PREVALENCE AND CORRELATES OF HIV-RELATED RISK BEHAVIOURS AMOUNG OUT-OF-SCHOOL ADOLESCENTS AND YOUTHS IN ILORIN METROPOLIS, NIGERIA

BY

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CERTIFICATION

We the undersigned supervisors certify that the project titled " The Prevalence and Correlates of HIV-Related Risk Behaviour among Out-of-School Adolescents and Youths in Ilorin, kwara state was duly carried out and also meets the regulations governing the award of the degree of M.Sc (Epidemiology & Satistics) of the University of Ibadan. This project was also duly supervised and is therefore approved for its contribution to knowledge and literacy presentation

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DEDICATION

This work is dedicated to my wife and children for their patience and tolerance during the period of writing this project

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ACRONYMS

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immunodeficiency Virus

STIs: Sexually Transmitted Infection

FGD Focus Group Discussion

LGA: Local Government Area.

PHC: Primary Health Care

TRA: Theory of Reasoned Action

IUCDs: Intrauterine Contraceptive Devices

OCPs: Oral Contraceptive Pills

DEFINITION OF TERMS

For the purpose of this study the following terms were used

Adolescent: Is a person whose age is between 10-19 years. It is also the period of transition from childhood to adulthood

Youth: Is a person whose age is between 15-24years. It is important to note that youth age overlaps that of adolescent

Sexually Active: This describes adolescents and youths who had sex within the preceding four weeks to the study

Sexual Intercourse: Means heterosexual vaginal penetration

Sexual Experience: Refers to ever having sexual intercourse

High –risk sexual Behaviour: Means sexual intercourse with casual and/or commercial partners without regular use of condom

HIV-related risk Behaviour: Behaviour that increases the risk of contracting HIV

Casual Sex: Sexual relationship that is not more than one contact with an acquaintance or unknown partner.

Multiple sexual relationship: Sexual relationship with more than one partner.

Knowledge: It is a state of being informed about a particular thing,situation,events person or concept.It is preceded by awareness Awareness or familiarity gained by experience of a person, fact or thing. It also means those items of fact and procedures by

which individuals learn what to do in a given situation and why it is done to make the procedure meaningful, in so far as it is understood

Behaviour: A known pattern of belief and attitude of an individual, group or population as expressed and related to a concept or event. It also means any activities of a human being that can be observed directly by others

Attitude: This is an organized and a consistent manner of thinking, feeling, belief and reacting with regards to people, groups, social issues or more generally any event in ones environment. It also means the tendency to take or not to take a particular health action (s) e.g. emotion, values

Perception: It is an interpretation, expressions and meanings given a message, symbol, concept or idea as related to past, current, prospective events or experiences.

Practice: This is a process of putting ideas into action as dictated by rules either from the society, culture or religion.

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SUMMARY

In order to implement effective preventive measures for the control of HIV/AIDS, there is need for more information on the perception, attitude and knowledge of AIDS and the HIV risk behaviours of adolescents and youths. This descriptive cross-sectional study was carried out among 315 randomly selected adolescents and youths between 10-24 years of age in Ilorin Metropolis in order to determine the prevalence and correlates of HIV risk behaviours. A structured questionnaire was used to collect data over a period of four months (Jan–April, 2004). Focus Group Discussion was also carried out to complement the information obtained from the questionnaire.

Most of the respondents were 15-19 years old (47.6%) from polygamous family (62.5%) of low socio economic status and 47.6% had completed secondary school. More than two-thirds (74.3%) were aware of AIDS. The major source of information was from friends (36.5%). Only 58.4% knew that AIDS can be transmitted through sexual intercourse and 14.9% knew virus to be a causative agent. About a quarter (24.4%) said AIDS was due to wrath of God while 34.4% had no idea. Two hundred and thirty five (74.6%) were sexually active, and of this, 66.4% had multiple partners and only 38.1% always practiced the use of condom during sexual intercourse. "Decreased pleasure" (35.8%) was the main reason for not using condoms. There is a correlation between positive attitude towards condom use and frequency of use ($p<0.05$). There was also a significant relationship between social class and frequency of sexual intercourse ($p<0.05$).

There was no statistical significant relationship between education status and sexual behaviour. About one quarter (25.9%) of respondents admitted history of abortion and about half of respondents (52,4% males and 65.1% females) are currently using a contraceptive method. The condom and oral contraceptive pills were commonly used contraceptives in males (72.2%) and females (47.1%) respectively. Lack of knowledge and shame were the reasons given by 22.4% males and 32.5%females respectively for not using condoms. Respondents on drugs and alcohol were 62.2% and 66.8% respectively with 4.3 % and 20.2% under the influence of alcohol and drugs respectively during sexual intercourse. There was a correlation between gender, drug and alcohol use. The relationship between gender and alcohol use in influencing sexual intercourse is statistically significant ($p<0.05$) but no significant relationship between gender and drug use in influencing sexual intercourse ($p>0.005$). The prevalence of tattooing and scarification in this study was 13.3% and 16.8% respectively. This study re-echoes the urgent need for intensive sex education for out-of-school adolescents and youth due to poor knowledge about sex education shown by respondents during focus group discussion. In addition there is need for increased communication between parents and their children concerning sex education as revealed by report of focus group discussion. Education of parents is also recommended in order to overcome the cultural barriers that discourage parents from providing sex education to their children at home. The prevailing poor economic conditions in the country make the female adolescents and youths vulnerable to sexual exploitation and in turn to HIV infection.

Female empowerment will help to reduce this risk. Moral decadence and decreased parental care are noticed through FGD in this study to increase the susceptibility of respondents to taking risks. The findings from this study would be useful for designing health education interventions outside the school environment and for behavioural surveillance of adolescents and youths. A peer-education intervention with government support for adolescent and youth sexual education and sexuality will help in reducing the risk of HIV among out-of school adolescents and youths. There is also an urgent need to promote AIDS campaign among out-of-school adolescents and youths because of limited knowledge on HIV and high-risk behaviours practiced.

CHAPTER ONE – INTRODUCTION

1.1 Background Information: Acquired Immunodeficiency Syndrome (AIDS) is presently the greatest health problem challenging science and mankind. Unfortunately, it may remain so for a long time unless there is a scientific break through in its therapy as well as serious behavioural modification and changes. At the end of 2001, an about 40 million people globally were living with HIV/AIDS, number of deaths was estimated to be 3 million and about 5 million were newly infected with the virus, while over 15,000 new HIV infections occur every day, globally. In many parts of developing world, the majority of new infections occur in young adults, with women being the most vulnerable (Salako, 2003). About one third of those currently living with HIV/AIDS are aged 15-24 years. Regional HIV/AIDS statistics by the end of 2001 revealed that 70.3%, or 281, million of adults and children living with HIV/AIDS are from Sub-Saharan Africa (Population report Series, 2001and National HIV/AIDS Data base, 1999). HIV prevalence in Nigeria has been increasing at an alarming rate. National prevalence rate was found to increase from 1.8% in 1991 to 4.5% in 1996. In 1999, HIV prevalence in Antenatal clinic attendees was 5.4% and rose to 5.8% in year 2001(FMOH, 2001).

For most people, adolescence is a time of experimentation and sexual initiation. The World Health Organization (WHO) defines an adolescent as a person in the age group of 10-19 years (WHO, 1989). Adolescence is characterized by rapid rate of physical growth and development with the attainment of secondary sexual characteristics occurring under the influence of sex hormones. Social, cultural, economic and individual factors contribute to

increased risk and vulnerability among young people to HIV. Knowledge about habits and practices prevalent among adolescent and youth is important because it provides a basis for planning preventive strategies, evaluating ongoing interventions, and undertaking epidemiologic surveillance. In most countries of the developing world, only a small proportion of young people infected with HIV know they are HIV-positive. Symptoms of AIDS may not emerge until 3-15 years after initial infection, and may not be recognized or officially reported.

1.2 Statement of the Problem: Adolescence is a period that has come to be regarded as a period of intense sexual drive, including experimentation with sex and drugs . Adolescents, therefore, are a vulnerable group at risk of contracting HIV/AIDS. Indeed, the first case of HIV/AIDS reported in Nigeria in 1984 was in a sexually active 13-year old girl. Adolescent sexual activity is increasing globally with a trend towards early onset (Odujirin, 1989). In developing countries, factors such as early onset of menarche, changing values due to increasing urbanization, exposure to foreign cultures through migration, tourism and mass media, erosion of traditional norms and values, peer influence and lack of parental control have been implicated (Odujirin, 1989). An important HIV related risk behaviour found to increase incidence of HIV/AIDS among adolescents is sexual experimentation. More than 20% of secondary girls in Nigeria are sexually active, or have had sexual relationship at least once (Okpani & Okpani, 2000).

The spread of HIV/AIDS among adolescents is a growing public concern world wide, but more especially in Sub –Saharan Africa countries. It is one of the unfavourable outcomes of adolescent sexual activity. One of the consequences of sexual activity is unwanted pregnancy and its following sequelae of abortion. In Nigeria, abortion is illegal; therefore

most abortions are usually done by 'quacks' (Wada, 2000). Induced abortion by quarks and its outcomes are of enormous burden to the family and society because of devastating complication like HIVAIDS.Sexual risk behaviours, such as sex under the influence of drugs and alcohol occur among adolescents in Nigeria. A recent survey among high students in Japan 0.4% had ever used marijuana, 0.45% amphetamines, and 1.3% solvents (Wada, 2000).

The HIV/AIDS epidemic continues to grow in Nigeria. Sentinel surveillance among antenatal clinic attendees' shows a nearly fourfold rise in HIV prevalence from 1992 to 1999 (FMOH, 1997). An estimated 170,000 persons (adolescent inclusive) died of AIDS in Nigeria in 2001, living behind about one million orphans (UNAIDS, 2001). HIV also disproportionately affects young adults. In a study of sexually transmitted disease (STD) clinic attendees in Ibadan, Ekwezor and colleagues found that persons aged 21-30 years accounted for 65% of cases of HIV infection; many of this individual probably became infected in adolescence (Ekweosor et al, 1995). Adolescents engaging in sex, because of their low use of condoms, are at high risk of contracting STIs including HIV. It is estimated that about one in twenty adolescents worldwide contracts an STI yearly (Henry, 1993). Young people aged between 10-24 years account for about 30% of the world's population- about 1.7 billion people in total. However, they are by no means a homogeneous group. At the lower end of the age range, consist of pre-teenage girls and boys most of whom are not yet sexually active. At the upper end, consist of those physically and sexually active for several years and in some cases many have children of their own.

There is also enormous diversity among young people of the same age, depending on the individual's level of physical, physiological and sexual development. Factors such as economic circumstances, family situation, religious beliefs, cultural background and education also contribute to differences observed. One feature common to young people in many parts of the world, however, is their potential vulnerability to HIV and other sexually transmitted infections. In most parts of the world, mid or late adolescence is a period of risk taking, often with little regard for possible consequences. It is also the time when most people have their first sexual experiences-either within or outside of marriage. In many developing countries young men and women are becoming physically and sexually mature at a younger age than in the past. At the same time traditional taboos against pre-marital sex are breaking down. One consequence of these changes is that more young people are becoming involved in pre-marital sex, usually without using any form of contraception. In Nigeria, the average age of first sexual intercourse for girls is 16 years, but this figure conceals wide variations, for example many young people especially girls are initiated into sex even earlier. A study of young women in Southeast Nigeria in1992, for example, found that 44% were sexually active before the age of 17, and 80% were sexually active before the age of 20years (Fawole et al, 1999)

Apart from widespread sexual activity, many young people in Sub-Saharan Africa are poorly informed about the basic facts on reproduction. Many unmarried young women become pregnant and resort to illegally induced abortion, with all the attendant health risks- in order to terminate the pregnancy. Researchers in Tanzania found that 71% of patients admitted to public hospitals for complications following abortions were teenager.

1.3 <u>Rationale and Justification:</u> The rationale for this study include among others:

1.To understand the risk behaviours that are peculiar to out-of-school adolescents and youths in Ilorin. Premarital sexual activity of adolescents and youths is associated with increasingly evident reproductive health problems. First, sexual activity outside marriage and multi-partnership are closely associated with STIs including HIV. Second, pregnancies that occur in an unstable, socially disapproved sexual union may lead females to seek abortion, which is often performed under unsafe conditions. In such a context, more research is needed to gain better insights into HIV related risk behaviour among adolescents and youths

2.To document the knowledge, attitude and practice of these adolescent and youths concerning risky behavious ,

3.To help plan intervention programmes to improve knowledge, influence attitudes and encourage safe sexual practices. The AIDS epidemic has made it necessary to inform and educate young people about sexual health and AIDS prevention. This is aimed at increasing their knowledge and skills, to adopt and maintain desirable behaviour that can virtually eliminate their risk of becoming infected with human immunodeficiency virus. Knowledge about HIV – related habits and practices prevalent among adolescents and youths is important from the public health point of view since it provides solid basis for structuring preventive strategies.

The 10-to 19- year age group accounts for approximately one fourth of Nigeria's population (UNAIDS, 2001). Personal observation has shown that many adolescents participate in risky sexual practices, including unprotected sex with multiple partners. The report of a study by Araoye and Adegoke (1996), is in support of this observation.

Such practices and other HIV- Related risky behaviour deserve to be identified, properly studied and documented. Though alot of studies on adolescents had been carried but an in-depth study of this nature is yet to be undertaken in the study area. It is hoped that the result of this study will influence policy makers to take action on adolescent HIV – related risky behaviour as well as instituting HIV/AIDS preventive strategies for adolescents.

This study is also being carried to explore the feasibility of conducting HIV prevention programmes among the Out-of- school adolescents and youths in Ilorin Metropolis.. Furthermore, adolescents and youths have not been targeted for HIV/AIDS control in Ilorin Metropolis except the general campaigns by National AIDS and STIs control programme. With all these adolescents and youths justify being study as a priority group for HIV/AIDS control. This study intends to proffer solutions to help reduce adolescents and youths sexual risk behaviour and improve reproductive health. The adolescents and youths perceived HIV-related risk behaviour as well as their own reproductive health education needs will be documented. The risk-reduction needs of adolescents and youths will be identified and focused health education approaches utilized.

1.4 OBJECTIVES:

Broad Objective: The goal of this study is to document information about the correlates and prevalence of HIV-Related risk bevaviour among out-of-school school adolescents and youths in Ilorin Metropolis

Specific Objectives:

1.To assess the level of Knowledge and attitudes of adolescents on transmission and prevention of HIV/AIDS

2.To identify HIV/AIDS high-risk behaviours practiced by adolescents and youths

3.To determine the prevalence of HIV-related risk behaviours such as sexual intercourse without use of condom and abortion among adolescents and youths

4.To describe the social demographic characteristics of adolescents and youths.

5.To document factors promoting HIV/AIDS risky behaviours in adolescents and youths

6. Based on the above recommendations would be made for HIV prevention programmes for out-of-school adolescents and youths.

1.5. HYPOTHESES.

1.Adolescents and Youths knowledge of transmission and prevention of HIV/AIDS does not influence their behahiour.

2.Adolescents and Youths attitude to HIV does not influence their practices of HIV/AIDS-related risky behaviour.

3.HIV/AIDs related risky behaviour is not prevalent among adolescents and youths.

4.Socio-demographic characteristics of adolescents and youthshave influence on their HIV/AIDS related risky behaviour

5.There are no factors that promote or militate against HIV/AIDS risky behaviour among adolescents and youths

CHAPTER TWO – LITTERATURE REVIEW

2.1 Clinico-epidemiological patterns of HIV/AIDS: Human

immunodeficiency virus (HIV) infection is now pandemic and the clinical disease acquired immune deficiency syndrome (AIDS) is now occurring in many parts of tropical Africa. . Studies show that there are important regional differences in the epidemiology of the infection (Quinn et al, 1986). For example the major route of transimission in an African population is through heterosexual contact (Sewankambo et al, 1987), while in Europe and the United States of America, it is homosexual contact (Melbye et al, 1984). In addition to this, in Europe and America, the prevalence of HIV infection in heterosexual populations is relatively low but in some African cities it is over 10% (Whittington et al, 1986). Another important observation is the very rapid spread of AIDS in sub-Saharan Africa especially in East and Central Africa and some parts of West-Africa (Biggar, 1986). Of the 6.11 billion of the world population in 1999 (World Bank, 1994), 40 million people were living with HIV by the end of the year 2001 (Agnew, 2002). AIDS disproportionately burdened Sub-Saharan African to the tune of 28 million people (Agnew, 2002). Prostitution, transfusion with infected blood and use of unsterilised needles and unsterilised sharp objects were found to be responsible for the spread of HIV infection in this region (Piot et al, 1992)

Of the Nigerian population of 130 million (World Bank, 1994), 3.5 million people aged between 15-49 years were found by to be living with HIV/AIDS (FMOH, 2001). The National prevalence has been increasing from 1.8% in 1991 to 4.5% in 1996, 5.4% in 1999 and 5.8% in 2001 (FMOH, 2001). Presently, Nigeria's HIV prevalence rate is one

of the highest in West Africa, second only to Ivory Coast with a prevalence rate of 9.7% (UNAIDS, 2002). As a result of its large population size, Nigeria has the fourth highest number of HIV infected people in the world, behind South Africa, India and Ethopia (UNAIDS, 2002). Factors, which may influence the spread of HIV infection, include poor socio-economic conditions, urbanization and migration, the stage of the HIV pandemic in the population and the societal response to the epidemic (Wapel, 1998).

2.2 Adolescent behavioural risk factors and Vulnerability to HIV/AIDS:

Today's adolescents and youths were born within HIV/AIDS era. They have never known a world without HIV/AIDS. Millions already have died. Yet HIV/AIDS epidemic among adolescents remains largely, invisible to adults and to young people themselves. Therefore, reducing or even stopping HIV/AIDS requires comprehensive strategies focusing on adolescents.

A risk factor is an aspect of personal behaviour or life style, an environmental exposure or an inborn or inherent characteristic, which on the basis of epidemiological evidence is known to be associated with health- related condition(s) considered important to prevent (Last, 1998). Risk factor can also be defined as attribute such as habit (e.g. cigarette smoking) that leads individual concerned to have a likelihood of developing an illness such as lung cancer (Erinoso et al, 1982). Some risk factors are modifiable while others are not. Modifiable risk factors amenable to intervention include smoking, sexual behaviour and physical activity while the unmodifiable risk factors that are not subject to change include age, race and sex (Erinoso et al. 1982).

Behavioral risk factor is a characteristic, or a pattern of belief and attitude of an individual, group or population that is associated with increased probability of a specified

outcome (Last, 1998). One of the principles of health education states that all health and disease states of which there is a reasonable etiology have behavioural component (Thior et al, 1997). According to Uwakwe (1988), adolescence, is probably the most challenging and tasking phase in the developmental process of human being. These challenges, which are often traumatic to most people from the fact that young males and females are faced with the task of biological, sexual, and physical maturity as well as adult society induced demand for emotional stability. Each of these invariable processes of maturation is independent of personal control of the adolescent, which may often result in conflicts that the younger may attempt to resolve by engaging in inappropriate and socially undesirable pattern of behaviour. One of such is risk-taking, especially on sexual intercourse. Sexual practice in which male or female has more than one partner is a common phenomenon all over the world. A study done among the adolescent girls in Benin- City (Nigeria) showed that 35 % had multiple sexual partners (Unigbe, 1999). In many cultures the premium placed on having children often leads to children marriages. Among the Nigerian Fulanis, girls are allowed great deal of sexual freedom since no value is attached to virginity. Hrdy (1982) reports that girls as young as 10years are given to older man in marriage to cement friendship and economic ties in between families. When girls are married to older men they can be vulnerable to STI- HIV infections, because their husbands usually have already had a number of sexual partners.

Cultural rites of passage from childhood into adulthood, although traditionally serving to cultural values and unite communities can increase the risk of HIV. For example, traditional male or female circumcisions are sometimes carried out using unsterilised equipments. In some Africa communities, circumcision ceremonies often are

accompanied by post-initiation sexual experimentation, which increases risk. For example among the Massi of East Africa, the relationship among male peers is so close that after circumcision the initiated ones share wives and girlfriends (Population Report, 2001).

The risk of becoming infected with STIs/AIDS during unprotected sex is four times greater for a woman (Oyewo, 2001). Male to female transmission is more likely because during vaginal intercourse, a woman has a larger surface of her genital tract exposed to her male partner sexual secretion than does a man. Also HIV concentrate is generally higher in man semen than in a woman sexual secretion. Adolescent women are even in greater risk than adult women (Oyewo, 2001). The vaginal and cervix of young women are less mature and less resistance to HIV and other STIs, such as chylamidia, syphilis and gonorrhea. Changes in the reproductive tract during puberty make the tissue more susceptible to penetration to HIV. Also, hormonal changes associated with the menstrual cycle often are accompanied with t a thinning of the mucus plugs which is the protective scalant covering the cervix. Such thinning can allow HIV and other STIs to pass more easily. Furthermore, adolescent females produce secretions, providing little barrier to HIV transmission.

Injection of drugs with needles contaminated with HIV plays a key role in spreading AIDS among young people, especially young men (Uwakwe, 1991). Many injection drug users are young (Uwakwe, 1991). The average for commencing drug use dropped as the supply of illicit drugs grows. For example, in the United States of America the highest users of illicit drug are among people ages 18-20 years (Oyewo, 2001). It has also been observed that use of non-injectable recreational drugs like marijuana, alcohol and cocaine

made it psychologically easier to engage in prostitution (Estebanez et al, 1993).

Excessive consumption of alcohol, cannabis and cocaine use were all associated with high-risk sexual behaviour (Castilla et al, 1999). Immunusupression occurs with a high level of alcohol consumption and use of other drugs, thus, further increasing susceptibility to HIV infection (Estbanez et al 1993,).

Extent of communication with family members and friends is an important factor in sexual risk taking among Nigerian adolescents (Karofsky et al, 2000). Many studies among adolescents in U.S. have shown that communication with parents and other family members on sex and reproduction is protective against sexual risk taking behaviours (Karofsky et al). However, others, have found that such communications are a risk factor, and others have found no association with such behaviours (Casper, 1990). Parental influence on adolescent sexual risk-taking behaviours may be supplemented by the influence of young people's best friends (Bearman and Brucker, 1999). Adolescents are vulnerable to influence by peers, and review of literature indicate that peer bhaviours have both positive and negative influences (Bosompra, 2001). Youth who perceived that their friends were sexually active were more likely to be sexually experienced than were youth who thought their friends had not yet initiated intercourse. This observation/finding was larger among females than for males (Ali et al, 2003). Females who perceived that that their friends were sexually experienced had been found to have elevated odds of having multiple partners. Having a sister who had become pregnant pre-maritally has been found to be associated with increased likelihood of been sexually initiated and with a greater number of lifetime sexual partners among males. Furthermore, friends opinion was found to be associated with the likelihood of initiated intercourse among males (Ali

et al, 2003). In contrast, the U.S study revealed that females are more susceptible to peer influences than males (Bearman and Brucker, 1999).

A number of studies have reported a relationship between stereotypic, male-dominant gender role perceptions and risk taking behaviours (Foshee and Bauman, 1992). Gender role perceptions are important in Nigeria context; research in many sub-Saharan African settings has revealed substantial gender inequalities in power within sexual relationships (Agha , 1998). A number of observers have called for priority to be given to influencing male attitudes and behaviours in adolescent health interventions (Agha , 1998).

Partner communication, which in some ways is also related to self-efficacy, pertains to the practice of discussing reproductive health risks- e.g. pregnancy and sexually transmitted infections (STIs)- and negotiating sex and contraceptive use with sexual partners. In the United States of America, programmes that have emphasized specific skills, such as partner communication or negotiating skills, have tended to be more effective than programmes that stress general knowledge (Kirby, 2001). However, although such skills are receiving increasing attention in sexuality education and life skills training efforts in much of the world, relatively few studies have documented the impact of partner communication on sexual and contraceptive behaviours (Ali, 2003).

2.3 Factors that Influence HIV-Related Risky Behaviour: Social and economic issues have aided the spread of HIV/AIDS. For example poor social acceptance of condom and abstinence has aided the spread of STIs/HIV. This is particularly common among the adolescents and youths. Poverty coupled with low literacy rates; urbanization and migration are social factors contributing to increase in adolescent prostitution, and invariably widened the spread of HIV. Low literacy rate limits the access of most

adolescents to information on HIV while migration of people from one region to another increases the spread. A study by Decosas (1996), showed that migration from other West African States to Cote d,Ivoire was responsible for high prevalence of adolescent prostitution and HIV in that country.

2.4 Gender difference in Adolescent sexual activity: Literature on sexual behaviour indicates that male and female adolescents exhibit different pattern of sexual behaviour. Adolescent males and females have different interests, motivations and strategies for engaging in premarital sexual relationships (Calves et al, 1996). Adolescent females enter into sexual relationships for various reasons including the enhancement of prospects of marriage (Koussidji and Muller, 1983), prove fertility (Meekers, 1994), and for financial gain (Dinan, 1993). Adolescent males on the other hand are more likely to engage in sexual relationships before marriage for sexual experience and sexual satisfaction. Having multiple partners is often a means for adolescent males to gain social status and respect from their peers (Calves et al, 1996). As a result of these differences; adolescent males and females are exposed to reproductive health risks and different STIs including HIV/AIDS. Also, sexual activity among adolescents may be affected by the family environment and the example set by parents and older siblings, exposure to the media and peer pressure in school (Calves et al, 1996).

2.5 Sexuality and Contraceptive use: Adolescents are usually not targeted for family planning programmes and their use of contraceptive is low in Nigeria (Population Reference Bureau, 1992). Only 11% of single sexually active young women aged

between 15-19years used modern contraceptive methods. Twenty two percent used traditional methods such as rhythm and withdrawal. These rates are much lower than in the industrialized countries, where 58% of adolescents in the United States, and up to 90% in Sweden, used contraceptive methods (Population Reference Bureau, 1992). In general, adolescents sexuality is characterized by low contraceptive use at first sexual intercourse and overall lack or inconsistent use of contraception (Buga et al, 1996).

Results of studies have shown that a large proportion of teenagers who are sexually active use birth control only occasionally or not at all (Abdool Karim et al, 1992). The consequences of teenage sexual behaviour in Africa are high rates of adolescent unwanted pregnancies, abortions and STIs, which increase the risk of HIV infection (Brabin et al, 1995; Kapiga et al, 1992).

2.6 Heath consequences of Adolescent Sexual Activity: Sexual activity of young men and women is associated with important reproductive health risks. Maternal mortality and pregnancy-related complications occur disproportionately at early ages and at first deliveries. Very young mothers, especially those below 15years old are at higher risk of pregnancy related complications such as haemorrhage, obstructed labour, fistulas and eclampsia than those above (National Research Council, 1993). Such reproductive health problems stem from the mother's physiological immaturity. Other negative health consequences arise from social condemnation of the context in which pregnancy takes place. For example, in a context in which premarital pregnancy is not always welcomed, especially when it terminates a girl's education, abortions are on the increase (Coeytaux, 1988). In Cameroon, it is estimated that 18% of all adolescent pregnancies are terminated through abortion (Leke, 1990). Abortions are particularly dangerous to young single

women because they are more likely to resort to unsafe illegal or self-induced abortions. They also tend to postpone abortion longer than older women. This is as a result of financial problems and fears about a lack of confidentiality (Odujirin, 1991). Complications resulting from abortion are multiple and include perforation of the uterus, bladder, haemorrhage and sometimes death (Leke, 1989). In Cameroun, 32% of emergency hospital admission (for adolescents and youths) at the principal maternity hospital for obstetric complications is due to abortion-related issues (Leke, 1989). Extra-marital sexual activity and multi-partnership are also closely associated with sexually transmitted diseases including HIV. AIDS studies in three African countries estimate that women aged between 15-25 years account for 70% of the 3000 women who contract HIV every day, and of the 500 who die from it (Reid and Bailey, 1993).

2.7 Interventions to Increase HIV /AIDS Knowledge, Attitudes and Sexual Behaviour:

The effectiveness of peer education among adolescents and youths may be due to their belief in their peer. At this stage in their life they find it difficult to trust, communicate with adults (Sloane and Zimmer, 1993). Hence, they turn to their peers as important and credible source of information especially in areas such as human sexuality, drugs and alcohol (Edelstein and Gonyer,1993). They may also seek information from magazines, newspapers and movies (Azuzu, 1994). Seeking information from uninformed sources place youth at health risks. Thus, to protect these groups, utilization of peer educators have been utilized and found useful (WHO, 1998). Protective factors that help adolescents reduce high-risk behaviours such as unprotected sex and using drugs (UNAIDS / WHO Documents, 2003). These protective factors include

- Positive relationships with parents, teachers and other adults in the community
- Feeling valued by their peers and society
- Positive school environments
- Exposure to positive values, rules and expectations
- Having spiritual beliefs and goals
- A sense of hope for the future

A recent study in Zimbabwe, for example, showed that being a member of a well – run community youth group reduces a young woman's risk of contracting HIV (UNAIDS/WHO Documents, 2003).

For many young people, the most obvious obstacle to their sexual and reproductive health is the lack of accurate information. Many parents, teachers, community and religious leaders in Sub-Saharan Africa and in many parts of the world feel that withholding information about sex from young people will discourage them from becoming sexually active at an early age. This view does not stand up to scientific test (UNAIDS/WHO Documents, 2003). Indeed numerous studies in different parts of the world have found no convincing evidence to support the belief that sexuality education increases sexual experimentation among young people (UNAIDS/WHO Documents, 2003). Rather, education about sex generally leads to initiation of sexual intercourse at a later age and to safer sexual behaviour, such as the effective use of contraceptives (UNAIDS/WHO Documents, 2003).

2.8 Contraceptive methods for Adolescents: Adolescents are usually not targeted for family planning programmes and use of contraceptives is low in Nigeria. In 1990, the Demographic Health surveys (FMOH, 1990) found that only eleven percent

(11%) of single, sexually active women aged 15-19 years used modern methods, and twenty-two (22%) used traditional methods (rhythm and withdrawal). These rates are much more than in the industrialized countries, where 58% of adolescents in the US, and up to 90% in Sweden use contraceptive methods (Population Reference Bureau). In developing countries, available information reveals that the percentage of sexually active adolescents using contraceptives is small (Nigerian Demographic and Health Survey, 1992; Adetoro and Anate, 1988). There is no contraceptive, which is completely safe, effective, reversible, easy to obtain, simple and convenient with minimal planning and motivation (Anate, 1993) Planning and motivation are particularly important factors for most unmarried adolescents. Similarly, no single method of contraception exists today, which is best for adolescents. Available contraceptive methods are:

1.***Rhythm Method*** (Safe period or periodic Abstinence): Many adolescents that wish to avoid unwanted pregnancy reportedly practice this method. Unless it is carefully practiced using calendar, billings and temperature methods, rhythm is an ineffective method of birth control. This is because of difficulty in predicting precisely when ovulation will occur to abstain from sex. Also many sexually active adolescents are ignorant of the theoretical safe period (Anate, 1993).

2. ***Coitus Interuptus***: This method of birth control is unreliable and may be difficult to practice for adolescents and youths who are sexually inexperienced (Anate, 1993). Despite this, coitus interuptus is useful because it does not require preparation and is useful in unplanned intercourse. However, the method must be timely and complete to avoid semen deposition into or too close to the vagina.

3.*Oral contraceptive:* This is the most effective contraceptive method for the sexually active adolescent girls without medical contraindications and who are sufficiently motivated. However, young or unmarried girls who have irregular intercourse may use the pill ineffectively (Cole et al, 1975). The major problem associated with oral contraceptive use by adolescents is the non-compliance of daily pill taking. It has been found that adolescents, particularly unmarried girls having infrequent sexual activity, are often unable or unwilling to use the pill regularly for long period of time (Adetoro and Anate, 1988).

4. *Intrauterine Contraceptive Devices (IUCDs)*: Intrauterine contraceptive Devices (IUCDs) like copper-T and Copper 7 can be effective for many adolescent girls. Such devices are recommended for girls with poor motivation (Adetoro and Anate,1988). Several studies of adolescent girls reveal a lower pregnancy rate with IUCDs use than with the use of pills. This is because of the inconsistency in taking pills (Hunt, 1976; Edwards et al, 1974). Traditionally, the IUCD is often considered more appropriate for nulligravida. Higher rates of expulsion and pain following insertion have been reported in such young nulligravida (Hunt, 1976; Edwards et al, 1974). Newer devices like Copper-7 and Copper-T have been used successfully in nulligravida adolescents with low expulsion rates and fewer removals for pain or bleeding (Edwards et al, 1974).

5.*Diaphragms*: These are difficult for many adolescent girls to use but when used with spermicides, they require planning and preparation for each intercourse, skill in insertion and facilities for washing and storing them (Anate, 1993). Some girls may find it difficult to insert and remove the diaphragm. Femshield, when it becomes more readily available may be more acceptable to adolescents.

6 *Postcoital Contraception*: This may be useful in emergency situation like rape and for girls who have irregular intercourse (Anate, 1993). Treatment with hormones or IUCD insertion is necessary soon after the intercourse (within 24-48 hours). In rural areas lacking medical facilities, this method may be difficult to obtain and is not widely available in most developing countries.

7.*Condoms*: These are widely used by young people as contraceptives, and are suitable for unmarried adolescents and youths. Sexually active adolescents and youths engaging in sex, because of their low use of condoms, are at high risk of contracting STIs/AIDS. It is estimated that about one in twenty adolescents worldwide contracts an STI yearly (Henry, 1993). Furthermore, the presence of certain STIs (especially those with ulcerative lesions) has been identified as risk factor for HIV (Jessamine et al, 1990).

2.9 Abortion in Adolescents: It has been reported that adolescents tend to present themselves for abortion when the pregnancy is advanced and requires relatively more complicated termination procedures and that the younger the girl, the more advanced the pregnancy before seeking termination (Briggs, 1992; Anate, 1986). According to Anate (1993), the reasons for late presentation may be due to combination of factors such as:

a. Inexperience of the young in recognizing pregnancy possibly due to the irregularity of menses at this reproductive age

b. Unwillingness to accept the situation and seek prompt treatment

c. Ignorance concerning the sources of advice and help

d. Hesitation to confide in adults and obtain guidance

e. Lack of economic sources to pay for abortion services

f. Laws that do not allow adolescents to obtain medical services without parental consent

g. The use of pregnancy as a bait for and getting married to the male partner.

In countries where abortion is legalized, the total abortions performed on adolescent girls have increased (Anate, 1993). More than a third of single girls treated for abortion at a Bangkok Hospital from 1968-1974 were under 20 years, while a five year review of women treated for abortion at a Nigerian Hospital (Akingba, 1972) found that over 90% were single, mostly adolescents. Illegal abortion is common in developing countries (Anate, 1986) because these countries have refused to legalise abortion despite the high incidence of unwanted pregnancy and the clients find it easier and possibly cheaper to obtain such abortions with quacks.

2.10 Health Belief Model: According to Rsentock (1974), the health belief model offers a framework for understanding young people's willingness to undertake preventive health action against HIV/AIDS. This model assumes that the perception and knowledge of people about a particular subject such as HIV/AIDS are critical determinant of their health–related behaviour. It further holds that intervention such as information from peer

educators and drama have better prospect of improving their understanding. For example the use of condom during each sexual activity is dependent upon an individual's view of his own vulnerability to HIV/AIDS, belief about severity of the infection, perception of the benefits of recommended action to reduce level of threat or vulnerability and evaluation of potential barriers associated with the proposed action compared with its potential benefits.

The Theory of Reasoned Action assumes that an individual's behaviour is under volitional control and can be predicted from intention (Adedoyin and Adegoke, 1995). According to this model, the intention of an individual to perform behaviour is based on his positive or negative assessment of the performance of such behaviour. It further proposes that different external variables influence intention, normative belief, motivation to comply, or the relative weights of the attitudinal and normative components. Demographic variables (age, sex, occupation, socio economic status, religion and education) and personality traits can influence the relative importance of the two components (attitudinal and normative).

The erosion of the traditional African values, which places emphasis on chastity and encourages marriage at an early age, especially for girls, including the adoption of western cultures, which has a more permissive attitude to sexual matters (Adedoyin and Adegoke,1995), have contributed to the more liberal attitude to sex and increased sexual activity by Nigerian adolescents. This increased sexuality is confirmed by by Olayinka and Osho (1997), who found Nigerian adolescents to be sexually active and at an early age, and to have multiple partners.

3.0 CHAPTER THREE: METHODS

3.1 The setting and study population: The setting for the study was Ilorin Metropolis, the capital of Kwara State. It is located in the middle belt area of Nigeria. Ilorin Metropolis is bordered by three local government area namely Ilorin West, East, South with head quarters at Oja- Oba, Oke- Oyi and Fufu respectively. The current population of Ilorin is about 940, 000 based on 1991 population census projected figures. The identified occupations of the people in Ilorin metropolis are civil service, trade, and skilled and unskilled labour. Islam and Christianity are the two most practicing religions with Yoruba as the main ethnic group. Other ethnic minorities are Hausa, Fulani, Nupe, and Igbo. There are fifty-three public secondary schools and seven private secondary schools in the metropolis (Ministry of Education 2003). The study population consisted of adolescents and youths of two major groups, namely, (1) those in organized apprehentiship programmes (2) and unaffiliated adolescents. Most of the adolescents in organized programmes live with their parents or guardians and report daily to their various workshops. The unaffiliated adolescents (i.e those not in any organized apprehentiship) are highly mobile and very difficult to trap down for questioning. This because they keep on moving from one place to another to sell their goods or service.

3.2 Study Design: This is descriptive cross-sectional survey. It is also exploratory in nature. The sample was designed to gather information about two major social groups of adolescent and youth: those in organized apprenticeship programs (e.g. hair dressers, carpenters, masons, roadside mechanics) and unaffiliated adolescent (pure-water sellers, vendors of newspaper and other small items, shoeshine boys, cassette sellers). The

unaffiliated adolescents and youths are very difficult to reach because they are mobile and often on the street.

3.3 Sampling Technique: A purposive sampling procedure was used to select the required sample size. To select the sample of adolescent in organized apprenticeship programme, a list of small-scale enterprises was obtained from the different associations such as hairdressers, carpenters, masons, and roadside mechanics. These were then grouped based on trade-group or specific job carried out to ensure all groups were represented. A sample of firms (occupational workshops) was randomly chosen from each group, and apprentices were then randomly selected from each firm. Proportionate sampling technique was adopted to determine the number of apprentices that were interviewed from each firm (occupational workshop) For unaffiliated social group, a quota sampling method (stratified by sex) was used to select adolescents and youths who are willing to participate in the study (i.e. give their time to provide responses to questions asked by the interviewers) in commercial areas of the city such as saw-mill garage, Taiwo road, Oloje market and Emir's Market and Post Office/Station area. To ensure full support for the study various occupational (firm) associations under the organized apprenticeship programme were approached and their permission and cooperation were obtained. Furthermore, all the shop owners or instructors were also approached to obtain approval to recruit apprentices working in their shop. Appointments were fixed for recruiting and interviewing apprentices in the participating firms/workshops. If an apprentice was absent from the firm/workshop on the day of the interview, a second appointment was fixed. The purpose of the study and the opportunity to decline were discussed with all the respondents. Informed consent was obtained

verbally from all eligible adolescents and youths. Of all 350 adolescents approached, 315 responded.

3.4 Sample size determination: The sample size was determined using Andrew Fisher's et al (1998) formular stated below. For a study population of equal or greater than 10,000 people, the desired sample size is calculated with the following formular

$$n = \frac{Z^2 pq}{d^2}$$

Where n = desired population size

Z = Standard normal deviate set at 1.96 which corresponds to 95% confidence level

p = Proportion in the target population estimated to have a particular characteristic. When it is unknown, 0.5 is used.

d = degree of accuracy desired, usually set at 0.05.

q = 1-p

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$= 384$$

The entire population of out-of- school-adolescents and youths is less than 10,000 then the required minimum sample size is obtained by the formular below

$$nf = \frac{n}{1+\frac{n}{}}$$

$$\frac{N}{}$$

Where nf = desired sample size when population is less than 10,000

n = desired sample size when population is greater than 10,000

N = Estimated population size (approximately 1000)

$$nf = \frac{383}{1+\frac{384}{1000}}$$

= 278

To give room for non-response and attrition a sample size of 350 was used

Two hundred and fifty-five and sixty respondents were interviewed from the organized apprehentiship programme group and unaffiliated group respectively

3.5 Study Period: The study was conducted over a period of 4 months (Jan – April 2004).

3.6 Data Sources and Collection Procedures/Methods: Data was collected with a semi-structured questionnaire with open and closed ended questions. The questionnaire was pre-tested among adolescents and youths in a different area (Ganmo) of Ilorin Metropolis. The questionnaire was developed after consultation with other researchers who either currently working or had worked on adolescent sexuality, adolescent health education experts, as well as review of relevant literatures. The questionnaire was designed to obtain information on the following areas.

1. *Socio-demographic characteristics:* Data on gender, age, educational status, family income, family characteristics ,living arrangement and parent's employment status were collected.
2. *Knowledge and attitude towards HIV/AIDS*: Awareness on issues relating to HIV/AIDS in general, were assessed to uncover adolescents and youths level of

knowledge, attitudes and beliefs about their susceptibility to HIV/AIDS as a result of their risky behaviours

3. *Prevalence of HIV/AIDS related risk behaviour:* This was sought to enable identification of forms of risky behaviours that could make the adolescents and youths more susceptible to HIV/AIDS.

4. *Sexual practices and related variables including the use of condom:* The researcher assessed the age of sexual initiation corresponding to the first penetrative intercourse, number of partners, sexual practices, frequency of condom use, reasons for using and not using condoms, contraceptive use, and previous abortion.

5. *Substance use variables*: Respondents were asked about use of alcoholic beverages or drugs. This was related to sexual intercourse.

Before administration of questionnaire, the purpose of the study was explained to the respondents and they were encouraged to respond truthfully. To ensure confidentiality, respondents were advised not to give their names and their instructors or Bosses (Masters) were not allowed to be within ear shot (not allowed to participate).

Questionnaires were administered by three trained interviewers. The interview took approximately 45-60 minutes. The interviewers were young men and women (with health background and with nursing and midwives qualifications) who could easily identify with the participants. Concerning the unaffiliated adolescents, the interview was interrupted, as many respondents were busy trying to sell their wares or services. Despite these difficulties all interviews were satisfactorily completed.

In order to gain further information on knowledge, attitude, behaviour and prevention approaches and issues surrounding HIV/AIDS related risk behaviour among adolescents, four Focus Group Discussions (FGD) were conducted and responses were tape-recorded to complement the activities of the note taker. All subjects that completed the questionnaire were invited to participate in the focus groups. Selection of FGD participants is optional and voluntary. FGD participants were between 8-10 respondents.

The focus group guide included questions on reasons for HIV/AIDS related risk behaviours, HIV Risk Perception, and the potential feasibility and content of HIV/AIDS prevention interventions targeted to adolescents and youths. The researcher (trained moderator) conducted the focus group discussion in both English or Yoruba language as suggested by the participants. The research assistant who was the note taker recorded all proceedings and noted attitude behaviours of the participants. The discussion lasted between 45 minutes to one hour. A total of 40 adolescents and youths comprising 25 males and 15 females, aged between 15-19 years participated in the focus group discussion. Only one focus group discussion consisted of all males. The participants were encouraged to discuss freely all issues pertaining to the topic and summary of the discussion were presented to the participants

3.7 Reliability and validity: Following the pre-test of the questionnaire, some questions were amended before data collection commenced. The content validity of data collection instruments was verified from literature, experts on adolescent reproductive health and senior colleagues. The questionnaire was pre-tested on a number of adolescents and youths similar to the respondents.

3.8 Data and Statistical Analysis: Questionnaire data were cleaned, coded, entered into computer and analysed using Stata version 7.0 so*ft ware package*. Statistical analysis *included* frequency tables, means, standard deviation, and point prevalence of variables, and prevalence ratios with 95 % confidence interval. Chi- square test was used to assess the relationship between two variables and results were considered statistically significant if p-value is less than 0.05 ($p<0.05$). Confounding by age group and sex was assessed using Mantel-Haenszel method. Demographic characteristics, sexual behaviour, drug and alcohol uses prior to the study were examined as correlates. Information from FGDs was translated, analysed manually and the data described.

3.9 Inclusion and Exclusion Criteria: Only out-of-school adolescents and youths were studied while the school adolescents and youths were totally excluded.

3.10 Limitations: This study was constrained by inadequate time and resources that would have allowed for a large sample study. Age and cultural belief were also limiting factors for some respondents who felt shy in discussing their sexual behaviour despite the fact that the interviewers were young men and women who communicate with the participants. Inadequate literature on out-of school adolescents is also a constraint to this study. The sampling strategy and the sometimes chaotic interviewing environment made the responses for the unaffiliated adolescents and youths in this study very time consuming and cumbersome than those for the adolescents and youths in organized apprenticeship programme

4.0 CHAPTER FOUR RESULTS

4.1 Response Rate: Out of 350 questionnaire administered, a total of 315 respondents completed the Questionnaire. The rate of refusal was ten percent (10%), principally due to lack of time or interest in the study.

4.2 Socio-demographic characteristics (N=315)

Table 1: Socio- Demographic Characteristics (N = 315)

Variable	Frequency	Percentage (%)
Age		
10-14	65	(20.6)
15-19	150	(47.6)
20-24	100	(31.8)
Sex		
Male	103	(32.7)
Female	212	(67.3)
Ethnic Group		
Yoruba	268	(85.1)
Hausa/Fulani	35	(11.1)
Igbo	12	(3.8)
Religion Affiliation		
Christianity	112	(35.6)
Islam	203	(64.4)
Others	0	(0)
Level of Education		
None	69	(21.9)
Primary	88	(28)
Secondary (completed)	150	(47.6)
Tertiary	8	(2.5)
Type of Family		
Monogamous	118	(37.5)
Polygamous	197	(62.5)
Number of Siblings		
1-2	87	(27.6)
3-4	100	(31.8)
Greater or equal to 5	128	(40.6)
Living arrangement		
Alone	48	(15.2)
Parent	163	(51.7)
Relation	92	(29.3)
Friend	12	(3.8)

Table 1 shows details of personal socio-demographic variables of the 315 adolescents and youths involved in the study. The age range of the respondents was from 13 to 24 years. The mean age of the males was 16.8 years (SD = 3.4), while that of the females was 17.6 years (SD = 4.1). Two hundred and twelve (67.3%) of the respondents were females and one hundred and three (32.7%) were males. Majority of the respondents were Yorubas (85.1%) by tribe and of Islamic faith (64.4%) by religion. About two thirds (62.5%) of respondents came from polygamous type of family setting. One hundred and twenty eight (40.6%) of the respondents were from large families with more than four siblings. More than half (51.7%) of the respondents live with their parents and 92 (29.3%) lived with relations while forty-eight (15.2%) lived alone and only twelve lived with friends.

Table 2: Socio -Demographic Characteristics of Respondents' Parents

Variable	Father Freq (%)	Mother Freq (%)
Educational level		
None	28 (8.9)	57 (18.2)
Primary	218 (69.2)	180(57.1)
Secondary	56 (17.8)	70(22.2)
Tertiary	13 (4.1)	8(2.5)
Occupation		
Unemployed	45 (14.4)	73 (3.3)
Civil servant	69 (29.6)	56 (17.8)
Trading/Buisness	126 (40)	162 (51.2)
Artisans	50 (16)	16 (5.2)
Professional	14 (4.5)	6 (1.9)
Farming	11(3.5)	0.6)
Monthly income		
<N10, 000	135(42.8)	187(59.4)
N11, 000-20,000	64(20.3)	56 (17.7)
N21, 000-30,000	38 (12.1)	30 (9.5)
N31, 000-40,000	20 (6.3)	15 (4.8)
>40,000	18 (5.7)	6(1.9)
Don't Know	40(12.8)	21(6.7)

This study indicates that respondents' parents had low level of education (Table 2). More than half of the respondents parents {Father (69.2%; Mother (57.1%)} had primary education. Mothers' education and occupation were found to be lower compared with that of the fathers. Most of the parents' income was less than N10, 000 per month ({Father (42.8%; Mother (59.4%).

Table 3: Distribution of Respondents by Social Group, according to selected characteristics

Characteristics of Respondents by Social Group	Apprenticed (N =255)		(Unaffiliated N =60)	
	Freq	(%)	Freq	(%)
Sex				
Male	98	(38.5)	26	43.3
Female	157	(61.6)	34	56.7
Total	*255*	*(100)*	*60*	*(100)*
Age				
10-14	27	10.6	35	58.4
15-19	168	65.9	5	8.3
20-24	60	23.5	20	33.3
Total	*255*	*(100*	*60*	*(100)*
Education				
None	59	23.2	32	53.3
Primary	30	11.9	21	35
Secondary	162	66.3	7	11.7
Tertiary	4	1.6	0	0
Total	*255*	*(100)*	*60*	*(100)*
Religion				
Christianity	83	32.5	14	23.3
Islam	172	67.5	46	76.7
Others	0	0	0	0
Total	*255*	*(100)*	*60*	*(100)*
Living situation				
Both parents	120	47.1	19	31.7
One parent	70	27.5	8	13.3
Other relative	37	14.5	26	43.3
Friend	17	6.7	4	6.7
Alone/On own	11	4.2	3	5
TOtal	*255*	*(100)*	*60*	*(100)*
Ethnic group				
Yoruba	202	79.2	44	73.3
Hausa/Fulani	34	13.3	9	15
Igbo	19	7.5	7	11.7
Total	*255*	*(100)*	*60*	*(100)*

Two hundred and fifty five (80.9%) of sampled respondents were in apprentice programs and sixty (19.1%) were unaffiliated as shown in Table 3. Among respondents in the unaffiliated social group were concentrated the younger age categories (10-14 years) while most (65.9%) apprenticed respondents were mainly between 15-19 years with

average of 17.3 years. Some apprenticed and unaffiliated respondents had had only primary school education; this proportion was statistically significantly ($p<0.05$) higher among unaffiliated respondents than among apprenticed ones (35% vs 11.9).

Unaffiliated were the most likely to live with a relative and apprenticed were the most likely to live with both parents. Less than ten percent (6.7%) of respondents each in apprenticed and unaffiliated groups lived with friends. There were no substantial differences in the characteristics of respondents when compared by tribe.

4.3 KNOWLEDGE OF HIV/AIDS

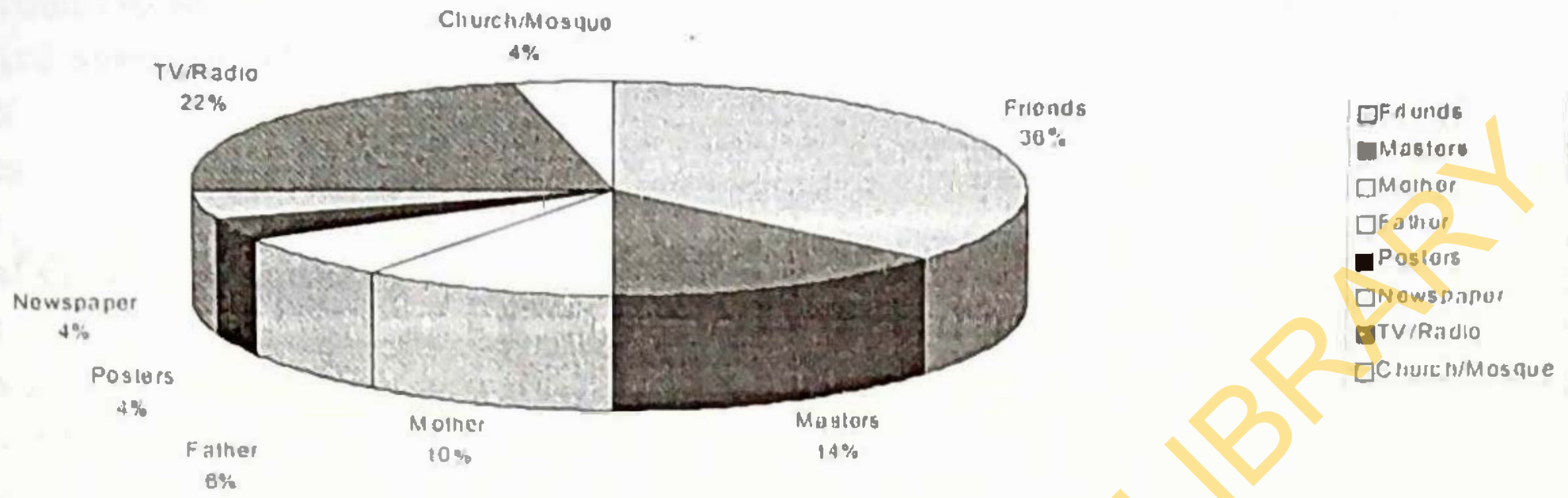

Figure 1: Respondents, sources of information about HIV/AIDS

Most (36.5%) mentioned source of information being friends while less than ten percent (3.5%) stated posters. Apart from friends, television and radio (70 or 22.3%) consistitute source of information. Only 30 (9.5%) obtained information on AIDS from mother and 20 (6.4%) from father. Masters in 24 (7.6%) and church as well as mosque in 12 3.8% formed the other sources of information.

Table 4 : Respondents Knowledge about HIV/AIDS

HIV/AIDS Knowledge	Frequency (%)
Aware about HIV/AIDS	
Yes	234 (74.3)
No	81 (25.7)
Body Defense Can not fight AIDS (Cure of AIDS)	
Agree	138 (43.8)
Disagree	96 (30.4)
Unspecified/No Idea	81 (25.8)
Causative agent of AIDS	
Bacteria	54 (17.2)
Parasites	29 (9.2)
Virus	47 (14.9)
Wrath of God	77 (24.4)
No Idea	108 (34.3).
AIDS is spread through	
Sexual intercourse	184 (58.4)
Transfusion with unscreened blood	40 (12.8)
Use of unsterilised instruments	16 (5.2)
Homosexuality	12 (3.9)
Kissing and using somebody's comb or hair brush	21(6.7)
Mother to Child transmission (Transplacenta)	16 (5.1)
Mosquito bite	26 (8.3)
Perceived consequences of AIDS	
Death	302 (95.9) *
Stigmatization & Discrimination	188 (59.7) *

*Multiple responses

Table 4 above shows the knowledge of the study population about HIV/AIDS. Two hundred and thirty four (74.3%) claimed to be aware about HIV/AIDS while 81 (25.7%) unaware. Ninety-six (30.4%) respondents felt that the disease could be cured; while 138 (43.8%) said that AIDS is incurable. Answers to the question about the causative agent of AIDS showed that 54 (17.2%) and 29 (9.2%) respondents claimed that bacteria and parasites cause AIDS, respectively. Only 47 (14.9%) knew that AIDS is caused by a virus. For 77 (24.4%), AIDS is caused by the wrath of gods and as much as 108 (34.3%) had no idea about the cause of AIDS. Knowledge of respondents on the possible ways AIDS can be transmitted is still shown in Table 4 above. One hundred and fifty four

(58.4%) knew that AIDS could be transmitted through sexual intercourse while 40 (12.8%) were aware that transmission could be through blood transfusion. However, only 16 (5.2%) of the respondents attributed its transmission to transplacental transfer.

Percentage distribution with regards to perceived consequences of AIDS is also shown in the table above. Majority (95.9%) knew that death is a possible consequence of AIDS

FIG 2: Respondents' Knowledge of HIV/AIDS Prevention

NOTE: AB = Abstinence, SWIFP = Sexual Intercourse with only one faithful partner
UOC = Use of condom, UOD = Use of drugs, NM = Native medication
TWSB = Transfusion with screened blood, USI = Using sterilized needle, ASN = Avoid sharing of Needles

Responses provided to the question on HIV/AIDS prevention is in Figure 2 above.

Abstinence (keeping away from sex) was mentioned by majority (22%) of respondents as

a method of prevention of HIV infection followed by use of condom (16%). Having sexual intercourse with only one faithful partner consistitutes 9%

4.4 ATTITUDES OF RESPONDENTS

Table 5: Respondents' Attitude towards AIDs

Attitudinal Statements	Agree Freq (%)	Disagree Freq (%)	Not sure Freq (%)	Total Freq (%)
AIDS is not a problem as people think	86 (27.3)	214 (67.9)	15 (4.8)	315 (100)
I am not worried about contracting AIDS	161 (51.1)	130 (41.3)	24 (7.6)	315 (100)
Enough about AIDS, I don't want to hear more	70 (22.2)	216 (68.6)	29 (9.2)	315 (100)
People living with AIDS should be kept somewhere and not allowed to move around.	259 (82.2)	45 (14.3)	11 (3.5)	315 (100)
I can show love and care for people living with AIDS	281 (89.2)	30 (9.5)	4 (13)	315 (100)

NOTE: Not sure means unspecified

The attitude of the respondents to AIDS and people living with AIDS is displayed in Table 5 above. More than two thirds (214 or 67.9%) of the respondents agreed that AIDS was a problem while 86 (27.3%) felt that AIDS was not a problem. Attitudinal disposition of respondents was found to be low with respect to being worried about contacting AIDS (130 or 41.3%) and wanting to hear more about AIDS (70 or 22.2%). A more favourable attitude was noted among respondents especially concerning showing love and care for people living with AIDS (89.2%). More than two thirds (89.2%) of

respondents' felt that people living with AIDS should be kept somewhere and not allowed to move around.

4.5 SEXUAL BEHAVIOUR

Table 6: Sexual behaviour of Respondents (n=315)

Parameters	Frequency	Percentage
Ever had sex		
Yes	235	74.6
No	80	25.4
Age of first sexual intercourse (N=235)		
10-14	24	10.2
15-19	144	61.3
20-24	57	24.3
Unspecified	10	4.2
Frequency of Sexual Intercourse		
Once a week	10	4.3
Once a month	36	15.3
Equal or greater than 2 times a month	183	77.9
Not specified	6	2.5
Number of sexual partner		
One	72	30. 6
Two	130	55.3
Three or more	26	11.1
Unspecified	7	3
Type of people ever had sex with		
Fellow Apprentice	15	6. 4
Boy/Girl friend	99	42.1
Some approached for financial assistance	71	30.2
Commercial sex worker	0	0
Casual Friend	50	21.3
Same Gender with me	0	0
No of sexual intercourse in the last 3 months		
None	13	5.5
1 or more times	156	66.4
Unspecified	66	28.1
Of those who had sex in the last 3 months, always use condoms		
YES	64	27.2
NO	171	72.8

Table 6 shows the sexual behaviour of adolescents and youths studied .Of the 315 respondents interviewed, 235 (74.6%) admitted ever having sexual intercourse. The age at which sexual activity started ranged from from 15 to 21 years with a mean of 16.1 years for boys and 10 to 24years with a mean of 17.8years for girls. Age of first sexual intercourse generally ranged from 10 to 24 years with a large concentration in the 15 to 19 years age group with a mean of 18.1years. On frequency of sexual intercourse, majority (183 or 77.9%) of respondents admitted to having sex two or more times in a month while 10 (4.3%) and 36 (15.3%) reported having sex once a week and once in a month respectively. Of sexually active group, majority (130 or 55.3%) had two sexual partners and 26 (11.1%) had three or more sexual partners. The Table 7 shows that ninety-nine (42.1%) of the respondents had ever had sexual intercourse with either boyfriend or girlfriend. Seventy-one (30.2%) claimed to have had sex with men for financial reasons. There was no report of homosexuality or having had sex with a prostitute. About two thirds (66.4%) of respondents reported sexual intercourse one or more times in the last 3 months. Of those who had had sexual intercourse in the last 3 months, only 64 (27.2%) used condoms sometimes.

Table 7: Distibution of Respondents, by sexual experience, according to social group

All Respondents (n=315)

EVER HAD SEX (N=235)

	Freq	Percentage
Male	128	54.5
Females	107	45.5
Total	235	74.6

HAD SEX IN THE LAST 3 MONTHS All respondents (N=206)

	Freq	Percentage
Male	111	53.9
Female	95	46.1
Total	206	87.7

Social Group

Apprenticed (n=255)

EVER HAD SEX (N= 192)

	Freq	Percentage
Male	107	55.7
Female	85	44.3
Total	192	75.3

Social class	No	M	F	X^2	p-value
Apprentice	192	56%	44%	5.04	<0.05

HAD SEX IN THE LAST 3 MONTHS

Apprenticed (N=82)

	Freq	Percentage
Male	56	68.3
Female	26	31.7
Total	82	46.3

Social class	No	M	F	X^2	p-value
Apprentice	82	68%	32%	21.95	>0.05

Unaffiliated (n=60)

EVER HAD SEX (=43)

	Freq	Percentage	X^2	p-value
Male	24	55.8	0.03	0.86493
Female	19	44.2	0.04	0.83652
Total	43	71.7		

Social class	No	M	F	X^2	p-value
Unaffiliated	43	56%	44%	1.16	>0.05

Unaffiliated (N=23)

	Freq	Percentage	X^2	p-value
Male	15	65.2	0.05	0.82349
Female	8	34.8	0.01	0.93922
Total	23	53.5		

Social class	No	M	F	X^2	p-value
Unaffiliated	23	65%	35%	4.26	>0.05

Differences across social groups are not statistically significant (p>0.05). Differences between genders within each group is statistically significant (p<0.05) only for apprentice group and not for unaffiliated. Note all percentages adjusted for age.

No =Total number in each group

M = Male

F = Female

Considering all respondents, 235 (74.6%) of them had ever had sexual intercourse (Table 7). Males were more likely than females to be sexually experienced (54.5% vs 45.5%) With respect to social group, and after adjustment for age, the apprenticed group had more sexual experience than those in the unaffiliated group (75.3% vs 71.7%). Overall, more than two thirds (87.7%) of respondents reported having had sex at least with one sexual partner in the last three months. Again, males were found to have had sex more than females (53.9% vs 46.1%) and unaffiliated were more likely than apprenticed (53.5 vs 46.3%) to have had sex in the last 3 months. Within each social group, higher

proportions of males than females had been sexually active in the last 3 months; this difference is statistically significant ($p < 0.05$)

Table 8:Frequency of Sexual Intercourse by Work Group (Social Class)

Social Class	Once a week	Once a month	Two or more time in a month	Total
Apprenticed	11	19	162	192
Un-Affiliated	5	17	21	143
Total	**16**	**36**	**183**	**235**

df = 2, X^2 = 27.64, p = 0.000001

Among the respondents who claimed to have been sexually active, 16 (6.8%) had sexual intercourse at least once a week, 36 (15.3%), once in a month, 183 (77.9%) two or more times in a month. The work group was found to have influence on the frequency of sexual activity as shown in Table 8. There was statistical significant difference between the work group and frequency of sexual intercourse ($p<0.05$).

Table 9: Distribution of Respondents (sexually active females) by Abortion experience and number of abortion ever Procured (n=212)

Variable	Frequency	Percentage
Ever had abortion		
Yes	55	25.9
No	157	74.1
Total	*212**	*100*
Number of times abortion was procured		
1	24	43.6
2	16	29.1
3 or >	15	27.3
Total	*55***	*100*

**Total number of sexually active females*

***Number of respondents that ever had abortion*

According to Table 9, fifty-five respondents (25.9%) had ever procured abortion before. Of these respondents, majority (24 or 43.6%) had had abortion once and 15 (27.3%) had procured abortion in three or more times.

Table 10: Contraceptive methods currently used among respondents by Gender

Variable	No of sexually active Male(N=103) Freq	%	No of sexually (N=212) active Female Freq	%
Currently using contraceptive				
Yes	54	52.4	138	65.1
No	49	47.6	74	34.9
Total	*103*	*100*	*212*	*100*
Types of contraceptive Used				
Condom	39	72.2	7	5.1
Oral contraceptive pill (OCP)	-	-	65	47.1
Coitus interuptus (Withdrawal)	9	16.7	52	37.7
Safe period/Cycle calculation	6	11.1	14	10.1
Total	*54**	*100*	*138***	*100*

** Number of Males using contraceptive*
*** Number of Females using contraceptive*

Current use of contraceptive was higher among females (138 or 65.1%) compared with males (54 or 52.4%). Majority (72.2%) of the male respondents used condom as means of contraception while most (65 or 47.1%) females used oral contraceptive pills. Coitus interuptus (Withdrawal) was used by 9 (16.7%) of males. Safe period (11.1%) and condom (5.1%) remain the least used contraceptives by males and females respectively. Among the contraceptive users none reported use of multiple of methods (Table 10).

Table 11: Reasons for non-use of contraceptives among sexually active respondents by Gender

Variable	Male (N=49)		Female (N=74)	
	Freq	%	Freq	%
Lack of knowledge	11	22.4	6	8.1
Don't know source	4	8.2	1	1.3
Religious belief reasons	2	4.1	9	12.1
Non-availability	8	16.3	12	16.2
Feel ashamed to buy	10	20.4	24	32.5
High cost	-	-	7	9.5
Fear of being reprimanded by parents	14	23.6	15	20.3

Various reasons for non- use of contraceptives are depicted in Table 11 above. Fear of being reprimanded by parents was the commonest (14 or 23,6%) reason given by males while 'feeling ashamed' to buy was given' by most (24 or 32.5%) females

Table 12: Condom use and related Variables (N = 235)

Variables	Frequency	Percentage
Ever Used Condom during Sexual intercourse		
Yes	126	53.6
No	109*	46.4
Total	*235*	*100*
Frequency (Pattern) of Use of Condom for sexual intercourse (N=109)		
Always	48	38. 1
Occasionally	78	61.9
Total	*126***	*100*
Reasons for Non-use of Condom		
Stable partner (Steady partner)		22
20.2		
Decreased pleasure	39	35.8
Partner's refusal	17	15.6
Difficulties in access	21	19.3
Shame	10	9.1
Total	***109****	***100***
Persons with whom condom is not used		
Stable boy friend/Girl friend	82	75.2
Non stable partner	17	15.6
Unspecified	10	9.2
Total	***109 ****	***100***

**Number of respondents who had never use condom*
*** Number of respondents who had ever use condom*

Slightly more than half (53.6%) of respondents use condom during sexual intercourse.

Among those that use condom only 48 (38.1%) always use it during sexual intercourse.

All sexually experienced respondents reported only one reason or the other for not using condom during sexual intercourse. The most commonly stated reason was 'decrease

pleasure' (35.8%) as shown in Table 12 above. The second and third most common reasons were related to Stable partner (22 or 20.2%) and difficulties in access (21 or19.3%). Partner's refusal (17 or 15.6%) and feeling ashamed about asking someone else for a condom (10 or 9.1%) were also given as reasons for non-use of condom during sexual intercourse.

Figure 3 Percentage distribution of pattern of condom use among respondents

The percentage distribution of pattern of condom use is shown in Figure 3. The results show that a large percentage of sexually experienced respondents have used the condoms and use increases with age. Among those aged 15-19 years, 39% of females and 43 % of males have used condom at least once. Among those aged 20-24 years these percentages increased to 58% and 72% respectively.

Table 13: Correlation Coefficients between Attitudes towards condom Use and Frequency of Condom use among respondents that ever used condom during sexual intercourse

Frequency of Condon use with	N=126	Attitudes	
		PACSP	PACNSP
Stable partner (Vaginal)	100	0.023*	0.017*
Stable Partner (Oral)	26	0.45**	0.93**
Unstable Partner (Vaginal)	73	0.003*	0.002*
Unstable Partner (Oral)	53	0.87**	0.96**

n =Frequency of condom Use
PACSP = Positive Attitude towards condom use with Stable Partner
PACNSP = Positive Attitude towards condom use with Non–Stable Partner
***p-value< o.05;** p-value > 0.05*

Table 13 above shows that those with positive attitude towards condom use in general had more frequently used condoms with stable partner for vaginal sex than those who had less favourable attitudes towards condom use ($r = 0.43$, $p<0.05$). Those who had positive attitude towards condom use with unstable partners (casual partners) had used a condom with unstable partners for vaginal sex more frequently than those who had less positive attitudes towards condom use ($r =0.68$, $p<0.05$). Frequency of use of condom for stable and unstable partners with regards to oral sex was found to be statistically non significant ($p>0.05$).

Table 14: Factors influencing Sexual Risk Behaviour

Factors	N	Sexual Risk Status		X^2	df	p-value
		Low	High			
Sex						
Male	75	28.4	71.6	18.5	1	0.00017
Female	51	66.3	33.7			
Exchange of gifts or money						
YES	85	22.4	77.6	24.9	1	0.00001
NO	41	67.8	32.2			
Parent Monthly Income						
<N10, 000	162	34.5	65.5	12.22	1	0.00005
>N10, 000	73	58.9	41.1			
Age						
10-14	26	74.3	25.7	12.41	2	0.00209
15-19	88	52.6	47.4			
20-24	121	38.2	61.8			
Type of Family						
Monogamous	72	53.6	46.4	7.12	1	0.00764
Polygamous	163	35.8	64.2			
Peer Pressure						
Yes	168	21.7	78.3	49.8	1	0.00000
No	67	69.8	30.2			
Educated						
Yes	122	48.4	51.6	12.4	1	0.00202
No	113	49.1	50.9			

NOTE: Sexual risk . statuswas classified into two main categories The categories of the risk status are:
1.High-risk sexual status consists of respondents with more than one sexual partner or who does not use condom always or those who injected drugs or tattooing
2.Low –risk sexual status consists of those who always use condom or those with one faithful sexual partner and they themselves are also faithful.

The result of the analysis of examined factors is shown in Table 14 above. Two hundred and thirty five (74.6%) respondents studied admitted being sexually active. As shown in the Table 14 above, high risk behaviour was found to be statistically significant higher in males than females, in those who exchange sex for gifts or money, in respondents whose parents earned less than N10.000 per month than those with more than N10.000 per month and also found to increase with age. Respondents from polygamous family as well

as those admitted being influenced by peer groups were also more sexually active ($p<0.05$). There was no statistical significant relationship in sexual behaviour between those educated and un-educated ($p>0.05$).

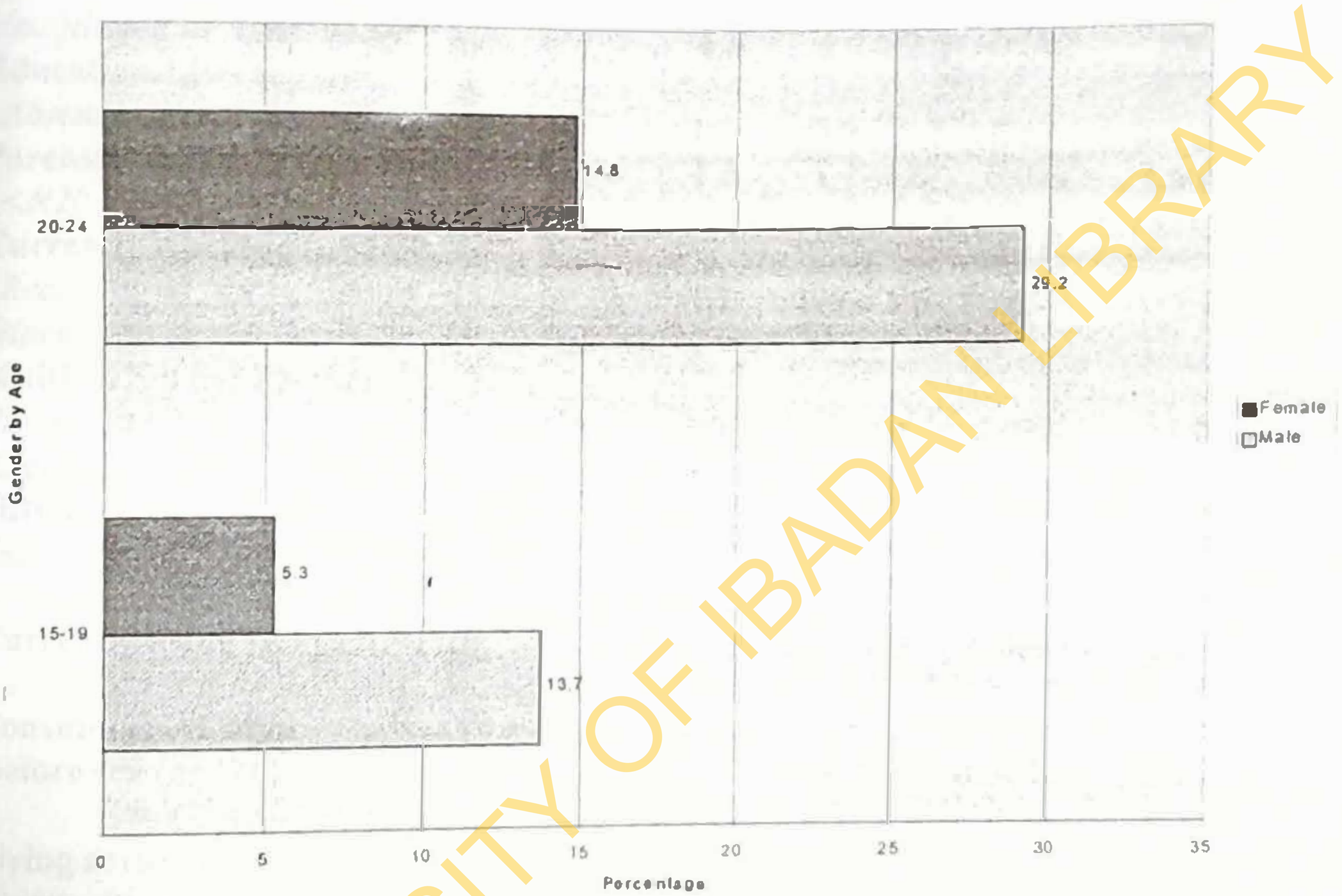

FIG 4: Percentage distribution of Respondents who ever exchanged sex for Gifts/Money by gender

Figure 4 above shows the percentage distribution of respondents who ever exchanged sex for gifts/money. This transactional aspect of sexual relationships increases with age and is more prevalent in males than females i.e more males engaged in using money to entice females for sexual intercourse.

Table 15: Correlates of HIV Related Risk Behaviour

Variables	CPR	95%CI	p-value	APR (p-value)
Gender (n=315)				
Male vs Female	1.7	1.6-2.4	0.036	-
Age (n=315)				
>15 vs <15 years	1.8	1.4 -2.3	0.021	-
Social class (n=315)				
Unaffiliated vs Apprenticed	1.5	1.7 – 2.5	0.042	1.8 (0.075)
Education/Literacy (n=315)				
Absent vs Present	1.3	0.9 – 1.7	0.57	2.3 (0.034)
Parensts' monthly Income (n=315)	1.5	1.1- 1.8	0.019	1.6 (0.027)
<N20,000 vs > N20,000				
Currently working (n=255)				
Receiving vs Not receiving Stipends	1.2	0.9 – 1.6	0.65	1.1 (0.78)
Multiple Sexual Partners (n =243)				
Present vs Absent	1.7	0.8 –1.8	0.038	1.0 (0.042)
Exchange sex for gifts or money (n=315)				
Yes vs No	1.6	0.5 – 4.7	0.015	3.2 (0.020)
Currently using Drugs (n=116)	2.5	1.7 – 2.9	0.0001	2.2 (0.0002)
Consuming Alcohol before sex (n=178)	3.1	2.6- 3.9	0.004	2.8 (0.0024)
Living arrangement (N =315)				
Living with vs Not Living Friends	0.006	1.9 –3.2	0.28	0.004 (0.36)
Sexual Intercourse without condom use (109)	2.8	1.4 – 1.7	0.031	2.6 (0.018)
Traditional practices with unsterilised instruments				
Tattooing (n=42: Presence vs Absent	1.6	0.7 – 1.8	0.025	1.7 (0.032)
Scarification (n=53): Presence vs Absent	2.1	1.6 – 2.7	0.013	1.9 (0.027)
Abortion (n=55)	1.7	1.2-1.5	0.035	2.3 (0.018)

CPR= Crude prevalence ratio
Mantel- Hanzel prevavence ratio and p-value after adjusted for gender and age

Table 15 displays correlates of HIV-related risky behaviour. Male gender, older age, being un-educated, parent's monthly income, having multiple sexual partners, exchange sex for money, Use of illicit drugs, having sex under the influence of alcohol traditional practices with unsterilised instruments were associated with HIV-related risky behaviour using a bivariate analysis. These associations were found to remain significant after adjusting for gender and age using Mantel- Hanzel method, although the magnitude of association was reduced in some cases.

The test for homogeneity across age and gender strata for two of these variables was statistically significant ($p < 0.05$). The prevalence ratios for having sex under the influence of alcohol varied from a low of 1.4 (for females) to a high of 4.8 (for males); for using illicit drug varied from a low of 1.2 (for females to as high as 5.7 (for males). When the analysis was restricted to those who were sexually initiated, only two of the associations remained statistically significant, and only one remained so when adjusted for gender and age group. Never exchanging money or gifts for sex was associated with unprotected sex in the unadjusted analysis, but not when adjusted (CPR =2.6, p =0.013;APR = 2.8, p = 0.87). Having sex under the influence of alcohol remained significant in both analysis (CPR = 3.1,0.004; APR = 2.8, p = 0.0024). Male gender and older age remained highly significant predictors of unprotected sex.

Two modified versions of the main outcome variable of HIV-related risky behaviour were also considered. The first modification was 'frequent condom use' (in addition to always) as not risky. The second modification was condom use with all partners, which was also considered as not risky. It was observed that, for the most part, using these two modified versions of the outcome variable there was neither a change in the strength nor

the significance of the association with the predictor variables. Using the second modified definition, two notable differences were noted. Low family income was significantly associated with HIV-related risky behaviour both in the adjusted and unadjusted analysis (CPR = 1.5, p = 0.019; APR = 1.6, p = 0,027), and respondents in the unaffiliated social class had higher risk than those in apprenticed group, before adjustment (CPR = 1.5, p = 0.042; APR = 1.8, p = 0.075). Other variables that might be considered risk factors for HIV transmission were also examined. Fourty-two (13.3%) of the respondents said they that they had received a tattoo and all of them had their tattoos done without use of sterilized instruments. The practice of making cuts in the skin, mostly for family or tribe identification purposes (scarification), was reported by 53 (16.8%) of the respondents and none of them was sure if it is done under sterile condition since they were young when the practice was performed on them. Both practices were highly correlated with outcome variable of 'HIV-related risky behavior. Their CPRs and APRs as well as p-values are shown in Table 15. Abortion is also statistically significant

HIV-Related risky behaviiour

4.6 DRUG AND ALCOHOL USE

Table 16: Drug and Alcohol use Behaviour

Drug and Alcohol use	Frequency	Percentage
Ever used illicit drug (n=116)		
YES	116	67.2
NO	199	32.8
Type of drug used		
Agbo (Native concortion)	18	15.5
Marijuana/India hemp	36	31.1
Pasuma (Sexual stimulant)	62	53.4
Ever use drug to influence sex		
YES	5	4.3
NO	111	95.7
Ever injected drugs (n = 116)		
YES	8	6.9
NO	108	93.1
Ever consumed alcohol (n= 178)		
YES	119	66.8
NO	59	33.2
Ever use consumed alcohol to influence sex		
YES	36	20.2
NO	142	79.8

One hundred and sixteen reported ever using illicit drugs (Table 11). Among them 62 (53.4%) reported using Pasuma (to enhance performance), 36 (31.1%) Marijuana and 18 (15.5%) native concoction. Five (4.3%) respondents reported a history of sexual experiences under the influence of illicit drug. Respondents who had used drugs reported having had their first experiences within a median age of 2.3 years . Only eight (6.9%) injected drugs. One hundred and nineteen stated that they currently still consume alcohol (Table 11). The respondents began their alcohol use within a median age of 1.6 years. Thirty-six (20.2%) of the respondents reported a history of sexual experiences under the influence of alcohol.

Table 17: Drug and alcohol use Behaviour by Gender

Variable	Behavioural risk Status					
	Freq	High	Low	X^2	df	p-value
Ever use Drug (n =116)						
Male	64	52.1	47.9	0.14	1	0.0708
Female	52	48.8	51.2			
Ever had sex under the Influence of drug (n = 5)						
Male	3	51.6	48.4	5.96	1	0.0651
Female	2	49.3	50.7			
Ever consume Alcohol (n= 178)						
Male	136	76.4	23.6	29.52	1	0.0000
Female	42	32.1	67.9			
Ever had sex under influence of alcohol (n = 36)						
Male	29	80.5	19.5	2.14	1	0.0144
Female	7	38.6	61.4			

There were gender differences regarding both alcohol and drug use. Current use of alcohol was more reported in males than females (76.4.7% vs 32.1%; p = 0.0000) as was sexual intercourse under the influence of alcohol (80.5. vs 38.6%; p = 0.0144). Males also more frequently reported current use of illicit drugs than females, although the difference was not statistically significant (52.1% vs 48.8%; p = 0.0708). There was no statistical significant difference between males and females who reported having sex under the influence of drugs (p> 0.05).

4.7 FOCUS GROUP DISCUSSION REPORT:

A series of four focus group discussions were conducted among the respondents. Volunteers were solicited for the discussion. Recruitment into FGD was optional after due explanation. Participants' verbal consents were obtained. The discussions were segregated by sex and divided according to age group to ensure homogeneity and enable participants to feel at ease in obtaining complete and detailed information. The FGD revealed inadequate participants' knowledge about HIV and its related risk behaviours. Only few discussants could provide information on the predisposing factors and prevention of HIV/AIDS. Misconceptions on how HIV could be contacted. These include sharing utensils and other materials with victims, mere touching and sleeping with the people living with AIDS. Others include AIDS is not a black man disease, AIDS could only affect those that have sexual intercourse with commercial sex workers, that AIDS does not exist and that it is due to destiny. In one focus group, majority of the participants believed AIDS is a "retributive justice for promiscuity", while others felt it is caused by 'witches and wizards' who take human blood "and that is why AIDS victim get slimmer and slimmer until they die". In general there was a serious concern about AIDS and a greater fear was expressed because the disease has no cure and it causes disgraceful death.

Concerning reasons for HIV-related risk behaviours, some participants gave peer influence, poor financial support from parents, lack of discussion between parents and adolescents concerning adolescent sexual education, lack of information and source of information about adolescent sexuality and two participants gave decline in moral teachings as reason. For example one female participant said her daily living is financed

by her boy friend and she is therefore obliged to obey him. In general, the attitudes of the FGD participants toward adolescent sexual behaviour (e.g premarital sex) showed the prevailing socio cultural norms in our society. Almost all focus group participants indicated that adolescents and youths should exercise patience until marriage before initiating sexual intercourse with their partners. This is not un-expected because both normative and pragmatic reasons were giving why sexual intercourse has to be delayed until marriage. These include "maintaining family and personal honor," "earning the husband and his family respect," "avoiding STIs including HIV/ADS," " avoiding complications of abortion such as death and infertility" as well as " obeying religious obligations and teachings. Despite the apparent agreement with the above stated reasons why adolescents and youths should wait until marriage before initiating sexual activity, there were indications that this was not the case. For example a male participant explained that sexual initiation before marriage is way of proving manhood and assuring one's parents that somebody is "complete". Another male participant also said some parents would be worried if by 18 years one is not seen with a female partner. The FGD results on how participants deal with their sexual urges and desires were found to be fairly consistent with questionnaire findings, as majority reported having sexual intercourse with girl friends, boyfriends, and some with fellow apprentices. Other means of satisfying sexual urges and desires not reported in the questionnaire survey include, rape (3 persons), masturbation, holding a girl friend or boy friend closely tight, and having sexual intercourse with house maids (2 persons) and casual friends through financial and material inducements. Only two participants reported satisfying their sexual urges and desires by having sex with commercial sex workers and one of them gave to

"have experience" as a reason while the other said he was being influenced by another friend outside this study. On why participants have to satisfy their sexual urges and desires, majority gave " to feel relief," "repeat practice of film show or video scenes," " and adolescents way of life" as reasons.

With regards to contraceptive use, divergent opinions were expressed. These opinions vary from; it is meant for married couples only, suspicion of prosmiquity, feeling ashamed to use it, no body to approach for information about its source and use, adolescents and youth should be able to control themselves all the time, and fear of being rebuked by parents and guidance. FGD participants had greater acceptability for use of condom and oral contraceptive pills. This is because condom helps to prevent STIs including HIV and avoid unwanted pregnancy. One participant even argued vehemently that although it is the responsibility of girls to remain virgin until marriage but it is also important to avoid bringing disgrace to the family by out-of-wedlock pregnancy by using a combination of condom and oral contraceptive pills.

FGD corroborate the survey findings and even confirmed that condom use depends greatly on partner type. In general the more stable the relationship, the lower is the condom use. A female participant said, " If I say I don't want to use a condom it means I trust my boy friend. If he also says that he does not want to use a condom then he trusts me. Another male participant had similar view. Other participants reported that most adolescents and young people use condom within first year of courtship, but inevitably stop because of development of trust for each other. Some female participants expressed frustration at feeling incapable of buying and using condoms. Socially, girls cannot

express their sexuality and being seeing with condoms is suggestive of being too "free" and 'prosmisqous' as said by another female participant.

Although data suggest high levels of risk taking among the respondents, many FGD respondents rarely believed themselves to be at high risk. When FGD participants were asked about their risk for HIV, none felt that he/she is at high risk, even though many of them reported that they engage in unprotected vagina sex with multiple sexual partners.

One male participant's comments echoed the others and it reads thus: I don't think my risk is high even though "I don't use condoms all the time but my sexual partners were all safed". Furthermore, he also said he does not have sex with prostitutes and have never seen any of my partners with another boy or man since I started dating them for the past 3 years. When asked to discuss about other risky behaviours, most of the participants mentioned only use of unsterilised instruments like clipper and razor blade only.

5.0 CHAPTER FIVE: DISCUSSION

5.1 General information: The findings from this study have shed light on different environmental and cognitive factors associated with prevalence and correlates of HIV-Related risk behaviour among the respondents. Hughes and Mccaulay (1998) have expressed concern that cognitive models have put too much emphasis on risk behaviour, whereas Specific Learning Theory addresses a dynamic relationship among three factors: an individual, his/her social environment and a specific behaviour in question, for example condom use (Bandura, 1986). In an attempt to severe out specific attitude and perceptions that are associated with behavioural choices researchers may forget that Social Learning Theory provides an opportunity to examine the fact that attitudes and perceptions are formed within an environmental context. In relation to this study, the influence of the general environment and specifically the family type (Monogamous and Polygamous) has important influences on adolescents and Youths behaviour with respect to HIV/AIDS. It is the cultural environment that is responsible for early formation of major gender attitudes (Asenico, 1999). Social Learning theory in the present work also offers cognitive influences on behaviour. In Ghana, Adih and Alexandra (1999), discovered that self-efficacy was found to be associated with use of condoms by young Ghanaian men. Since this is a cross sectional survey, it is not possible to determine whether use enhanced self-efficacy or self efficacy enabled use. The Social Learning Theory states that opportunities to practice behaviour do enhance self-efficacy. Other means include information, encourage from significant others and various learning from others who have performed the behaviour (Clark and Zimmerman, 1990). These offer

guides for developing adolescent reproductive education, including the role of peers in enhancing self –efficacy and sexual attitudes

5.2: Socio-Demographic Characteristics: This study shows that most (47.6%) respondents were in the 15-19 years age group. This age group appears to be the common learning age group for most adolescents in Nigeria. Females (67.3%) were also found to be more than males (32.7%) This could be attributed to traditional views held that females should be encouraged to learn apprentice trades while males should go to school. Yorubas was the most common (85.1%) ethnic group because Ilorin Metropolis was founded by a Yoruba Hunter (Ojo Isekuse) and most importantly the Metropolis is also populated by Yoruba indigenes. The fact that Kwara State and Ilorin in particularly are administrative and politically grouped, as part of Northern Nigerian does not make them to be culturally and indigenously homogeneous with part of Northem Nigeria. This was revealed by this study. About two-thirds of respondents were adherents of Islamic faith. This is expected because Islam was the first religion to be established in Ilorin and furthermore the earlier settlers migrated to Ilorin purposely to seek for Islamic knowledge and more so the Islamic Jihadists popularized the religion (Islam). Despite all these Christianity is also an important religious faith that is also reckoned with in Ilorin. Majority (79.1%) of respondents had attended some school with only 21.9% none educated. This is not surprising because Yorubas dominate the study area and Yoruba ethnic group places a high premium on education even to the extent of being hungry purposely to get a child educated. A high percentage (62.5%) of respondents came from polygamous family. This could be attributed to their culture and religious backgrounds. In Nigeria especially and among Yorubas in particular, the society is unfair and even

plays double standards with respect to sexual issues. Another researcher has also reported similar view. For example little or no restrictions are placed on extramarital activities of males while females are confined to their homes, and in some places chaperoned on outings (Fawole et al, 1999). Such double standards and activities have encouraged and even led to some men being polygamous. This situation was observed during the course of this study and probably may be the reason why most respondents came from polygamous home. Furthermore, heavy restrictions are placed on women and any woman caught engaging in extramarital relationships is severely punished. The researcher does not support the religious factor as a reason for being polygamous as expressed by many people including the respondents in this study.

The researcher's opposition against this reason is because Islam as a religion does not support being polygamous and the conditions laid down by this religion for one to be polygamous is so strict that it is almost always impossible for anyone to fulfill. But regrettably some people are polygamous purposely for self-interest. A significant percentage (15.2%) of respondents were reported in this study to be living alone. This is an indication of decline in parental care and society morals and such living arrangement encourages high risk HIV-Related behaviour such sexual promiscuity and use of illicit drugs as well alcohol consumption.

Some of the demographic characteristics of respondents' parents' surveyed put them at increased of HIV. Of particular note is their relatively poor economic condition, the main reason for exchanging sex for money or other gifts. Adolescents and Youths largely depend on their parents until they are gainfully employed for their sustenance. The economic condition of these parents where about half (42.8%) earned less than N10, 000

per month is a sober reflection of economic situation in Nigeria where poverty is big problem and even increase daily. The deteriorating economic condition in Nigeria has compelled some and encouraged many respondents to engage in various HIV-related risky behaviour such as exchange of sex for money or other gifts and having many sexual partners. Some of the respondents have been victims of different forms of HIV related risky behaviour (e.g exchangé of sex for money or other gifts and having many sexual partners) due to poor family background, confirming findings from previous studies by Adedoyin and Adegoke (1995) that family background, including poverty and early sexual experience are important determinant for entry into teenage prostitution (a risky HIV- Related behaviour), a new social problem identified among Nigerian adolescents. This study discovered that 40.6% of respondents were from large families (Table 1) with low socio economic background. This is consistent with arguments and reports that economic hardship encourages girls to become sexually active at an early age for economic reasons (Odujirin, 1989 and Wada,2000).

5.3: Knowledge and Attitudes about HIV/AIDS: The level of awareness of AIDS was found to be high (74.3%) among the respondents, with the major (36.5%) source of information being friends. This shows the importance of peer influence on behaviour especially among the adolescents and youths. In addition this finding is of importance in planning educational intervention programme for adolescents and youths as these groups of informants can serve as an effective means of communication. However, these friends must be correctly informed to ensure they pass correct information to their peers. In this study parents were a poor source of information to the respondents with regards to HIV/AIDS (Table 4). This because the Yoruba culture does not encourage parents to

discuss sexual issues with their children because it is seen as away of encouraging children to be sexually active and promiscuous. Communication between parents and their children has been found to be positively influenced by the amount of time parents spent at home and parents level of education (Adeyemo and Breger, 1994). The low level of education among respondents' parents contributes to poor communication between respondents and their parents on HIV/AIDS. However, it was observed from both the survey findings and focus group discussion that respondents' knowledge about HIV/AIDS is incomplete and technically inaccurate. It is important to note that despite high level of awareness of respondents about HIV, a few misconceptions still persist and these might increase risk of contracting HIV/AIDS. Some of these misconceptions reflect old ideas that are deeply rooted in the customs and tradition of Yoruba people as previously reported by Fawole et al (1999). Furthermore, despite this high level of awareness in the study, the overall knowledge about HIV/AIDS was poor. Only 14.9% knew that a virus caused AIDS, 43.8% believed AIDS is curable and 20.9% believed that drugs could prevent the disease. Some of the respondents patronized traditional healers who largely claim that they have a cure for all diseases including AIDS. Surprisingly, this claim is often given publicity by local artists, musicians as well as the electronic media. In view of this, information reaching the public, especially through the electronic media, needs to be censored to avoid the spread of incorrect information about AIDS. Poor knowledge of respondents about non-sexual mode of transmission and curability of HIV is a reflection of knowledge gaps. The implication of this is that the adolescents and youths are at risk of contracting STIs including HIV.

A high percentage (67.9%) of respondents did not feel AIDS was a problem. This attitude case for concern. This may be because there is a fertile ground for the spread of AIDS as also been reported by Fawole et al (1999). With respect to being worried about contracting AIDS, the attitude of respondents was poor. This could be an indication of the extent to which respondents engaged in HIV- related risky behaviours. Attitude of respondents towards people living AIDS however was more favourable. This is not unexpected as people generally show love and concern for people with incurable diseases especially the one with poor prognosis.

5.4: HIV/AIDS Related Risk Behaviour: Respondents felt embarrassed discussing their sexual experiences and practices. This is because sexual activity is a highly private and secret issue and most especially premarital sex is culturally and religiously unacceptable in this environment being discussed openly especially with a stranger. A very high proportion of respondents in this study admitted they were sexually active. This result is almost similar to previous finding by Brabin et al (1995), where 80.1% of those studied were sexually active. A high percentage (66.4%) of the respondents admitted having multiple partners of which 46.4% did not practice the use of condoms during sexual intercourse. These results show that we have adolescent and youth population that is potentially at risk of having HIV/AIDS because of their sexual habits and practices. This trend, if not corrected, will predictably result in an increase in the prevalence of AIDS in this population. This trend calls for urgent need for sex education and for information about HIV/AIDS for adolescents and youths especially those out of school. The mean age of sexual initiation in this study is 16.1 years. This finding is contrast to that reported by Unuigbe and Ogbeide (1999) in their study where mean age of sexual initiation was 14.1.

The contrast in these two findings could be because of difference in the study subjects and areas of study. In addition sex education is expected by society to take place earlier in school than outside the school environment probably because of earlier exposure to information about sexual education and most importantly adolescents and youths like implementing what they are being taught. The early initiations of sexual intercourse, having multiple partners and limited use of condoms have grave health consequences in this era of HIV/AIDS. Unprotected sexual intercourse among adolescents result in teenage and unwanted pregnancies with attendant complications of stillbirths, high infant and maternal morbidity and mortality including child abandonment and abortions. There is a gender differential in adolescent sexuality. This study found out that males were more sexually active than females. This is not unexpected because males are known to take risks more than females and more so they like experimentation. Furthermore, some males can be very adventurous and determined and may coerce the females to initiate sexual activity. Greater involvement of males than females in adolescent sexuality should be interpreted with caution because this could be exaggerated by under reporting among females as also previously reported by Araoye and Fakeye (1998).

As a result of adolescents' and youths' involvement in casual and / or commercial sex, multiplicity of sexual partners and inconsistence use of condoms, they are exposed to a high risk of contracting STIs including HIV. Specifically two out of three respondents in this study are at high risk of contracting STIs/HIV as a result of their sexual behaviour and with the occurrence of sexual networking among the respondents, the existence of a reservoir of HIV could lead to explosive situations among them and within the community. Most of the respondents cited condom use as their primary method of both

childbearing may also affect the acceptance of contraception especially in the adolescent group who fear infertility as possible consequence of contraceptive use. Fear of sterility subsequent to contraceptive use (Briggs, 1994) as documented in literature may be another reason preventing the use of contraceptives by respondents in this study.

Furthermore, in many countries in Africa, there has been some reluctance and ambivalence on the part of government, communities, parents and providers about the promotion of contraceptive for unmarried youth (Baker, 1990).

As a result of the long incubation period of HIV, adolescents and youths rarely see their colleagues with all the features of AIDS and by the time they do they don't believe and they do not see themselves as being at risk. Hence, they rarely take precautions and preventive measures in risk behaviour. As reported by Akande and Ross (1994), for effective risk reduction, individuals must see the disease as being serious, avoidable, and themselves at risk.

Sexual relationship often involves exchange of gifts or money, and that in some cases this transactional component becomes so important that these relationships become prostitution (Songue, 1986). Exchange of sex for gifts or money as revealed by this study confirms the reports (Songue, 1986) in literature, indicating that relationships that approach semi prostitution are not uncommon among adolescents and young adults. This transactional aspect of sexual relationships may help to encourage adolescents and youths to have sexual relationships with multiple partners.

It was found from the result of this study that there was consumption of alcohol and use of illicit drugs before and during sex, and more than one-fifth of the sample reported sexual experiences under their influence (20.2% and 4.3% for alcohol and illicit drug

respectively). The researcher is unaware of documentation of the freqtiency of these practices. The high prevalence of these behaviours (alcohol consumption and illicit drug use) could be as a result of greater exposure to sexual experience and alcohol use in male than female respondents as shown by survey and FGD findings. The researcher is unaware of previous studies documenting the frequency of drug injection in this age group, which was reported by 6.9 % of respondents in this study.

This study through FGD established that pregnancies in adolescents are unwanted. Although abortion is illegal in Nigeria, one-quarter (25.9%) of the sexually active females in this study who had been pregnant resorted to clandestine abortion. This is comparable with abortion rate of 23.5% reported in Lagos (Odujirin, 1989). Previous studies (WHO, 1989 and Odujirin, 1989) have noted that most adolescents procure illegal abortion from unskilled personnel and by dangerous methods. Between 150,000 and 200,000 women including adolescents and youths die every year from complications of illicit abortion (Anochie et al, 2001). Findings from previous studies in Nigeria have shown that 16% of maternal death was due to adolescent abortion (WHO, 1989 and Goddard, 1995). This problem of quackery, with the complications of clandestine abortion (a high risk behaviour) will remain with the adolescents and youths for a very long time unless efforts are intensified to reduce adolescent and youth sexual activity and pregnancy.

6 CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION: This study describes the HIV- related risk behaviour of out-of-school adolescents' and youths in Ilorin Metropolis whose population belongs to two social groups – those who are apprentice and those in unaffiliated. The study provides detailed baseline data that can be useful for the epidemiologic surveillance on adolescent health. Females were found to be more than males. Many (74.6%) respondents were sexually active and most of them (53.6%) have used condoms, but consistent use was low (38.1%). Condom use is influenced by many factors and most important is the type of relationship. Respondents with stable partners see themselves as being safe and having a stable/regular partner was perceived as good reason for non-protection. Sexual relationship often involves exchange of gifts or money and this transaction is more commoner in males than females. Other means of satisfying sexual urges and desires as revealed by FGD are rape, masturbation, holding a boy friend or girlfriend closely tight and having sexual intercourse with housemaids through financial and material inducements. Results of this study showed that there is significant degree of awareness about HIV/AIDS but this awareness does not translate to good behaviours as well as avoidance of HIV. It is important to note that despite high level of awareness of respondents about HIV, misconceptions still persists. Both the survey findings and FGD revealed that respondents' knowledge about HIV/AIDS is incomplete and technically inaccurate. Friends of the adolescents and youths studied consistitute a major source of information. This shows the importance of peer influence on behaviour especially among this age group. Parents were found to be poor source of communication to their adolescents and youths. The low level of education of parents contributes to poor

communication. A high proportion of respondents in this study had a negative attitude towards AIDS, as they did not feel AIDS was a problem. However, attitude of respondents towards people living with AIDS was found to be favourable. Many respondents do not perceive themselves as risks for failing to use condom during sexual intercourse w as also revealed by FGD. There is a high prevalence of alcohol consumption and use of illicit drugs and more in males than females. The prevalence of drug injection among the study population is 6.9% and this is a case for concern. Some respondents also engaged in clandestine abortion. Tatooing and scari fication arc the only traditional practices reported in this study and they are correlates of HIV-Related risk Behaviour.

This study has implications for policy because it contributes to the knowledge of and attitude to HIV-related risk behaviour of out-of-school adolescents and youths. For Focus Group Discussion, it provides a basis for designing strategies to prevent HIV/AIDS in out-of- school environment

6.2 RECOMMENDATION

1. Organization of public lecture for adolescents and youths on adolescent reproductive health, adolescent sexuality and HIV/AID. The public lecture must create awareness on the implications of sexual practices under the influence of drug or alcohol. Awareness should be created that emotional relationships do not provide protection and this may promote the necessary changes towards consistent use of condoms

2.There should be free distribution of condom to adolescents and youths.

3. Family life of parents must show good behaviour and attitude to adolescents and youths from which they can emulate.

4 Sex education should begin from individual homes and parents. Parents should encourage free communication concerning adolescents' sexuality and reproductive issues.

5.Prevention of sexual violence through promotion of adolescent and youth empowerment encouraged and promoted. This will help in reducing exchange of sex for gifts/money and forced sexual acts (e.g rape) as well as promoting willingness to come forward to report these atrocities.

6.Encouragement and promotion of stuctural interventions that provide out-of-school adolescents and youths with economic opportunities, such as vocational training and access to credit. This will help break a cycle of financial dependency, sex for money and risk of HIV.

7.Adolescents and youths play an integral role in HIV prevention. They should be used in conducting health education outreach. Such health education should include the use of popular opinion leaders and peer educators to change social and cultural norms around sexual practices, condom use and other harmful traditional practices such as scarification and tattooing.

. Structural interventions such as implementation of upper age limits on "teen scenes"

nd club catering to youth or stricter enforcement on age limits on alcohol consumption,

nay help interrupt HIV transmission between older men and young women.

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APPENDIX I: QUESTIONNAIRE

TOPIC: PREVALENCE AND CORRELATES OF HIV-RELATED RISK BEHAVIOURS AMOUNG OUT-OF-SCHOOL ADOLESCENTS AND YOUTHS IN ILORIN METROPOLIS, NIGERIA

Introduction: Dear Respondents, this questionnaire is designed for research purpose towards attainment of a Master Degree in Epidemiology and Biostatistics and the information given will be used for academic purpose only. Your responses would be given utmost confidentiality. Kindly tick or fill the appropriate response.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age group (yrs)
   a. 10-14 [ ]
   b. 15-19 [ ]
   c. 19-24 [ ]
2. Sex (a). Male [ ] (b). Female [ ]

3.Level of Education attended
   (a). Primary [ ]
   (b) Secondary [ ]
   (c) Technical [ ]
   (d) Arabic [ ]
   (e) None [ ]

4.Father's Educational Level
   a. None [ ]
   b. Primary [ ]

c. Secondary [ ]
d. Tertiary [ ]

5. Mother's Educational Level
a. None [ ]
b. Primary [ ]
c. Secondary [ ]
d. Tertiary [ ]

6.Father's Occupation
a.Civil Servant (e.g Police,Teacher, Clerks,Typist [ ]
b.Trading/ Buisness (e.g. Buying and Selling of Goods) [ ]
c.Artisans (Tailoring, Carpenters,Bricklayers, Hair Dressers,Plumbers) [ ]
d.Professional(Doctor,Lawyer,Engineer,Nurses) [ ]
e.Farming [ ]
f. Unemployed [ ]

7. Mother's Occupation
a.Civil Servant (e.g Police,Teacher, Clerks,Typist) [ ]
b.Trading/ Buisness (e.g. Buying and Selling of Goods) [ ]
c.Artisans (Tailoring, Carpenters,Bricklayers, Hair Dressers,Plumbers) [ ]
d.Professional (Doctor,Lawyer,Engineer,Nurses) [ ]
e.Farming [ ]
f. Unemployed [ ]

8.Ethnic Group
a. Yoruba [ ]
b. Hausa [ ]
c. Fulani [ ]
d. Igbo [ ]
e. Others [ ]

9.Religion (a) Islam [ ] (b) Christianity [ ] (c) Others [ ]

10.Number of Sibling
a.1-2 [ ]
b.3-4 [ ]
c Greater or equal to five [ ]

11. Monthly income of Father
a. Less than N10, 000 [ ]

b. N11, 000-20,000 [ ]
c. N21, 000-30,000 [ ]
d. N31, 000-40,000 [ ]
e. Greater than N40, 000 [ ]
f. Don't know [ ]

12. Monthly income of Mother
a. Less than N10, 000 [ ]
b. N11, 000-20,000 [ ]
c. N21, 000-30,000 [ ]
d. N31, 000-40,000 [ ]
e. Greater than N40, 000 [ ]
g. Don't know [ ]

13.Type of Family
a. Monogamous [ ]
b. Polygamous [ ]

14. Do you live with your parent (a) YES [ ] (b) NO [ ]

15. If NO, What is the relationship between you and the person you live with. ---------

16. What is the education status of the person you live with?
a. None [ ]
b. Primary [ ]
c. Secondary [ ]
d. Tertiary [ ]

SECTION B: KNOWLEDGE AND ATTITUDE ABOUT HIV/AIDS

Knowledge of HIV/AIDS

17. Are you aware about HIV/AIDS (a) YES [ ] (b) NO. [ ]
18.Source of information
a. Masters (a) YES [ ] (b) NO [ ].
b. Mother (a) YES [ ] (b) NO. [ ]
c. Father (a) YES [ ] (b) NO. [ ]
d. Posters (a) YES [ ] (b) NO [ ].
e. Newspaper (a) YES [ ] (b) NO [ ].
f. TV (a) YES [ ] (b) NO [ ]
g. Church/ Mosque (a) [ ] YES (b) NO.

19.AIDS is a disease in which the body defence cannot fight.
(a) Agree (b) Disagree (c) Unspecified

20. AIDS is caused by a virus
(a) Agree [ ] (b) Disagree [ ] (c) Unspecified [ ]

21 AIDS is spread through

a. Having sex with more than one partner YES [ ] /NO [ ]
b. Transfusion with infected blood. YES [ ] /NO [ ]
c. Taking injections with un-sterilized needles and syringes YES[ ] /NO[ ]
d. Homosexuality YES [ ] /NO [ ]
e. Kissing and using somebody's comb or hairbrush. YES [ ] / NO [ ]
f. HIV can spread through mosquito bites YES [ ] /NO [ ]
g. One can get HIV from first sexual intercourse YES [ ] /NO [ ]
h. One can get HIV from one episode of intercourse without a condom YES [ ] /NO [ ] .

22. You can prevent AIDS by

a. Keeping away from sex YES [ ] /NO [ ]
b. Having sex with only one partner YES [ ] /NO [ ]
c. Using condom during each sexual intercourse. YES [ ] /NO [ ]
d. Use of drugs e.g taking injections only from hospital or clinic. YES [ ] /NO [ ]
e. Native medication YES [ ] /NO [ ]
f. No idea YES [ ] NO [ ]

Attitude towards HIV/AIDS

23. AIDS is not a problem as people think (a) Agree [ ] (b) Disagree [ ] (c) Unspecified [ ]

24. Are you worried about contacting AIDS? YES [ ] /NO [ ]

25. I have heard enough about AIDS and I don't want to hear more
(a) Agree [ ] (b) Disagree [ ] (c) Unspecified [ ]

26.People with AIDS should be kept somewhere and not allowed to move around
(a) Agree [ ] (b) Disagree [ ] (c) Unspecified [ ]

27.One should show love and care for people with AIDS. (a) Agree [ ] (b) Disagree [ ] (c) Unspecified [ ]

SECTION C: HIV/AIDS RELATED RISK BEHAVIOUR

28.Are you aware of condom (a) YES [ ] (b) NO? [ ]

29.Do you use condom during sexual intercourse (a) YES [ ] (b) NO [ ] .

30.If YES, how often do you use condom (a) Always [ ] (b) Sometimes [ ] (c) Never [ ]

31. Who are the people you have ever used condom for?
    a. Stable Partner [ ]
    b. Casual Partner [ ]
32. If NO to question 29, what are the main reasons for non-use of Condom?
    a.Having stable parner [ ]
    b.Decreased pressure [ ]
    c.Parner,s refusal [ ]
    d.Difficulties in access [ ]
    e.Shame. [ ]

33.Have you ever had blood transfusion (a) YES [ ] (b) NO [ ]

34 If YES to Q 30, where and why---------

35.Which of the following traditional practices have you ever engaged in
    a. Scarification YES [ ] /NO [ ]
    b. Tattooing YES [ ] /NO [ ]
    c. Uvulectomy YES [ ] /NO [ ]
    d. Ear piercing. YES [ ] /NO [ ]
    e. Nose piercing. YES [ ] /NO [ ]
    f. Hair barbing using un-sterilised instrument YES [ ] /NO [ ]
    g. Bear shaving using un-sterilised instrument YES [ ] /NO [ ]

36. Lifetime number of sexual partners
    a.1-3 [ ]
    b.4-6 [ ]
    c 7. & above [ ]
37.Do you currently have a stable partner YES [ ] /NO [ ]
38 Have you ever exchanged sex for gifts or money YES [ ] /NO [ ]

39. Have ever engaged sexual rape (a) YES [ ] (b) NO [ ].

SECTION D: SEXUAL PRACTICES AND RELATED VARIABLES.

40. Have you ever had sex before (a) YES [ ] (b) NO [ ] (c) Un-specified [ ]

41. Age at first sexual intercourse/sexual initiation
    a. 10-15 yrs [ ]
    b. 16 yrs and above [ ]
    c. Unspecified [ ]

42. Frequency of Sexual Intercourse.
    a. Once a week [ ]
    b. Once a month [ ]
    c. Once a while [ ]
    d. Not specified [ ]

43. How many people have you ever had sex with since you started having sex
    a.1 person [ ]
    b.2. Person [ ]
    c.3 persons
    d.Greater than 3 persons [ ]
    e. Unspecified. [ ]

44. How many times have you had sex in the last 3 months?
    a. None [ ]
    b 1 or more times [ ]
    c. Unspecified [ ]

45. Person always use condom for in the last 3 months
    a. Stable partner [ ]
    b. Casual partner [ ]

46. Type of people you have ever had sex with
    a Fellow Apprentist [ ]
    b. Boy/Girl friend [ ]
    c. Casual friend. [ ]
    d. Some approached for financial assistance [ ]
    e. Prostitute [ ]
    f. Some of the same gender with me. [ ]

47.Doyou use contraceptive before during or after sexual intercourse
(a) YES [ ] (b) NO [ ].

48.If YES, Which method of contraceptives do you use

a.Condom [ ]
b.Oral contraceptives [ ]
c.Coitus interruptus [ ]
d.Safe period/ cycle calculation [ ]
e. Others, please specify [ ]

49.If NO,Why?

a. Lack of Knowledge [ ]
b. Don't Know any source [ ]
c. Religious belief [ ]
d. Non-availability [ ]
e. Fell ashamed to buy [ ]
f. High Cost [ ]
g. Fear of reprimand by Parents. [ ]

50.Have you ever had an abortion before (a) YES [ ] (b) NO [ ].

51.If YES, How many times ----------

SECTION E: SUBSTANCE USE VARIABLE

52.Do you take drug to increase your sexual performance (a)YES[ ](b)NO[ ]
53. If YES, Name the drug ----------
54.What are the modes of administration of dug ever taking to increase sexual performance

a.Orally [ ]
b.By injection [ ]

55. Do you drink alcohol to influence your sexual performance (a) [ ] YES (b) NO [ ]

56.Have you ever injected yourself a drug before (a) YES [ ] (b) NO [ ].

APPENDIX 2: Distribution of respondents by social, trade and work group

Social group	Trade group	Freq	%
Apprentice (N=255)	➢ Hair dressing/barbing saloon	70	22.2
	➢ Tailors	40	12.7
	➢ Carpenters	30	9.5
	➢ Motor mechanics	50	15.9
	➢ Sawmill industry	20	6.3
	➢ Battery chargers	10	3.2
	➢ Vulganizers	15	4.8
	➢ Traditional cloth weaving	20	6.3
Sub-Total		*255*	*80.9*
Social group	**Work group**	**Freq**	**%**
Unaffiliated (N= 60)	➢ Pure water sellers	23	7.3
	➢ Newspaper vendor	10	3.2
	➢ Food vendor	13	4.1
	➢ Cassette sellers	6	1.9
	➢ Shoe shiners	8	2.6
Sub-Total	-	*60*	*19.1*