has become a subject of increasing concern throughout the world because of the importance of this age group to public health and the changing patterns of their sexual and reproductive health behaviour. Adolescent girls who marry have always been at greater risks of illness, injury and death arising from early pregnancy and childbirth. But in recent times, population growth in developing countries, urbanization, the crossing of cultural boundaries by rapidly expanding telecommunication and information technology, early menarche combined with delayed marriage, and the decline of the family, have given rise to new patterns of sexual behaviour. Unprotected premarital sexual relations at early ages are associated with the problems of early pregnancy and child bearing, induced abortion in hazardous circumstances, sexually transmitted diseases and human immuno-deficiency virus leading to AIDS (UNAIDS/WHO, 2006). Hence, information dissemination about reproductive and sexual

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health to young people becomes important to their sexual development and in developing behaviour change initiatives target at them.

The development of young people involves a period of transition from childhood to adulthood, which is shown from various changes in the body, in the mind and in social relationships. The body develops in size and reproductive capacity and becomes more sexually defined. The mind becomes more capable of abstract thinking, foresight, and internal control and acquires a greater awareness of the environment. The close relationship with and dependence upon parents and older family members begin to give way to more intense relationships with peers and adults outside the family as new challenges are met and new responsibilities assumed(WHO, 1989). This makes the tasks of both young persons and the traditional guardians of their development more difficult since they are now faced, not only with the problems of their personal transition to adulthood, but also with the changes in the world. The need and the wish to behave differently are often accompanied by risk-taking; anxiety about succeeding, and uncertainty about the future; as well as by intense excitement and creativity. Whether these new forms of behaviour and feelings lead to an enhancement of self-esteem and greater maturity depends not only on the success of the adolescent in achieving development but also on the way in which adults and peers react to him or her(WHO,1989;WHO1997). This period of development can be characterised by lack of opportunities for education, training, jobs, secure and loving family relationship which can eventually lead to attraction of dangerous substances such as tobacco, alcohol and other drugs. The combination of instability in the family with excessive negative pressures in the environment is more likely to lead to these health-damaging behaviours (WHO, 2002).

**Sexual Reproductive Health behaviour**

Reproductive health behaviours the describe practices which have an effect on reproduction. These behaviours include sexual initiation, frequency and rate of intercourse once initiated, protected and unprotected sexual intercourse (which may result in pregnancy and STIs); and course of action during pregnancy (which may include ante-natal care, delivery or abortion). Other reproductive health behaviours include talking to others about sexuality, seeking information and help, having sex for money or favour and prostitution. All these behaviours carry health risks, especially for adolescents (WHO, 2011). In many developing countries, sexual feelings or expressions of the sexual urge are often greeted with anxiety or anger by adults and frequently with fear, guilt, and shame by young people. These responses combine to drive both sexual feelings and sexual behaviours underground there by making communication about them more difficult.

A major potential consequence of unprotected sexuality in adolescence is the acquisition of Sexually Transmitted Infections (STIs) often with devastating effects on future fertility. The incidence of STDs among adolescents has increased remarkably in the last 20 years(WHO,2011). As a consequence, the rates of admission to hospitals for pelvic inflammatory disease are also rising in many developed and developing countries; the two age groups mostly affected being 15-19 and 20-24 years(WHO, 2011). Included amongst the major STDs are gonorrhea, Chlamydia infection, syphilis, herpes, and HIV/AIDS (also transmitted by other means). Three of the major obstacles to the control of these diseases among adolescents are the ignorance of young people of the symptoms of STDs, the symptomatic nature of some STDs, particularly in women, and the reluctance of young people to present themselves for help because they expect to be met with anger and hostility(WHO, 2011).

Young people, like adults, sometimes have sexual problems that are especially frightening because they encounter them without a wider experience of the world. These problems include sexual dysfunction, sexual variation and sexual harassment or abuse (especially of girls by older men). Sexual variation, particularly homosexual feeling is common but transient in young adolescents and perhaps 5-10% remain homosexually orientated throughout their lives, many more being bisexual (NPC, 2009, WHO, 2011).

In the last one decade, a number of studies have focused on the reproductive and sexual behaviour of adolescents in sub-Saharan Africa in large part because of the related social and reproductive health problems and special family planning needs of the population sub-group (Advocate for Youth, 2003). Although various programmes have evolved to address the reproductive health needs of this group of people in many places, the need for action to promote the healthy development of the group has never been more urgent than now.

Earlier studies from Ladipo, Nicholas, Paxman, Delano, Kelly and Otolorin (1983) and Makinwa-Adebusoye (1992) reveal that adolescent sexual activity in Nigeria has always been on the increase. This finding was in line also with that of Moronkola and Fakeye (2008:229) who found out that 53.4% of their respondents (secondary school students) were sexually active. This trend is said to have resulted from earlier onset of menarche, social change and modernisation, which have lengthened the socially defined period of adolescence, and of increased urbanization and educational opportunities. These changes have weakened the traditional family centered constraint on sexual behaviour. Other contributory factors are increased mobility, coupled with the tremendous flow of young people to the urban centers from rural areas and the spread of telecommunication across cultural and geographical boundaries (Friedman, 1993). Changes from traditional to modern systems in education and mode of social interaction have led to changes in adolescent sexual behaviour.

**Factors affecting sexual behaviour of young people**

The period of adolescence is characterised by rapid physical growth, significant physical and psychological changes, and evolving personal relationships. The rapid changes associated with it may have major effects on the health of the individuals, and, conversely, variations in health may significantly affect the transition through adolescence. Thus, data on how young people move through adolescence, and factors that influence the success of and difficulty with this transition should include measures and indicators of health.

World Health Organisation (WHO) has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO,1989). The socio-cultural context in which adolescent development takes place has a profound influence on individual health. Some of the conditions that affect them can be categorized into four: the physiological, sociological, psychological and cultural/economic factors.

1. *Physiological Factors:* The physiological changes in adolescents affect the size and shape of the body which differentiates boys from girls. Puberty is a time when reproductive capacity is developed. The sex hormones secreted during this period not only affect the tissues of the body but also stimulate changes in the sexual and emotional behaviour. The timing of these events however, shows wide variations from one individual to another. In normal boys, for example, there is roughly a five-year range (from about 11 to 16) for the age at which puberty is reached. In girls, puberty begins, on the average some two years earlier and extends over a slightly shorter period. These

changes are often a source of anxiety in adolescents, who are highly sensitive to differences between themselves and their peers especially in appearance (WHO,2002).

2. *Sociological Factors*: This is associated with the social environment and the experience that it provides. For example, young people who grow up in an environment where drugs and other substances are easily accessible and are used by both young people and adults are more likely to abuse substances themselves. Disrupted social relationships in the home environment, for example, separation, divorce or death of parents can be cited as predisposing factors which affect the development of the youths. Other aspects of the social environment such as sexual abuse are important contributing factors (WHO, 2002).

3. *Psychological Factors:* Young people's development is affected by various psychological factors among which are lack of self-esteem and self-image, inability to resist negative peer pressure, non-coping skills and lack of control over one's environment. All these are believed to affect the development of the youth. Other factors such as feelings of invincibility, desire for seeking pleasurable experiences, curiosity, experimentation and risk-taking are also contributory factors. These factors may cluster with other behaviours e.g. poor school performance, etc. There is growing evidence to suggest that problem behaviours cluster together. They include alcohol and drug abuse, cigarette smoking and sexual precocity. Young people face greater challenges than ever because of the physical and the emotional changes they experience during puberty. Such changes make young people highly vulnerable to risks such as drug taking, tobacco and alcohol use, or behaviour related to sexual maturation (WHO, 2002).

In many developing countries, unbiased sex education is not provided either in schools or in other settings, thereby placing young people in vulnerable situations during a period of life when experimental activity is normal. Unnecessary emotional stress is created by the lack of information and understanding about issues on sexuality, bodily changes and functions, and emotional feelings. Inadequate provision of confidential health services for young people can also inhibit them from accessing appropriate health care and advice (WHO, 2011).

4. *Cultural and Economic Factors:* Worldwide adolescents are disproportionately affected by sexual assault and rape. Data from rape crisis centers show that 40-58 percent of assaulted women are under the age of 15. Data regarding sexual abuse of children in Africa are scanty, but evidence reported through non formal sources indicate a problem. A study conducted in Nigeria reveal that 16 percent of female patients receiving STD treatment were less than 5 years old; another 6 percent were between age 6 and 15; while another study found that 22 percent were under the age of 10(Advocate for Youth, 2003). Rape can be particularly devastating for women in societies where virginity is expected for marriage. Early marriage, polygamy and sexual networking ("sugar daddies") are common, thereby increasing the risk for pregnancy and STD/AIDS through sex with older men (Advocate for Youth, 2003). Marriage often occurs between young girls and older men. Young women married to older men often have less power in decision making around sexual intercourse, childbearing, and birth control, and are less able to protect themselves from STDs, exploitation, or abuse. Among 315 adolescent abortion clients surveyed in a hospital in Dar es Salam, almost a third of the pregnancies were caused by a man 45 years or more older (Advocate for Youth, 2004).

This situation reveals that young men often begin sexual activity earlier and have more sexual partners than young women. Hence, gender imbalance in sexual decision-making determines young girl's contraceptive use due to cultural and economic situation which favours the men (International Center for Research on Women, 2006).

**Sexual Reproductive Health behavioural patterns among Nigerian Adolescents**

The poor information seeking behaviour of young people in Nigeria has led to various sexual and reproductive health patterns that are risky to their development. Studies from the survey conducted by Federal Ministry of Health (FMOH) reveals that the reproductive health status of the Nigerian adolescent is poor (FMOH, 2007). Hence, the current reproductive health practices among young people constitute substantial threat to the realization of safe reproductive health initiatives in Nigeria. A study of reproductive health facts among young people in Nigeria reveals that young people have not been prepared for the development from childhood to adulthood (FMOH, 2007). Hence, inadequate sexual health information and services could result to risks of unwanted pregnancy, illegal and unsafe abortion, sexually transmitted infections (STIs), and HIV/AIDS among young people. In a survey of adolescent sexual behaviour, findings show that over 16% of teenage girls had their sexual debut by age 15. The same survey revealed that 13% of the girls and over 27% of the boys reported exchanging money, gifts or favours for sex in the previous 12 months (Nwaorgu, Onyeneho, Okolo, Obadike, and Enibe, 2008).

Hence, studies on the sexual reproductive health behaviour patterns of young people in Nigeria have shown that early onset of sexual activity and early marriages are highly prevalent as evidenced by the median age at first marriage of 16.6 years, the consequences of which include unwanted pregnancies, unsafe abortions and sexually transmitted infections including HIV/AIDS (FMOH, 2007). The 2010 national HIV sero-prevalence survey conducted at sentinel ante-natal care clinics reported a rate of 3.0% and 5.7% for young people aged 15-19 years and 20-24 years respectively (FMOH, 2010). These have long term consequences such as infertility and increased rates of maternal mortality and morbidity. Other issues impinging on the health and development include sexual exploitation, domestic violence, and issues of social practices harmful to women including female genital mutilation and early marriage. Lack of accurate information and limited access to adolescent-friendly health services are major contributory factors to the poor reproductive health status of young people in Nigeria. This reflects in the fact that only 57% of young people in 2005 knew all the transmission routes for HIV (FMOH, 2007; Sedgh, Bankole, Okonofua, Imarhiagbe, Hussain, and Wulf, 2009).

**Low Knowledge of Contraception**

Studies show that there is low, insufficient and inconstant knowledge of contraception among young people. In a survey among the teenage girls it was found that 37.5% knew some method of contraception; 36.3% knew modern methods while their male counterparts, 50.3% knew some modern methods (NDHS,2003). However, only 29% of the young people in this survey ever used a modern method of contraceptive. Reason for non-use of contraception, among the sexually active single teenagers included fear of complication (46.7% of males and 48.5% of females) and religious and ethical beliefs (12% for males, 21.2% for females) (Advocate for Youth, 2001). Hence, young girls with the risk of unwanted pregnancy take to ineffective methods like douching and unorthodox techniques after sexual intercourse irrespective of adverse effect to their reproductive health. Unwanted pregnancies among youths disrupt the social development of these girls who live with stigma. Mindful of the social stigma of having unwanted pregnancies, many young girls who become pregnant seek abortion as the only way to end unwanted pregnancies. (Nwaorgu, Onyeneho, Okolo, Obadike, and Enibe, 2008). Another survey of 989 adolescents from 24 North-Eastern Nigerian secondary schools on their reproductive health knowledge, sexual activities and sexuality education reveals that 72% of females had experienced menstruation. Overall, 9% were sexually active, 3.1% knew when

ovulation occurs, 47% knew pregnancy could result from first coitus and 56% knew of contraception (Adeokun, Ricketts, Ajuwon, and Ladipo, 2009).

**High Infection Rates**

The level of infection among young people in Nigeria is relatively high due to increase in sexual activities among them. This statement is true because they often face tremendous pressure especially from peers to engage in sexual activities, unlicensed erotic video films and the desire for economic gain (Adeoye, Ola, and Aliu, 2012). In a study on the perception of risk among college students in Osun State, Nigeria, 40 percent of the respondents reported engaging in unprotected sex in the month prior to being surveyed. Only 15 percent of the college students surveyed perceived themselves to be at moderate-to-high risk of HIV infection. Health investigators categorized 77 percent of the students surveyed as having a high risk of HIV infection and a mere 23 percent as having a low risk of contracting the virus (Advocates for Youth, 2010).

Adeokun, et al (2009:38) assert that: "despite the fact that several educational programs have been carried out among in-school adolescents in Nigeria to increase awareness about risky sexual behaviour and promote safe and responsible sexual behaviour, it has been found that in many cases, several misconceptions exist among them and there are gaps in their knowledge. Although almost all adolescents have some information about sexually transmitted infections, they lack adequate knowledge about transmission and presentation". All these reveal the high sexual activities among young people in Nigeria which have great consequence for their health.

**Early Sexual Activity**

In an earlier study in Nigeria documented by Advocate for Youth (1995), the average age at first intercourse for girls is 16 years and a little higher for boys. In another survey of more than 5500 urban youth aged 12 to 24 years by Makiwa-Adebusoye (1992), 41 percent had experienced sexual intercourse. Of these, 82 percent of females and 72 percent of males had had intercourse by age 19. Young men have also been found to report having multiple sexual partners and having intercourse with casual partners while in contrast young women usually report they had their first encounter with acquaintances or steady boyfriends (Makiwa-Adebusoye,1992). This shows a high prevalence of sexual activities among young men than women. In a recent study of 1000 young people (500 males, 500 females) aged 15 – 24 at tertiary education institutions in Ilorin, the males reported having their first sexual experience earlier (mean age 17 years) than females (mean age 19 years). Among those who were sexually experienced, 11% had had casual sex at least once in the previous four weeks (Action Health Incorporated, 2005). In another documented survey of sexual activity among young men and women in Nigeria findings reveal that the median age at first sexual intercourse is 17.8 years for women and 20.6 for men. One in five women had initiated sexual intercourse by age 15, and the trend is the same with men. More than half of women (52 percent) have experienced sexual intercourse for the first time by age 18(NDHS, 2008). The findings from these studies show that young people engage in early sexual activities with no proper protection against infections hence, they are exposed to the risk of various sexually transmitted infections including HIV and AIDS.

**Early Childbearing and Unsafe Abortions**

Studies show that over 1.3 million unintended pregnancies occur annually in Nigeria, while over a half (760,000) of these pregnancies result in abortion (USAID, 2009). Further studies revealed that fifty-four percent (54%) of young women in Nigeria gives birth by age 20 (USAID, 2009). The maternal mortality estimate for Nigeria suggests that

54,000 women die each year due to pregnancy-related complications. The risk of injury and death from pregnancy-related complications is higher among teenage mothers because they are more likely to experience an unsafe abortion and because they experience a higher risk of complications at birth due to underdeveloped bodies (Guttmacher Institute, 2008). Abortion is illegal in Nigeria except to save a woman's life. Teenagers account for 80 percent of unsafe abortion complications treated in hospitals (Advocate for Youth, 2001). Nigeria has one of the highest maternal mortality rates in the world with an estimated 800 maternal deaths per 100,000 women (Advocate for Youth, 2001). During a two-year period at the University of Ilorin Teaching Hospital, 264 women had complications from induced abortions. Of these, 74.4 percent were adolescents with septic abortion. Fifty-five percent of Nigerian women who have abortions are under 25 years old (Sedgh, Bankole, Okonofua, Imarhiagbe, Hussain, and Wulf, 2009; Advocate for Youth, 2010).

**Lack of Information on STIs/HIV**

Lack of accurate information and limited access to adolescent-friendly health services are major contributory factors to the poor reproductive health status of young people in Nigeria. This reflects in the fact that only 57% of young people in 2005 knew all the transmission routes for HIV (FMOH, 2007). Various stakeholders tend to withhold reproductive health and sexuality information from young people mainly as a result of negative traditional and socio-cultural beliefs. The social and traditional values that used to shape young people's behaviour to make the transition from childhood to adulthood have become weakened in the face of urbanization and new attitudes toward sexuality (FMOH, 2007). Hence, they are typically poorly informed about how to protect their sexual and reproductive health. Consequently, they often engage in risky sexual behaviours, which increase their susceptibility to HIV and other sexually transmitted infections, some of which cause lifelong problems including infertility, if left untreated (Adeokun et al, 2009). As a result, more young people are sexually active but without adequate information to protect themselves. The need for adequate information to empower young people cannot be over stressed because of the prevalent rate of HIV infection in Sub-Saharan Africa where Nigeria is situated (FMOH, 2010).

**Theoretical Framework**

***Health Belief Model***

The Health Belief Model (HMB) asserts that health behaviour is guided by an individual's perception about the behaviour. It takes into account four key issues: "susceptibility, seriousness, barriers to, and benefits of the behaviour" to determine the extent to which a person takes on a behaviour. The model, which was developed by Rosenstock (1950), asserts that people will change behaviour depending upon their knowledge and attitude (National Institute of Health, 2005). The key variables of the HBM are perceived threat; perceived susceptibility; perceived severity; perceived benefits; perceived barriers and cues to action. Research on HRM has been used to explore a variety of health behaviours in diverse populations. For instance, researchers have applied the HBM to studies that attempt to explain and predict individual participation in programs for influenza inoculations, Tay-Sachs carrier status screening, high blood pressure screening, smoking cessation, seatbelt usage, exercise, nutrition, and breast self-examination. With the advent of HIV/AIDS, the model also has been used to gain a better understanding of sexual risk behaviours. However, the limitations of the model are that it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and the model does not incorporate the influence of social norms and peer influences on people's decisions

regarding their health behaviours (John, Guadalupe and Stewart, 1999). Applying this model to adolescent health is to determine the perceive threat to adolescent not seeking information about their sexual and reproductive health, assess the perceived barriers and benefits in seeking appropriate information and be cued to the potential consequences of failing to change unhealthy behaviour practices. This can help them overcome the barriers to developing a positive behaviour in seeking information about their health.

We shall examine the principles as they relate to developing behaviour change in adolescents. The first principle deals with "perceived susceptibility to a particular health problem". Several finding from studies above revealed that majority of adolescents involve in health risk behaviours without knowing the implication to their health. However, adolescents should have sufficient knowledge and information about what constitutes a risk to their health. The second principle deals with "perceived seriousness of the condition". Majority of adolescents do not know the severity of risky behaviour to their health. But if they do, this will help them to develop responsible behaviour in order to avoid risk. Also adequate perception of risk will encourage majority of adolescents to be serious about programmes and interventions to help them develop positive sexual behaviours in the society. The third principle deals with "belief in effectiveness of the new behaviour". Adolescents should understand that developing new behaviour requires a lot of practice. Their stage as adolescents shows this as difficult. For example abstaining from sexual intercourse for adolescents may be difficult in the face of multiple sexual images in the media. But their conviction of abstinence as a good behaviour will help them to practice and sustain that behaviour. The fourth principle deals with "cues to action". Adolescents should learn to practice their new behaviour to avoid risk even when it is difficult. The fifth principle deals with "perceived benefits of preventive action". Adolescents should see the benefits of practicing the new behaviours as better than the risk of engaging in the old behaviours. The sixth principle deal with: "barriers to taking action". Adolescents should understand that developing new behaviour requires practice and continuous practice. Hence, they should have the correct knowledge and information of the challenges they will face in practicing the new behaviour and how to cope with these challenges. Hence, the concept of health belief model is useful in encouraging adolescents to understand the various steps involved in developing positive behaviour while avoiding risky ones and the benefit of seeking adequate information when necessary.

**Barriers to sexual and reproductive health information seeking behaviour**

Studies by the Federal Ministry of Health in Nigeria have shown that there is a general tendency of parents and other adults to be secretive about sensitive developmental issues such as sexual and reproductive health (SRH) issues(FMOH, 2010). As the 2005 National HIV/AIDS and Reproductive Health Survey showed, only 39% of adults have discussed sexual issues with their male children/wards over 12 years of age and 51% had discussed such with their female children/wards in the one year preceding the survey (NARHS, 2005). Poor level of parent-child communication has also been widely reported, which revealed gaps in youth sexual information behaviour. The cultural belief which regards sexual and reproductive health and related issues as things to be discussed only in the secret, parents' sense of inadequacy and low self-efficacy in providing information to their young ones about healthy development also constitute major barriers to youth sexual information seeking behaviour. Thus, it is not surprising that young people usually turn to alternative sources of information (especially friends who are themselves lacking in appropriate and correct information). Consequently, the information to which young people have access is such that encourage them to act in conformity to the peer group

subculture. Because they want to be accepted, young people usually behave in ways that meet the approval of their peer group, irrespective of the consequences (FMOH, 2010).

The question is why do young people engage in risky behaviours? We shall examine the Erikson stages of Psychosocial development in table 1 to see some of the barriers that adolescents could face in their various stages development.

The stages of psychosocial development by Erik Erikson (1902-1994) deals with how children socialize and how this affects their sense of self. The model has eight distinct stages, each with two possible outcomes. According to the theory, successful completion of each stage results in a healthy personality and successful interactions with others. Failure to successfully complete a stage can result in a reduced ability to complete further stages and therefore a more unhealthy personality and sense of self (Fleming, 2004). Hence, according to the model, each part of the personality has a particular time in the life span when it must develop if it is going to develop at all. If a capacity does not develop on schedule, the rest of the individual's personality development is unfavorably altered. The individual's capacity to deal effectively with reality is then hindered (Fleming, 2004). Stage 1: is a stage in which a child develops a sense of trust in their self and others especially their parents who usually cares for them. If this is absent then a sense of mistrust develops in them. Stage 2: is a stage of autonomy in which children becomes autonomous and develop a sense of self-control without loss of self-esteem and if this is absent then it has implication of children who depend on their parent to think and do things for them. The is a psychosocial problem in terms of behaviour development. Stage 3: is a stage in which children develop their initiative and are curious about things and desire for directions to avoid mistakes in doing things. Stage 4: is a stage of puberty in which children are leaving their teenage stage gradually and are curious about how things are made and how they work and wish to develop a sense of mastery and competence about things around them and about themselves. Stage 5: is a stage at which young people experience identity formation versus role confusion. At this stage majority of adolescents begins to explore information about them and asking questions like "Who am I?", "Why am I like this?" They begin to develop a coherent sense of self and ego identity. This is a time of great change in which the body and the sexual organs mature. This is a time of identity crisis, which Erikson describes as "a turning point of increased vulnerability and heightened potential" (Fleming, 2004). Stage 6: is an early adulthood stage in which adults are able to reach out and connect with others, become intimate with someone and work toward developing a career for themselves. Stage 7: is a stage of middle adulthood in which many adult look beyond themselves and embrace the society more and future generations. They develop concern for those outside family since they already established their identity. Stage 8: is a stage of late adulthood in which adult take stock of their past to get sense of satisfaction or despair if they failed to succeed as an adult. However, the primary focus of this paper is to appraise the stage of adolescence and the challenges in seeking appropriate information to cope with this stage in order to move to the next stage of developing positive sexual and reproductive health life. Hence, adolescence stage is a crisis stage of development which could lead to manifestation of risky behaviours among them. This development however is dependent on the willingness to seek appropriate information to cope with these challenges. The new direction that young people take depends on multiple factors, but there seems to be a clustering of health-enhancing or health-damaging forms of behaviour that become progressively more ingrained through the years of adolescence. Moreover, the concern and understanding that young people show for their own health and the contribution that they make to their health are significantly affected by human and material environment in which their development takes place. Hence, to achieve and sustain the health of young people, the need to provide relevant information to empower

them to take up various challenges in their stage of development becomes highly essential (UNAIDS/WHO, 2006).

**Improving Adolescent sexual and reproductive health information seeking behaviour**

The provision of information and health services to young people during the period of early adolescence is especially challenging. It affects the way they deal either positively or negatively with their sexuality. The difference of adolescent development which is based on socioeconomic, cultural, family and community characteristics determines their cognitive capacities which in turn determine sexual curiosity and their quest for information and experiences (WHO, 2011).

Several studies gathered by WHO, (2011) on sexual and reproductive health of younger adolescents in developing countries, (Awusabo-Asare et al. 2006; Guiella and Woog, 2006; Munthali et al. 2006; Neema et al. 2006; Bankole et al. 2007) show little information on how and where adolescents obtain their sexual reproductive health messages. This shows the need to study the patterns of information-seeking behaviours among young people in diverse settings, along with information sources, the accuracy of what they are learning, and the gendered content of sexual messages.

Research studies from Rani, Figueroa and Ainsle, (2003); Hennink, Rana and Iqbal, (2005) and Lloyd, (2005) documented by WHO, (2011) reveal that adolescent males information seeking behaviour is different from that of the females. Findings reveal that adolescents male are "often relying on friends and on sexually explicit magazines, videos or Internet sites rather than on parents, teachers, and other legitimate (although not necessarily responsive or well-informed) sources". The study did not show the age and content of such information. Hence, the need to ascertain what young adolescent girls and boys are learning, and from whom, and what information they may be receiving and passing along about various forms of sexual expression that they have heard about or in which they may be (or are about to be) engaged.

Other studies (Elegbe, 2009; Khan and Mishra, 2008; Singh, Bankole and Woog, 2005; UNESCO 2009) have been conducted to document the sources of information on sexual and reproductive health knowledge of young people especially their beliefs about issue of pregnancy, STIs/HIV, condoms and other contraceptives. However, the limitation of these surveys are that the information collected are not about adolescents' understanding of their sexuality or their sexual rights and responsibilities due to other studies which reveal lack of knowledge among adolescents issue like whether a girl can become pregnant at first sexual intercourse, how to use a condom correctly, whether there are other STIs aside from HIV, and how they are transmitted (Hennink et al. 2005; Mohammadi et al. 2006; Vuttanont et al. 2006 cited in WHO, 2011).

Hence, studies from Lloyd (2009) reveal the importance of what adolescents need to know and when they need to know it and the sex– gender cultures of which they are a part would help to determine the appropriate timing and content of interventions in different communities to improve their information seeking behaviour. In addition, there is need not only on what young adolescents want and need to know, but also on how they react to the information that they do receive from in-school or out-of school programmes and other sources. Young people's critical assessments of the quality and comprehensibility of what they are learning and of the practical relevance of such information to their lives would be extremely helpful in advancing the understanding of their immediate concerns and the extent to which the content and messages of particular source or sources correspond approximately with their "evolving capacities" to absorb them (WHO, 2011).

**Conclusion and Recommendations**

The challenges of adolescents are enormous at their stage of development which requires the support of various stakeholders to support them in seeking appropriate information in dealing and coping with this stage in order to develop into a responsible adulthood. For adolescents to develop positive information seeking behaviour there is need for the dissemination of reliable information through public health campaigns, the media, and the educational system to ensure that young people acquire knowledge about their health, especially information on sexuality and reproduction; there is need for the promotion of mutually respectful gender relations as well as appropriate information and health services to enable adolescents relate appropriately to the opposite gender; there is need to introduce formal and non-formal education that should encourage behaviour that protects adolescents from early and unwanted pregnancy, sexually transmitted infections (STIs) including HIV/AIDS, and sexual abuse, incest and violence, there is need for adolescents' to have access to appropriate information and services which should not be restricted by legal, regulatory or social barriers or by the attitudes of health-care providers and there is need for programmes to safeguard adolescents' rights to privacy, confidentiality, respect and informed consent and to non-discrimination (World Health Organisation, 2011). This will go a long way to reduce the challenges of adolescents in seeking appropriate information relevant to their sexual and reproductive health.

**Table 1: Erikson's Eight Stages of Psychosocial Development**

| Stages | | Developmental Period | Characteristics of Stage | Favored Outcome |
|---|---|---|---|---|
| **1** | **Trust vs. mistrust** | Infancy (birth to 1 year) | Come to trust or mistrust themselves and others | Develop trust in self, parents, and the world |
| **2** | **Autonomy vs. shame and doubt** | 2 to 3 | With increased mobility, decide whether to assert their will | Develop sense of self-control without loss of self-esteem |
| **3** | **Initiative vs. guilt** | 4 to 5 | Are curious and manipulate objects | Learn direction and purpose in activities |
| **4** | **Industry vs. inferiority** | 6 to puberty | Are curious about how things are made and how they work | Develop a sense of mastery and competence |
| **5** | **Identity vs. identity Confusion** | Adolescence | Explore "Who am I?" question | Develop a coherent sense of self and ego identity |
| **6** | **Intimacy vs. isolation** | Early adulthood | Are able to reach out and connect with others | Become intimate with someone and work toward career |
| **7** | **Generativity vs. stagnation** | Middle adulthood | Look beyond self to embrace society and future generations | Begin family, develop concern for those outside family |
| **8** | **Integrity vs. despair** | Late adulthood | Take stock of one's past | Get sense of satisfaction from looking at past |

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