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PSYCHOLOGICAL BARRIERS TO SATISFACTION OF REPRODUCTIVE HEALTH NEEDS OF THE AGE-COHORT 10-24 YEARS IN IMO STATE, NIGERIA

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ABSTRACT: *This study sought to investigate psychological barriers to satisfaction of reproductive health needs of the age-cohort 10-24 years in Imo State, Nigeria. To facilitate the realization of this objective, three research questions and two hypotheses were postulated for the study. The population for the study was 93,250 which comprised students in all the secondary and tertiary institutions in Imo State. Using the multi-stage sampling procedure, a sample size of 5010 students was drawn. The sample size represented 5 per cent of the population. The study adopted cross-sectional survey research design. The instrument used for data collection was a self-constructed questionnaire, known as PSYBARNAC which contained 13 items in two sections A and B. Section 'A' contained the personal data (age and gender) of respondents while section 'B' contained the psychological barriers to satisfaction of reproductive health needs. The instrument was validated by a jury of three drawn from the Department of Physical and Health Education, Alvan Ikoku Federal College of Education, Owerri. The reliability co-efficient of 0.88 was derived using Pearson Product Moment Reliability co-efficient. The data obtained was analyzed using descriptive statistics of percentage and mean in answering the research questions, while inferential statistic of Z-test and ANOVA were used to test the hypotheses at 0.05 level of significance. The result showed that young persons are faced with psychological barriers to reproductive health needs. The findings further revealed that the psychological barriers experienced by age cohort 10-24 years vary by age and gender. Based on the findings of the study, the investigators recommended that, the government through the Ministry of Education and Health should package a sex education programme for young persons of varying age and other status (gender, sexual activity). This is to meet their unique reproductive health needs; the government, NGOs and communities should also develop appropriate strategies to up-date the home (parents and older siblings) with the reproductive health needs of youths and barriers to such needs. This will equip them to join effectively in providing and supporting the young persons in satisfying their reproductive health needs; health stakeholders should organize reproductive health programmes which should be comprehensive, well located and attractive to youths in terms of cost and relationship. This will motivate youths to participate in such programmes; reproductive health service providers should be trained by the government to help them evaluate their own values and understanding of needs of those they are serving, so as to ensure that all young people are treated with dignity and receive comprehensive reproductive health services that address their reproductive health needs; service providers and parents should improve on their interpersonal relationship with young person; this will help to reduce the psychological barriers that hinder young persons from accessing reproductive health services, as well as, make the services more attractive to young persons.*

KEYWORDS: Reproductive Health, Needs Psychological, Barriers, Age And Gender.

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INTRODUCTION

Human sexual behaviours in part determine their reproductive health. Reproductive health according to United Nations (1994) definition is that "it is a state of complete physical, mental and social well-being and not merely the absence of diseases or disorders in all matters relating to the reproductive system and its processes. This implies that people should have the ability and capability to reproduce and infants survive and grow up healthy. Reproductive behaviours can be positive or negative. They are positive when they are in agreement with cultural, social, religious and health norms, as well as expectations. They are negative when the behaviours fall short of expectations and norms, as well as violate norms that are shared across cultures and expose the individuals to risk, injury or loss. The negative behaviours include all forms of unsafe sex which put reproductive health at risk (Goddes & Grosset, 2002).

According to Population Reference Bureau (PRB) (2000), Barnett (2003), and Family Health International (FHI, 2006) serious reproductive health risks and their consequences accompany increased sexual activities among young people particularly when they do not have access to adequate reproductive health services and information. Such negative sexual and reproductive behaviours include: unchecked sexual activity and involving multiple partners, premarital sex, unprotected sex, and or non-use of contraceptives and unplanned sex (FHI, 2000). Others include lowered age at marriage (14-19 years); lowered age at first intercourse; high rate of birth to young women which is more in less developed countries; unintended, unwanted and too early pregnancy; sexually transmitted infections (STI) including HIV and AIDs; unsafe abortion (Obaid, 2003; PRB, 2000). These risks result in serious medical, psychological, social and economic consequences.

To reduce the above listed risks, there is need to promote reproductive health. Functionally, reproductive health according to Luffy, Evans and Rodiat (2015) `include satisfying and safe sex life; ability to reproduce; successful maternal and infant survival and outcomes; freedom to control reproduction, having information about and access to safe, effective, and affordable methods of family planning; and ability to minimize gynaecological diseases throughout life. Achieving reproductive health plays a role in reducing morbidity and mortality as well as increasing life expectancy. Reproductive health is achieved when reproductive health needs are met or satisfied (Campbell, Garcia-Moreno & Sharps, 2014).

Certain factors prohibit the attainment of reproductive health. These factors could be external or internal. According to Silverman, Decker, Saggurti, Balaiad and Raj (2008) these factors are termed barriers. Barriers according to the World Bank (2002) are any types of interference with the process of achieving an objective or satisfying a need, such as reproductive health need. These barriers are grouped into three namely psychological barriers, physical barriers and socio-cultural barriers.

Psychological barriers as reported by Derbyshire (2002) include among others, misconception, fear and myths, feeling of shame, fear of disapproval, stigmatization or judgement by family, community members and clinic staff. The effect of these psychological barriers to reproductive health abounds. For instance, fear caused by pervasiveness of misconception and myths (e.g. that contraception causes infertility), as well as reported side effects act as a barrier to young people voluntarily accessing sexual and reproductive health and family planning services. On the other hand, shame as reported by Luffy, et al. (2015) prevents young people to seek access to contraception, particularly due to the issue of lack of

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confidentiality. This report is supported by the findings of Jewkes, Dunkle, Nduma and Shai (2010) that young people do not trust health workers in keeping their secret particularly, in relation to contraception.

Psychological barriers as reiterated by United Kingdom Department for International Development (2012) are the internal barriers, that is, they are mainly within the individual. According to Family Health International (2000) and as postulated in Health Belief Model (Becker, 1974; Galli, 1980) and Trans-theoretical theory (Redding, Rossi, Rossi, Velicer & Prochaska, 2000), these psychological barriers determine the readiness within the individual for action. As identified by Galli (1980), Best (2000), Jeng (2002), psychological barriers include fear to admit circumstances, being shunned and being stigmatized, lack of confidence, embarrassment, pain, shyness, lack of motivation and understanding by clinic staff and parents. These psychological barriers play significant role in preventing young people to attain satisfaction to reproductive health. Satisfactions to reproductive health needs are influenced by several factors. The factors according to Galli (1980) are termed modifying factors and include among others, gender, age, race, ethnicity, education, socio-economic status and religion. In this study age and gender were considered.

Age plays a significant role on sexual and reproductive health. As revealed by Trenholm, Daveney, Fortson, Clark, Quay and Wheeler (2008) age influences not only the acquisition of reproductive health information and knowledge, but also the application of such information and knowledge. For instance, it is observed that younger youths shy away from initiating safe sex due to lack of confidence. This assertion is supported by the findings of Luke (2003); Robinson, Partrick, Eng and Gustafson (2012) that increase in age is associated with increase in self-confidence and that use of condom among youths, increases with age. Centre for Disease Control and Prevention (CDC) (2010) observed that decision-making in terms of satisfying reproductive health needs differ by age. In sub-Saharan African countries, Slap, Lot, Huany, Daniyam, Zink and Succop (2003); Etuck, Ihejiamaizu and Etuck (2004) revealed that adolescent girls' lack of negotiating power in sexual relationship is influenced by the large age difference common in many relationships. It is pertinent to note that the age-cohort 10-24 years is globally classified into three 10 to 14 years as early adolescents, 15-19 years as mid-adolecents and 20-24 years as late-adolescents (PRB, 2000; Brook-meyer & Henrich, 2009, Oparah, 2010).

Gender is another intervening variable that influences psychological satisfaction to reproductive health need. Gender as defined by Patient Education Institute (2010) is a range of physical, biological, psychological and behavioural characteristics pertaining to and differentiated between masculinity and feminity. Psychological barriers to satisfaction of reproductive health needs may differ by gender. Oparah, Fidelis and Mgbeahuruike (2015) reported that reproductive health needs of adolescents differ by gender and in favour of males. This difference is attributed to gender-role and gender based violence (GBV). Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationship between men and women [United Nations Population Fund, (UNFPA), 2002]. It occurs in many forms, including but not limited to intimate partner violence (IPV), domestic violence, sexual violence, and femicide or the killing of women because of their gender by males. Gender-based violence has direct link to reproductive health problems and its consequences on reproductive health abounds. As reported by Silverman, et al. (2008); Jewkes, et al. (2010) gender-based violence is associated with sexually transmitted infections, high rate of unintended pregnancies, unsafe

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abortion, and high rate of teenage pregnancy. Abuses during pregnancy increase chronic problems such as substance abuse; fear; anxiety; and depression (Campbell, et al., 2004). The above stated problems associated with GBV are psychological in nature, and they influence satisfaction to reproductive health needs. Adolescent females as reported by UNFPA (2003) are infected with HIV at a ratio of 8 to 1 when compared with adolescent males. This shows that gender influences satisfaction to reproductive health needs. Based on the above discourse, this study was conducted to determine psychological barriers to satisfaction of reproductive health needs among the age-cohort 10-24 years in Imo State, Nigeria. The report of this study will among other significances fill the gap in literature which shows that there is a limited study report on this area in Nigeria.

Statement of the problem

Being reproductively healthy implies having a satisfying and safe sex. But studies have revealed that youths are the most-at-risk group of reproductive health problems such as sexually transmitted infections, unintended pregnancies, and unsafe abortion (Society for Family Health and Action AIDS, 2006). This may be because many youths are sexually active. Sexual activeness when not properly guided exposes youths to unprotected sex which invariably increases the vulnerability of youths to reproductive health problems.

Moreover, though youths may easily access reproductive health knowledge via internet and mass media, and may have available, accessible and affordable reproductive health services, they may not be able to utilize these services due to certain negative psychological factors. For instance, when the reproductive health services are not youth-friendly and the service providers are unfriendly, hostile and aggressive. Therefore, the problems are what are the psychological barriers to satisfaction of reproductive health needs among the age cohort 10-24 years and, could their satisfaction of reproductive health needs differ by age and gender?

Purpose of the study

The study examines the psychological barriers to satisfaction of reproductive health needs among the age cohort 10-24 years. The specific purpose of the study is to determine:

1. The psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State
2. The psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State based on their different age groups.
3. The psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State based on their different gender.

Research Question

1. What are the psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State?
2. What are the psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State based on their different age groups?
3. What are the psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State based on their gender?

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Null Hypotheses

1. There are no significant differences in the psychological barriers to satisfaction of reproductive health needs of different age groups of the age cohort 10-24 years in Imo State.
2. There are no significant differences in the psychological barriers to satisfaction of reproductive health needs of females and males of the age cohort 10-24 years in Imo State.

METHOD

The cross-sectional descriptive survey research design was adopted to carry out this study on psychological barriers to satisfaction of reproductive health needs of Age-cohort 10-24 years in secondary and tertiary institutions in Imo State of Nigeria. A 5% sample size of five thousand and fifteen (5015) of such young persons was drawn from the population of ninety-three thousand, two hundred and fifty (93,250). The sample consisted of 2000 (61% of 3,250) from tertiary and 3,015(3.3% of 90,000) from secondary schools. A multi-stage sampling procedure of three stages along with proportional sampling technique to take care of the uneven number of subjects in each stratum (LGAs, school & Students) vis-à-vis stratified sampling technique by independent variables of age-limit (10-14, 15-19, 20-24) and gender (male and female) to ensure equal representation of subjects, were utilized to draw the subjects for the study.

A personally-developed, valid and reliable (r = 0.88) questionnaire called PSYBARNAC 10-24 was used for data collection. Two sections close-ended question items covering the respondents' personal data and psychological barriers to satisfaction of their reproductive health needs as highlighted in the objectives formed the content of the questionnaire. The retrieved data were analyzed using the descriptive statistics of percentage and mean to answer the research questions, as well as, inferential statistics of ANOVA and z-test to test the hypotheses.

RESULTS

Research Question 1

What are the psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years in Imo State?

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Table 1: Means of Psychological Barriers to Satisfaction of Reproductive Health Needs of Age Cohort 10-24 years in Imo State

S/N	Psychological Barriers	F(x%)	Sig
1.	Fear to admit having had sex	1086(13.45)	*1 Sig
2.	The desire to be left alone and to get married	847(10.49)	√
3.	Lack of confidence in the service providers	761 (9.42)	√
4.	Reluctance over discussing or asking about reproductive or sexual issues.	754 (9.34)	√
5.	Embarrassment from service provider	726 (8.99)	N. sig
6.	Hostile and aggressive behaviour of services provider to young and unmarried people	722 (8.94)	√
7.	Lack of courage to discuss or ask for reproductive or sexual health services	710(8.79)	√
8.	Unnecessary self-confidence over matters relating to sex	701 (a.68)	√
9.	Self-trust over matters of sex	631 (7.81)	√
10.	Negative effect of contraceptives on one's health and future fertility.	598(7.40)	√
11.	Rejection by service providers	540 (6.69)	√
	Ex	**8076(100%)**	

Figures in parentheses are percentages. N.Sig. = Not Significant.

Table mean percentage = 9.09% *1 = Most Significant

Sig. = Significant *2 = Least (and not) Significant

Table 1 presents data on the mean percentage responses on the psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years in Imo State and their relationship with the table mean percentage (9.09%). The table shows that four of the barriers were significant whereas seven were not significant. The most significant was the fear to admit having had sex with a mean percent of 13.45% while, the least and not significant was rejection by service providers (6.69%).

Research Question 2

What are the psychological barriers to satisfaction of reproductive health needs of the age-cohorts 10-24 years in Imo State based on their different age groups?

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Table 2: Psychological Barriers to Satisfaction of Reproductive Health Needs of Age-Cohort 10-24years in Imo State by Age Limit

S/N	Psychological Barriers	1 A: 10-14years N:688 Ex: 9.09% F (%)	Sig. Level	2 A: 15-19years N: 2837 Ex: 9.09% F (%)	Sig. Level	3 A: 20-24years N: 1485 Ex: 9.09% F (%)	Sig. Level
1.	Fear to admit having had sex	*1 137(1.78)	Sig	*1 556(12.25)	Sig	*1 393(16.54)	Sig
2.	Unnecessary self-confidence over matters relating to sex	111(9.54)	√	410(9.04)	N.Sig	180(7.58)	N.Sig
3.	Reluctance over discussing or asking about reproductive or sexual issues	114(9.80)	√	417(9.19)	Sig	223(9.39)	Sig
4.	Embarrassment from service providers	112(9.63)	√	401(8.84)	N.sig	213(8.96)	N.sig
5.	Rejection by service providers	*2 71(6.10)	N.Sig	*2 307(6.77)		*2 162(6.82)	√
6.	Self trust over matters of sex	90(7.74)	√	367(8.09)		174 (7.32)	√
7.	Lack of confidence in the service providers	122(10.49)	Sig.	434(9.57)	Sig	205(8.63)	√
8.	Hostile and aggressive behaviour of service providers to young and unmarried people.	1 16(9.97)	√	396(8.73)	N.sig	210(8.84)	√
9.	Lack of courage to discuss or ask for reproductive or sexual health services.	100(8.60)	N. sig	432(9.52)	Sig	178(7.49)	√
10.	Negative effect of contraceptive on one's health or future fertility.	84(7.22)	√	319(7.03)	N.sig	195(8.21)	√
11.	The desire to be left alone and to get married	106(9.11)	Sig	498(10.98)	Sig	243(10.23)	Sig
		1163 (100%)		**4537(100%)**		**2376(100%)**	

Figures in parentheses are percentages, N.Sig. = Not Significant, Table mean percentage = 9.09%, *1 = Most Significant, Sig. = Significant, *2 = Least (and not) Significant

Table 2 presents responses on psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years in Imo State as indicated by the three groups of age-cohort studied namely 10-14 years, 15-19 years and 20-24 years. From the table, variations exist among the significant levels of the psychological barriers across the three age groups. For instance, three were significant for the three groups; the were not significant for the three groups while five were inconsistent.

The table shows that fear to admit having had sex was the most significant for the three age groups 10-14 years (11.78%), 15-19 years (12.25%) and 20-24years (16.554%). On the other side, rejection by service providers was the least (and not) significant for the three groups 10-14 years (6.10%), 15-19 years (6.77%) and 20-24 years (6.82%). Generally three barriers

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were significant for the three groups namely, fear to admit having sex; reluctance over discussing and asking about reproductive and sexual issues (9.80%, 9.19% & 9.39%) and the desire too be left alone an to get married (9.11%, 10.98% & 10.23%). Another three psychological barriers were not significant for the three groups namely rejection (6.10%, 6.77% & 6.82%); self- trust over matters of sex (7.74%, 8.0% & 7.32%); and negative effect of contraception on one's health and future fertility (7.22%, 7.03% & 8.21%). The five inconsistent barriers were unnecessary self -confidence over matters relating to sex, embarrassment from services providers, hostile and aggressive behaviours of service providers to young and unmarried people, lack of confidence in the service providers and lack of courage to discuss or ask for reproductive and sexual health services.

Hypothesis 1

There are no significant differences in the psychological barriers to satisfaction of reproductive health needs of the different age groups of the age-cohort 10-24 years in Imo State.

Table 3: ANOVA Summary of Influence of Age on Barriers to Satisfaction of Reproductive Health Needs of Age-cohort 10-24 years in Imo State

Age	N	$\bar{x}$	Sum of Square	df	Mean square	F-cal	Significance	F-critical
10-14 years	688	9.0799						
15-19 years	2837	8.7043	882.9164	2	441.4582	15.04	<.0001	2.998
20-24 years	1485	9.6552						

Significant at 0.05 level

Table 3 shows that the F-value of age group differences in relation to psychological barriers was 15.04 which is greater than 2.998, (0.05). Thus, the null hypothesis was rejected and the Ha accepted. That is, there were significant differences among the psychological barriers to satisfaction of reproductive health needs of different age groups of the age-cohort 10-24 years in Imo State.

Research Question 3

What are the psychological barriers to satisfaction of reproductive health needs of age cohort 10-24 years in Imo State based on their gender?

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Table 4: Psychological Barriers to Satisfaction of Reproductive Health Needs of Age-Cohort 10-24 years in Imo State by Gender

S/N	Psychological Barriers	1 G: Female (N: 2693) F (%)	Sig. Level	2 G: Male (N: 2317) F (%)	Sig. Level
1.	Fear to admit having had sex	*[1] 494(11.39)	Sig	*[1] 592(15.84)	Sig
2.	Unnecessary self-confidence over matters relating to sex	392(9.04)	N.sig	309(8.27)	N.sig
3.	Reluctance over discussing or asking about reproductive or sexual issues	400(9.22)	Sig	354(9.47)	Sig
4.	Embarrassment from service providers	372(8.58)	N.sig	354(9.47)	√
5.	Rejection by service providers	314(7.24)	√	*[2] 226(6.05)	N.Sig
6.	Self trust over matters of sex	*[2] .297(6.85)	√	334(8.94)	√
7.	Lack of confidence in the service providers	428(9.87)	Sig	333(8.91)	N.sig
8.	Hostile and aggressive behaviour of service providers to young and unmarried people.	437(10.07)	Sig	285(7.62)	√
9.	Lack of courage to discuss or ask for reproductive or sexual health services.	398(9.17)	√	312(8.35)	√
10.	Negative effect of contraceptive on one's health or future fertility.	340(7.84)	N.Sig	258(6.90)	√
11.	The desire to be left alone and to get married	466(10.74)	Sig	381(10.19)	Sig.
	EX	**4438(100)**		**3738(100%)**	

Figures in parentheses are items mean percentage
f = frequency
*[1] = Most significant
*[2] = Least (and not) significant

Table 4 presents responses on psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years in Imo State as indicated by females (2693) and males (2317) in the age-cohort studied. From the table, there are variations in the significant levels of the barriers between the two groups. For instance, three were significant for the two groups, four were not significant for both sexes and four were inconsistent.

The table shows that fear to admit having had sex was the most significant barrier for both females and males (11.39% & 15.84% respectively). But, self- trust over matters of sex (6.85%) and rejection by service providers (6.05%) were the least and not significant psychological barriers of females and males respectively. The three significant barriers for both females and males were four (11.39% & 15.84%), reluctance over discussing or asking about reproductive or sexual issues (9.22% & 9.47%), and the desire to be left alone and to get married (10.74% & 10.19%). The four non-significant barriers for the two groups were unnecessary self-confidence over matters relating to sex, rejection by service providers, self-

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trust over matters of sex, and negative effect of contraceptives on one's health and future fertility. Lastly, among the four inconsistent barriers, lack of confidence in the service providers, hostile and aggressive behaviours of service providers to young and unmarried people, lack of courage to discuss and ask for reproductive and sexual health services were significant (9.87%, 10.07% & 9.17%) respectively for females but not (8.91%, 7.62% & 8.35%) for males, while embarrassment from service providers which was significant (9.47%) for males was insignificant (8.58%) for females.

Hypothesis 2

There are no significant differences in the psychological barriers to satisfaction of reproductive health needs of females and males of the age-cohort 10-24 years in Imo State.

Table 5: Z-test summary of Influence of Gender on Barriers to Satisfaction of Reproductive Health Needs of Age-cohort 10-24 years in Imo State

Gender	N	$\bar{x}$	Known Variance	Z-cal	Two-tail Z-critical
Female	2693	9.36	30.1876	4.5950*	1.9600
Males	2317	8.66	28.4899		

* Significant at 0.05 level.

From table 5, the Z_{cal} value for the gender differences on psychological barriers was 4.5950 > Z-critical (1.9600; 005). Thus, the null hypothesis was rejected in favour of the alternative. It was therefore concluded that, there were significant differences among the psychological barriers to satisfaction of reproductive health needs of females and males in the age-cohort 10-24 years in Imo State.

Major Findings

The major findings as guided by the three research questions and the tested two hypotheses are:

1. The significant psychological barriers were fear (18.45%), the desire to be left alone to get married (10.49%), lack of confidence in service providers (9.42%) and reluctance over discussing and asking questions about reproductive and sexual issues (9.34%). Embarrassment (8.99%) as well as hostile and aggressive behaviours of service providers (8.94%) were also identified (See table 1).

2. The psychological barriers experienced by age-cohort 10-24 years vary by age groups (10-14, 15-19, 20-24 years) although some were common to all age limits. Three significant psychological barriers common to the three age-groups were fear to admit having had sex (11.78%, 12.25%, 16.54%), reluctance over discussing or asking questions about reproductive and sexual issues (9.80%, 9.19%, 9.39%), and the desire to be left alone to get married (9.11%, 10.98%, 10.23%) (See table 2). Summarily, the psychological barriers decreased with increase in age (10-14, 7; 15-19, 5 & 20-24, 3).

3. The psychological barriers experienced by age-cohort 10-24 years vary by gender (Z_{cal} 4.5950> $Z_{critical}$ 1.9600) although there were some significant ones that were common to both female and male groups. There were three significant psychological barriers

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common to both groups (female and males). They were fear to admit having had sex (11.39% and 15.84% respectively), reluctance over discussing and asking about reproductive or sexual issues (9.22%, 9.47% respectively), and, the desire to be left alone to get married (10.74%, 10.19% respectively) (See table 4).

DISCUSSION

This study generated data and information on psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years in Imo State. The discussion will be in line with the three research questions and two hypotheses.

The results on table 1 are evident to young persons in Imo State experiencing psychological barriers to satisfaction of their reproductive health needs. Among the eleven psychological barriers considered in the study only four were significant and the other seven were non-significant. Although with minor variations in levels of significance, the finding tally with those of Luffy, et al. (2015) which showed that the young ones avoid reproductive health services because there is shame, lack of protection, confidentiality, reliability and safety for youth in their environment.

The psychological barriers are clear evidences of the influence of physical and socio-cultural values and beliefs of the society over youth reproductive and sexual issues and behaviours. For instance, the high significance of fear to admit having had sex can be attribute to the Nigerian adults (parents in particularly) pretentious idea that young ones do not indulge in sexual activities (or are sexually active). Summarily, the desire to be left alone about sexual matters until marriage agrees with the society's (Igbo) emphasis on marriage as ultimate for a young person and the qualification for partaking in sexual issues (Derbyshire, 2002).

The detrimental effect of psychological barriers to satisfaction of reproductive health needs cannot be ignored. It is a well-known fact that attitude is a precursor of behaviour (Galli, 1980). Thus, the feeling of fear, insecurity and self-doubt interfere with good reproductive beahviour, and when combined with lack of confidence do delay or hinder seeking reproductive health services. This invariably leads to productive risks and problems among youths. Suffice it to say that, the psychological barriers undermine the youth's internal readiness to utilize the existing reproductive and sexual health services. Hence, understanding such barriers with social pressures inclusive would help to improve on reproductive health services effectiveness in Imo State and Nigeria.

The findings on the age influence on psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years show that there are significant differences within and among the barriers (see Tables 2 & 3). The finding is in accordance with past reports (Trenholm et al. 2008, CDC, 2010 & Robinson et al, 2012). The resemblance is not surprising but expected because age has always been proved to be a modifying factor of individual's perceptions and, influences health-related behaviours. Although this study was not intended to determine the direction of influence of age, but it revealed that the significant psychological barriers of the 10-24 years young persons decreased with increase in age. For instance, 10-24 years had 7 barriers, 15 to 19 years had 5 and 20- 24 years had 3 barriers. This agrees with the well-known condition that age is a predictor of intention and use of services. It is also evident that the young humans are more afraid, embarrassed, unwilling and unable to take precaution. The younger youths are less aware of the risks they take, thus less

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able to manage themselves, take decisions; have less power and courage to say "No" to sex and, to access service providers. Hence they appear to be more vulnerable than the older ones to pregnancy, abortion and teenage parenting.

Findings on table 4 and 5 revealed that gender differences exist in psychological barriers to satisfaction of reproductive health needs of age-cohort 10-24 years. The major difference was that females experienced six (6) psychological barriers as against four (4) for males. The difference was found significant with the z-test result of Z-cal 9.5950 > $Z_{critical}$ 1.9600.

The differences observed were expected because of the differences in the socio-cultural and psychological norms and expectations of the various cultural groups in Imo State and Nigeria as a whole. Such cultural sensitivities and gender disparities regarding sexuality in Nigeria and particularly in Imo State heighten females' barriers to actualizing their reproductive health needs hence, their reproductive risks and resultant problems. This agrees with the fact that individuals' perspectives are molded by the situations they find themselves or live (Becker, 1974; PRB, 2000) as well as the submission of UNFPA (2002). Therefore, health-care providers need to understand how youth and gender insensitive health services make it difficult for youths to gain access to information and services they need. It is also very important they understand that change in gender norms can help girls become more capable to negotiate their preventive measures and boys may develop more nurturing and less risky behaviours.

CONCLUSIONS

Based on the findings and discussions, the following conclusions were drawn:

1. There are psychological barriers to age-cohort 10-24 year's satisfaction of their reproductive health needs; although they vary in their levels of significance. Four of them were significant (x = > 9.09) namely, fear to admit having had sex; the desire to be left alone and to get married; lack of confidence in the service providers; and, reluctance over discussing or asking about reproductive or sexual issues.

2. Age differentiated significantly the psychological barriers although some similarities existed among the age-limits. Also significant barriers decreased with increase in age.

3. Gender differentiated significantly the psychological barriers to satisfaction of reproductive health needs of the age-cohort 10-24 years with females having more (6) significant barriers than males (4). Nevertheless, some barriers were common to females and males.

4. Finally, the existence of psychological barriers is an indicator of the high risky sexual behaviours of the age group 10-24 years and predicts their reproductive and sexual problems namely; unplanned and unwanted pregnancy, abortion, early and forced marriage, sexually transmitted infections and death.

RECOMMENDATIONS

From the conclusions, it does seem that the educational system is not influencing the attitudes and behaviours of young persons. Thus, there is the urgent need to readdress the health and education policies to beef-up the health and education curriculum at the lower levels and to

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inject into the reproductive health programmes contents issues that will help the young ones develop the reproductive knowledge and skills that will boost their attitude for positive reproductive and sexual behaviours.

In specific terms, the recommendations include:

1. The government through the Ministry of Education and Health should package a sex education programme for young persons of varying age and other status (gender, sexual activity). This is to meet their unique reproductive health needs.

2. The government, NGOs and communities should also develop appropriate strategies to up-date the home (parents and older siblings) with the reproductive health needs of youths and barriers to such needs. This will equip them to join effectively in providing and supporting the young persons in satisfying their reproductive health needs.

3. Health stakeholders should organize reproductive health programmes which should be comprehensive, well located and attractive to youths in terms of cost and relationship. This will motivate youths to participate in such programmes.

4. Reproductive health service providers should be trained by the government to help them evaluate their own values and understanding of needs of those they are serving, so as to ensure that all young people are treated with dignity and receive comprehensive reproductive health services that address their reproductive health needs.

5. Service providers and parents should improve on their interpersonal relationship with young persons. This will help to reduce the psychological barriers that hinder young persons from accessing reproductive health services, as well as make the services more attractive to young persons.

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