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Knowledge, Practices and Associated Factors to Sexual and Reproductive Health of Young People of Cotonou, Bénin in 2022

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ABSTRACT

Background: The sexual and reproductive health of young people is a public health priority, especially in developing countries such as Benin. The objective of this research is to measure the level of knowledge and practices of young people regarding sexual and reproductive health and the factors associated with it in the city of Cotonou in 2022.
Subjects and Method: This is a descriptive cross-sectional study with an analytical focus on a sample of 318 young people aged 15 to 25 years, randomly selected in the community by three-stage cluster sampling. The dependent variables were young people's overall knowledge of sexual and reproductive health with the modalities 'good knowledge' and 'poor knowledge' and young people's SRH practices with the modalities 'good practices' and 'poor practices'. The independent variables were socio-demographic data and individual background and factors. The data were analyzed by logistic regression.
Results: In the study population, 51.3% were male with a sex ratio (M/F) of 1.05. The overall level of good knowledge of young people on sexual and reproductive health was assessed at 13.5%. The overall level of good sexual and reproductive health practices of young people was assessed at 72.6%. Good sexual and reproductive health knowledge was more prevalent among young people over the age of 19. The risk of having good SRH knowledge increased eightfold when the type of household in which the young person spent their adolescence was monogamous (OR = 8.03; 95% CI= 2.12 to 30.44; p= 0.017) compared to the single-parent/ isolated household.
Conclusion: Promoting sexuality education from early adolescence within communities would be a high-impact solution to improve the quality of sexual and reproductive health of young people and the general population.

Keywords: sexual and reproductive health, sexual and reproductive rights, youth, Benin.

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BACKGROUND

The sexual and reproductive health of young people is a public health priority, especially in developing countries. There is clear evidence that improving the sexual and reproductive health of young people not only

reduces child and maternal mortality, but also facilitates long-term political stability and economic development (UNFPA and WCARO, 2017).

In West and Central Africa, the population is predominantly made up of young people, with 65% under the age of 24 and 32% between the ages of 10 and 24 (UNFPA, 2017). In this region, 45% of women marry or are married before the age of 19 and a large proportion of girls under 15 give birth each year (UNFPA, 2014).

Young people, driven by curiosity and risk-taking, develop unhealthy sexual behaviours such as early sexual debut (before the age of 15), unprotected sex and multiple sexual partners (Abiodun et al., 2020). Like the countries of West Africa, Benin has a predominantly young population with a sustained demographic growth rate of 3.5% on average per year. Two out of three Beninese are under 25 years of age (INSAE, 2015). More and more young Beninese, especially in urban areas, are becoming sexually active at a very early age and are thus exposed to several sexual and reproductive health problems. In 2018, the EDSB surveys revealed that 12% of young girls aged 15-19 were sexually active before the exact age of 15, compared to 6% of young men in the same age group (INSAE, 2019).

The city of Cotonou, being the main economic city of the country, is the centre of all the socio-cultural, behavioural and educational mixing between young people, increasing the risks of bad sexual and reproductive practices.

However, there is very little scientific data on young people's knowledge, attitudes and practices regarding sexual and reproductive health in the city of Cotonou.

It is therefore to fill this gap that the present research was implemented and its objective is to measure the level of knowledge and the level of practices of young people in sexual and reproductive health (SRH) in the city of Cotonou in 2022.

SUBJECTS AND METHOD

1. Study Design

This is a descriptive cross-sectional study with an analytical aim in two parts: quantitative and qualitative. The data collection was carried out in the community, in households over the period from 21 to 30 April 2022 among young people aged 15 to 25 years residing in the city of Cotonou. Young people who did not give their informed consent or who were unable to answer the questions clearly and precisely were excluded from our sample.

2. Population and Sample

Three-stage probability cluster sampling was used. The three levels of clustering were represented by the district level, the city ward level and the household level respecttively. Six boroughs were drawn at random and written on a piece of white paper that was tightly closed. Then within each district, a number of three city districts were drawn.

At the level of each district, we delimited the four cardinal points. The first route was identified randomly by throwing a bottle. The first household chosen was the first on the route indicated by the bottle; then the following households were identified according to the sampling step of 2. Within each household, we randomly selected a single young person who met our inclusion criteria from among those existing in the household.

3. Study Variables

The dependent variables were young people's overall knowledge of sexual and reproductive health with the modalities 'good knowledge' and 'poor knowledge' and young people's SRH practices with the modalities 'good practices' and 'poor practices'. The independent variables were socio-demographic data and individual background and

factors.

4. Operational Definition of Variables

Knowledge of sexual and reproductive health divided to: Bad (1); Good (2).

Practices of sexual and reproductive health divided to: Bad (1); Good (2).

Gender divided to: Male (1); Female (2).

Age group (years) divided to: 15-19 (1); 20-25 (2).

Ethnicity divided to: Fon and related (1); Others (2).

Religion divided to: Christian (1); Others (2).

Marital status divided to: Single without a lover (1); In a relationship (2).

Profession divided to: Pupil/Student (1); Liberal profession (2).

Level of education divided to: Not in school/ Primary (1); Secondary/ University (2).

Sibling rank divided to: 1st (1); 2nd and more (2).

Household in which the young person lived his adolescence divided to: Monogamy (1); Polygamist (2); Single parent/ Single person (3).

Current place of residence divided to: In the family (1); Other (2).

Existence of religious beliefs on SRH practices; Sexual activity; History of pregnancy/paternity; History of STIs; Victim of rape; Alcohol consumption; Tobacco/ Drug Use divided to: Yes (1); No (2).

Age at 1st sexual intercourse (years) divided to: ≤ 15 (1); > 15 (2).

Number of current sexual partners divided to: ≤ 1 (1); > 1 (2).

5. Study Instruments

Data was collected through a type of digitalized questionnaire administered to young people using the CS Entry software installed on smartphones for data collection after conducting a pre-test.

6. Data Analysis

Data analysis was carried out using Epi info version 7 and SPSS version 25 software. Cross-tabulations between the dependent variables and the independent variables were performed to assess the relationships between them in univariate analysis. Several variables were retained in order to calculate sexual and reproductive health knowledge and practice scores. For knowledge, the variables used were: sources of information on puberty, sources of information on SRH concepts, mastery of SRH concepts, traditional or religious beliefs, knowledge of contraceptive methods, knowledge of STIs/ HIV/AIDS and their transmission routes, sexual and reproductive rights of young people and knowledge of SRH services.

A wrong answer was scored as 1 and a right answer as 2. The knowledge threshold was set at 75% correct answers.

With regard to SRH attitudes and practices, the variables used were: discussions of sexuality with family and friends, initiation of discussions of sexuality with family and friends, number of current sexual partners, previous abortion practices, history of STIs, initiation of sexual activity, contraceptive method used to avoid unwanted pregnancy, use of SRH services and recent HIV testing. The threshold for good practice was thus set at 75% of correct answers.

Multivariate analysis using logistic regression allowed us to identify the factors associated with young people's knowledge and practices of SRH in the city of Cotonou, but also to measure the strength of association of each determinant (Odds ratio) at the α significance level of 5%.

7. Research Ethic

The health, university and administrative authorities of the city of Cotonou were notified and their authorisations were obtained. Given the sensitive nature of the subject matter, respondents were taken separately in

order to guarantee them complete privacy and confidentiality. The informed consent of each volunteer participant was then obtained in addition to that of the parent for young people under the age of 18.

RESULTS

A total of 318 young people were enrolled in this study, 51.3% of whom were male with a sex ratio (M/F) of 1.05. The average age of the youth was Mean= 18.83; SD= 3.04 years. The majority of the young people surveyed (78.9%) had at least a secondary education and 61.9% of them were in a romantic relationship (married or not).

Table 1 shows the distribution of adolescents by socio-demographic characteristics. Traditional or religious beliefs about SRH were present in 44.3% of young people. These were mainly: abstinence until marriage, prohibition of abortion and prohibition of family planning. More than half of the young people, 61.3%, were sexually active, of whom 28.6% had their first sexual intercourse before the age of 15. The mean age (SD) of first sexual intercourse was 15.88 ± 2.57 years.

Table 2 shows the distribution of young people according to their background and individual factors.

About 18.6% of young people had a good knowledge of contraceptive methods. In terms of STIs/ HIV/ AIDS and the routes of transmission of STIs/ HIV/ AIDS, 15.4% and 41.5% of the young people surveyed respectively had a good level of knowledge of these concepts. Very few young people (33%) had a good knowledge of sexual and reproductive health services (Table 3).

Most of the young people surveyed, 64.5%, used to discuss SRH issues with their relatives. However, only 4.7% discussed these issues with their parents or guardians. In addition, 77.3% of the young people had never used FP and almost half (42.8%) did not use a recommended FP method to avoid unwanted pregnancies. It should be noted that only 33.6% of the young people had a good use of SRH services (Table 4).

The overall level of knowledge of young people about sexual and reproductive health was estimated at 13.5% (Table 5). The overall level of practice of young people on sexual and reproductive health was assessed at 72.6% (Table 5).

By examining socio-demographic, individual and background factors, the variables (age, occupation, education, sibling rank and type of household in which the young person lived as an adolescent) were statistically associated with knowledge of SRH among the young people in the study (Table 6). And the variables (occupation and number of current sexual partners) were statistically associated with SRH practices (Table 7).

Analysing these variables in a logistic regression model, the multivariate analysis shows that young people over 19 years of age are three times more likely to have good SRH knowledge than younger people with an OR= 3.35; 95% CI= 1.32 to 8.53; a pupil or student is twice as likely to have good SRH knowledge with an OR= 2.13; 95% CI= 1.01 to 4.51 and more likely to have good SRH practice with an OR= 1.78; 95% CI= 1.08 to 2.95, than a young person with a professional background. It should also be noted that the risk of having good SRH knowledge increases four times when the type of household where the young person spent their adolescence is polygamous with OR= 4.13; 95% CI= 1.29 to 13.23) compared to the single parent/ isolated household, and eight times when the household is monogamous with OR = 8.03; 95% CI= 2.12 to 30.44.

Furthermore, although SRH knowledge was significantly associated with education ($p < 0.001$), sibling rank ($p = 0.016$), the risk of having good SRH knowledge was

lower among young people with at least secondary education compared to those with at most primary education; and among young people who were junior or youngest in their sibling group compared to older people. The same was true for the association between the risk of SRH practices and the number of current sexual partners (p= 0.019), which was not pronounced.

Table 1. Socio-demographic characteristics of young people surveyed in 2022

Variables of Workforce	Frequency (n)	Percentage (%)
Gender		
Male	163	51.3
Female	155	48.7
Age (years)		
≤ 19	196	61.6
>19	122	38.4
Ethnicity		
Fons and related	219	68.9
Others (Adja, Yoruba, etc.)	99	31.1
Religion		
Christian	243	76.4
Others	75	23.6
Marital status		
Single without a lover	121	38.1
In a relationship (married or not)	197	61.9
Profession		
Pupil/ Student	200	62.9
Liberal profession	118	37.1
Level of education		
Not in school/ Primary	67	21.1
Secondary/ University	251	78.9
Sibling rank		
1st	111	34.9
2nd and more	207	65.1
Household in which the young person lived his adolescence		
Monogamy	165	51.9
Polygamist	87	27.3
Single parent/ Single person	66	20.8
Current place of residence		
In the family (parent or guardian)	265	83.3
Other (spouse/ friend/ single)	53	16.7

Table 2. Distribution of young people surveyed according to their individual factors and background in 2022

Variables of Workforce	Frequency (n)	Percentage (%)
Existence of religious beliefs on SRH practices		
Yes	141	44.3
No	177	55.7
Sexual activity		
Yes	195	61.3
No	123	38.7
Age at 1st sexual intercourse (years)		

Variables of Workforce	Frequency (n)	Percentage (%)
≤ 15	91	28.6
> 15	227	71.4
History of pregnancy/ paternity		
Yes	37	11.6
No	281	88.4
Age 1st pregnancy/ paternity in years (n=37)		
≤ 15	2	5.4
> 15	35	94.6
Number of current sexual partners		
≤ 1	254	79.9
> 1	64	20.1
History of STIs		
Yes	27	8.5
No	291	91.5
Victim of rape		
Yes	7	2.2
No	311	97.8
Alcohol consumption		
Yes	134	42.1
No	184	57.9
Tobacco/ Drug Use		
Yes	38	11.9
No	280	88.1

Table 3. Distribution of young people surveyed according to their knowledge of sexual and reproductive health in 2022

Variables of Workforce	Frequency (n)	Percentage (%)
Source of information on SRG		
Friends, brothers/ sisters	203	63.8
Parents/ Trainers	76	23.9
Other (Books/Media)	39	12.3
Mastery of SRH concepts		
Good	145	45.6
Low	173	54.4
Knowledge of contraceptive methods		
Good	149	46.9
Low	169	53.1
Knowledge of STIs/ HIV AIDS		
Good	131	41.2
Low	187	58.8
Knowledge of transmission routes STI/ HIV AIDS		
Good	230	72.3
Low	88	27.7
Knowledge of rights in SRH		
Good	112	35.2

Variables of Workforce	Frequency (n)	Percentage (%)
Low	206	64.8
Knowledge of SRH services		
Good	154	48.4
Low	164	51.6

Table 4. Distribution of young people surveyed according to their sexual and reproductive health practices in 2022

Variables of Workforce	Frequency (n)	Percentage (%)
Habit of discussing sexuality with others		
Yes	205	64.5
No	113	35.5
Usual interlocutors for discussions on sexuality		
Friends, brothers/ sisters	303	95.3
Parents/ Guardians	15	4.7
Beginning of sexuality discussions with family and friends		
Before puberty	117	36.8
At puberty/ After	201	63.2
Previous abortion practice		
Yes	14	4.4
No	304	95.6
Frequency of FP use		
Never	244	77.3
If necessary	72	20.7
Age 1er FP use (n=72)		
≤ 15	13	18.1
> 15	59	81.9
FP method used to avoid pregnancy		
None/ Interrupted coitus	91	28.6
Morning-after pill/ Other	65	20.5
Condoms	162	50.9
Sex with more than one partner		
Never	311	97.8
At least once	7	2.2
Use of SRH services		
Good	175	55.0
Low	143	45.0
HIV testing in the last 12 months		
Yes	47	14.8
No	271	85.2

Table 5. Knowledge and practice thresholds for sexual and reproductive health among young people in Cotonou, Benin in 2022

Variables of Workforce	Frequency (n)	Percentage (%)
Knowledge		
Good	43	13.5
Wrong	275	86.5
Practice		
Good	231	72.6
Wrong	87	27.4

Table 6. Factors associated with knowledge of sexual and reproductive health among youth in Cotonou in 2022

	Knowledge of SRG			
	Good n (%)	Bad n (%)	OR (95% CI)	p
Age (years)				
≤ 19	18(41.9)	178 (64.7)		0.004
>19	25 (58.1)	97 (35.3)	3.35 (1.32-8.53)	
Occupation				
Pupil/student	33 (76.7)	167 (60.7)	2.13 (1.01-4.51)	0.043
Liberal profession	10 (23.3)	108 (39.3)		
Education level				
Not in school/ Primary	1 (2.3)	66 (24.0)		
Secondary	25 (58.1)	175 (63.6)	0.04 (0.01-0.41)	<0.001
Academic	17 (39.5)	34 (12.4)	0.40 (0.16-1.00)	
Sibling rank				
1 ^{er}	22 (51.2)	89 (32.4)		0.016
2ème and more	21 (48.8)	186 (67.6)	0.46 (0.24-0.87)	
Adolescent Life Household				
Single parent/ Isolated	11 (25.6)	55 (20.0)		
Monogame	28 (65.1)	137 (49.8)	8.03 (2.12-30.44)	0.017
Polygamist	4 (9.3)	83 (30.2)	4.13 (1.29-13.23)	

Table 7. Factors associated with sexual and reproductive health practices among youth in Cotonou in 2022

	SRG practices			
	Good n (%)	Bad n (%)	OR (95% CI)	p
Occupation				
Pupil/ student	154 (66.7)	46 (52.9)	1.78 (1.08-2.95)	0.023
Liberal profession	77 (33.3)	41 (47.1)		
Number of sexual partners				
≤ 1	192 (83.1)	62 (71.3)	0.50 (0.28-0.90)	0.019
> 1	39 (16.9)	25 (28.7)		

DISCUSSION

This study of sexual and reproductive health knowledge and practices among young people in the city of Cotonou allowed us to investigate and analyse the sexual education

and sexual and reproductive health behaviours of young people. In the literature, we noted that the majority of studies on sexual and reproductive health are often oriented towards young people in schools or in refugee situations. In contrast, our methodology allowed us to target a representative group of the study community in order to include young people from different socio-professional categories.

The average age of the young people was Mean= 18.83; SD= 3.04 years, close to that observed by Abiodun in Nigeria (Abiodun et al., 2020) and the majority of them had at least secondary education as noted by Mbadu in Kinshasa (Mbadu et al., 2018). The general level of knowledge was low among young people regardless of gender as in several other studies (Brunelli et al., 2022; Ivanova et al., 2018). Similar to some studies (Guan et al., 2021; Vongxay et al., 2019) we found that most young people (54.4%) were unfamiliar with reproductive health, abortion and sexual and reproductive rights, but this proportion is slightly higher than that reported by Ayalew et al. (2019) in Ethiopia, where the study population was exclusively students. Very few young people had good knowledge of contraceptive method (18.4%) and good knowledge of STIs/ HIV/ AIDS (15.4%) and their transmission routes, as found by other authors (Tanabe et al., 2015; Okanlawon et al., 2010; Tanabe et al., 2017).

The low level of knowledge of young people on SRH could be explained by the fact that the majority of them had as source of information their friends or brothers and sisters of the same age group. Religious beliefs about sexual and reproductive health, present in almost half of the young people (44.3%), including prohibitions on family planning. These religious beliefs, coupled with young people's lack of information about family planning and STIs/ HIV/AIDS, could explain why the majority of young people had never used family planning (77.3%) and believed that coitus interruptus and the morning-after pill were the best practices for preventing unwanted pregnancy. Other authors have established the influence of religious beliefs and lack of information on contraception and STI/ HIV/ AIDS on the use of family planning (Alomair et al., 2020; Eltomy et al., 2013; Linsoussi, 2017).

Factors associated with knowledge of SRH included age, occupation, education, sibling status, and the type of household in which the young person spent their adolescence. Good knowledge of SRH was found among young people over 19 years of age, pupils and students, and young people who had spent their adolescence in a polygamous or monogamous family unit. This finding supports the results of the Bhatta et al. (2021) study, which showed that adolescents with good communication with their parents developed better SRH knowledge and practices.

Paradoxically, we found that despite the low level of knowledge of young people about SRH, their level of practice was good (72.6%). This could be due to the fact that 38.7% of the young people surveyed had not yet begun sexual activity at the time of the survey. Among those who were sexually active, 28.6% had had their first sexual intercourse before the age of 15, and the mean age (SD) of first sexual intercourse was Mean= 15.88; SD= 2.57 years. Also, very few young people (4.4%) had had abortions, as well as having multiple sexual partners. These findings could be justified by the fact that the socio-cultural norms of the environment in which these young people live impose a certain restraint in terms of sexual practices, and also by the fact that the majority of the respondents not only live with their parents or guardians, but are also in school.

Conclusion in this study that promoting sex education from early adolescence

within communities and parent-child communication on sexuality issues would be a high-impact solution to improve the quality of sexual and reproductive health of young people and the general population.

AUTHOR CONTRIBUTION

SDNL, DBG and AB design the study. SDNL collected the data. SDNL wrote the first draft the paper. DBG and AB reviewed the paper. All authors read and approved the final manuscript.

CONFLICT OF INTEREST

The author declare that they have no conflict of interests.

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