PARENTAL KNOWLEDGE ON APPROPRIATE CONTRACEPTIVES AND THEIR ATTITUDE REGARDING ITS PROVISION TO UNMARRIED YOUTHS IN IBADAN NORTH-EAST LOCAL GOVERNMENT AREA, NIGERIA

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DEDICATION

This project is dedicated to God almighty for his guidance throughout the period of my research work and for his faithfulness and provision all through my MPH programme.

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ABSTRACT

Short-acting contraceptive methods such as condoms and emergency contraceptive pills are considered appropriate for sexually active Unmarried Youths (UYs) to address increasing occurrences of unintended pregnancies (UPs) and sexually transmitted infection (STIs). While provision of contraceptives have been used as an intervention in preventing UPs and STIs among UYs, there is a need to study parental knowledge of appropriate contraception and their attitude regarding its provision to UYs. This study was designed to assess parental knowledge on Appropriate Contraceptives (ACs) and their attitude regarding its provision to UYs in Ibadan North-East Local Government Area, (IBNELGA) Oyo State, Nigeria.

A cross-sectional survey which employed three stage sampling technique was used to select 6 wards randomly from IBNELGA. Seven communities were selected from the wards using probability proportionate to size. Three hundred and six respondents (parents who had UYs aged 15-24 years) were then purposively selected from the communities. A pre-tested semi-structured interviewer-administered questionnaire was used to elicit information on respondent's socio-demographic characteristics, level of knowledge on ACs and attitude regarding its provision to UYs. Respondents' knowledge on ACs for UYs and attitude were measured on 34-point and 28-point scales respectively. Knowledge scores of ≤17 and > 17 were rated as poor and good respectively. Attitude scores of ≤14 and >14 were rated as negative and positive respectively. Six Focus Group Discussion (FGD) sessions were also conducted among the respondents. Quantitative data were analysed using descriptive statistics, Chi square test and logistic regression model at p=0.05. The qualitative data were analysed using the thematic approach.

More than half (57.8%) of the respondents had tertiary level of education and 50.0% were males. Most (92.2%) were Yoruba and 89.0% lived with their youths. Respondents' overall knowledge score on ACs was 14.7±6.6. More than half (53.6%) of the respondents had poor knowledge on ACs and of those who did, 61.4% were males. Overall, 54.9% of respondents had positive attitude towards provision of contraceptives to UYs out of which, 55.1% were males. Fifty three percent were of the opinion that sexually active UYs should be provided with contraceptives and 50.7% also supported provision of contraceptive to UYs with history of STIs. Knowledge of ACs was significantly higher among female respondents (OR: 2.0, CI: 1.2-3.7). Parents who had good knowledge were more likely to have positive attitude towards the provision of contraceptive to

UYs (OR: 3.0, CI: 1·8-4.8). Parents who had used contraceptives in the past and reported negative experiences such as excessive bleeding and weight gain were less likely to approve of its provision to UYs (OR: 0·3, CI: 0.2-0.5). Most FGD participants supported free access of sexually active UYs to contraceptives for the prevention of UPs and STIs.

Parents had poor knowledge on appropriate contraceptive, but only marginally positive attitude regarding its provision to unmarried youths. Parents should be educated on appropriate contraceptives for unmarried youths to fill the gaps in knowledge.

Keywords: Contraceptive use, Unmarried youths, Unintended pregnancies.
Word count: 477

CERTIFICATION

I hereby certify that this research was carried out by Akpesiri UBOKO in the Department of Health Promotion and Education, Faculty of Public Health, College of medicine, University of Ibadan, Ibadan.

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ACRONYMS

AHI	Action Health Incorporated
AGI	Alan Guttmacher Institute
AIDS	Acquired Immune Deficiency Syndrome
ARFH	Association for Reproductive and Family Health
ARH	Adolescent Reproductive Health
BTL	Bilateral Tubal Ligation
CEDPA	Centre for Development and Population Activities
ECP	Emergency Contraceptive Pills
FGD	Focus Group Discussion
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family Planning
HIV	Human Immuno-deficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUCD	Intra-Uterine Contraceptive Device
LGA	Local Government Area
MCH	Maternal and Child Health
NACA	National Agency for the Control of AIDS
NDHS	National Demographic and Health Survey
NGO	Non Governmental Organization
NISER	Nigerian Institute of Social and Economic Research
NPC	National Population Commission
PRB	Population Reference Bureau
SEM	Socio Ecological Model
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS

OPERATIONAL DEFINITION OF TERMS

Sexually Active Unmarried Youth: This is a young male or female individual between the ages of 15 and 24 years who is sexually experienced

Parents of Unmarried Youth: Parents who have unmarried children who are between the ages of 15 and 24 years

Appropriate Contraceptives for Unmarried Youths: These are non-prescriptive contraceptives that can be used by sexually active unmarried youths and they are condom and spermicidal (e.g. foaming tablets and jelly). However, Emergency contraceptive pills (ECP) are widely available and used by unmarried youths.

CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Nigeria is home to a population of over one hundred and forty million people (NPC, 2006) undoubtedly one of the most populated nations in Africa. Occupying one third of her population are youths between the ages of 15 and 24 years. Projection from the 2006 national population census shows that adolescents and young adults constitute over a third (31.6%) of Nigeria's large and growing population (NPC, 2013) making this group of people quite important to the development of the nation. As at 2012 when Nigeria's population was estimated to have grown to over 172 million, young persons aged 10-24 accounted for over 55 million (NPC, 2013; Ahonsi, 2013).

Young people are generally a healthy cohort possessing high level of energy and creativity. They are seen as a healthy segment of the population but recently, however have received low priority for pertinent developmental issues. According to the United Nation Population Fund (UNFPA), youths are confronted with numerous challenges spanning from biological and societal origin including unintentional injuries, substance abuse, antisocial behaviors such as violent crimes, homicide and unsafe sexual practices among others. Studies have recorded increasing cases of unprotected sexual activities leading to occurrences of Sexually Transmitted Infections (STIs) and Human Immuno deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), unintended pregnancies and unsafe abortions among youths (Ajuwon and Brieger, 2007).

Studies among young people have shown that teenage sex and premarital sex are no longer disapproved by young people with the rate of sexual debut on the increase. Studies also revealed low use of contraceptives, existence of multiple sexual partners, casual sex, unplanned pregnancies and sexually transmitted infections such as syphilis and gonorrhoea among youths (WHO, 1995a). According to the World Health Organization (WHO) there are about 333 million new cases of curable STIs every year with the highest rates occurring among those between 20 and 24. This is closely followed by those between the ages of 15 and 19 (WHO, 1995a). Despite the wide spread evidence of the need to prioritize attention required to address early and risky

sexual activities among young people, young people's access to correct reproductive health information and services including contraceptives (Ikeako, Lawal and Akpabio, 2005)

Controversies still surround the provision of contraceptives to youths. Certain school of thought are of the opinion that provision of contraceptives to unmarried youths intensifies their involvement in early sexual acts (Oyediran et al., 2013; Foege, 2003). Others argued in favour of contraceptive use stating that its use will reduce the burden of sexual reproductive health problems faced by youths (Hilland, 1993; Kane, Du, Taylor-Thomas, and Jeng, 1993). Many believe that its introduction to youths will not translate to increased sexual activities among youths (Blake, 2003). While these arguments linger, Hock-Long (2003) in his research revealed that youths can be sexually active for at least a period of 22 months before their first visit to a family planning provider. This finding shows that in most cases, sexual activities are not influenced by contraceptive discussions.

The needs to focus attention on key aspects of the development of youths, particularly their sexual and reproductive health, have drawn the attention of relevant stakeholders across the global community (Godswill, 2012). Implementing specific strategies to address these challenges will successfully propel young people to transit healthily to adulthood, and will give rise to self-actualised individuals, responsible parents, healthy workforce and formidable economy. The sexual behaviours of youths is important not only because of the possible reproductive health outcomes they may encounter but because risky behaviours increases the likelihood of HIV/AIDS infection among them. Studies have shown that new cases of HIV infection are more common among young people, in Africa, about 7 in every 10 new HIV infections among females occur among those aged 15 to 24 years (Katz, 2006). Most youths who enter into a sexual relationship for the first time do not use any form of contraception and were ignorant of the consequences of their actions leaving them vulnerable to unintended pregnancies and unplanned-parenthood (Magnani, Seiber, Gutierrez and Vereau, 2001; Oyedirun, Isiolo, and Adewuyi, 2002).

Nigerian social and cultural norms strongly oppose pre-marital sex. Thus neither the information nor services for family planning are readily available to adolescents and youths (Uriggs, 1994). Prominent among obstacles to the provision of sexual and reproductive health information and services is the persistence of traditional patriarchal norms controlling young women's sexuality

on the part of adult gatekeepers – policy makers, programme managers, service providers and parents (Cui, Li and Gao, 2001). Thus strategies designed to address reproductive challenges of young people should be embraced.

1.2 Statement of Problem

According to the National Demographic Health Survey conducted in 2013, only 24.2% of females age 15-24 years had comprehensive knowledge on HIV and AIDS and ways to protect themselves. Among males aged 15-24 years, only 33.5% had such knowledge. Almost half of the females (46.2%) and about a quarter of males (22.1%) have engaged themselves in sexual intercourse. Less than 4 out of every 10 sexually active adolescent females (15-19 years) while half of female youths (20-24 years) use any modern contraceptive. Among youths (15-24 years) only a tenth of females and a fifth of males used condom at first sex (NPC/ICF International, 2013).

Youths are characterized by early sexual debut, increased premarital sexual activities, experimentation of sporadic unprotected sex (Onyeonoro, Oshi, Ndunele, Chuku, Onyemuchara, Ezekwere, et al, 2011). This has resulted in high prevalence of HIV. This is supported by a study (Kulz, 2006) which showed that 7 out of 10 new cases of HIV infection occur among young people. Unwanted pregnancies and unsafe abortions have also been observed to be prevalent among them. In Nigeria, complications from abortion account for 72% of all deaths in young women under age 19 years; moreover, half (50%) of all maternal deaths result from illegal abortions among Nigerian adolescents (Aiede and Ikele, 2003). These problems could be attributed to lack of information on sexuality and low prevalence of contraceptive use (15%) among young people (Makinwa-Adebusoye, 1992). Despite all attempts to curb adolescent sexual reproductive health problems, they continue to persist.

In Nigeria, issues such as the use of contraceptives among unmarried youths are hardly discussed and shrouded in secrecy by gatekeepers including parents (Onyeonoro et al, 2011). Given the traditional unacceptability of premarital sex or discussion of matters with sexual undertone with young people, parents' little or no correct access to appropriate information on sexual and reproductive health issues could serve as a factor that fuels the reproductive health problems faced by youths (Kaim et al, 2007; Cui et al. 2001). This has forced young people to obtain inaccurate information from unreliable sources such as peers and media. Previous reports have

shown the poor attitude of parent towards sexuality education as most parents believe that this will cause youths to become sexually active (Hudson, 2012). Studies have shown that those who have positive attitude towards contraceptives are more likely to promote the idea of contraceptive use among sexually active young people (Adekunle, Arowojolu, Adedimeji and Roberts, 1999).

A study by Briggs in 1998 explored the viewpoints of parents in the Niger Delta on the use of contraceptives by sexually active unmarried adolescents. The findings from that study showed that about 79% of the parents interviewed did not favour the use of contraceptives by sexually active unmarried adolescents. In recent years, there has been a dearth of information on the views of parents on the use contraceptives by sexually active unmarried young people. Results obtained 14years ago from that study lacks substantive evidence to describe the present opinions of parents on the issue of contraceptive use by unmarried youths. There has been an explosion of information on contraceptives, high publicity of contraceptives by the media and easy accessibility to contraceptives. Considering this, not much has been documented on the current trend of parents' perspective on contraceptive use by unmarried youths though most studies have focused on the opinions of health workers. Hence the need for this study.

1.3 Justification of Study

Findings from researches have shown a pattern of increasing sexual activities among young people worldwide (Onyemaro et.al. 2011). These activities include early sexual debut, risky sexual activities such as unprotected sexual activities, casual sex and multiple sexual partners, unplanned pregnancies and the high prevalence of sexually transmitted infections such as HIV/AIDS. There are reports of low level of communication about sexuality issues between parents and their children. These findings stress the need for this study to identify the role parents play in addressing reproductive health problems of youths.

Identifying the role of parents and their views about the use of contraceptives by unmarried youths is a step closer to solving the reproductive and sexual problems of unmarried youths. This study will help to provide insight to parents' opinions on the provision of contraceptives to unmarried youths and would answer questions which includes if parental influence is a determinant of contraceptive use by young people. For a meaningful family planning program directed towards youths to succeed, the contributions and influence of parents should be

examined. It has been established that young people are still under the control and supervision of their parents however limited it may be. Hence the need to explore the attitude of parents in relation to the sexual needs and rights of young people.

Furthermore, the effectiveness of programmes directed towards addressing the sexual reproductive health problems of young people may be improved by a better understanding of the influence of parents on youths' sexual activities.

The findings from this research will also provide prospective gaps for further exploration by interested researchers.

1.4 Research Questions

This research will help to provide answers to the following questions:

1. How much knowledge do parents of unmarried youths have about contraceptives?
2. What is the attitude of parents concerning the introduction of contraceptives to unmarried youths?
3. What is the perception of parents on the use of contraceptives as a means of addressing young peoples' sexual reproductive health problems?
4. What is the practice of parents as regards contraceptive use?

1.5 Broad Objective

The study aims to determine the knowledge, attitude and perception of parents in Ibadan North-east Local Government Area on the provision of contraception to unmarried youths

1.6 Specific Objectives

1. To assess the level of knowledge of parents on the contraceptives
2. To assess the attitude of parents on the provision of contraceptives to unmarried youths.
3. To assess the perception of parents on the provision of contraceptives to unmarried youths as a means of addressing their sexual reproductive health problems
4. To determine the practice of parents as regards contraceptive use

1.7 Research Hypotheses

1. There is no significant relationship between the socio-demographic characteristics of the parents and their knowledge on contraceptives
2. There is no significant relationship between the socio-demographic characteristics of the parents and their attitude towards contraceptives use by unmarried youths
3. There is no significant relationship between the socio-demographic characteristics of the parents and their willingness to approve use of contraceptives by unmarried youths
4. There is no significant relationship between the contraceptive experience of parents and their attitude towards its use by unmarried youths
5. There is no significant relationship between the contraceptive knowledge of parents with unmarried youths and their attitude towards its use by unmarried youths
6. There is no significant relationship between the contraceptive knowledge of parents with unmarried youths and their willingness to approve of its use by unmarried youths

CHAPTER TWO

LITERATURE REVIEW

2.1 Concepts of Adolescence and Youth

Adolescents as defined by the WHO are persons between the ages of 10 and 19 (WHO, 1998a). The period of adolescence is also defined as a transition in which an individual is no longer considered a child, but an adult (McCauley and Salter, 1995).

According to Dehne and Riedner (2005), adolescence is a period comprising of a lengthy transition from childhood to adulthood. This period is associated with awareness of sexuality. There are biological markers which render the period of adolescence a dynamic concept. The period of adolescence is marked by physiological changes such as the appearance of secondary sexual characteristic (puberty) and sexual reproductive maturity (WHO, 1995).

The period of adolescence is characterized by changes regardless of the individual's race, religion and educational status (FHI, 2010). These changes which occur physically in the form of facial hairs for boys and the onset of menstruation for girls usually take place during the period of puberty. Another researcher describes the term adolescence as a sociological construct applied by adult members of the society to describe a person who is in the transition to acquire biological features peculiar to the adult population group (Ikorok et al., 2005).

On the other hand, the Oxford dictionary defines youth as being young. The World Health Organization defines a youth as an individual between the ages of 15 and 24 (WHO, 1998a). The period of youth is considered by many as the period that forms the foundation of a healthy adult life. This is also a stage where many young people move towards emotional independence and establish new interests and relationships. As individuals progress towards the period of youth, they consider sexual relationships, marriage and parenthood as signs of maturity (FHI, 2010).

Young peoples' health and its promotion have and will still be of great concern to national and international stakeholders. Across the globe, young people encounter problems which could adversely affect their growth and development. Recent programmes have been targeted towards youths as they have been identified to play a pivotal role in the development of the society they belong. The World Health Organization in a conference held in Geneva designed a strategic

approach to strengthen reproductive health policies and programmes. Among these strategies are those designed to provide information and services that responds to young people's needs (WHO, 2007).

The periods of adolescence and youth are periods when young people seek information on sexuality from different sources. Although these young people are open to a great deal of information, most of the information they have are incorrect. Many youths indulge in risky activities and the consequences may translate into adulthood as the youthful period is characterized by a great deal of vulnerabilities and risks (Godswill, 2012). This could be prevented if the right interventions are put in place. Young people fall victim to sexual exploitations due to lack of information. According to NDHS 2013, only 24.2% of females between the age of 15 and 24 years have comprehensive knowledge about HIV. Among the males, only about 33.5% of those between the age of 15 and 24 years have comprehensive knowledge about HIV and AIDS (NPC/ICF International, 2014). According to a report by WHO in 2008, HIV infections among youths between the ages of 15 and 24 account for about 40% of the total cases of HIV infection in adults. These reports emphasize the need to enlighten these youths and increase accessibility to sexual and reproductive health services such as contraceptives.

The Concept of Sexuality

Sexuality is perceived by different people in different contexts. The term sexuality refers to the attitudes, thoughts and behaviours concerning sexual activities. According to Ozumba and Amaechi (1992), sexuality is a comprehensive concept that encompasses the physical capacity of sexual arousal and pleasure as well as personalized and shared social meanings attached to the formation of sexual identities. Young people must develop a concept of themselves as sexual beings and integrate their sexual selves into their overall identity. The process of sexual identity begins when young people first recognize their sexual feelings and this may continue for life (Graber, Brooks-Gunn and Galen, 1998). Sexuality is a vital aspect of the lives of young people (Lynn, 2000). It is believed that as an individual approaches puberty, the interest for sexual activities increases (Carlson and Heth, 2007).

Sexuality does not only include social identities but also includes sexually transmitted infections and birth control methods. As an individual matures, there are marked changes that accompany

the growth process. He/she experiences changes which are both physiological and emotional in nature. The concepts of youth and sexuality cannot be separated. As young people develop, so does the need to explore their sexuality. The marked increase in the need to explore their sexuality is accompanied by sexual activities and consequently, increase in sexually transmitted infections and unplanned pregnancies; hence the need for the promotion of birth control methods among sexually active youths.

Reproductive health problems affecting Youths

Nearly one third of Nigeria's population is between the ages of 10 and 24 thus making them an integral part of the country's development (PRB, 2006). As youths, they are constantly faced with various reproductive health problems that adds to the slow-paced rate of development in the country. These problems range from unavailability and inability to access information on contraceptives to the aftermath of indulging in risky and unprotected sexual intercourse.

Although different research studies have recorded high level of knowledge of contraceptives among youths however this does not translate to positive attitudinal behaviour and adoption of a healthy sexual lifestyle. Young people still indulge in early and risky sexual activities with little or no clue as to how to protect themselves from the health problems that may follow. The NDHS report in 2003 showed that about 36% of adolescent males and 49% of adolescent females have reported having sex. A similar study among undergraduates in 2002 showed that about 87% of them were sexually active and 67% of them had more than one sexual partner (Arowojolu, Ilesanmi, Roberts and Okunola; 2002). The study also showed that 87.5% were knowledgeable about contraceptives but only about 34% used any form of contraceptives during sexual intercourse (Arowojolu, Ilesanmi, Roberts and Okunola; 2002).

While the reason for the poor attitude towards contraceptives remains unclear, it is clear that the health of young people worldwide is suffering and demands immediate attention. It is in this regard that the strategic approach by the World Health Organization was proposed (WHO, 2007) to provide information and services that address the health needs of young people. The World Health Organization is not alone in the fight to restore the health of young people to positive level. Other line ministries including Non-Governmental Organizations (NGOs) such as the

Association for Reproductive and Family Health (ARFH) and Action Health Incorporated (AHI) also have clear-cut agenda that involve adolescent and young peoples' health.

Lack of access to information and contraceptive services

The period of youth is characterized by increase in sexual awareness and the need to explore ones sexuality (Onyeonoro et al., 2011). Most of the information obtained during this growth stage is characterized largely by inconsistencies and in most cases, incorrect and is fuelled by the shrouded secrecy that surrounds discussion of sexuality matters. Most sexuality studies conducted in Nigeria have documented the fact that majority of Nigerian parents hardly discuss sexuality issues with their unmarried youths (Kunnuji, 2012). There is a school of thought that suggests that when an individual is provided with correct information on sexuality, he/she is more equipped to make informed decision and those decisions made tend to be of benefit to the individual. Most youths who are not provided with information, are forced to seek alternatives which in most cases are erroneous. On the other hand, when information on contraceptives is made available to youths, their access and availability to contraceptives could be hindered by certain factors. Adolescentres where contraceptives are provided are not youth friendly. This to a large extent affects the decisions of youths to use contraceptives. A youth who feels he/she will be reprimanded if he/she seeks contraceptive services is unlikely to visit centres for such services. Another factor could also be attributed to the unwillingness of adults to openly discuss issues concerning contraceptives among young people. The unwillingness of young people to seek contraceptive services has direct effect on their sexual activities as they are likely to indulge in risky sexual activities which could to unwanted pregnancies, STIs and unsafe abortions.

Though recommendations have been instituted on how to improve young people's access to reproductive health services and information (UN, 1995) during the International Conference on Population and Development (ICPD) which held in Cairo in 1994, notwithstanding, the cases of unwanted pregnancies and sexually transmitted infections continue to persist in Nigeria.

Unprotected sexual activities

According to the Alan Gutumacher Institute, the trend of sexual activities is assuming an alarming rate. Involvement of youths in sexual practices has increased over the last two decades. About 20% more male youths and female youths are having sex by the age of 18 than they were in the early 1970s (The Alan Gutmacher Institute, 1994). The 2013 NDHS report shows that

26% of unmarried females and 22% of unmarried males studied had sexual activities 12 months prior to the study and only 44% and 58% of unmarried females and males respectively used condom (NPC/ICF International, 2014). 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 (Ajidahun et al, 2007; Advocate for Youths, 2009). It is not surprising that Nigerian youths have the highest level of fertility with 112 births/1000 females (Godswill, 2012). Regardless of availability of wide variety of contraceptives, sadly unprotected sexual activities by youths still continue to rise. Reasons for sexual involvement could be attributed to stigmatisation and unfriendly attitude of health workers, reduced access to correct sexuality information which leads to their exposure to unprotected sexual activities.

Unwanted Pregnancies

Involvement of females in unprotected sex is directly linked to the occurrence of unintended pregnancies (Briggs, 1993). Child brides and sexual abuse events, with reduced possibilities of contraceptive use are likely to result in unplanned pregnancies. Fertility rate among young people in Sub-Saharan Africa is generally higher than for other regions of the world. On the average, 30-40% of girls have a baby before the age of 18 in Madagascar, Burkina Faso, Senegal, Nigeria, Malawi, Central African Republic and Uganda (United Nations, 2005; Singh and Darroch, 2000). In Nigeria, over 1.3 million unintended pregnancies occur annually (Guttmacher Institute, 2008). A study among young people in rural and urban Ekiti State, South-Western Nigeria showed a high percentage unintended pregnancies among young people (Tinuola, 2006). There may be indirect consequences of an unmarried female becoming pregnant and they include:

1. Shame and rejection by parents, peers and society.
2. Social consequences such as dropping out of school.
3. Economic consequences which include poor financial status and low quality of life.
4. Abortion which may result in subsequent health problems such as sepsis, infertility or death.

Unsafe abortion

Most abortions are conducted outside the legal framework and are frequently performed by unqualified and unskilled providers, or are self-induced. In most developing countries where

about 97% of the unsafe abortions occur (Haddad et al, 2009), high number of maternal deaths are recorded. According to WHO, every 8 minute, a woman in a developing country will die of complications arising from unsafe abortion. Approximately 68,000 women die annually from unsafe abortion making it the leading cause of maternal mortality (Haddad and Nour, 2009). Similar to trends obtained in countries like Asia, Latin America and the Caribbean, about 13% maternal deaths related to unsafe abortions and over 40% of abortion related deaths are in Africa (WHO, 2004). Young people also engage in abortion. About 60% of unsafe abortions in Africa are among women under the age of 25 (Iqbal and Alunan, 2004). Statistics shows that no fewer than 48 million cases of abortion occur worldwide on a yearly basis. Of this proportion, 20 million cases can be considered as unsafe while 22 to 4 million are young people who tend to seek abortion later in pregnancy but do delay seeking health care in the event of complications (Olukoya, Kaya, Ferguson and AbouZahr; 2001).

Most abortions often take place in unhygienic conditions, and involve the use of dangerous methods or incorrect administration of medications. Even when performed by a medical practitioner, any abortion carried out in secret, outside a recognized facility, generally carries additional risk: medical back-up is not immediately available in an emergency, the woman may not receive appropriate post-abortion attention and care, and if complications occur, the woman may hesitate to seek care (Berer, 2004).

In Nigeria, unwanted pregnancy is also a notable outcome of young people sexual activity (Okonta, 2007). Over 1.3 million unintended pregnancies occur annually in Nigeria. Well over half (760,000) of these pregnancies result in abortion (AGI, 2008). Abortion is illegal in Nigeria, except to save a woman's life. Still about 610,000 abortions are performed in the country each year (Henshaw, 1998) under unsafe conditions. As such, the majority of the abortions occurring in the country are unsafe. Experts believe that unsafe abortions account for up to 40% of maternal deaths in Nigeria (AGI, 2008).

If the fifth millennium development goal is to be achieved, then the issue of unsafe abortion among pregnant unmarried females ought to be addressed as more than one third of all pregnancies are unintended and one in every five pregnancies ends in abortion (Singh and Vlassoff, 2003).

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In Nigeria, unwanted pregnancy is also a notable outcome of young people sexual activity (Okonta, 2007). Over 1.3 million unintended pregnancies occur annually in Nigeria. Well over half (760,000) of these pregnancies result in abortion (AGI, 2008). Abortion is illegal in Nigeria, except to save a woman's life. Still about 610,000 abortions are performed in the country each year (Ilensbaw, 1998) under unsafe conditions. As such, the majority of the abortions occurring in the country are unsafe. Experts believe that unsafe abortions account for up to 10% of maternal deaths in Nigeria (AGI, 2008).

If the fifth millennium development goal is to be achieved, then the issue of unsafe abortion among pregnant unmarried females ought to be addressed as more than one third of all pregnancies are unintended and one in every five pregnancies ends in abortion (Singh and Vlassoff, 2003).

Sexually transmitted Infections/HIV

Youthful age is characterized with experimentation and involvement in risky sexual activities (Onyeonoro et al. 2011). There is the likelihood that young people who indulge in risky sexual activities could contact sexually transmitted infections including HIV/AIDS, chlamydia, syphilis, gonorrhoea, herpes, etc. Young people are believed to represent at least a third of the cases of Chlamydia worldwide and equal share of gonorrhoea (Cates and McPheeters, 1997; Senderowitz, 1997). While young people represent a large proportion of those affected by these diseases, they also contribute significantly to the HIV/AIDS statistics. A total of 2% of females between the ages of 15-19 years and 1% of males between the ages of 15-19 are infected with HIV (NACA, 2012). Nigeria's STI/HIV Control also estimates that more than 60% of new HIV infections occur in youths aged between 15 and 25 years (AVERT.org, 2007). Although most STIs are not fatal, they can lead to major pregnancy complications, infertility and general ill-health, and could also be a predisposing factor in the transmission of HIV (Okonofua, Coplan and Collins, 2003; Horizon Programme, 2001; Temin, Okonofua, Omorodion, Renne, Coplan, Heggenhougen and Kaufman, 1999; Onifade, 2011).

The effect of sexually transmitted infection and HIV on youths may be severe as they could result in rejection and stigmatization by the society if discovered, infertility and in extreme cases death. The consequences of poor sexual health among youths are numerous and quite severe. It has effect on the society both directly and indirectly. It is this light that major organizations seek to desperately address the reproductive health issues faced by youths.

The Concept of Contraception

According to The American Heritage Medical Dictionary, contraception is the prevention of the fusion of gametes during or after sexual activity. The term *contraception* is a contraction of *contra*, which means *against*, and the word *conception*, meaning fertilization. Contraception can occur both naturally and via artificial means in humans and in animals (The American Heritage Medical Dictionary Copyright 2007, 2004).

Methods of Contraception

Contraception can be divided into two types; modern and traditional methods (NPC/ICF International, 2014).

Traditional method

Several family planning methods pre-date the emergence of modern birth control. Before the advent of condoms and hormone-altering drugs, men and women utilized primitive methods for preventing conception.

- **Abstinence**

The most effective method of contraception is complete abstinence from heterosexual intercourse. As a contraceptive technique, abstinence is ultimately 100 percent effective and offers additional protection against sexually transmitted infections. Although couples using this family planning technique may engage in other forms of sexual contact, most find it challenging to abstain from intercourse entirely.

- **Withdrawal**

The withdrawal method also known as coitus interruptus or "pulling out," is one of the world's oldest family planning techniques. Withdrawal prevents conception by preventing sperm from entering the vagina However, this method is not completely effective; sperm may leak if withdrawal is improperly timed. In some cases, viable sperm may also appear in pre-ejaculatory fluid, leading to an unplanned pregnancy.

- **Rhythm**

The rhythm method is also known as the calendar method; it works by predicting the days in which a woman is most fertile. To use this technique, a woman must chart her menstrual history for several months in order to anticipate the dates in which she is ovulating. Women using this technique must abstain from unprotected sex on the days during which she is most fertile. The rhythm method can be somewhat effective, but it requires careful record-keeping and diligent adherence to the technique.

These methods listed above constitute the traditional methods of contraception (NPC 2008)

Modern Methods

The modern methods employ specific techniques to prevent fertilization by physically preventing sperm from entering the uterus. Modern devices commonly used include male condoms, female condoms, cervical caps, and diaphragms. Hormonal contraceptives inhibit female ovulation or fertilization. These include injectables (Hendrick, 1997) and oral contraceptives. The most

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common hormonal contraceptives are the combined oral contraceptive pill, commonly referred to as "The Pill", which includes a combination of an oestrogen and a progestin (progestogen), and the minipill that contains only synthetic progestogens and do not contain oestrogen. Sterilization is a permanent form of providing contraception using surgical techniques, such as tubal ligation for females and vasectomy for males, to alter the reproductive function of the sex organs.

Emergency contraceptives, or "morning-after pills", are drugs that disrupt ovulation or fertilization in order to prevent pregnancy taken after sexual intercourse. An IUD can also be used as an emergency contraceptive, if it is implanted early enough, although it has a contragestive effect when it is implanted later (Ammer, Manson, and Brigham, 2009 ; Morris, Young, and Kearney, 2000).

Types of Contraceptives

- **Birth Control Pills**

There are two types of Birth Control Pills: Combined Oral Contraceptive Pills and Progestin-Only Pills (WHO, 2006). These are pills that contain chemicals with hormonal properties. The combined oral pills contain two hormones found in females. They function by preventing ovulation and inhibition of movement of sperm (WHO, 2006). On the other hand, the Progestin-only pill is made up of one hormone only, which is progestin. This helps to thicken the cervical mucus so as to prevent the entrance of sperm cells. These pills also function at times by preventing ovulation (WHO, 2006; Society for Adolescent Medicine, 2004). The pills may also offer protection against cancers like endometrial and ovarian cancers, pelvic inflammatory disease, ovarian cysts and may prevent osteoporosis which is the thinning of the bones (Onifade, 2011).

- **Condoms**

Effective condoms are made of latex or polyurethane. They prevent body fluids from mixing when two people have sex.

Latex condoms, when used consistently and correctly during vaginal, oral, or anal intercourse, are highly effective in preventing the sexual transmission of HIV. They are also effective in preventing most sexually transmitted infections (STIs). Condoms provide a great level of protection against these STIs because they protect both partners against exposure to the other's

body fluids. Condoms also provide some protection against STIs such as genital herpes, syphilis, chancroid, and human papillomavirus (HPV) which is transmitted primarily through contact with infected skin or with mucosal surfaces. Because these STIs may be transmitted by contact with surfaces not covered or protected by the condom, condoms provide a lesser degree of protection against them (WHO, 2006).There are two types of condoms and they include the male and the female condoms. The male condom is worn on the penis before sexual intercourse to prevent the entrance of sperm cells into the uterus of the female. The male condom is about 88% to 98% effective in the prevention of pregnancy if used correctly and is effective in preventing most sexually transmitted infections. The female condom is inserted into the vagina before sexual intercourse to prevent the entrance of sperm cell into the uterus. Unlike the male condom, it is more expensive than and 82% to 94% effective in the prevention of pregnancies and effective in preventing sexually transmitted infections.

- **Injectable Hormonal Contraceptive**

The injection of the hormone Progestogen prevents the release of an egg, and thickens cervical mucus thus preventing the entry of sperm into the uterus. The injection works in the same way in the body as the Progestogen, but has the advantage that you do not have to remember to take a pill every day. It does however have the same disadvantage as the hormonal pill, in that it provides no protection against STIs. The injectable hormonal contraceptive has 99.7% effectiveness (typical and perfect use) at preventing pregnancy (Onifade 2011). The advantages include exclusion of daily medication or hormone intake, protection against pregnancy for 12 weeks and easy use by specific women who cannot take Estrogen containing birth control methods. Furthermore, it protects against cancer of the lining of the uterus and iron deficiency anaemia (Onifade 2011). However, many women using the injectable can have changes in their monthly periods, which can include missing monthly periods (Onifade 2011). Side effects may include weight gain and irregular bleeding although fertility may be delayed as long as twelve months after last injection (Onifade 2011).

- **Intra Uterine Device (IUCD)**

This is a small plastic device placed in the uterus. It contains copper or hormones that keep sperm from fusing with an egg. by creating an intrauterine environment that is hostile to sperm (copper) or by thickening the cervical mucus and preventing sperm from entering the uterus.

IUCD is 97.4-99.2% effective and may be kept in place for up to ten years depending on the type of IUCD. Though some IUCDs are reversible they have the benefit of reducing menstrual cramps and the amount of menstrual bleeding. However some women experience an increase in cramps, spotting heavily and longer during their menstrual periods (primarily with copper). On the other hand, IUCDs do not effectively protect against sexually transmitted infections and diseases (Wieldemeersch, Istvan, Biran, Amaury, Shongchun, Jing and Xiaoming, 2003).

- **Contraceptive Implants**

The contraceptive implant (Implanon) is a single implant inserted into the upper arm. The implant performs a similar function to the pills. Implants give off very small amounts of a hormone much like the progesterone a woman's body produces during the last two weeks of each monthly cycle (WHO, 2006). After a woman is given a local anaesthetic, insertion of the implant requires only about few minutes. The implant is considered to have an advantage over the pill as it is inserted and left over a period of time unlike the pill which is ingested on a regular basis.

- **Diaphragm**

A diaphragm is also called the cervical cap and is made of latex. It is usually inserted into the vagina and should be left in the vagina at least 6 hours but no more than 24 hours after intercourse. The diaphragm blocks the male's semen from entering the cervix (the opening to the womb) while the spermicide placed onto the diaphragm kills sperm. The diaphragm and the spermicide work synergistically to keep sperm from getting to the egg (WHO, 2006).

Surgical Contraception

Sterilization process is performed via surgical operation designed the fusion of a male sperm with the female egg. Below are the various sterilization methods:

Bilateral Tubal Ligation (BLT) – This method is intended to permanently block the woman's fallopian tubes.

Vasectomy – This procedure is intended to permanently block the sperm carrying tubes.

These options are 99.5 – 99.9% effective at preventing pregnancy and is a permanent method of birth control without any lasting side effects for women or men. However, they are not effective at protecting against sexually transmitted infections & HIV and reversibility cannot be guaranteed.

Utilization of contraceptives by unmarried youths

Based on the existing evidence of high prevalence of sexually transmitted infections and unplanned pregnancies among unmarried people, one would expect the current level of utilization of contraceptives to be high. But this is not the case as the sexual and reproductive health of youths continues to suffer. According to the NDHS report in 2008 and 2013, the level of utilization of the various forms of contraceptives is still low.

Table 2.1: Prevalence of Contraceptive use among unmarried youths in 2008

Type of contraceptive used	Males (15-19)	Females (15-19)	Males (20-24)	Females (20-24)
Any method	65.2%	64.5%	83.4%	79.6%
Any modern method	58.6%	55.9%	79.6%	72.2%
Sterilization	1.5%	0.0%	1.7%	0.0%
Condom	58.3%	0.7%	79.1%	1.3%
Pills	—	6.5%	—	12.4%
IUD	—	0.3%	—	0.5%
Injectables	—	2.6%	—	4.1%
Implants	—	0.0%	—	0.3%
Diaphragm	—	0.0%	—	0.2%
Foam/jelly	—	0.0%	—	1.5%
Emergency contraceptives	—	12.3%	—	15.4%
Long acting methods	—	0.0%	—	0.6%
Any traditional method	32.0%	30.9%	49.6%	43.3%
Rhythm	10.8%	13.2%	23.8%	24.1%
Withdrawal	30.2%	17.6%	45.2%	27.8%
Folk method	0.0%	14.2%	0.7%	12.1%

Source: *NPC/ICF International, 2008*

An updated report by NDHS in 2013 shows the trends of contraceptive utilization although figures presented shows contraceptive use only among unmarried females.

Table 1.2: Prevalence of Contraceptive use among unmarried women in 2013

Type of contraceptive used	Females (15-19)	Females (20-24)
Any method	61.1%	76.3%
Any modern method	49.7%	63.5%
Female Sterilization	0.0	0.0
Male Condom	40.7%	48.9%
Pills	6.4%	7.8%
IUD	0.0%	1.3%
Injectables	0.1%	1.2%
Implants	0.0%	0.0%
Diaphragm	0.0%	0.0%
Foam/jelly	0.0%	0.0%
Long acting methods	0.0%	0.0%
Any traditional method	11.3%	12.8%
Rhythm	4.3%	5.0%
Withdrawal	4.5%	5.7%
Currently not using	38.9%	23.7%

Source: *NPC/ICF International 2013*

Although the data presented in the 2013 report covers only contraceptive utilization by unmarried women only, there is a marked reduction in the use of most of contraceptive types

Factors That Affect Provision of Reproductive Health Services of Unmarried Youths

There are various factors that influence the accessibility of reproductive health services to unmarried youths. They include the following:

- **Socio-cultural factors**

The shrouded secrecy and perceived taboo discussing matters pertaining to sex and sexuality no doubt, fuels the increased young people's reluctance to discuss and address sexual health issues on confrontation (Godswill, 2012). Unmarried adolescent girls are routinely denied or have limited access to sexual reproductive health services regardless of their increased vulnerability to

violence and sexual abuse (Wood and Aggleton, 2004). There is a school of thought that suggests that most decisions made by young people are strongly influenced by the culture in which they live in (FIII, 2010). Studies have also identified the role of both parents and community in influencing the decisions of unmarried youths (Fernandez and Fogli, 2006)

- **Access to health facilities**

Very few reproductive health services are accessible to youths. Barriers to Reproductive Health services were extensively discussed and highlighted repeatedly through the discussions. Availability, accessibility, acceptability, confidentiality and even lack of publicity and visibility of available services were the main barriers. These services include contraceptives for unmarried youths (WHO, 2001). An important contributing factor to the use of contraceptives by young persons' is accessibility (Addie et al, 2001). Other factors may include availability, affordability, and poor attitude of health workers, inadequate information and fear of confidentiality (James-Traore, 2001; Boyd, 2000; Blanc & Way, 1998; Sendrowitz, 2000)

Health providers' disapproval of young people using contraceptives also present barriers to provision of contraceptives to unmarried youths (Katz & Nare, 2002; Stanbock and Twum-Baah, 2001; Addie et al, 2001; Oloyu, 1998; Nare et al, 1997). Services in countries where pre-marital sex is prohibited or frowned at are also regularly denied to unmarried youths. Although health clinics might seem to be the right place both for accurate and confidential information as also for services, they are not always helpful in appropriately providing services to young persons.

- **Religious Factors**

Certain religious policies and practices promote the narrowing down of sexuality education programmes and also limit access to information on contraceptives (Wood and Aggleton, 2001). A review of Literatures by Amimba and Roberts in 2008 revealed different beliefs and acceptance of contraceptives by different religion. According to some religious circles, the use of contraception alters our understanding of human sexuality by changing its purpose. It also has re-reaching effects and affect the way that we understand relationships, gender roles and the human person hence should not be encouraged (Hudson, 2012). There are certain religious denominations that do not accept the use of contraceptives. For Roman Catholics, the use of any form of artificial methods such as chemicals and barrier forms of contraceptives are prohibited. The only approved methods are abstinence and rhythm methods of contraception (Schenker and

Rabenou, 1993). For other denominations such as the orthodox, use of contraceptives is not prohibited but any method that does not destroy the product of conception maybe used (Zion, 1992). For other religion such as Islam, while some were of the opinion that contraceptives were not forbidden (Omran, 1992), other believed that the use of contraceptives is a violation of God's laws (Poston, 2005).

Religious beliefs such as those listed above are vital in influencing the attitude of parents to allow their children access to contraceptives. Parents who hold strongly to these doctrines are more likely to live by their tenets hence their decision to allow the use of contraceptives will be strongly dependent on the regulations set by their religion.

- **Political factors**

There are still laws which are inconsistent and ambiguous, evident in some countries, which permit young people within the ages of 16 and 17 years to consent to sex but restrict their use of services and information regarding contraceptives (Wood and Aggleton, 2004).

The National Policy on Health and Development of Adolescents and Young People in Nigeria recognises the need for easy access to reproductive health information and services to help address the reproductive health challenges of young people. Some of the objectives of this policy include:

- Increase the proportion of young people who have access to accurate and comprehensive reproductive health information and services by 50%
- Increase access of all categories of young people to comprehensive youth-friendly health services by 50%
- Reduce incidence of unwanted pregnancies among young females by 50%
- Integrate family life and HIV&AIDS education into the curricula of all primary and secondary schools
- Halt the spread of HIV&AIDS among young people

Availability of laws that promote the reproductive health and welfare of youths is paramount in addressing these challenges but the place of parental roles cannot be ignored. Parents who are

aware of the existence of these policies are more likely to have favourable disposition towards the use of contraceptives by sexually active unmarried youths than those who do not

Policies on contraceptive use by young people

Different countries are governed by different policies concerning the use of contraceptives. While some countries have strict laws on who should be provided with contraceptive services, others have laws that permit health care services to be available to all including reproductive health services to unmarried youths (Onifade, 2011).

In a bid to combat maternal mortality, Nigeria acknowledged the need to revise the National Health bill which addresses the issue of provision of unrestricted reproductive health services to all individuals including adolescents. The burden of high maternal mortality in Nigeria cannot be effectively tackled without addressing reproductive health problems of youths considering the fact that youths are the major contributors to maternal mortality both in Nigeria and worldwide. Hence the reproductive health problems of youths have a direct effect on the maternal mortality rate of most countries.

A policy was formulated to address the reproductive health issues of adolescents (National Adolescent Health Policy, 1995). The policy highlighted strategies to address the peculiar needs of young people and specified health problems faced by young people which include sexual behaviour and reproductive health among others (FMoH, 1995; Onifade, 2011). This policy which is supportive of unrestricted access of the young people to reproductive health services was an offshoot of the Maternal and Child Health/Family Planning (MCH/FP) policy which provides for the unrestricted services to all categories of individuals, including young people.

Interventions to promote contraceptive use among young people

Different strategies have been put in place to address the reproductive and sexual health issues of young people.

- **Sexuality Education**

Risky sexual activities among youths have resulted in high HIV prevalence among them. It has been reported that 50% of new infections and abortion complications respectively occur among young people. It was also reported that abortion among young people account for about 15% contribution to maternal mortality ratio in Nigeria (FMoH, 2006). The situation has been

attributed to poor access to reproductive health information and services. This is evident in the proportion of youths aged 15-24 (60%) who had inaccurate knowledge about routes of HIV transmission (UNAIDS, 2008).

Sexuality education is a planned process of education that fosters the acquisition of factual information, the formation of positive attitudes, beliefs and values as well as the development of skills to cope with the challenges of growing up (AHI, 2003). Sexuality education can also be described as a process of providing information, skills and services that enable persons adopt safe sexual behaviours including abstinence, non-penetrative sex such as hugging, holding hands, as well as correct and consistent use of condoms (Ajuwon, 2005). Young peoples' understanding of their sexuality has been recognized as a bold step towards solving most of the negative adolescent sexual health outcomes. Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (WHO, 2002).

The issue of sexuality education was introduced at various times in different countries (Adepoju, 2005). During the sexual revolution which was in the 1800s, women began agitating for more debates on issues concerning their sexuality. They questioned rules prohibiting the use of contraceptives and the spread of information about them. The first six to seven decades saw both males and females questioning the concept of virginity and male dominance (Adepoju, 2005). In 1897, a female doctor, Caroline Widerstom saw the need to educate young ones about sexual hygiene. According to her, if they knew in good time how pregnancy and sexually transmitted diseases came about they would be better able to protect themselves (Lema, 2000).

Provision of comprehensive sexuality education which includes provision of information on contraception to young people has been identified as one of the effective approaches to addressing sexuality related matters among young people. This just addresses a phase of the problem as research has shown that a large number of young people are sexually active and some of these sexual activities start at an early age (Makinwa-Adebusoye, 1992; Oyediran, Isholo and Adewuyi, 2002; Isiugo-Abanihe and Oyediran, 2004). Another step to tackle these problems is the actual provision of these contraceptives through the establishment of youth friendly centres where these youths can easily access health care since it is almost impossible to completely eradicate premarital sex among them.

In an attempt to address the unmet sexuality education needs of young persons, several governmental, non-governmental agencies and individuals have implemented various programs targeting different categories of young people including secondary school students, physically challenged youths, apprentices and hawkers across the country. There have also been various interventions across the globe as China recognised the need for such intervention. In urban china, more single women are becoming pregnant and resorting to induced abortion. This prompted the need for a work based intervention to promote the use of contraceptives among unmarried youths. But,despite the provision of free contraceptives to these young people, only a few (5% of the total study population) report the use of contraceptives (Qian, Smith, Huang, Zhang, Huang, and Garner, 2007).

Various studies showed sexuality education interventions among young people and the impact of these interventions on the sexual behaviour of this class of individuals. An assessment of an intervention by Osowole in 1998 among physically challenged boys and girls showed increased discussion of reproductive health issues, reduced occurrence of unintended pregnancies and a reduction in the number of sexual partners. Other interventions also provided evidence of increased use of condoms among young people (Osowole and Oladepo, 2000; Ajuwon, 2000; Brieger, Delano, Lane, Oladepo and Oyediran, 2001).

School-Based Sexuality Education

Comprehensive Sexuality Education was introduced in schools as a response to many reproductive health problems faced by young people. This was later scaled up into the Family Life HIV Education programme in schools (NERDC, 2003). This innovation provided evidence that sexuality education reduces the risks of early and unprotected sexual activities, unwanted pregnancies, unsafe abortion and occurrence of sexually transmitted infections (UNESCO 2009, IPPF 2009). Sexuality education is often perceived as incompatible with prevailing traditional societies' values and norms. In Nigeria, as in most countries, there are many groups, including those genuinely concerned about the well-being of adolescents, who strongly oppose sexuality education as not being in the best interest of adolescents (Asekun-Olarinmoye, Fawole, Dairo & Amusan, 2007; Orji and Esimai 2003; Brieger 2002; Oshi, Nalubeme, and Oshi 2005).

In South-Western Nigeria, an intervention study was conducted to evaluate school-based reproductive health education programme (Ajuwon and Brieger, 2007). Result from the

intervention showed significant increase in reproductive health knowledge of respondents. A qualitative study which was also conducted in South-West Nigeria also showed that teachers were in support of school based sexuality education as they believed that this is necessary to improve their knowledge on reproductive health and reduce the incidence and prevalence of risky sexual activities among young people (Aransiola, Asa, Obinjuwa, Olarewaju, Ojo, and Fatusi, 2013).

Home-based sexuality education

Most countries in sub-Saharan Africa have recorded high level of early sexual debut. A study carried out in Tanzania showed that at age 15, 11% of girls and boys have had sex and this study also recorded low utilization of condoms among sexually active youths (Wamoyi, Fenwick, Urassa, Zaba and Stones, 2010; National AIDS Control Programme, 2001).

The fact that youths begin sexual activities at an early age is enough reasons for parents to be involved in providing early training for children as the home is regarded as the first institution. It has been noted that the determinants of sexual behaviour are a function not only of the individual but of structural and environmental factors as well. Parent-child communication has been identified as a protective factor for adolescent sexual, and reproductive health (Bastien, Kajula & Muhwezi, 2011; MarkHam, Lormund, Gloppen, Perkins, Flores, Low and House, 2010).

In time past, the discussion of sexual reproductive issues between adults especially parents and young people in the sub-Saharan Africa was considered a taboo and have been well documented (Ainuyuruzu-Nyamongo, Biddlecom, Ouedraogo and Woog, 2005; Mbugwa, 2007; Paruk, Petersen, Bhana, Bell and McKay, 2005). A study by Adeyemo and Brieger in 1994 showed that most parents were free discussing issues on growth and development, few discussed pregnancies, child birth and abortion and even very few (16%) ever discussed all six topics of family life education including contraception (Adeyemo and Brieger, 1994; Bastien et al., 2011).

Another study conducted by Amoran, Anadeko and Adeniyi in 2005 showed that a greater proportion of adolescents who received sexuality information from their peers were sexually experienced when compared to those who received sexuality information from their parents. Recently, there have been promising interventions to improve the communication process between parents and their unmarried youths. One of such interventions is the Intervention with

Microfinance for AIDS and Gender Equity (IMAGE). This intervention is directed towards the reduction of HIV and intimate partner violence. This intervention makes provision for the promotion of parent-child communication on issues bothering on sexuality (Phetla, Busza, Hargreaves, Pronyk, Kim, Morison, Watts and Porter, 2008). The outcome of the intervention showed that parents who participated in this intervention reported more frequent discussions on sexual and reproductive health issues and youths whose parents were participants reported that these discussions were more specific about risk reduction strategies rather than vague messages. Strategies such as this have helped in the building of skills among parents with unmarried youths hence impacting on the sexual practices of unmarried youths. A programme on family matters which was adapted from the United States of America was evaluated to assess the intervention effects of parenting practices and parent-child communication. The intervention on family matters sought to improve the parent-child communication process (Vandenhoudt, Miller, Ochura, Wyckoff, Obong and Otwoma et al., 2010). These interventions have proven to be effective in reducing the risky practices of unmarried youths and addressing the issue of parent-child communication on sexual and reproductive health of unmarried youths including discussions on contraception.

Parental knowledge on appropriate contraceptives for unmarried youths

Although the 2013 NDHS report documented good contraceptive knowledge among women of reproductive age, the need for the knowledge of appropriate contraceptives for use by sexually active unmarried youths cannot be over emphasized.

According to International Planned Parenthood Foundation (2008), non-prescriptive contraceptives such as condoms and spermicidal (e.g foaming tablets and jelly) are regarded as safe for use by sexually active unmarried youths. However, prescriptive contraceptives such as emergency contraceptives are widely available and used by unmarried youths (Arowojolu and, Adekunle, 2000).

The knowledge of appropriate contraceptives to be used by unmarried youths with minimal or no side effect is an influencing factor on parents' willingness to permit the use of contraceptives by sexually active unmarried youths. The knowledge about contraceptives and the myths surrounding its use may account for the acceptance or non-acceptance of contraceptive use as a study by Oyediran, Farombi and Ajibade in Osun State of Nigeria showed that more than half of

parents studied had good knowledge on suitable contraceptives for unmarried youths (Oyediran, Faronbi and Ajibade, 2013).

Contraceptive use have been identified as an important aspect of preventive medicine and a means of improving health of unmarried youths (Foege, 2003) although the study conducted in Osun State showed that less than half of the respondents agreed that contraceptive use leads to improved health outcomes among sexually active unmarried young people (Oyediran, Faronbi and Ajibade, 2013). A similar study conducted in China showed a relatively poor knowledge on reproductive health issues including contraceptives (Cui, Tian, Li and Shah, 2012).

Several studies have implicated parent-child communication as a factor influencing the reproductive health choices of youths as those who communicate better with their parents in issues of sexual health are more likely to make better health decision (Kinaro, 2013; Weinman, Small, Buzi and Smith, 2012). Hence good knowledge about contraceptives is imperative for parents during reproductive health discussions with their children.

Parents' attitude towards use of contraceptives by sexually active youths

Despite eroding cultures, most parents still have tremendous influence over their children. This brings to the fore that meeting the reproductive needs of these youths rests majorly on the shoulders of the parents (Briggs, 1998; Oyediran et al., 2013).

The conclusion from the study done by Briggs in 1998 was that most of the parents (79.1%) studied at that time had negative attitude about the use of contraceptives by sexually active youths. A study carried out by Kinaro in Nairobi Kenya showed that parental approval was significantly associated with contraceptive use by youths as those who perceived that their parents would not object were more likely to use contraceptives than those who perceived that their parents would not approve (Kinaro, 2013).

Even till date, parents shy away from discussions that centre on sexual activities. In situations where the level of sexual activities among young people is high and the discouragement of the use of contraceptives by sexually active youths is equally high, a large number of sexually active young people are left unprotected. In the same study by Briggs in 1998, most mothers affirmed that they only advised their sexually active daughters to stay away from men. This supports the

fact that most parents shy away from discussing sexual issues with their sexually active youths at home although most parents were of the opinion that sexuality education should be introduced into the school curriculum.

A study conducted in Osun State revealed that more than half of parents (69.3%) studied had negative attitude towards contraceptive use by unmarried youths (Oyediran et al., 2013). Similarly, finding from the qualitative study by Kinaro in Nairobi showed that parents had negative attitude towards contraceptive use by unmarried youths (Kinaro, 2013).

There are different reasons why parents all over the globe react differently to the use of contraceptives by sexually active unmarried youths. This could be due to socio-cultural reasons or religious reasons. Notwithstanding, there are a number of parents who are willing to accept the use of contraceptives by sexually active unmarried youths. Some parents believe that the provision of contraceptives is a lesser evil when compared to unplanned pregnancies which may not be carried to term. While there are few parents who belong to this school of thought, there are also others who would not subscribe to this in any circumstance (Oyediran et al., 2013).

Parental perception on contraceptive use by sexually active unmarried youths

Different factors may play important role in influencing the perception of parents towards contraceptive use by their unmarried youths. Studies have recognised the importance of parental perception about contraceptives and the role it plays in influencing the use of contraceptives by unmarried youths (Kinaro, 2013). Many myths and misconceptions have discouraged the use of contraceptives by parents which in turn has affected their opinion about contraceptive use by their unmarried children. The NDHS report for 2013 showed that some of the respondents studied reported negative experiences while using various forms of contraceptives hence discontinued its use (NPC/ICF International, 2014). Reasons such as these are often used as basis by parents not to support the use of contraceptives by unmarried youths.

The Bingga study in 1998 recorded various myths and misconception which might affect the opinion of parents on contraceptive use by sexually active unmarried youths. Many parents still hold firm to the cultural beliefs and the sacred nature of sexual discussion hence do not usually discuss these issues with their children and do not see any reason to provide contraceptives to these unmarried youths. While some parents are ready to compromise their stand on the use of

contraceptives by unmarried youths as a means of solving the increasing reproductive health problems facing youths, there are others who would oppose the argument and insist that provision of contraceptives to these youths will lead to promiscuity among them (Oyediran et al., 2013; Foege, 2003).

Other reasons which may affect the views of parents towards contraceptive use are poor knowledge and misconceptions about contraceptives. When asked their reasons for not supporting the use of contraceptives by unmarried youths, about 46% of parents studied believed that contraceptives kills and others believed that contraceptives has effect on fecundity (Briggs, 1998). These beliefs influence the attitude of parents on the use of contraceptives by sexually active youths whether they are accurate or not. Most parents (93.2%) during that study consented to the introduction of sexuality education in school curricula but the idea to introduce the topic at home was not completely welcomed as most of the parents (87.8%) reported that they do not discuss issues concerning sexuality with their unmarried children. Parental opinion is a strong determining factor which may contribute to the use of contraceptives by sexually active youths. Societal rejection and the perceived sacredness of sexual activities and its discussion have not completely prevented youths from indulging in sexual activities. This is not different from the issue of perceived parental approval of contraceptives. The result from the Briggs study showed that although the parents did not approve of contraceptive use and warned their children to stay away from sexual activities, these female unmarried youths still turned out pregnant.

Parental experience as an influencing factor to their attitude to contraceptive use by unmarried youth

Parental use and experience could also be a factor influencing their attitude towards contraceptive use by sexually active unmarried youths. The qualitative study by Kinaro (2013) showed that respondents who had used contraceptives in the past and recorded negative effects were less likely to permit its use by their unmarried children. Some of the reasons mentioned include the fact that contraceptives constitute health hazards to the health of young people and could lead to bodily harm. The NDHS report for 2013 showed that 14.3% of women reported getting pregnant while using contraceptives hence discontinued its use while 7.1% discontinued due to health concerns (NPC/ICF International, 2014). Negative experiences such as these could greatly influence the opinion of parents on the use of contraceptives by unmarried youths

2.1 CONCEPTUAL FRAMEWORK

The model to be adopted for this study is the Ecological model. The Social Ecology Model (SEM), also called Social Ecological Perspective, is a framework to examine the multiple effects and interrelatedness of social elements in an environment. The SEM can provide a theoretical framework to analyse various contexts in multiple types of research and in conflict communication (Oetzel, Ting-Toomey, and Rinderle, 2006). Social ecology is the study of people in an environment and the influences on one another (Hawley, 1950). The ecological model stresses that while individuals are responsible for instituting and maintaining lifestyle changes necessary to reduce risks and improve health, the behaviours of individuals could be influenced largely by external factors such as significant others, community norms and values, organizational interventions and societal influences.

Individual: This includes the individual's knowledge attitude and perception about a particular behaviour.

Inter-personal: This component addresses the infuence of significant others on the individual to perform a particular behaviour.

Community: This addresses the community norms and values that influences the performance of that behaviour.

Organization: This includes various organization and social institutions that support the performance of that behaviour.

Public policies: This includes policies in place to promote the performance of that behaviour.

Application of the theory to the study

As earlier stated, the ecological model emphasizes the influence of others on an individual to perform a behaviour. The influence of parents (interpersonal relationship) on their children is being examined in this study. Parents with adequate knowledge about contraceptives and its benefits to sexually active youths are likely to promote its use among them. Parents without adequate knowledge about contraceptives may have negative attitudes toward contraceptives and are less likely to promote its use (questions 14-16 of appendix I). The personal experience of parents may likely affect their willingness to allow their young children use contraceptives (see question 17 of appendix I).

The influences of various organizations and social society may play an important role in enlightening of parents and youths on the importance of contraceptives in the prevention of unplanned pregnancies and sexually transmitted infections. If there are organization programmes to promote the use of contraceptives among unmarried youths, then they are likely to adopt the behaviour. On the other hand, when there are no programmes to enlighten parents and youths alike on the importance of contraceptives, then the likelihood of adopting the behaviours is reduced (see question 18 of appendix 1).

Community norms and values also play important roles in determining if parents will support the use of contraceptives by unmarried youths. If the community norms are favourable, then the likelihood that parents will support the use of contraceptives by youths is high. But if the norms are not favourable, then the reverse will be the case (see questions 35-46 of appendix 1).

Lastly, parents' knowledge of the existence of public policies could serve as a means of influencing their attitudes. When there are positive policies in place as regards adolescent health, parents may have positive attitude towards contraceptive use by unmarried youths. But when there are no policies in place to promote the health of young people, then they are unlikely to have negative attitude towards its use (See question 11 of appendix 1)

Figure21. The application of the Ecological Model on parental knowledge and attitude towards contraceptive provision to unmarried youths

Questions were designed using the Ecological Model and applied on the field. These questions bordered on the issues such as personal use of contraceptives as a determining factor for their approval of its use by unmarried youths and discussion of reproductive health issues including contraceptive use with their unmarried youths. Other areas explored include community norms and values regarding the use of contraceptives by unmarried youths and the knowledge of public policies that promote the provision of contraceptives to unmarried youths.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive cross sectional survey was conducted among parents of unmarried youths (both male and female parents) in Ibadan North-East Local Government Area of Oyo State. The study was a community based survey.

3.2 Study Area

The study was carried out in Ibadan North-East Local Government Area (IBNELGA) which was created by the Federal Military Government of Nigeria on 27th August, 1991. The L.G.A was carved out of the defunct Ibadan Municipal Government and derived its name from the metropolitan nature of the area of about 12.5 square kilometres that it covers. It is bounded on the East by Egbeda and Ona Ara Local Governments, on the West by Ibadan North East Local Government. On the North, the Local Government shares boundaries with Lagelu and Akinyele Local Governments with Ibadan South East Local Government on the South.

The inhabitants of the L.G.A are predominantly Yoruba, although it accommodates people from various other tribes who either engage in commercial activities or work in the public service. The populace consists of civil servants, teachers, traders, students and artisans. It has a population of 331,444 people. The male population is made up of 163,844, while the female population is 167,600 people (National Population Council, 2006); there are 12 wards in the L.G.A (Handbook on Ibadan North East Local Government, 2007). Majority of residents in this area are traders. Christianity and Islamic religions are practiced by residents of this location.

There are few reproductive health programs that expose unmarried youths to reproductive health information in the LGA. Most interventions on reproductive health are carried out by Non Governmental Organizations such as Association for Reproductive and Family Health (ARFH) and the Nigerian Urban Reproductive Health Initiative (NURHI). There are about 3 primary health facilities and other private facilities within the LGA that provide contraceptive services but these services are not readily available to unmarried youths.

The 12 wards which make up the LGA are represented in table 3.1

Table 3.1: List of Communities and Wards in Ibadan North-East LGA

Wards	Areas
1	Odo Osun, Labiran
2	Ogbonri Efon, Ita Baale, Oranyan, Beyerunka
3	Kosodo, Labo, Alafara
4	Adekile, Aremo, Orita Aperi
5	Labiran Aderogba
6	Oje Aderogba, Alafara
7	Oke Ofla, Atipe, Oja Igbo, Aremo Alafara, Ajegede
8	Ode Aje, Padi, Alase, Aremo Ajibola
9	Koloko, Agugu, Oke Ibadan, Idi-Obi
10	Oje Irefin, Ita Akinloye, Baba Sale
11	Iwo Road, Abayomi, Basorun, Idi-Ape BCOS Quarters
12	Parts of Irefin, Agodi Gate, Oluyoro, Gbegila, Oke Adu, Aromolaran, Onipepeye

3.3 Study Population

The study population consisted of male and female parents of unmarried youths (between the ages of 15 and 24) in Ibadan North-east Local Government Area.

3.4 Inclusion Criteria

i. Individuals who were parents with unmarried youths within the age bracket for this study were included in the sample.

ii. Also included are all who consented to the study

3.5 Exclusion Criterion

Individuals who were not parents and parents without unmarried youths within the age specified for this study were excluded from the study.

3.6 Sample Size

The sample size formula for cross sectional studies was used:

$$n = \frac{Z^2pq}{d^2}$$ (Leslie Kish, 1965)

Where z= 1.96, (level of significance of 5% (1.96))

p=79·1% (Prevalence of parents who did not favour the use of contraceptives by sexually active adolescents, Briggs, 1998).

q=1-p=1-0.79% = 20.9% = 0.209=0.21

d=5% (Difference)

n= (minimum sample size)

$$n = \frac{1.96^2 \times 0.79 \times 0.21}{0.05^2} = 254.9 = 255$$

20% non-response rate was included, therefore, 0.2×255=51

Therefore, 51+255 = 306

The sample size was approximated to be 306 respondents

3.7 Sampling Technique

Simple random sampling was used to select the wards to be used for the study. This was done by simple balloting. Ibadan North-east consists of twelve (12) wards and half (6) wards (wards 1, 7, 8, 9, 11 & 12) were randomly selected for the study.

The total number of communities to be selected from the 6 wards was determined using the formula below:

$$\frac{\text{Number of Communities in ward A} \times \text{6 wards to be studied}}{\text{Total number of communities in all 6 wards}}$$

A total of seven (7) communities was obtained using the above formula and were subsequently selected using simple random sampling method

To select the number of households to be studied in each community, the total sample size was divided with the total number of communities studied in all twelve wards i.e

$\frac{306}{7}$ = 44 households/community

A total of 44 respondents were purposively selected from the communities. Equal number of males and females were selected. In a household where there was more than one eligible participant, random sampling (balloting) was done to select one individual for the study.

3.8 Instrument of Data Collection

Two instruments, namely the Focus Group Discussion Guide and a Semi Structured Questionnaire were used for data collection.

3.8.1 Focus Group Discussion Guide

The focus group discussion guide was used to capture the views of respondents on the topic of study. The guide consisted of questions on parents' views on reproductive health issues faced by unmarried youths, respondents' knowledge of contraceptives and those appropriate for use by unmarried youths, common beliefs and misconceptions about contraceptives use, opinions of parents on the use of contraceptives by unmarried youths and factors that may influence their opinions. (See Appendix 1)

3.8.2 Semi Structured Questionnaire

The quantitative data was collected using a semi-structured interviewer administered questionnaire. The questionnaire contained open ended and closed ended questions that addressed the study's objectives and was administered to respondents who were parents regardless of their sex by trained research assistants. The questionnaire contained 5 sections. The first section contained questions to elicit information on background characteristics of the respondents such as the sex, marital status, educational background and occupation of respondents. The second section focused on the knowledge of respondents on various types of contraceptives, sources of information on contraceptives and identification of contraceptives suitable for use by unmarried youths. The third section contained questions on respondents' use of contraceptives as factors that may influence their attitudes towards the provision of contraceptives to unmarried youths. The fourth and the fifth sections contained questions on the attitude of parents regarding the use of contraceptives by unmarried youths and their perception about contraceptives respectively (See Appendix 2).

3.9 Procedure for Data Collection

Four (4) research assistants were hired for the purpose of data collection. Training was conducted for the research assistants to ensure that they had adequate understanding of the tool prior to the commencement of data collection. The training focused on the objectives of the study, the sampling process, how to obtain informed consent of the respondents, basic interviewing skills required to obtain necessary information from respondents and how to ensure completeness of questionnaires.

Six (6) focus group discussions were conducted among respondents from selected study sites and these sessions were facilitated by research assistants with the aid of a focus group discussion guide. Respondents were grouped according to sex hence three (3) sessions of focus group discussions were conducted for male parents and same for female parents and each group contained a minimum of eight (8) persons and a maximum of ten (10) persons. Sessions were conducted within the residential areas of respondents as most of the participants were resident within close proximity of each other. The sessions which were recorded using a tape recorder lasted for a minimum of 35 minutes and a maximum of 45 minutes.

3.10 Validity of Instruments

The face and content validity of the instrument was ensured by review of relevant literatures, formulation of research objectives and research hypotheses which were tested. The research tools were developed in line with the research objectives. The validity of the instruments was also established through the judgement of lecturers in the Faculty of Public Health and was subjected to peer-review. The instrument was reviewed to justify the validity of the content in terms of the clarity, appropriateness of the language and the ability to elicit the accurate information for the attainment of the stated objective. The instrument was also modified based on the inputs.

3.11 Reliability of Instruments

Both the focus group discussion guide and the questionnaire were pre-tested among respondents in a different location (Ibadan South-west LGA) with similar characteristics to the study location. The pre-test of the questionnaire was carried out among Ten percent of the total sample size which summed up to 31 respondents resident in Apata Community of Ibadan South-west LGA of Oyo State. This was done to ensure that the questions in the quantitative and qualitative tools

addres the study objectives. There was no need for modification of the instruments after the pre-test hence no revision was made.

The quantitative instrument was subjected to measures of internal consistency through the use of the Cronbach alpha coefficient analysis to confirm its reliability. The instrument was considered reliable as the result showed a value of 0.91 which is greater than 0.05.

6.11 Data Analysis

In order to determine the true knowledge, attitude and perception respondents based on response to questions asked during the study, a scoring system was developed. A scale of 0-24 was used for respondents' awareness of contraceptives and knowledge of all listed contraceptives. A scale of 0-6 was used to measure the respondents' knowledge on suitable contraceptives for unmarried youths and a 4 point scale was used to measure reasons for their choices (See section B of Appendix 2). Hence a total knowledge scale of 34 points was adopted for this study. The mean knowledge score of respondents was used as a basis to determine respondents with poor and good knowledge. Scores ranging from 0-17 was considered poor and scores ranging from 18-34 was considered good.

Respondents' attitude was analyzed on a scale of 0-28 (See section D of Appendix 2). For each positive response, a score of '2' was awarded, while any negative response was scored '0'. The mean attitudinal score of respondents was also used for further classifications such that scores between '0 and 14' were classified as negative attitude and scores between '15 and 28' were classified as positive attitude.

Respondents' perception was analyzed on a 24 point scale (See section E of Appendix 2). Positive responses were scored '2' while negative responses were scored '0'. The mean perception score of respondents was also used as a basis to determine respondents with negative and positive perception. Respondents with score below '12' were classified as respondents with negative perception while those with score of 13 and above were considered to have positive perception.

6.12 Data Management

In order to ensure adequate data management, the following steps were taken.

1. The questionnaires were serially numbered for control and recall purposes.

2. Each administered questionnaire was carefully cleaned on a daily basis
3. A coding guide was developed and used for coding both the open ended and close ended questions.
4. The information obtained was carefully entered and analyzed by using the version 16 of Statistical Packnge for Social Sciences (SPSS).
5. The data were analyzed by using descriptive and inferential (chi square and logistic regression model) statistics
6. The focus group discussions were recorded on audio tapes, transcribed and analyzed using thematic approach
7. The results were presented in appropriate graphical illustrations, diagrams and tables

3.13 Ethical Considerations

Ethical approval was sought from Oyo State Ethical Review Board before the commencement of the study to ensure that the principles of research were upheld. (See Appendix 3)

Informed consents were obtained from the respondent before the interview. Respondent's anonymity and confidentiality was maintained by using identification numbers and not name. Interviews were conducted as privately as possible. No harm was done to the respondents as the study did not involve any invasive procedure.

To ensure proper understanding, participants were enlightened on the objectives of the study. Emphasis was made on their rights of non-participation and withdrawal. Adequate information about the research was provided to the research participants.

3.14 Limitations of Study

Several factors affected the responses of respondents during the study

- Many respondents who were Yoruba by tribe had reservations about specifying the number of children they had as they insisted that it was against their cultural beliefs
- The sensitivity of the research topic posed a challenge as some respondents believed that discussion of such topics are not morally acceptable or was against their religious beliefs.
- The use of purposive sampling technique in selecting research participants was also a limitation. Participants were purposively selected due to the unconventional nature of the study area as it is both commercial and residential in nature

However, efforts were made to address these challenges as respondents were assured of the confidentiality of the information provided during the research and they were informed that there was no form of identification and the interview was conducted as privately as possible.

CHAPTER FOUR

RESULTS

4.1 Demographic Characteristics of Respondents

4.1.1 Respondents' Sex, Marital Status, Type of Marriage and Level of Education

The demographic profiles of respondents are shown in Table 4.1. Equal number of males and females (153 each) were selected for the study. Majority of the respondents (95.8%) were married and two (2) amongst the respondents constituting about 0.7% were single parents. About 2.6 and 0.3 of the study population were widows and widowers respectively. Among the 306 respondents, 80.4% had monogamous marriages while 15.4% were involved in a polygamous relationship. Slightly above half (57.7%) of the total number of respondents had tertiary education. This was followed by those who had secondary education (23.9%) while 10.1% and 2.6% had primary and non-formal education respectively.

Focus group discussion participants were grouped into male and female groups. Three FGD sessions were held for both males and females. All participants were married and most of the females had monogamous marriages.

4.1.2 Respondents' Religion, Ethnicity and Occupation

The respondents were predominantly Christians (70.3%) while 29.3% were Muslims. The majority of the respondents (92.2%) were Yoruba and others including Igbos, Hausas, Urhobos and Edos constituted 7.8%. Among the 306 respondents studied, 22.2% were teachers, 20.9% were civil servants and 28.1% were traders. Others were artisans and professionals such as Engineers and Health workers which constituted a total of 18.6% and 10.1% respectively.

Majority of the FGD participants were Christians and belonged to Yoruba ethnic group. Most of the participants were traders and artisans.

Table 4.1: Socio-demographic Characteristics of Respondents (N = 306)

Demography	No.	100%
Sex of Respondent		
Male	153	50.0
Female	153	50.0
Marital Status		
Single	2	0.7
Married	293	95.8
Divorced	2	0.7
Widowed	9	2.9
Type of Marriage		
Monogamy	246	80.4
Polygamy	47	15.4
Level of Education		
No Education	17	5.6
Informal/Adult Education	8	2.6
Primary	31	10.1
Secondary	73	23.9
Tertiary	117	57.7
Religion		
Islam	91	29.7
Christianity	215	70.3
Occupation		
Professional	31	10.1
Artisan	57	18.6
Civil Service	64	20.9
Teaching	68	22.2
Trading	86	28.1
Ethnic Group		
Yoruba	282	92.2
Others*	24	7.8

* Others are Igbos, Hausas, Urhobos and Edos

4.1.3 Respondents' Parity

About 29.4% of the respondents had four (4) children, 23.9% had three (3) children and 16.7% had five (5) children. Other respondents who had 1, 2,6,7,8,9,11 child(ren) constituted 3.6%, 14.7%, 7.8%, 2.0%, 1.0%, 0.7% and 0.3% respectively. Respondents who had a youth constituted about 37.3% while those who had two children who are youths constituted about 37.6%. Other respondents had varying number of children who are youths constituting the minority. Among the 306 respondents, 88.6% of them had their youths living with them while 11.4% had their youths living separately from them.

All the FGD participants had one or more children between the ages of 15 and 24 years of age.

Table 4.2: Respondents Parity "N = 306"

Respondents' Parity	No.	100%
1	11	3.6
2	45	14.7
3	73	23.9
4	90	29.4
5	51	16.7
6	24	7.8
Above 6	12	3.9
Number of Male Children		
0	25	8.2
1	99	32.4
2	103	33.7
3	52	17.0
4	17	5.6
Above 4	10	3.1
Number of Female Children		
0	27	8.8
1	93	30.4
2	100	32.7
3	52	17.0
4	23	7.5
5	9	2.9
Above 5	2	0.6
Number of unmarried youth		
1	114	37.3
2	115	37.6
3	47	15.4
4	17	5.6
5	12	3.9
6	1	0.3

4.2. Knowledge on Contraceptives

4.2.1. Respondents' Level of awareness about contraceptives

Result from table 2 indicates that 99.3% had heard about contraceptives while 0.7% had not heard of contraceptives. A large proportion of the respondents (66.3%) revealed that their source of information on contraceptives was through the television and the radio. Few respondents (26.5% and 20.3%) heard about contraceptives through the newspaper and from friends respectively. Only a few of the respondents reported hearing about contraceptives from their parents and schools and they constitute 3.6% and 8.8% respectively. Approximately half of the total respondents sampled (57.5%) reported to have heard about contraceptives from health workers.

Issues identified by the FGD respondents include violence, drug abuse and reproductive health problems. Most of the respondents agreed that of all the problems listed, the reproductive health issues takes precedence. "*Of all this problems, the most important one is the issue of young girls getting pregnant without being married*".

All the FGD participants have heard about contraceptives. Some participants heard from television, radio, newspapers and others from health personnel.

Figure 4.1: Awareness and source of information on contraceptives

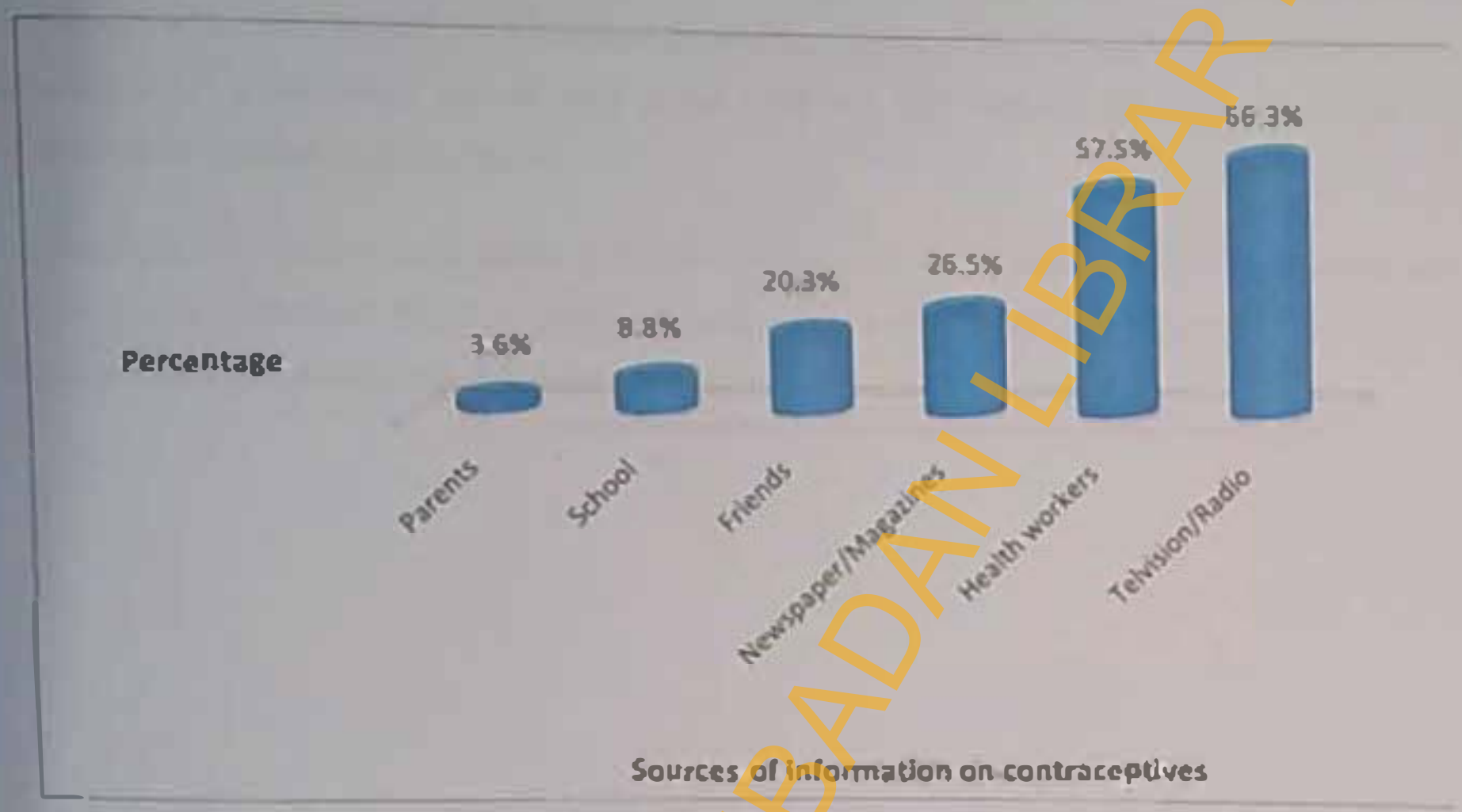

Figure 4.1: Awareness and source of information on contraceptives

4.2.2 Respondents' Knowledge of Specific Contraceptives

Almost all the respondents (96.7%) had knowledge of male condoms. The knowledge of female condoms was close to average (42.5%). Seventy Five per cent of the respondents had knowledge of pills and about 64.1% had knowledge of injectable. Those of implant and other contraceptive methods were considerably low as only about 13% and 14% respectively had knowledge on bilateral tubal ligation and vasectomy.

All the FGD participants have heard of condoms and pills. Some have heard of injectables and only a few of them have heard of implants, vasectomy and bilateral tubal ligation. "*Everybody knows condom and medicines to stop pregnancy*".

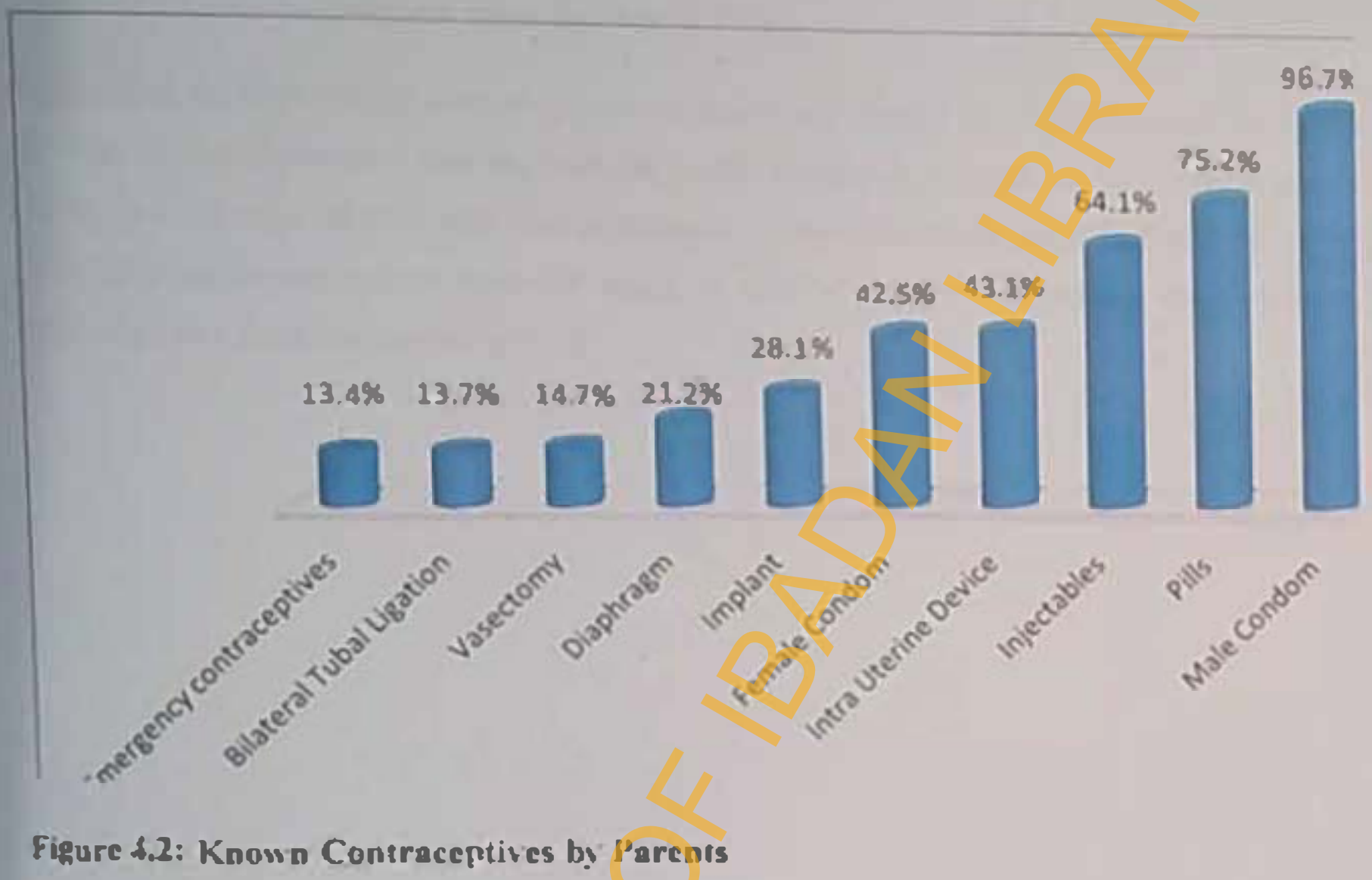

Figure 4.2: Known Contraceptives by Parents

4.2.3 Respondents' Knowledge on appropriate contraceptives for youths

Most respondents (71.2%) agreed that condoms were appropriate for use by sexually active unmarried youths. Few of the respondents mentioned pills (28.4%), emergency contraceptives (5.6%), implants (3.9%), injectables (7.8%), intra uterine devices (8.2%), diaphragm (2.0%), vasectomy (0.3%) and bilateral tubal ligation (0.7%).

When asked the appropriate contraceptives for unmarried youths, most FGD participants were of the opinion that abstinence was the best but in the absence of it, condom was appropriate. This choice was followed by pills and then injectables. The female participants had better knowledge on appropriate contraceptives than the males as most of the above responses were supplied by the participants from the female groups.

Table 4.3: Respondents knowledge of appropriate contraceptives for unmarried youths

Appropriate Contraceptives for Youths	Frequency		Total
	Yes (%)	No (%)	
Condoms	218(98.2)	4 (1.8)	222(100.0)
Pills	87 (39.8)	135 (60.8)	222(100.0)
Emergency Contraceptives	17 (7.7)	205 (92.3)	222(100.0)
Implant	12 (5.5)	142 (95.5)	217(100.0)
Injectables	24 (10.8)	198 (89.2)	222(100.0)
Intra Uterine Device	25 (11.3)	197 (88.7)	222(100.0)
Diaphragm	6 (2.7)	216 (97.3)	222(100.0)
Bilateral Tubal Ligation	2 (0.9)	220 (99.1)	222(100.0)
Vasectomy	1 (0.5)	221 (99.5)	222(100.0)

4.2.5 Respondents' use of contraceptives

More than half (63.4%) of the respondents had ever used one form of contraceptive or the other. Of all the respondents who had ever used contraceptives, 58.5% had used condoms, 15.5% had used pills. Those who had used IUCD were also 15.5% which was followed by those who had used injectables (11.3%). Only a few of the respondents have used diaphragm (1.0%) and none have used bilateral tubal ligation and vasectomy.

Figure 4.3: Respondents' History of Contraceptive use

Table 4.4: Types of Contraceptives used by Respondents

Respondents who have ever used contraceptives	No.	100%
Condom		
Yes	114	58.5
No	81	41.5
Implant		
Yes	10	5.1
No	185	94.1
Emergency contraceptives		
Yes	0	0.0
No	195	100.0
Pills		
Yes	30	15.4
No	165	84.6
Diaphragm		
Yes	2	1.0
No	193	99.0
Injectables		
Yes	22	11.3
No	173	88.7
Intra uterine device		
Yes	30	15.4
No	165	84.6

Table 4.4: Types of Contraceptives used by Respondents

Respondents who have ever used contraceptives	No.	100%
Condom		
Yes	114	58.5
No	81	41.5
Implant		
Yes	10	5.1
No	185	94.1
Emergency contraceptives		
Yes	0	0.0
No	195	100.0
Pills		
Yes	30	15.4
No	165	84.6
Diaphragm		
Yes	2	1.0
No	193	99.0
Injectables		
Yes	22	11.3
No	173	88.7
Intra uterine device		
Yes	30	15.4
No	165	84.6

4.2.6 Respondents currently using contraceptives

A total of 50% who have ever used contraceptives stated that they were currently using while the other 50% said that they were no longer using contraceptives. Of all the respondents currently using contraceptives, about 58% of them were using condoms and 5.1% were using implants. Only few respondents (9.2%, 11.2% and 16.3%) were using injectables, pills and intra uterine devices respectively. None of the respondents were using emergency contraceptives, diaphragm, bilateral tubal ligation and vasectomy.

Table 4.5: Respondents' current use of Contraceptives

Contraceptives Methods	Sex	Currently using contraceptives	
		Yes (%)	No
Condom	Male	49 (49.5)	2 (2.0)
	Female	8 (8.1)	40 (40.4)
Implant	Male	- (0.0)	51 (51.5)
	Female	5 (5.1)	43 (43.4)
Emergency Contraceptive	Male	- (0.0)	51 (51.5)
	Female	1 (1.0)	47 (47.5)
Pill	Male	- (0.0)	51 (51.5)
	Female	10 (10.1)	38 (38.4)
Diaphragm	Male	- (0.0)	51 (51.5)
	Female	- (0.0)	48 (48.5)
Injectable	Male	- (0.0)	51 (51.5)
	Female	9 (9.1)	39 (39.4)
Intra Uterine Device	Male	- (0.0)	51 (51.5)
	Female	15 (15.2)	33 (33.3)

*N=99

4.2.7 Respondents' experience while using contraceptives

One hundred and forty four respondents (73.7%) reported a positive experience while using contraceptives and agreed that the various contraceptives used were effective. Twenty six which accounts for 13.4% of those who had used contraceptives stated that they had negative experience such as excessive bleeding, weight gain and some individuals reported that conception occurred while they were still using contraceptives. Almost a similar number of respondents (25) which accounts for 12.8% were indifferent to the use of contraceptives.

4.2.8 Parent-youth discussion on reproductive health

Table 4.6 shows parental discussion on reproductive health issues with unmarried youths. More than half of the parents (59.5%) reported that they have at one time or the other, discussed the issue of reproductive health with their children while only about 40.5% said that they do not discuss reproductive health issues with their unmarried youths. Of all the parents who discussed reproductive health issues with their unmarried youths, 50.5% were females. Only 35.2% of parents who have ever discussed reproductive health issues discussed contraceptive use with their unmarried youths. About 57.7% discussed reproductive health issues with their unmarried youth one month prior to the study and about 31.3% discussed reproductive health issues with their unmarried youth six months prior to the study. Majority (81.7%) of female parents said that their sex does not affect their discussions about reproductive health with their youths who are males. On the other hand, fewer males (73.9%) than females stated that being a male does not affect their discussions about reproductive health with their youths who are females.

Most of the FGD participants supported home-based sexuality education by parents to their unmarried youths. *"Children should be taught by their parents the risk of involving in such things without being married"*.

On the other hand, most male participants believed it was the responsibility of the mothers to perform such duties. The opinion of a male participant was captured thus: *"It is the duty of the mothers to talk to their children when they are of age so that they will know how to behave with the opposite sex"*.

Table 4.6: Parent to youth discussion on reproductive health issues

Sex	Ever Discussed (%)	Never Discussed	Total (%)
Males	90 (58.8)	63 (41.2)	153 (50.0)
Females	92 (60.1)	61 (39.9)	153 (50.0)
Total	182 (59.5)	124 (40.5)	306 (100.0)

*N=306

Table 4.7: Parent to youth discussion on contraceptives

Sex	Ever discussed contraceptives (%)	Never Discussed Contraceptives (%)	Total (%)
Males	31 (34.4)	59 (65.6)	90 (49.5)
Females	33 (35.9)	59 (64.1)	92 (50.5)
Total	64 (35.1)	118 (64.9)	182 (100.0)

4.3 Parents' attitude towards contraceptive use by sexually active unmarried youths

4.3.1 Less than half (46.7%) of respondents approved of contraceptive use by sexually active unmarried youths while 53.3% disapproved of its use. Of the parents who approved of contraceptive use by unmarried youths, 52.1% were males while 47.9% were females. Females constituted a larger proportion (52.5%) of those who disapproved of the use of contraceptives by unmarried youths. When respondents were asked the reasons for their approval of the use of contraceptives by unmarried youths, 19.3% said that it would help to prevent both unwanted pregnancies and STIs while another 18.3% gave only pregnancies as a reason why they support contraceptive use by sexually active youths. Those who did not support the use of contraceptives by sexually active unmarried youths (53.3%) gave various reasons why they did not support its use. Only a few (16%) of the respondents said that supporting the use of contraceptives will promote promiscuity among unmarried youths while 14.7% had beliefs that it was better to wait until marriage before they indulge in sexual activities. Some of the respondents (6.5%) believed that using contraceptives had health implications and would therefore adversely affect them later in life.

Most FGD participants were unreceptive towards contraceptives use by unmarried youths as they believed that unmarried youths should abstain from sex. Nonetheless, a male participant was of the opinion that youths who cannot abstain should use condoms and avoid pills. *"You see a lady that is taking pills is endangering her life because it can affect her from giving birth. This pills can block her womb"*

Table 4.8: Parental Approval of contraceptive use by unmarried youths

Sex	Approve of contraceptive use (%)	Disapprove of contraceptive use (%)	Total (%)
Males	73 (52.1)	76 (47.5)	149 (49.7)
Females	67 (47.9)	84 (52.5)	151 (50.3)
Total	140 (46.7)	160 (53.3)	300 (100.0)

*N=300

4.3.2 Parental consent to use contraceptive services

Majority (78.0%) of the respondents believed that unmarried youths should seek parental consent before they are provided contraceptive services and 22.0% said that unmarried youths can be provided with contraceptive services without the consent of their parents. Of those who agreed that unmarried youths should seek parental consent, 51.8% were females. Those who said parental consent was necessary gave various reasons. Few (38.6%) respondents said it was necessary for parental guidance and 17.0% wanted to be aware so as to put a stop to their use. For those who said unmarried youths do not require parental consent, 64.5% were males. Respondents who said that parental consent was not required gave their reasons as better off not knowing (6.5%), the youths have their own rights (4.9%) and not having enough knowledge so discussing it makes no difference (0.6%). Few (2.0%) respondents said that if the unmarried youths choose to indulge in sexual activities, then they are responsible for themselves.

Table 4.9: Need for parental consent before contraceptive use by unmarried youths

Sex	Yes n(%)	No n(%)	Total (N=306) n(%)
Male	106 (48.2)	40 (64.5)	146 (51.7)
Female	114(51.8)	22 (35.5)	136 (48.2)

X^2: 5.169, p-value: 0.023

4.33 Conditions in which parents will permit the use of contraceptives by unmarried youths

More than half (53.5%) of the respondents said that they would permit the use of contraceptives if the youth was sexually active. Of these respondents, 56.2% were males. A similar percentage (51.2%) said that they would permit contraceptive use by youths who have had history of pregnancies or sexually transmitted infections and 54.8% of this category was males. Less than half (49.8%) said that they would permit the use of contraceptives by youths who have a history of abortions and males also constituted a higher percentage (55.6%). Slightly above half (53.1%) said they would permit its use if the youth has a child and does not want a repeat. Less than half (40.3%) said that they would not approve of contraceptive use by unmarried youths under any condition. Females constituted a higher percentage (54.1%) of those who did not approve the use of contraceptives by unmarried youths under any condition.

Table 4.10: Conditions in which parents will permit the use of contraceptives by unmarried youths

Conditions in which parents will permit the use of contraceptives by unmarried youths	Frequency		Total
	Yes (%)	No (%)	
If the youth is sexually active	162 (53.5)	141 (46.5)	303(100.0)
If the youth has a history of pregnancy or sexually transmitted infections	155 (51.8)	148 (48.2)	299(100.0)
If the youth has a history of abortions	151 (49.8)	152 (50.2)	303(100.0)
If the youth has a child and does not want a repeat	161 (53.1)	142 (46.9)	303(100.0)

1.3.4 Parents' role in sexuality education

Majority (72.8%) of the respondents believed that parents are in the position to provide sexuality education including information on contraceptives to unmarried youths while 27.2% believed that parents should not provide sexuality education including contraceptive information to unmarried youths.

The opinion of the FGD participants was that parents have active roles to play in educating their unmarried youths on sex education but not all subscribed to sexuality education that includes information on contraceptives. *"Parents should educate their children in the right way but telling them about family planning put pressure on them to start engaging in sexual intercourse because they know that they cannot get pregnant once they engage in family planning"*

1.3.5 Attitude of parents to provision of reproductive health information and services

More than half (64.8%) of respondents agreed that information on contraceptives should be provided to unmarried youths while 35.2% were of the opinion that information on contraceptives should not be provided to unmarried youths.

Majority of the respondents (68.8%) encouraged sexuality education in schools to include on information on contraceptives and 31.2% did not support the provision of information on contraceptives in schools.

Most (90.0%) of the respondents agreed that the reproductive health of young people is important and should be considered a priority while 10.0% did not agree that the reproductive health of young people is a priority.

Results from the table below indicate that 57.9% of parents studied supported the creation of youth friendly centres where sexually active youths can have access to contraceptives while 42.1% did not support.

During the FGD discussion, most FGD participants were supportive of the idea of provision of youth friendly centres in the communities as they believed that youths can obtain appropriate information from such centres. *"It is in the hands of the government. It is right for the children to go and receive orientation and the right information"*.

The study findings revealed that most of the parents (74.8%) believed that they should be informed if their children who are unmarried should seek contraceptive services from a service provider while the others (25.2%) did not agree that parents should be informed if their children who are unmarried should seek contraceptive services from a service provider.

When asked, 79.0% of parents disagreed that youths should be provided with contraceptive services without the consent of their parents while 21% agreed that youths can be provided with contraceptive without the consent of their parents.

Many of the respondents (60.5%) agreed that youths should be provided with information on contraceptives whether they are sexually active or not but 39.5% of them disagreed that youth should be provided with contraceptive information whether they are sexually active or not.

Table 4.11: Parents' views on provision of comprehensive sexuality education (N=304)

Statement	Response	Male n (%)	Female n (%)	Total n (%)
Parents are not in the position to provide sexuality education including information on contraceptives to unmarried youths	Agree	38 (48.1)	41 (51.9)	79 (27.2)
	Disagree	105 (49.8)	106 (50.2)	211 (72.8)
Parents should not support the provision of information on contraceptives to unmarried youths	Agree	45 (44.6)	56 (55.4)	101 (35.2)
	Disagree	98 (52.7)	88 (47.3)	186 (64.8)
Parents should encourage the provision of sexuality education in schools to include information on contraceptives	Agree	97 (49.5)	99 (50.5)	196 (68.8)
	Disagree	44 (49.4)	45 (50.6)	89 (31.2)
The reproductive health of young people is not a priority	Agree	12 (41.4)	17 (58.6)	29 (10.0)
	Disagree	134 (51.1)	128 (48.9)	262 (90.0)
Parents should encourage the creation of youth friendly centres for easy accessibility of contraceptives by youths	Agree	80 (51.9)	74 (48.1)	154 (57.9)
	Disagree	55 (49.1)	57 (50.9)	112 (42.1)
Parents should be informed if their unmarried youths should seek contraceptive services	Agree	96 (46.8)	109 (53.2)	205 (74.8)
	Disagree	45 (65.2)	24 (34.8)	69 (25.2)
Youths can be provided with contraceptives without the consent of their parents	Agree	34 (57.6)	25 (42.4)	59 (21.0)
	Disagree	106 (47.7)	116 (52.3)	222 (79.0)
Youths should be provided with information on contraceptives whether they are sexually active or not.	Agree	79 (46.5)	91 (53.5)	170 (60.5)
	Disagree	63 (56.8)	48 (43.2)	111 (39.5)

4.3.12 Respondents' attitude on the provision of contraceptives to sexually active unmarried youths

The table below shows the overall attitude of the respondents as regards the provision of information on contraceptives and contraceptives to sexually active unmarried youths. An overall mean attitudinal score of 14.0±7.8 was obtained. The mean attitudinal score was considered a reference for the scoring system as described in the methodology. Generally, the result shows a positive trend as more than half of the respondents agreed that sexually active unmarried youths should be provided with information on contraceptives and contraceptives.

Hence, with reference to the scoring system described in the methodology, the respondents' attitude was computed as follows: 167 (54.9%) of the respondents had positive attitude towards the provision of contraceptives to sexually active unmarried youths while 137 (45.1%) had negative attitude towards contraceptive use by sexually active unmarried youths

Table 4.12: Parents' attitude on provision of contraceptives to sexually active unmarried youths

N=304

Attitude of respondents	Frequency	Percentage
Positive Attitude	167	54.9
Negative Attitude	137	45.1

Mean: 14.0±7.8.

Key:

Positive Attitude: >14

Negative Attitude: ≤14

4.7.1 Parents' Perception on the provision of contraceptives to sexually active unmarried youths

Represented on the table below are the perceptions of parents on the provision of contraceptives to unmarried youths. More than half (67.9%) of the respondents were of the opinion that information on contraceptives should be included in sexuality education taught in schools. On the other hand, the remaining 32.1% disagreed that information on contraceptives should be taught in schools alongside sexuality education. A majority of the respondents (76.2%) believed that contraceptives are effective against the prevention of unwanted pregnancies and 23.8% of them had the beliefs that contraceptives were ineffective in preventing unwanted pregnancies. A large percentage of the respondents (70.8%) agreed that contraceptives should not be used as an approach to solve the reproductive health problems while 29.2% of the respondents agreed that contraceptives should be used as an approach to solve the reproductive health problems faced by youths.

Slightly above half (56.7%) of the respondents agreed that provision of contraceptives to sexually active unmarried youths will promote promiscuity among them while only about 43.3% of the respondents believed that provision of contraceptives have no influence on the sexual behaviours of unmarried youths. A majority of the respondents (56.0%) believed that provision of information on contraceptives to unmarried youths will expose them to sexual activities while only 44.0% believed that the provision of information on contraceptives will not influence the sexual activities of unmarried youths. A large proportion of the respondents (61.3%) disagreed that contraceptives should not be made available to sexually active unmarried youths and 38.7% agreed that contraceptives should not be made available to sexually active unmarried youths.

Most parents (84.7%) did not agree that discussion on sex and contraceptives are sacred and should not be discussed while 15.3% agreed that such discussions were sacred and should not be discussed. More than half of the respondents (61.6%) believed that information on contraceptives should be publicized to unmarried youths while 38.4% disagreed with the idea of publicizing the use of contraceptives by the media to unmarried youths. Most of the respondents (60.6%) believed that perceived parental approval of contraceptives by youths may increase sexual activities among unmarried youths while only 39.4% disagreed with the statement. A large proportion of the respondents believed that do not have the right to freely procure or use

contraceptives while 32.7% believed that the youths have rights to use contraceptives freely. Slightly above half (54.3%) of respondents did not agree that there should be laws prohibiting the use of contraceptives by sexually active unmarried youths while 45.7% agreed that there should be laws prohibiting the use of contraceptives by sexually active unmarried youths. More than half (69.5%) of respondents disagreed with the idea of punishing unmarried youths seen using contraceptives while 30.5% were of the opinion that unmarried youths seen using contraceptives.

During the FGD discussions, some of the participants expressed their beliefs that discussions about contraceptives will promote sexual activities among unmarried youths while few believed that discussions about contraceptives will not influence the sexual behaviours of unmarried youths. *"Discussing about contraceptives will only lead young people to involve themselves in all this sex before marriage"*.

Other problems associated with contraceptive use mentioned by the participants include the effect of contraceptives on fertility and other side effects such as bleeding. *"Contraceptives have bad effects on people. I know of a woman who used contraceptive and she still got pregnant. Another one used contraceptive and she did not stop menstruating for one year"*

Most FGD participants supported the idea of establishing youth friendly centres to help address the reproductive health challenges of unmarried youths. *"This type of place is good for young people so that they can have health information"*.

On the other hand, few participants believed that contraceptives will be provided in such health facilities hence they did not favour the establishment of youth friendly centres. *"I believe that this kind of place will give young people the opportunity to become more sexually active so I do not support this"*

Table 4.13: Parents' perception on the provision of contraceptives to sexually active unmarried youths

Statement	Response	Male n (%)	Female n (%)	Total n (%)
Sexuality education in schools and at home should include information on contraceptives	Agree	100 (53.8)	86 (46.2)	186 (67.9)
	Disagree	37 (42.0)	51 (58.0)	88 (32.1)
Contraceptives are not effective against prevention of unwanted pregnancies	Agree	20 (31.7)	43 (68.3)	63 (23.8)
	Disagree	104 (51.5)	98 (48.5)	202 (76.2)
Provision of contraceptives should not be used as an approach to solve young people's reproductive health problems	Agree	95 (47.7)	104 (52.3)	199 (70.8)
	Disagree	43 (52.4)	39 (47.6)	82 (29.2)
Provision of contraceptives will make young people become sexually active	Agree	74 (47.1)	83 (52.9)	157 (56.7)
	Disagree	65 (54.2)	55 (45.8)	120 (43.3)
Information on contraceptives will not cause young people to indulge in sex	Agree	62 (53.0)	55 (47.0)	117 (44.0)
	Disagree	72 (48.3)	77 (51.7)	149 (56.0)
Contraceptives like condoms and pills should not be made available to sexually active youths	Agree	51 (47.2)	57 (52.8)	108 (38.7)
	Disagree	91 (53.2)	80 (46.8)	171 (61.3)
Issues on sex and contraceptives are sacred and should not be discussed with unmarried youths	Agree	16 (36.4)	28 (63.6)	44 (15.3)
	Disagree	125 (51.4)	118 (48.6)	243 (84.7)
The media should be encouraged to publicize the use contraceptives by unmarried youths	Agree	92 (53.2)	81 (46.8)	173 (61.6)
	Disagree	51 (47.2)	57 (52.8)	108 (38.4)
Perceived parental approval of contraceptives by youths may increase sexual activities among youths	Agree	67 (38.5)	107 (61.5)	174 (60.6)
	Disagree	73 (64.6)	40 (35.4)	113 (39.4)
Youths should have rights to procure or use contraceptives freely	Agree	56 (60.9)	36 (39.1)	92 (32.7)
	Disagree	83 (43.9)	106 (56.1)	189 (67.3)
There should be legislation prohibiting the use of contraceptives by unmarried youths	Agree	55 (46.6)	63 (53.4)	118 (45.7)
	Disagree	78 (55.7)	62 (44.3)	140 (54.3)
Unmarried youths seen using contraceptives should be punished	Agree	34 (41.5)	48 (58.5)	82 (30.5)
	Disagree	103 (55.1)	84 (44.9)	187 (69.5)

1.7.2 Summary of parents' perception on the provision of contraceptives to sexually active unmarried youths

An overall mean score of 12.0±6.8 was obtained during the study. This was used as a reference point for the determination of respondents who had positive and negative perception. Perception scores were measured on a 24 point scale. Scores ranging between 0-12 were considered negative perception while scores from 13 and above were considered positive. Generally, the result from the study showed more positive perception towards the provision of contraceptives to unmarried youths as respondents were scored according to the scoring system described in the methodology. A total of 164 (53.9%) respondents had positive perception towards the provision of contraceptives to sexually active unmarried youths while 140 (46.1%) of the respondents had negative perception.

Table 4.14: Overall Perception of parents on the provision of contraceptives to sexually active unmarried youths

Perception of Parents	Frequency	Percentage
Positive Perception	164	53.9
Negative perception	140	46.1

Mean: 12.0±6.8

Key:

Positive Perception: >13

Negative Perception: ≤13

Test of Hypotheses

Five hypotheses were formulated and tested in this study. The first states that: "There is no significant relationship between the demographic variables (sex, religion, level of education and occupation) and the knowledge of parents on appropriate contraceptives for unmarried youths". To ascertain the relationship between the demographic characteristics and the knowledge of respondents, a cross tabulation was done between the knowledge of respondents and their socio-demographic characteristics with p=0.05.

The hypotheses is true for the some of the selected demographic characteristics (type of marriage, ethnic group and number of youth per respondent) with the exception of sex, level of education and occupation.

Table 4.15: Relationship between the demographic characteristics of respondents and their knowledge on appropriate contraceptives for unmarried youths

Variable		Knowledge of appropriate contraceptives		
		Good (%)	Poor (%)	P-value
Sex of Respondent	Male	59 (39.1)	92 (60.9)	p=0.008
	Female	83 (54.2)	70 (45.8)	
Type of Marriage	Monogamy	119 (88.1)	126 (80.8)	p=0.085
	Polygyny	16 (11.9)	30 (19.2)	
Level of Education	No formal Education	9 (6.3)	15 (9.3)	p=0.000
	Primary Education	10 (7.0)	21 (13.0)	
	Secondary Educatioo	20 (14.1)	53 (32.7)	
	Tertiary Education	103 (72.5)	73 (45.1)	
Occupation	Artisans	23 (16.2)	34 (21.0)	p=0.031
	Teaching	33 (23.2)	34 (21.0)	
	Professionals	22 (15.5)	9 (5.6)	
	Trading	33 (23.2)	52 (32.1)	
	Civil service	31 (21.8)	33 (20.4)	
Ethnic Group	Yoruba	133 (93.7)	147 (90.7)	p=0.346
	Others	9 (6.3)	15 (9.3)	
No. of Youth/respondent	1	53 (37.3)	60 (37.0)	p=0.385
	2	50 (35.2)	65 (40.1)	
	3	22 (15.5)	25 (15.4)	
	4	12 (8.5)	5 (3.1)	
	5	5 (3.5)	6 (3.7)	

Hypothesis 2 states that there is no significant relationship between the socio-demographic characteristics of the respondents and their attitude towards contraceptive use by unmarried youths. To explore the relationship between these variables, cross tabulation was also done with $p<0.05$.

The hypothesis is true for the most of the selected demographic characteristics (type of marriage, ethnic group, level of education, occupation and number of youth per respondent) with the exception of sex.

Table 4.16: Relationship between the demographic characteristics of respondent and their attitude towards the provision of contraceptives to unmarried youths

		Attitude of Respondents		
Variable		Positive	Negative	P-value
Sex of Respondent	Male	92 (55.1)	59 (43.1)	p=0.037
	Female	75 (44.9)	78 (56.9)	
Type of Marriage	Monogamy	133 (83.6)	112 (84.8)	p=0.780
	Polygyny	26 (16.4)	20 (15.2)	
Level of Education	No formal Education	13 (7.8)	11 (8.0)	p= 0.228
	Primary Education	13 (7.8)	18 (13.1)	
	Secondary Education	35 (21.0)	38 (27.7)	
	Tertiary Education	106 (63.5)	70 (51.1)	
Occupation	Artisans	32 (19.2)	25 (18.2)	p=0.290
	Teaching	38 (22.0)	29 (21.2)	
	Professionals	22 (13.2)	9 (6.6)	
	Trading	41 (24.6)	44 (32.1)	
	Civil service	34 (20.4)	30 (21.9)	
Ethnic Group	Yoruba	157 (94.0)	123 (89.8)	p=0.173
	Others	10 (6.0)	14 (10.2)	
No. of Youth/respondent	1	62 (37.1)	51 (372)	p=0397
	2	64 (38.3)	51 (37.2)	
	3	28 (16.8)	19 (13.9)	
	4	10 (6.0)	7 (5.1)	
	5	3 (1.8)	8 (5.8)	

Hypothesis 3 states that there is no relationship between the socio-demographic characteristics of the respondents and their willingness to permit the use of contraceptives by unmarried youths

To ascertain the relationship between the demographic characteristics of the respondents and their willingness to permit the use of contraceptives by unmarried youths, cross tabulation was done between the variables with p<0.05

The hypotheses is true for all the selected demographic characteristics (Sex of respondents, type of marriage, ethnic group, level of education, occupation and number of youth per respondent)

Table 4.17: Relationship between the demographic characteristics of respondents and their willingness to approve of contraceptive use by unmarried youths

Variable		Respondents' willingness to approve contraceptive use: Yes	No	P-value
Sex of Respondent	Male	73 (52.1)	76 (47.9)	p=0.422
	Female	67 (47.5)	84 (52.5)	
Type of Marriage	Monogamy	111 (45.9)	112 (54.1)	p=0.709
	Polygyny	22 (48.9)	20 (51.1)	
Level of Education	No formal Education	11 (45.8)	13 (54.2)	p=0.219
	Primary Education	11 (35.5)	20 (64.5)	
	Secondary Education	27 (38.6)	43 (61.4)	
	Tertiary Education	91 (52.0)	84 (48.0)	
Occupation	Artisans	25 (44.6)	31 (55.4)	p=0.648
	Teaching	34 (50.7)	33 (49.3)	
	Professionals	14 (45.2)	17 (54.8)	
	Trading	34 (41.0)	49 (59.0)	
	Civil service	33 (52.4)	30 (47.6)	
Ethnic Group	Yoruba	130 (46.9)	147 (53.1)	p=0.830
	Others	10 (43.5)	13 (56.5)	
No. of Youth/respondent	1	53 (47.7)	58 (52.3)	p=0.597
	2	53 (46.9)	60 (53.1)	
	3	21 (44.7)	26 (55.3)	
	4	10 (58.8)	7 (41.1)	
	5	3 (23.3)	8 (72.7)	

Hypotheses 4 states that there is no relationship between the knowledge of respondents and their attitude towards the use of contraceptives by unmarried youths

To ascertain the relationship between the knowledge of the respondents and their attitude towards the use of contraceptives by ununarried youths, cross tabulation was done between the variables with p=0.05

Table 4.18: Relationship between the Knowledge of respondents and their attitude towards contraceptive use by unmarried youths

		Attitude of Respondents		
Variable		**Positive**	**Negative**	**P-value**
Knowledge of Respondent	**Good**	98 (69.0)	44 (31.0)	p=0.000
	Poor	69 (42.6)	93 (57.4)	

There was a significant association between the knowledge of respondents on appropriate contraceptives for unmarried youths and their attitude towards its use, ($p < 0.05$); the null hypotheses was therefore rejected.

Hypotheses 5 states that there is no relationship between the knowledge of respondents and their willingness to approve of contraceptive use by unmarried youths

To ascertain the relationship between the knowledge of the respondents and their willingness to approve of contraceptive use by unmarried youths, cross tabulation was done between the variables with $p=0.05$

Table 4.19: Relationship between the knowledge of respondents and their willingness to approve of contraceptive use by unmarried youths

		Willingness to approve of contraceptive use		
Variable		Yes	No	P-value
Knowledge of Respondent	Good	80 (56.7)	61 (43.3)	p=0.001
	Poor	60 (37.7)	93 (62.3)	

There was a significant association between the knowledge of respondents on appropriate contraceptives for unmarried youths and their willingness to approve of its use, ($p < 0.05$); the null hypotheses was therefore rejected.

Logistic regression analysis

Table 4.17 shows the result from the logistic analysis between the socio-demographic characteristics of respondents and their knowledge. Female parents were more likely to have better knowledge of appropriate contraceptives for unmarried youths than mal parents (OR=2.0: P=0.01). Also, respondents who had tertiary level of education were more likely to have good knowledge when compared with their counterparts with no formal education (OR=3.9, P=0.05). Respondents who were professionals were also more likely to have better knowledge when compared with those who were artisans (OR=4.7, P=0.01).

Table 4.20 Logistic regression analysis between socio-demographic characteristics of respondents and knowledge of appropriate contraceptives for unmarried youths

Variable	P value	OR	95%CI	
			Upper	Lower
Sex				
Male (reference)				
Female	0.01	2.0	1.2	3.7
Level of education				
No formal education (reference)				
Informal	0.42	0.4	0.1	3.4
Primary	0.51	0.6	0.1	2.4
Secondary	0.25	0.5	0.1	2.4
Tertiary	0.05	3.9	1.0	16.3
Occupation				
Artisan (reference)				
Teaching	0.60	0.8	0.4	1.8
Professionals	0.01	4.7	1.4	15.2
Trading	0.66	2.5	0.9	7.1
Civil service	0.15	2.1	0.8	5.7
Religion				
Islam (reference)				
Christianity	0.06	0.5	0.3	1.0

Table 4.18 shows the result from the logistic analysis between the socio-demographic characteristics of respondents and their attitude towards contraceptive use by sexually active unmarried youths. The result showed that female respondents were less likely to approve of contraceptive use by unmarried youths. Other variables tested showed no level of significance.

Table 4.21 Logistic regression analysis between socio-demographic characteristics of respondents and attitude towards contraceptive use by sexually active unmarried youths

Variable	P value	OR	95%CI	
			Upper	Lower
Sex				
Male (reference)				
Female	0.00	0.37	0.21	0.66
Level of education				
No formal education (reference)				
Informal	0.37	2.36	0.36	15.54
Primary	0.48	0.62	0.16	2.34
Secondary	0.68	1.29	0.38	4.35
Tertiary	0.30	2.08	0.51	8.5
Occupation				
Artisan (reference)				
Teaching	0.39	0.60	0.19	1.89
Professionals	0.40	0.58	0.16	2.11
Trading	0.25	0.62	0.28	1.40
Civil service	0.12	0.42	0.14	1.27
Religion				
Islam (reference)				
Christianity	0.82	1.05	0.65	1.73

while using contraceptives and their approval of contraceptive provision to sexually active unmarried youths. The result showed that respondents who had used contraceptives in the past and recorded negative experiences such as excessive bleeding, weight gain and pregnancies while using contraceptive were less likely to approve of contraceptive provision to unmarried youths.

Table 4.22 Logistic regression analysis between the respondents' experiences while using contraceptives and their approval of contraceptive provision to sexually active unmarried youths

Variable	P value	OR	95%CI	
			Upper	Lower
Positive experience (reference)				
Negative experience	0.00	0.30	0.20	0.50

CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Knowledge of Appropriate contraceptives for unmarried youths

Although the study revealed a good knowledge of contraceptive generally, knowledge of suitable contraceptives for unmarried youths among the respondents was less than average. This could be due to the fact that while parents are educated on the contraceptives to be used by them, they are not exposed to suitable contraceptives for sexually active unmarried youths. This Finding is supported by the result obtained in a study carried out in Osun State by Oyediran et.al. in 2013 which shows that more than half of respondents studied had good knowledge of contraceptives generally. On the other hand, the finding on suitable contraceptives for unmarried youths is supported by result obtained from a study conducted among Chinese parents by Cui et.al. in 2012 which showed a relatively poor contraceptive knowledge among parents with unmarried youths.

Knowledge for instance was consistent with sex, with more female respondents displaying a high knowledge. This could be explained by the fact that more women are exposed to contraceptive messages than their male counterparts. This could also be due to the fact that most of the contraceptive methods available are meant to be used mostly by women. This is consistent to the 2013 NDHS report which shows a higher level of contraceptive knowledge among females when compared to males (NPC/ICF, 2014).

Knowledge of the respondents was also consistent with level of education and occupation of respondents. Respondents who had tertiary education were more likely to have good knowledge of appropriate contraceptives for unmarried youths.

The poor knowledge of appropriate contraceptives for unmarried youths among respondents could be attributed to the lack of discussion of use of contraceptives as an option for the prevention of sexually transmitted infections and unplanned pregnancies. This is supported by a study by Amuyunzu-Nyamongo et.al in 2005 which confirmed that in time past, it was considered a taboo for an adult to discuss sexual matters with youths hence the lack of interest in appropriate contraceptives unmarried youths. The findings in the study conducted by Adeyemo

and Brieger in 1994 affirmed the fact that parents would prefer to discuss other issues such as growth and development rather than discuss issues of contraception.

Furthermore, the Focus Group Discussions showed that the most common form of contraceptives among the participants was male condom. Some FGD participants had knowledge of pills and injectables. This is consistent with the 2013 NDHS report which revealed the male condom as the highest known form of contraceptive.

5.3 The attitude of parents towards the provision and use of contraceptives by unmarried youths

Overall, more than half of the respondents approved of contraceptives use by unmarried youths although a large number were still against the use of contraceptives by unmarried youths. This is in contrast to the study conducted by Briggs in 1998 in which about 79% of the respondents did not favour the use of contraceptives by unmarried youths. This is also in contrast with the study conducted by Oyediran et.al in Osun State in 2013 which showed that 69.3% of respondents had negative attitude towards the provision of contraceptives to unmarried youths. This change in attitude may be attributed to the parental awareness of increasing sexual activities among youths and the need to protect them from sexually transmitted infections and unplanned pregnancies despite the continuous emphasis laid on the need for abstinence. Most of the respondents agreed that there were certain conditions in which they would permit the use of contraceptives by unmarried youths and such conditions include if the youth is sexually active. Others agreed that if the youth has a history of sexually transmitted infections, unplanned pregnancy and abortion and have a child out of wedlock then the youth is permitted to use contraceptives to protect him/her. The finding from this study contradicts that from a study done among mothers with unmarried youths which showed reluctance to approve of contraceptive use by unmarried youths (Senderowitz, Ackerman & Ackerman, 2005).

5.4 Perception of parents about the use of contraceptives by unmarried youths

Parents had various beliefs about the use of contraceptives by unmarried youths. These beliefs vary and in some situations correspond with previous studies done. The study shows that most parents were in support of the provision of comprehensive sexuality education including information on contraceptives although most of them believed that contraceptives should not be used as an approach to solve young people's reproductive health problems. This could also be

attributed to the increasing awareness of risky sexual activities among unmarried youths. Most respondents agreed that contraceptives should be made available to sexually active unmarried youths to prevent sexually transmitted infections and unplanned pregnancies. This is in contrast with studies done by Briggs in 1998, Adeyemo and Brieger in 1994, Foege in 2003 and Oyediran et al., in 2013 which showed parents negative perception about contraceptives and their unwillingness to allow discussions on contraceptives to their unmarried youths. The change in attitudes towards contraceptives use by unmarried youths may also be attributed to the level of enlightenment parents have been exposed to. The rate of sexual activities among unmarried youths is steadily on the increase. Parents have come to realise that as the level of these risky sexual practices increases, youths are more susceptible to sexually transmitted infections such as HIV, unplanned pregnancies and unsafe abortions. Intervention programmes such as CHAMP and Family Matters have led to increased acceptability of the sexuality of youths (Poulsen et.al, 2010; Vanklenhoudt, 2010; Bhana et.al, 2004).

Oronsaye and Okonofua, (2001) showed that many people may opt for abortion rather than use contraceptives. This is because there are misconceptions about contraceptive use. This may also account for the percentage of respondents who are still unwilling to approve of use by unmarried youths. The fears of parents mentioned in the Briggs study were in the findings of this study as parents who did not approve of contraceptive use by youths gave reasons such as approval by parents may lead to sexual promiscuity by youths. Other reasons given included its perceived health implications in the lives of these youths and religious factors.

5.5 Parental Practice as Regards Use of Contraceptives by Self and Youths

Most of the respondents have used one form of contraceptive or another. All who have used contraceptives have had various experiences. The use of contraceptives by parents was considered a factor that might influence the approval of contraceptive use by unmarried youths by parents. The analysis between both variables showed that parents who had previously used or are currently using contraceptives were less likely to approve of contraceptive use by unmarried youths. The study also showed that parents who had recorded negative experiences while using contraceptives were less likely to have positive attitude towards contraceptive use by unmarried youths. This is supported by the research carried out by Kinaro in 2010 as that research showed

that parents who experienced negative side effects while using contraceptives did not support the use of contraceptives by unmarried youths.

Parental discussion on contraceptives with unmarried youths was low although they discussed reproductive health issues with their unmarried youths. As earlier stated, most parents would discuss other issues with their unmarried youths rather than discuss issues of sexuality and contraceptive use with their unmarried youths. This could be explained by the fact that discussions surrounding sexual activities are usually considered culturally unacceptable. This finding is in concord with the findings from a study done in 2005 which showed that although about 50% of parents discussed sexual intercourse and the negative effects of becoming pregnant, only about 20% of parents have ever discussed the idea of contraceptive use with their unmarried children (Swain et.al, 2005). Among all who have discussed sexual reproductive health issues, only about half of them discussed it with their youths one month prior to the study. Although one would expect the level of sexual and reproductive health communication to have increased, there are still gaps in communication between parents and their unmarried children as recorded in this study and supported by a research in 2008 by Izugbara. More males than females reported that they have never discussed reproductive health issues with their unmarried youths. This is attributed to the role played by culture as it is assumed that it is mostly the responsibility of mothers to discuss reproductive health issues with their children especially the female children. This finding is consistent with the study carried out by Wamoyi et.al, (2010) where sexual and reproductive health lessons were most delivered by mothers and rarely by fathers.

5.6 Health Education Implications of findings

The following are the findings from the survey that have several health education implications:

a) Parents have high knowledge of contraceptives in general but most do not know the contraceptives that are suitable for use by unmarried youths. Female parents particularly, had better knowledge than the males.

b) There is a marginally positive attitude by parents towards provision of contraceptives to unmarried youths; however, male parents had more positive attitudinal disposition than females.

health education interventions such as jingles and programmes on mass media on Behavioural Change Communication (BCC) will be effective in bridging the gap in knowledge

Issues to be addressed should include suitable contraceptives for unmarried youths, and especially Emergency Contraceptive Pills and Spermicides; possible effects on young people and of parents having negative attitudes towards contraceptives provision to unmarried youths

Trainings on youth friendly services for health workers will also go a long way to improve the uptake of contraceptives among sexually active youths. On the other hand, parents are more likely to accept information when they are presented by trained health care personnel hence the need to train health care workers on appropriate contraceptives for unmarried youths

Intervention at the community level is a step in the right direction to improve the knowledge of parents on suitable contraceptives for sexually active unmarried youths. Parents in the community should be exposed to health talks and awareness campaigns on contraceptive use by unmarried youths. These health talks and awareness campaigns could be undertaken either by health workers at the LGA health sector and/or parents who are part of the community as other parents are more likely to adopt these behaviours based on the positive experiences of other parents

Structures that exist at the community level should be leveraged upon to promote knowledge on appropriate contraceptives for unmarried youths and parental attitude towards contraceptive usage. Health talks should be provided during community meetings such as youth meetings and town hall meetings among men in the community. Community drama should also be used to promote both knowledge and attitude of parents towards contraceptive use by unmarried youths

The use of community members as role models in the community should also be explored as members of the community are more likely to accept a particular behaviour based on the experiences of other community members

5.2 Conclusions

The role of parents is an important aspect of young peoples' sexuality that cannot be ignored as several studies acknowledge the importance of parental role in addressing the reproductive health needs of unmarried youths. The findings from this study have demonstrated increasing

acceptance of contraceptives by parents for sexually active youths who are unmarried. There are also evidence of increasing sexual and reproductive health discussions between parents and their unmarried children. The role of parents does not end in discussion of reproductive health issues but parents are expected to help sexually active youths make the right decisions which include appropriate contraceptive choices.

5.8 Recommendation

There is need for enlightenment programmes via the mass media to increase the knowledge of parents on appropriate contraceptives for unmarried youths and to dispel myths and misconceptions about contraceptive use.

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APPENDIX I

FOCUS GROUP DISCUSSION GUIDE

Introduction

My name is Uboko Akpesiri, an MPH student in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.

I am carrying out a study on parental knowledge on appropriate contraceptives and their attitude toward its provision to unmarried youths in Ibadan north-east local government area, Nigeria and would like to ask you some questions on the above topic.

Information gotten from this interview session will be treated with utmost confidentiality as no names will be used and will be used for strictly research purposes.

I would like to request your permission to record this session on tape to enable me capture every aspect of this session.

Thank you for your cooperation

SN	MAIN QUESTIONS	FOLLOW UP QUESTIONS
1	What are the health problems that unmarried youths face?	Probe for sexual reproductive health problems if not mentioned
2	What are the factors that promote these problems among young people?	Can poor communication between young people and elders be implicated as a factor that promotes these problems?
3	What are the possible ways of addressing these problems?	Probe for comprehensive sexuality education if not mentioned
4	Are parents actively involved in sexuality education	Probe for parental discussions of reproductive health issues with unmarried youths
5	What are the views of parents concerning the effectiveness of sexuality education?	Should sexuality education include information on contraceptives?
6	What are the contraceptives available and those available to unmarried youths? What are the views of parents concerning the provision of contraceptives to unmarried youths who are sexually active?	Are there beliefs that provision of contraceptives to unmarried youths will serve as a means of addressing the sexual health problems of youths or it may cause these problems to escalate?
7	What are the reproductive health services that are available to youths?	Do these services include provision of contraceptives and information about them? If yes, then what are the types of contraceptives that are available to the unmarried youths?
8	What are the common beliefs about contraceptives use among unmarried youths?	What are the common problems associated with the use of contraceptives?
9	What are the factors that influence parents' attitudes towards the provision of contraceptives to unmarried youths?	Are there factors such as moral values, religious beliefs and cultural norms that may affect parents' views of contraceptives?
10	What are your opinions about the creation of youth friendly centres where young people can assess health services such as contraceptive procurement?	Will these centres help to solve the sexual health problems of unmarried young people?

This discussion is over. Thank you for your cooperation.

APPENDIX 2

QUESTIONNAIRE

PARENTAL KNOWLEDGE ON APPROPRIATE CONTRACEPTIVES AND THEIR ATTITUDE TOWARD ITS PROVISION TO UNMARRIED YOUTHS IN IBADAN NORTH-EAST LOCAL GOVERNMENT AREA, NIGERIA

Introduction

My name is Uboko Akpesiri, an MPH student in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan.

I am carrying out a study on parental knowledge on appropriate contraceptives and their attitude toward its provision to unmarried youths in Ibadan north-east local government area, Nigeria

The findings from this study will be useful in the provision of information on the parental perceives of parents on the provision of contraceptives to unmarried young people

Information obtained from this study will be treated with utmost confidentiality and will be used strictly for research purposes.

Thank you for your cooperation

_____

Signature of respondent

Office Use Only
Interviewer's name: Serial No:_____ Date: _____

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

1. Sex of Respondent: 1. Male 2. Female
2. Marital status: 1. Single 2. Married 3. Divorced 4. Widow 5. Widower
3. Type of marriage 1. Monogamy 2. Polygamy
4. Level of Education: 1. No Schooling 2. Adult Education/Non formal 3. Primary school 4. Secondary school 5. Teacher training 6. NCE/HND/Higher Degree 7. Others (specify)

_____

5. Religion: 1. Islam 2. Christianity 3. Others, specify _____
6. Occupation 1. Teacher 2. Health professional 3. Engineer 4. Artisan 5. Not working 6. Others specify _____
7. Ethnic Group: 1. Igbo 2. Yoruba 3. Hausa 4. Others (specify)_____
8. Number of children _____
9. Number of males _____ Number of females _____
10. Number of children between the ages of 15 and 24 years _____
11. Are these children who are youths currently living with you? 1. Yes 2. No

SECTION B: KNOWLEDGE OF PARENTS ON CONTRACEPTIVES

12. Have you ever heard of contraceptives before? 1. Yes 2. No

Tick all that applies for Question 13

13. If yes, what are your sources of information? 1. Previously taught by parents 2. School 3. Television/Radio 4. Newspapers/magazines 5. Friends 6. Health talks 7. Others (specify)

_____

14. Which of the following contraceptives do you know of?

S/N	Contraceptives	Yes	No
a.	Male condoms		
b.	Female condoms		
c.	Implants		
d.	Emergency contraceptives		
e.	Pills		
f.	Diaphragm		
g.	Injectables		
h.	IUD		
i.	Bilateral tubal ligation		
j.	Vasectomy		
k.	Others, specify		

15. Are you aware of any policy on contraceptives? 1. Yes 2. No

16. Please list the contraceptives which can be used by unmarried youths?

1. _____
2. _____
3. _____
4. _____
5. _____

16a. What are the reasons for your choices? (Tick all that applies)

1. Most effective/no side effect
2. Prevent Unwanted Pregnancy
3. Prevent STIs
4. Prevent HIV/AIDS
5. Others, specify_____

SECTION C: PARENTAL PRACTICE AS REGARDS USE OF CONTRACEPTIVES BY SELF AND YOUTHS

17. Have you ever used any form of contraceptives? 1. Yes 2. No

If No, skip to question 19

17a. If Yes, which one have you used? _____

17b. How would you rate your experience of use of contraceptives? 1. Positive 2. Negative 3. Indifferent

18. Are you currently using any form of contraceptives? 1. Yes 2. No

18a. If yes, which one are you currently using?_____

19. Have you ever discussed issues on reproductive health with your unmarried youth? 1. Yes 2. No

If No, skip to question 22

19a. If yes, did you discuss the use of contraceptives with your unmarried youth?

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20. Did you discuss reproductive health issues with your unmarried youth in the last one month? 1. Yes 2. No

20a. If Yes, how many times? 1. Once 2. Twice 3. Three times 4. Every week

21. If No to question 20, did you discuss reproductive health issues with your unmarried youth in the last six months? 1. Yes 2. No

21a. If yes, how many times? 1. Once 2. Twice 3. Three times 4. Four times

22. Does being a female parent negatively affect your discussions on reproductive health with your youth who is a male? 1. Yes 2. No (Applicable to only female parents)

23. Does being a male parent negatively affect your discussions on reproductive health with your youth who is a female? 1. Yes 2. No (Applicable to only male parents)

SECTION D: ATTITUDE TOWARDS CONTRACEPTIVES

24. Would you approve of your unmarried children who are sexually active to use contraceptives?
1. Yes 2. No

24a. If yes, give reasons

24b. If no, give reasons

25. Should unmarried youths seek parental consent before they are provided contraceptive services? 1. Yes 2. No

25a. If yes, give reasons

25b. If no, give reasons

26. In which of the following conditions would you approve contraceptive use by unmarried youths?

Statement	Yes	No
a. If the youth is sexually active		
b. If the youth has a history of pregnancy/ sexually transmitted infection		
c. If the youth has a history of abortion		
d. If the youth has a child and wants to avoid a repeat		
e. I do not approve under any condition		

To what extent do you agree with the following statements?

	Statement	Agree	Disagree	Undeci
29	Parents are not in the position to provide sex education including information on contraceptives to their unmarried children			
30	Parents should not support the provision of information on contraceptives to youths			
31	Parents should encourage the provision of sexuality education including the provision of information on contraceptives in schools			
32	The reproductive health of young people is not a priority			
33	Parents should encourage the creation of youth friendly centres for easy accessibility of contraceptives by youths			
34	Parents should be informed by service provider if their unmarried children should seek contraceptive service from him/her			
35	Youths can be provided with contraceptives without the consent of their parents			
36	Youths should be provided with information on contraceptives whether they are sexually active or not			

SECTION E: PERCEPTION OF THE EFFECTIVENESS OF CONTRACEPTIVES

SN	STATEMENT	Agree	Disagree	Undecided
35	Sexuality education in schools and at home			

	should include provision of information on contraceptives			
36	Contraceptives are not effective in preventing unwanted pregnancies			
37	Provision of contraceptives should not be used as an approach to solve young people's reproductive health problems			
38	Provision of contraceptives will make young people to become sexually active			
39	Information about contraceptives will not cause young people to indulge in sex			
40	Contraceptives (e.g. condoms and pills, etc.) should not be made available to sexually active youths			
41	Issues on sex and contraceptives are sacred and should not be discussed with unmarried youths			
42	The Media should be encouraged to publicize the use of contraceptive?			
43	Perceived parental approval of contraceptives by youths may increase sexual activities			
44	Youths should have rights to procure or use contraceptives freely.			
45	There should be legislation prohibiting the use of contraceptives by unmarried youths			
46	Unmarried youths seen using contraceptives should be punished			

APPENDIX 3

TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.

All correspondence should be addressed to

the Honourable Commissioner quoting

the Ref. No. AD 13/479

25th September, 2012

The Principal Investigator,
Department of Health Promotion & Education,
College Of Medicine,
University of Ibadan
Ibadan

Attention: Uche Akeaki

Ethical Approval for the Implementation of your Research Proposal in Oyo State

1. This acknowledges the receipt of the corrected version of your Research Proposal titled "Knowledge, Attitude and Perception of Patients in Ibadan North-East Local Government Area on the Provision of Contraceptives to Unmarried Youths

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State Nigeria.

3. Please note that the committee will monitor, closely, and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
MINISTRY OF HEALTH, Ibadan

Signature Date

Director, Planning, Research & Statistics
Research Ethical Review Committee