SEXUAL PRACTICES AMONG YOUTHS WHO INDULGE IN THE ABUSE OF PSYCHOACTIVE SUBSTANCES IN SELECTED INNER-CORE AREAS OF IBADAN, NIGERIA

BY

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A Project submitted to the Department of Health Promotion and Education
Faculty of Public Health, College of Medicine
In partial fulfillment of the requirements for the degree of

MASTER OF PUBLIC HEALTH
(HEALTH PROMOTION AND EDUCATION)

of the

UNIVERSITY OF IBADAN

MAY, 2019

ABSTRACT

Drug abuse is a common public health problem among young persons worldwide. Indulgence in risky sexual practices is noted to be prevalent among them and this in turn makes them susceptible to Sexually Transmitted Infections (STIs). There is, however, dearth of information relating to the risky sexual practices among young persons who abuse psychoactive substances in the urban slums of Ibadan. This study was therefore designed to investigate the sexual behaviours of drug-dependent youths in selected inner core or slum areas of Ibadan metropolis.

The study was a descriptive cross-sectional survey which involved the use of a multistage sampling technique to select 215 psychoactive drug-using males in Beere and its environs. A pretested semi-structured, interviewer-administered questionnaire was used to collect data relating to the sexual behaviours, knowledge of condom, pattern of drug use and the influence of drugs on sexual behaviour of respondents. Eight Focus Group Discussions (FGDs) were also conducted to provide more insights into the study. Descriptive statistics, Chi-square and t-test statistics were used for the analysis of the quantitative data while the thematic analytical method was used to analyse the FGD data.

The respondents' ages ranged from 15-24 years with a mean of 22.2 ± 2.3 years. The drugs that had ever been used or abused by them included alcohol (78.1%), Marijuana (68.4%), Tramadol (65.1%), *"Skunk"* (60.9%), *Skushi* (60.5%), codeine (56.7%), caffeine (48.8%) and rophynol (48.4%). Respondents' age of sexual debut was 16.3 ± 3.4 years. Majority (71.2%) of them had ever taken psychoactive drugs to enhance sexual satisfaction. Tramadol (71.6%) topped the list of the drugs mostly used to enjoy sex. Majority of the respondents (73.0%) had ever used condom with 68.2% still involved in the practice as at the time of the study. Few respondents (25.5%) would proceed with sex without using condom if a sexual partner objected to its use. The other risky sexual practices included having casual sexual partners (63.0%), and indulgence in sex for money (47.0%). The FGD participants stated that alcohol and other drugs were used to gain energy needed to indulge in sexual intercourse and to perform other energy-sapping jobs. The FGD results revealed that opinion was divided on pattern of condom use among the drug-using youths; while about half across most of the groups said the practice was common while the other half disclosed that condom was rarely used by the youths. The

categories of persons condoms were used with included commercial sex workers and girls perceived to be sexually promiscuous. The main reasons for sustained condom use were to prevent pregnancy and Sexually Transmitted Infection.

The prevalence of using psychoactive drugs to enhance sexual intercourse was high among the respondents. In addition several sexual practices that can put them at risk of health-related challenges were noted. Health education strategies such as training, counseling, advocacy and social marketing are needed to promote healthy sexual practices and reduce the prevalence of drug abuse among the study population.

Keywords: Young persons, Drug abuse, Condom use, Risky sexual behaviour
Word count: 483

DEDICATION

My profound gratitude goes to Almighty God for giving me the grace to start and complete this study. I also dedicate this work to all my family members, most especially my parents, Prof. and Mrs. Jegede and my siblings for being there for me all the time.

ACKNOWLEDGEMENTS

My gratitude goes to God Almighty, who saw me through this programme. I hereby appreciate the patience and contributions of my supervisor, Dr F.O. Oshiname. His sustained guidance, meticulousness and constructive criticism helped me to carry out this research work successfully.

I am highly indebted to Dr O.E. Oyewole the Ag. Head of Department of Health Promotion and Education and all the members of the academic staff of the Department for their training, social support and advice that helped to shape me; their contributions each time I approach them are appreciated. I am equally grateful to the non-teaching staff of the Department for support and assistance each time I needed help from them.

My appreciation also goes to Mr Tayo Ogunwale for his immense contributions to the success of the project. I appreciate the solidarity of all my colleagues in the Department of Health Promotion and Education; They shared excellent ideas and offered various forms of contributions during the design and execution of the project. I hereby register my gratitude to my research assistants who were Mr Uche, Mr Akinola, Mr Mekene, Mr Adenle and Mr Paul. I express my thanks to all the youths of Beere and its environs who voluntarily participated in this research. Without them it would not have been possible to carry out this study. Special thanks go to the authors and organizations whose articles, books and reports contributed immensely to the design of this study.

Furthermore, special thanks are due to my father, Prof. A.S. Jegede who played a pivotal role in all aspects of this project. His encouragement, support and keen interest motivated me to work hard on this project. I am equally grateful to my mother, Mrs V.F. Jegede for her care, love, prayers and endless support throughout this programme. Lastly, I seize this opportunity to thank my siblings for standing by me all through the difficult times.

CERTIFICATION

I certify that this study was conducted by **Mr. Tolulope Joshua JEGEDE** in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria, under my supervision.

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CHAPTER ONE

INTRODUCTION

Background to the Study

According to the United Nations (UN), the concept of youth is best understood as a period of transition from the dependence of childhood to adulthood's independence. For statistical purposes, the United Nations defines 'youth,' as those persons age 15 to 24 years… (*United Nation, 1985*). Young persons include out-of-school youths aged 24years and less. Out-of-school youths are generally considered as the youths who do not attend school or who drop out prematurely from school, thus missing many of the fundamentals of basic education. According to UNESCO, 263 million children and youths are out of school worldwide with about 96.9 million of them based in sub-Saharan Africa. The agency noted that as of 2008, about 9.7 million youths were reported to be out of school in Nigeria (UNESCO, 2018).

Youth are vulnerable to misinformation from unreliable sources. This makes them more likely to engage in risky practices which include substance use/abuse, prostitution, risky sexual practices, stealing, and violence. There are other categories of youths or young persons who have not dropped out of schools; rather they are youths who completed the primary, secondary and tertiary education but indulge in certain risky sexual practices which are common among youths. These are youths who abuse alcohol and other psychoactive substances for instance many psychoactive drug using youths, like indulge in risky sexual practices. There are two broad typologies of sexual behaviours which the youths could indulge in; these are risky sexual behaviour and non-riskysexual behaviours.

Risky sexual behaviours include behaviour that increases peoples risk of contracting sexually transmitted infections or experiencing unintended pregnancies (Dimbuene, Emina, & Sankoh, 2014). Typical risky sexual behaviours include sex without using condom, mouth-to-genital contact, initiation of sexual activity at a young age, possession of multiple sexual partners, having high-risk partners, indulgence in anal sex, sex with a partner who injects drugs, engagement in commercial sex work and intake of alcohol and other psychoactive substances in order to enjoy sex (Healthwise, 2017).

Drug abuse is the use of drugs for psychotropic reasons rather than for medical purposes. Common psychotropic drugs which young persons abuse includes opiates (opium, morphine, and heroin), hallucinogens (LSD, mescaline, psilocybin), barbiturates, cocaine, amphetamines, tranquilizers, cannabis and tobacco of various forms and alcohol. However, alcohol and tobacco are socially accepted, and their possession and use are legally acceptable. The term drug abuse is normally applied broadly to excessive and addictive use of drugs. This implies that alcohol and tobacco can be abused. Psychoactive drugs can have severe physiological, psychological, and social, adverse consequences; consequently, many governments regulate their use or ban some of them altogether. (Steiner, 2016).

Individuals who abuse drugs build up a tolerance to their effects, and as they become more addicted, their health gets worse. The associated physical risks of use/abuse of psychoactive substances include heart problems, HIV/AIDS, damage to the lungs, and seizures. Possible psychological consequences include anxiety, poor judgment, impaired memory, and even psychosis. Individuals who use drugs are at risk of legal consequences (Hayver, 2017). In Nigeria, most psychoactive drugs are illegal under federal law, and psychoactive drug related offenses come with very high costs.

Studies have shown that many drug users also indulge in risky sexual practices. A survey conducted among 1,304 drug users in western China showed that nearly 54% of the respondents had never used condoms during sexual intercourse with either a spouse or cohabitant; 26% had had sex with casual sexual partners in the past year preceding the study, and about 34% never used condom when having sex with their casual partners. It was also noted that almost 14% had commercial sex and nearly 23% had never used condoms when having commercial sex. The study revealed that risky sexual behaviour among drug users was a source of concern (Huang et al., 2013).

Drug use behaviours among young persons inhibit their cognitive abilities or increase their urge to have sex. This, in turn, pushes them to practice risky sexual behaviours. A survey conducted among the youths in a rural community in North West Nigeria showed that about 10% of individuals aged 15-35 years abuse drugs with about 52.8% of them abusing Tramadol. They also reportedly abuse marijuana (Gobir et al., 2016). The age range implies that young persons aged 24 years and less are involved.

Another survey that focused on the use of psychoactive substance among 293 Nigerian showed that 60.8% take alcohol, 48.1% take codeine 44% abuse sleeping pills, 43.7% take nicotine while 25.6% take inhalation agents (Donald, 2017).

According to The Joint United Nations Program on HIV/AIDS (UNAIDS), in 2008 young people aged 15–24 years accounted for 42% of new HIV cases, and nearly 80% of this group live in sub-Saharan Africa. It has been stated that unless there are interventions that are focused on the needs of drug using out-of-school youths, certain sexual activities they engage in will put them at risk of STI including HIV/AIDS. As they are still young persons, they are exposed to much risky behaviour including casual sex and multiple sexual partners. These behaviours make them vulnerable to phenomena like HIV and AIDS and abortion (UNAID,). They could also be at risk of blood borne infections like Hepatitis B.

The risky sexual practices of young persons who abuse alcohol and other drugs have not however been well explored. This study is therefore designed to focus on the sexual practices of drug using youths in selected urban slums in Ibadan.

Statement of the Problem

Studies have revealed some of the sexual behaviours of young people in several parts of Nigeria including Ibadan. The results of these studies show that the socio-demographic characteristics of young people who are sexually active are highly varied.

The risky sexual practices among young people in Ibadan have been documented,and they include the following: early sexual debut, unprotected sexual intercourse, multiple sexual partnerships, and casual sexual intercourse. The potential adverse effects of risky sexual practices are grave. They include the following: STI including HIV, Hepatitis B infection and unwanted pregnancy.

Series of community diagnoses conducted by students of Health Promotion and Education, University of Ibadan revealed the involvement of young people in the city in risky sexual practices and the abuse of psychoactive substances. This is common among the youths who are resident in the, city's slum areas which sometimes referred to as the "inner-core"

areas based on the classification of students of Health Promotion and Education field work activities.

Studies have also revealed that those who abuse drugs are more susceptible to risky sexual practice which, in turn, exposes them to health risks such as HIV/AIDS and other STIs.

There is however dearth of information relating to young people's use of psychoactive substances to promote the enjoyment of sexual intercourse in Ibadan with special reference to the slum areas. This study was, therefore, designed to determine the following among young people who are involved in the use of psychoactive substances in a selected slum area in Ibadan: Sexual practices in general, the prevalence of use of psychoactive substances to enjoy sexual intercourse, typology of psychoactive substances used and pattern of safe sexual practices.

Justification

The results of this study have great potential for yielding results that can be used for the formulation of policies and the design of interventions related to the control and prevention of the use of psychoactive drug to promote sexual experiences among youths who abuse psychoactive substances in the study settings.

Research questions

The questions that this research was designed to answer was as follow:

1. What is the prevalence of risky sexual behaviours among the youth who abuse psychoactive substances the inner-core areas of Ibadan?
2. What are the psychoactive drugs abused by the youth in selected inner-core areas of Ibadan?
3. What is the pattern of abuse of psychoactive drugs among youth in selected inner-core areas of Ibadan?
4. What is the relationship between psychoactive drug usage and risky sexual behaviours among youth in selected inner-core areas of Ibadan?

Objectives of the study

The broad objective of this study was to investigate the sexual behaviour of drug-using youths in selected inner core areas of Ibadan.

The specific objectives were to:

1. Determine the prevalence of risky sexual behaviours among youth who abuse psychoactive substances in selected inner-core areas of Ibadan
2. Identify the psychoactive drugs abuse by youth in selected inner-core areas of Ibadan
3. Identify the pattern of abuse of psychoactive drug among youth in selected inner-core areas of Ibadan
4. Determine the relationship between psychoactive drug usage and sexual behaviours youth in selected inner-core areas of Ibadan

CHAPTER TWO

LITERATURE REVIEW

Introduction and Conceptual Clarification

Sexual health refers to a state of physical, emotional, mental, and social well-being about sexuality (World Health Organisation (WHO), 2015). It also refers to a positive approach to sexuality and sexual relationships and not only the absence of disease or infirmity. It entails abstaining from risky sexual behaviours. Risky sexual behaviours are sexual activities that are likely to expose an individual to the danger of having unplanned pregnancies, contracting sexually transmitted infections (STIs) including HIV/AIDs (Famutimi, 2014) as well as psychological ill health (Dimbuene et al., 2014; Fetene & Mekonnen, 2018). They include engaging in unsafe sex (unprotected sex, sex with multiple partners), early sexual debut, indulging in forced or coerced sexual intercourse, having sex with older partners and engaging in sexual intercourse either for monetary or kind reward (Alemu, Mariam, Belay & Davey, 2007; Famutimi, 2014).

Risky sexual behaviours may be more pronounced among young persons. According to WHO adolescents refers to individuals who are between the ages of 10-19 years and 'Youth' as those who are between 15-24 years while 'Young People' as those who are within the age range 10-24 years (Goodburn, Elizabeth , Ross, & David, 1995). There are two categories of youths. These are the in-school and out-of-school youth. The term "out-of-school" youth means refers to an eligible youth who has dropped out of school or an eligible youth who has received a secondary school education or its equivalent but is short of basic skills, unemployed, or underemployed (WIOA WIA, 2015). Risky sexual behaviour engaged in by adolescent is of public health concern as it has damaging effects on sexuality, leads to unwanted pregnancy, increases the possibility of contracting as well as spreading HIV/AIDs and other STDs (Kongnyuy, Wiysonge, Mbu, Nana, and Kouam, 2006; Gillespie, Kadiyala, and Greener, 2007; Awusabo-Asare and Annim, 2008)

Researches have documented a relationship between risky sexual behaviour and increased economic status, that is, people who have of high income or wealthy are likely to indulge in risky sexual behaviour thus increasing their vulnerability to HIV infection and other STIs (Kongnyuy, Wiysonge, Mbu, Nana, and Kouam, 2006; Awusabo-Asare and Annim, 2008). A study in Cameroon corroborated the hypothesis of relationship between risky

sexual behaviour and economic capability (Kongnyuy, Wiysonge, Mbu, Nana, and Kouam, 2006)

On economic capability and risky sexual behaviour, a study conducted by Berhan, Hailu, and Alano, (2011) found out that risky sexual behaviours among students may be associated with their personal as well as parents' socio-economic standing. The study further by revealing that place of residence also predicts risky sexual behaviour. It showed that university students who had their formal education in urban secondary schools are more probable to engage in risky sexual behaviour than their colleagues who schooled in rural high schools.

Knowledge of HIV is also correlated with risky sexual behaviours. Apart from knowledge about HIV, other correlated factors are personal characteristics such as religious affiliation, financial status, age, educational background and occupational status (Seidman et al. 1994; Gras, van Benthem, Coutinho, and van den Hoek; 2001; Kimuna and Djamba 2005). Furthermore, correlated factors also include smoking and alcohol (Weller and Davis 2002; *Opio, Mishra, Hong, Musinguzi, Kirungi, Cross, Mermin, and Bunnell, 2008) witnessing violence among parents (Pinkerton and Abramson 1997) and male circumcision (Cassell, Halperin, Shelton, and Stanton, 2006; Eaton and Kalichman 2009; Kibira, Nansubuga, Tumwesigye, Atuyambe, and Makumbi, 2014).

Factors such as age, peer pressure , and gender influence -young peoples' disposition to drug use and sexuality (Nwagu, 2015). Ifelunni and Okorie (2003) reported that females have a higher mean age of sexual debut than males. Domingo and Marquez (1999) also revealed that males are more likely than females to engage in use and abuse of alcohol, drugs, and tobacco. Moreover, studies have proven that as individual advances in age, the tendency to use and abuse drug also increases (Corraro et al., 2000). Peer preesure contributes to initiation of drug use among young people (Amonini and Donovan, 2006).

Substance use is the regular use of alcohol as well as abuse of prescription drug. It also means the consumption of illegal substances such as cannabis, cocaine, opiates, and ecstasy (Ritchwood et al., 2015). Analyses of the risk factors for adolescent use of substance can be categorized into four; psychological functioning, b) familial environment, c) social relationships, and d) life stressors (Ritchwood, 2012). Psychological functioning can be explained when substance use is connected to

psychological distress such as anxiety and depression. In this case, adolescent having issues with anxiety and depression can result into substance use to cope with situation he or she finds him or herself (Armstrong & Costello, 2002). The influence of familial environment according to some studies can be seen through the nature and quality of familial relationships. Poor familial relationship will likely produce a substance using adolescent (Brook, Brook, De La Roosa, Whiteman, Johnson, & Montoya, 2001)). The level of parental monitoring can be a protective factor against substance use (Barnes, Reifman, Farrell, & Dintcheff, 2002; Stewart, 2002).

Adolescents usually value relationships with peer; hence the strong influence of peers on their behaviours. The degree or rate at which adolescents' close friends use drugs can significantly predict the initiation of their use of marijuana (Wills, Sandy, Yeager, Cleary, & Shinar, 2001). Stressful life experiences such as violence such as sexual and physical abuse, divorce, separation have been linked with use of substance use as time goes on (Kirkpatrick, Acierno, Saunders, Resnick, Best,& Schnurr, 2000; Wills et al., 2001).

Substance use has negative consequences on adolescents' behaviour (Ritchwood, 2012). It is reported that it has fatal effect on academic performance, can lead to deviant behaviour and subsequent use of or addiction to substance in adulthood (Gilvarry, 2000; Sloboda, 2002). They may also engage in risky sexual behaviour such as having sex at a very age (Jiloha, 2009). In the US, consumption of alcohol is seen as an underlying factor to the top three causes of death among U.S. adolescents (National Institute on Alcohol Abuse and Alcoholism, 2003).

It has been argued that drug use influences the users' physical health, thought patterns and behaviours (Gabhainn and Francois, 2000). Alcohol impairs decision making and decreases self -consciousness about what is right or wrong (Gabhainn and Francois, 2000). Young people -naturally have less control over their emotions and the use of alcohol may aggravate the situation by impairing their ability to make rational decisions. Hence, the use of alcohol and other subtances such as Indian hemp increase the possibility of young peoples to engage in risky sexual behavious (Strunin and Hingson, 1992; Unachukwu and Nwankwo, 2003).

Sexual practices of out-of-school drug-using youths

The report of WHO, (2009) revealed that sexual activities among youth is on the increase worldwide. Family Health International Youth Net program, (2002) opined that youths are at high risk of dangerous sexual behaviours and reproductive health problems. Youths in Sub-Saharan Africa have been reported to frequently engage in risky sexual behaviours, for example, pre-marital sex, with dire consequences including unwanted pregnancy, STIs and HIV/AIDS (Mariam et al., 2018).

There is an association between drug use and sexual practices of both in-school and out-of-school youths (Mariam et al., 2018; Tarkang et al., 2018). Research has shown that young people who regularly abuse substances are more likely to have early sexual debut (Madkour, Farhat, Halpern, Godeau, & Gabhainn, 2010), engage in sex with multiple partners (Connell, Gilreath, & Hansen, 2009), be more susceptible to contracting STI (Swartzendruber, Sales, Brown, DiClemente, & Rose, 2013) and have unprotected sex (Tucker et al., 2012) when compared to their peers who do not engage in substance use

A study conducted among out-of-school youth in the Philippines revealed that they constitute a high risk population for STIs. Thus, health education may be vital so that they will be saved from STIs. When compared to the in-school youths, the out-school youths have fewer information sources. However, they were more sexually active than the in-school youths who had more sources of information about STIs (Tanaka et al., 2017).

The use of sexual stimulants such as Viagra, marijuana and local herbal substances is becoming rampant among youths especially among the teen boys. (Molobe, 2016). Sometimes, street drug hawkers sell these drugs to these people with the claim that they enhance satisfying sexual performance. A study conducted revealed that “Date Rape Drugs” including Rohypnol are sometimes used by young people (Howard et al., 2003). Alcohol is also believed to enhance sexual performance and thus its abuse.

Prevalence of risky sexual practices among drug-using young people

A study on the prevalence and causes of sexual risk behaviours among injection drug users (IDUs) in Tashkent, Uzbekistan revealed that risky sexual behaviours were common and associated with risky injection habits among IDUs. A substantial number of the participants who reported a diagnosis of STIs before the study had an association with

early initiation into drug use and abuse, sharing of needle with other drug users, multiple sex partners in the previous month prior to the study and daily injection use (Todd et al., 2007).

In a comparative study of risky sexual behaviour and associated risk factors among youths in south-west Ethopia, Fentahun & Mamo (2014) reported that consumption of alcohols makes female and male students 7 and 2.8 times respectively to be more susceptible to risky sexual behaviours than those who did not consume alcohol.

Youth friendly centers and clinics have an influence on the prevalence of risky sexual behaviour among youths. A comparative cross-sectional study on the prevalence of risky sexual behaviours among users and non-users of youth center reproductive health clinics users in Addis Ababa, Ethiopia revealed that the likelihoods of reporting risky sexual behaviour was 60% higher among respondents who are non-users when compared users of reproductive health clinic (Fetene & Mekonnen, 2018).

Psychoactive drug used by youths

One of the critical public health challenges being faced by youths is the use of psychoactive substances such as alcohol, tobacco, and cannabis (Oshodi, Aina & Onajole, 2010). According to Igwe, Ojinnaka, Ejiofor, Emechebe & Ibe, (2009), the rate of drug use and abuse is increasingly becoming common in Africa and a worrisome public health problem among the African youths. It is revealed that as the use of drug increases, the age of initiation into drug use and abuse decreases (Fatoye et al., 2002; 2006). Youths engage in the use of alcohol and cigarettes at the initial stage of drug use and later moved up to dangerous psychoactive substances such as cannabis and cocaine (Abiodun et al., 1989).
Youths gets involve in the drug business in diverse forms or positions. They can be drug users, drug cultivators or farmers, and or drug courier. Various factors come into play in the use of drugs by youths. These are personal, micro (family, schools and peers) and macro (socioeconomic and physical environment) factors. The early (10-14years) and late adolescence (15-19 years) are critical ages individuals get initiated into substance use (TEDS, 2014). Drugs are used by many youths to manage social and psychological challenges (such as crave to meet social and psychological needs such as the need to feel good; feel among, belong; socialize) that they may encounter at different developmental phases from adolescence to young adulthood which make them to use drugs (Shedler &Block, 1990).

According to the World Health Organization (WHO), tobacco is accountable for some 4 million deaths a year, a figure which is expected to rise to 8.4 million deaths a year by 2020 (Murray et al., 1997). A Canadian study conducted by Hammond (2003) revealed that young adulthood is a critical stage in the adoption of tobacco smoking behaviour. In the study, the highest prevalence rate of smoking is found among the young adults. The study also revealed that an approximation of one fifth of current young adults who smokes initiated smoking after they clocked 18 years. Findings further revealed that attempt to quit smoking among youths (less than 16) are rarely successful but an increase is observed after 17years. However, despite the cessation of smoking at 17 years, the prevalence of smoking continued to rise till age of 22 years. This indicates that a higher number of fresh smokers substituted those who had stopped smoking.

Similarly, the Centre for Disease Control (CDC) (2014) reported that almost all tobacco use was initiated during youth and grows during young adulthood. More than 3,200 children age 18 or younger initiate tobacco smoking daily. It is reported that nearly 9 out of 10 smokers initiate smoking before they clocked age 18 years and almost all initiated smoking by age 26. An adult who had premature death due to smoking is substituted by two new young smokers (CDC, 2014).

Tobacco smoking has damaging effects which can be immediate and future. Young people who smoke tobacco are at risk of being addicted to nicotine, experiencing reduced lung function and growth and having early cardiovascular damage. Nicotine exposure among adolescent can have lasting effects on their brain development (CDC, 2014).

Cannabis use among young people

Marijuana and cannabis are often juxtaposed and used synonymously in literature and this will be maintained in this literature review. Marijuana usually comes in a green or brown combination of dried, shredded leaves, stems, and flowers from the hemp plant (Cannabis sativa). It is usually smoked in form of packaged substance in cigarette paper, in cigars with the marijuana replacing tobacco (blunts), or in small pipes (bowls) (Foley, 2006). Marijuana can be taken singly (when smoked), eaten as a mixture with food or drunk as a brewed tea (National Institute on Drug Abuse (NIDA) InfoFacts, 2006)

Cannabis is the most widely used drug in most countries. The use of cannabis cuts across the general population but is more popular among the youth population. A 2016 report of accumulated data from 130 countries, released by UNODC suggests that, 13.8 million young people (mostly students, aged 15-16 years), equivalent to 5.6% of the population in that age range used cannabis at least once in the previous 12 months .

The use of cannabis is usually initiated in late adolescence (15 to 19 years) and peaks in young adulthood (Weier, 2016). Medical research reveals that cannabis use prior to age 16 years makes young people to be susceptible to acute harm; developing drug use and mental health disorders (Anglin et al., 2012). The use of cannabis usually paves the way for the use of other drugs. Furthermore, adolescents who use cannabis have a higher probability of using other drugs than non-users of cannabis, even when other significant co-variables such as genetics and environmental influences have been controlled (Lessem, 2006).

Initiation of the use of marijuana can be influenced by detrimental personal factors (e.g. conduct disorder, antisocial personality disorder); detrimental family factors (e.g. parental use of substance, weak parental supervision or monitoring, abusive parents); detrimental environmental factors (e.g. easy access to marijuana; peers using marijuana; frequency of marijuana offers) and detrimental school factors (e.g. low academic goals, weak school connectedness, low grades) (Foley, 2006).

Effects of cannabis use include pulmonary effects, cognitive effects, mental health effects, behavioural effects, stroke and cardiovascular effects (Foley, 2006). Wheezing, production of early morning sputum and coughing symptoms are common among young individuals who use marijuana alone (Taylor and Hall, 2003). It is reported that approximately 1 in 6 adolescents who use cannabis develop cannabis use disorders (Volkow, 2014). Cannabis use disorder refers to a problematic pattern of cannabis use resulting to clinically significant damage or distress (American Psychiatric Association, 2013).

Pattern of drug use and risky sexual behaviour

A study on pattern of risky sexual behaviour among undergraduate students of the University of Port Harcourt revealed that, 33.6% of the respondents had their sexual debut within the age range of 15-19 years; 23.5% had had sex with someone in the month preceding the study and 13.4% reportedly had one sexual partner. Only 31.8% of respondents used a form of protection. The study revealed a relationship between the current user of alcohol and having sex (Imaledo John, Peter-Kio, & Asuquo, 2012).

A similar study was conducted in Ibadan among 200 patients that attend the Association for Reproductive Family and Health (AFRH) Centre in Ibadan in 2011. The result showed that 55% of the respondents were infected with various STI pathogens and 10.5% had other bacteria. Risk factors that made them susceptible to contracting STI were identified to be a young age, sex, and marital status (Okerentugba, 2012). There is a longitudinal relationship between risky sexual behaviours and drug use. Adolescents with higher levels of drug use tend to have more sexual partners, thus higher frequencies of having unsafe sexual intercourse (Brook, Brook, Pahl, & Montoya, 2002).

Study conducted by revealed that male youths engage in risky sexual behaviour such as having sex with multiple sexual partners than the female youths (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010). A meta-analysis conducted by Berhan and Berhan, 2015 revealed that the pattern of risky behaviour can be explained in relation to the differences or categories. The analysis revealed that male youth who are between 15–19 years have higher likelihood to engage in higher-risk sexual activity than those who are between 20–24 years.

A national survey conducted by Johnston, O'Malley, & Bachman, (2001) among high school seniors found that majority (80%) of the respondents had, at least once in their lifetime, drank alcohol while 29% reported marijuana smoking at least one in a lifetime (Johnston, O'Malley, & Bachman, 2001). Epstein (2017) in the study conducted reported an approximation of 1 in 7 adolescents who fell between 12 and 17 years met DSM-IV standards for substance abuse or dependence. The rates of substance use are higher among the special population e.g. the criminal offenders, runaways, and homeless adolescents (Gilvarry, 2000). This can be linked to their special characteristics which make them different from the general population.

The report of the Canadian Tobacco, Alcohol and Drugs Survey in 2013 revealed that one quarter of Canadian youth who are between the ages of 15–24 years old reported the use of cannabis in 2013. This figure made cannabis to be the most commonly used illegal drug among this age group in Canada (Canadian Tobacco, Alcohol and Drugs Survey, 2013). The report also showed that 27.4% of youth who are into use of cannabis used daily or almost daily during the past three months. However, Porath-Waller, Brown, Frigon, & Clark, (2013) argued that the youths who are into cannabis use might be unconcerned about the pattern of use as cannabis is perceived to be natural/ organic, harmless and non-addictive. According to Volkow, Baler, Compton, & Weiss, (2014) the youths who perceive cannabis to be safe are likely to use it. Porath-Waller, et al., (2013) reported that some youths believed that cannabis use is advantageous as it helps them stay focus while driving; enhance their health and even a prevention or curative to cancer.

However, the perception is wrong as cannabis consumption poses dangerous threats to the individual user and the society at large. Batalla, Bhattacharyya, Yucel, Fusar-Poli, Crippa, Nogue, et al., (2013) reported that regular consumption of cannabis in adolescent years impedes function and development of the brain system. It is also observed that early initiation of regular can lead to behavioural and cognitive impairments (Mokrysz, Gage, Landy, Munafo, Roiser, & Curran, 2014). It can also makes operation of a motor vehicle unsafe as it leads to deficits in attentional focus (Hall, 2014). Regular consumption of cannabis is associated with the experience of psychotic symptoms and developing schizophrenia (Large, Sharma, Compton, Slade, & Nielssen, 2011). There is also a prediction that one in six individuals who consume cannabis during adolescence will develop a cannabis use disorder (Anthony, 2006).

There is age and gender dimension to smoking. While a substantial decline in smoking among adults in Europe has been observed in recent years, the same cannot be said of persons between the age 11 and 15 years olds. Little decline has been observed among this age category (ASPECT Consortium, 2004 and Currie, Roberts, Morgan, et al., 2004). Furthermore, regular smoking in girls is being higher when compared to their boys counterparts in 19 out of 31 European countries (Alexander, Currie Todd, et al., 2004; Currie, Roberts, Morgan, et al., 2004).

Explaining the rationale behind this gender patterns, Amos and Bostock (2006) from the

study conducted among young boys and girls of the same age category, found out that the differences in the gendered pattern of smoking *are factors of their social worlds; pattern of social interactions and relationships; interests, activities and concerns; their perceptions of smoking and the role smoking played in dealing with the daily experiences and realities of being an adolescent boy or girl. Hence, the authors recommended that it is essential for policies and programmes targeted at smoke reduction among youth to embrace gender-sensitive lens

Influence of psychoactive drug on sexual behaviours

Alcohol use or use of other drugs has been identiifed as a contributing factor to risky sexual behaviour. Alcohol and other drugs contribute to risky sexual behaviour as they have impairing effects on judgment and decision- making. Studies have shown that cannabis users engage in more risky sexual behaviours than non-users and thus, are at higher risk of contracting HIV infection and sexually transmitted diseases (Bon, Hittner, and Lawandales, 2001; Castilla, Barrio, Belza, and; Poulin and Graham, 2001). There is also a relationship between cannabis use and early sexual debut (Staton *et al.*, 1999) and having multiple sexual partners (Poulin and Graham, 2001).

The association between substance use and unprotected sex have been anchored on the effects of substance use including impairment of rational thinking (Kelleher, Stough, Sergejew, and Rolfe, 2004) ecstatic mood (Green, Kavanagh, and Young, 2003), and self-reported aphrodisiac effects (Kleiber and Soellner, 1998). These effects have the possibility of impairing behavioural control hence, enhancing the probability of engaging in unprotected sexual intercourse.

*Over the years, research studies have replicated findings of a relationship between marijuana use and sexual risk behaviour and refined the understanding of the association between substance use and sexual behaviour. For instance, using biomarkers to study a sample of African-American adolescent women, Liau et al, (2006) found that those who tested positive for recent marijuana use were less probable to have consistently used condoms in the previous 6 months before the test, more probable to not using condoms in the past 30 days before the test, and significantly have more likelikood of testing positive for STIs including gonorrhea or chlamydia. Schwartzendruber et al. (2016) further

examined whether baseline alcohol and use of marijuana among African American adolescent women aged 14-20 predicted sexual risk outcomes over the following 18 month period. They found that, compared to those who used alcohol only, women who used marijuana only were less probable to use condom as at last sexual intercourse. Users of both alcohol and marijuana were more likely than those who used only either one to become pregnant.

Agrawal et al. (2016) found that emerging adult sexually active women who reported adolescent marijuana use were much more likely to engage in repeated voluntary unprotected sex as an adult. Green et al. (2017) examined developmental trajectories of alcohol and marijuana use starting in adolescence and their relationship to emerging adulthood sexual risk-taking in an urban, mostly African-American sample. Participants were classified using their substance use over time into 1) consistent non-users, 2) moderate alcohol users, 3) moderate alcohol/increasing marijuana users, and 4) high dual users of both substances. They found that all three classes of substance use demonstrated elevated sexual risk behaviour such as unsafe sex and multiple sexual partners compared to the non-use class.

Hunter (2018) also found out that, when compared to non-users, adolescents who reported using both alcohol and marijuana use were more likely to report having had two or more sexual partners or unprotected sex in the preceding 3 months. Tyurina et al. (2013) had strikingly similar findings in a study of HIV-infected risky drinkers in Russia. When compared to non-users, those with current or recent marijuana use were more likely to report multiple sex partners, however with not more occurrences of unsafe sex.

It is non-controversial that there are relationships between use of psychoactive substance and risky sexual behaviours. However, researches on these do reveal picture that is complex and sometimes surprising (ACT for Youth Center of Excellence, 2012). According to Elkington, Bauermeister, & Zimmerman, (2010) substance use results into risky sexual risk behaviour when the user is intoxicated. This happened because intoxication leads to impaired judgment, suppressed inhibition, reduced risk perception and/or heightened desire. However, ACT for Youth Center of Excellence (2012) noted that demonstrating causation between substance use and risky sexual behaviour is difficult because most studies only looked for association between behaviours.

Hensel, Stupiansky, Orr, & Fortenberry, (2011) argued that while it is convenient to envisage that adolescents are likely not to use condoms when they are intoxicated with alcohol or under the influence marijuana, the causal relationships have not been empirically demonstrated. Though the study conducted by Stueve & O'Donnell, (2005) revealed a positive correlation between early drinking and unprotected sex, researches conducted by Hair, Park, Ling, & Moore, (2009); Floyd & Latimer, (2010) and Hensel et al., (2011) could not establish a link between unprotected sex and substance use. The findings of Springer et al., (2007) and van Gelder et al., (2011) revealed a link however this occurred among certain populations but not others. In the studies conducted by Howard & Wang, (2004) and van Gelder et al., (2011), the link was found in the type of substance use. For example, van Gelder and colleagues found that the use of cocaine was associated with unprotected sex among young males, but this association was not seen with the use of marijuana and injected drugs. The association was not also found among females irrespective of the drug being studied.

Most studies according to Poulin & Graham, (2001) did not find a correlation between substance use and having multiple sexual partners. However, most did put forward an association. An association has been established between drinking and multiple sexual partners (Howard & Wang, 2004; Morrison-Beedy et al., 2011; Nkansah-Amankra et al., 2011; Stueve & O'Donnell, 2005). Studies have also revealed association between marijuana use and multiple partners (Floyd & Latimer, 2010; Howard & Wang, 2004; MorrisonBeedy et al., 2011; van Gelder et al., 2011), cocaine and multiple sexual partner (van Gelder et al., 2011), and methamphetamine and multiple sexual partners (Springer et al., 2007). Turner et al., (2011) opined that out-of-school youth who are using substances have the tendency to have a higher multiple sexual partners than those who abstained from drugs and alcohol (Turner et al., 2011).

Explaining the link between substance use and risky sexual behaviour, Santelli et al., (2004) noted that drug use may likely suppress inhibitions to indulge in risky sexual behaviour. There may also be the belief among some youth that drugs (e.g. methamphetamine) increase sexual pleasure (Springer et al., 2007) and this may lead them to experiment with the drug. Nkhansah-Amankra et al., (2011) further explained that the intensified use of drugs may result to poor cognition, impaired judgment and a distorted perception of risk (Nkhansah-Amankra et al., 2011).

Theoretical framework

Burns and Grove (2011) define a conceptual or theoretical framework as an abstract, logical structure which guides in the development of a study. Theoretical framework helps researcher to link the associated varieties to be measured in a study. This leads to more effective theoretic framework than interventions compared to use developed without theory (Ammerman, Lindquist, Lohr, and Hersey, 2002; Legler, 2002).

The PRECEDE framework was adopted by the researcher to guide this study. It was developed in the 1970s by Green and colleagues (Green, Kreuter, Deeds, and Partridge, 1980). The acronym (PRECEDE) stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. The PRECEDE can be thought of like a road map, which presents the likely paths to follow. The main purpose of the PRECEDE model is not to predict or explain the relationship among factors thought to be associated with an outcome of interest. Rather, its main purpose is to provide a structure for applying theories and concepts systematically for planning and evaluating health behaviour change programs. The PRECEDE is based on the premise that, just as medical diagnosis precedes a treatment plan, so should educational diagnosis precede an intervention plan.

The components of the PRECEDE model as used to guide the study are as follows:

Environmental factors

These are the factors that are external to an individual that affect the health problem. In the context of this study, the factors will be the type of community the youths live, , the social values that are prevalent in the community with an emphasis on how drugs and sexual behaviours are perceived in the environment.

Predisposing factors

These are the factors which motivate behaviour. They include knowledge, attitudes, cultural beliefs, norms, values, perceptions and readiness to change. In the context of this study, these predisposing factors will be perceptions, knowledge, attitude or values related to sexual practices and psychoactive drug use.

Enabling factors

These are the factors which enable persons to act on their predispositions. These factors include available resources. In the context of this study, the enabling factors will be the availability of drugs, low prices of drugs, etc.

Reinforcing factors

These are the factors which come into play after a behaviour has been initiated. These factors encourage repetition or persistence of behaviours by providing continuing rewards or incentives. Social support, praise, reassurance, and symptom relief might all be considered reinforcing factors.

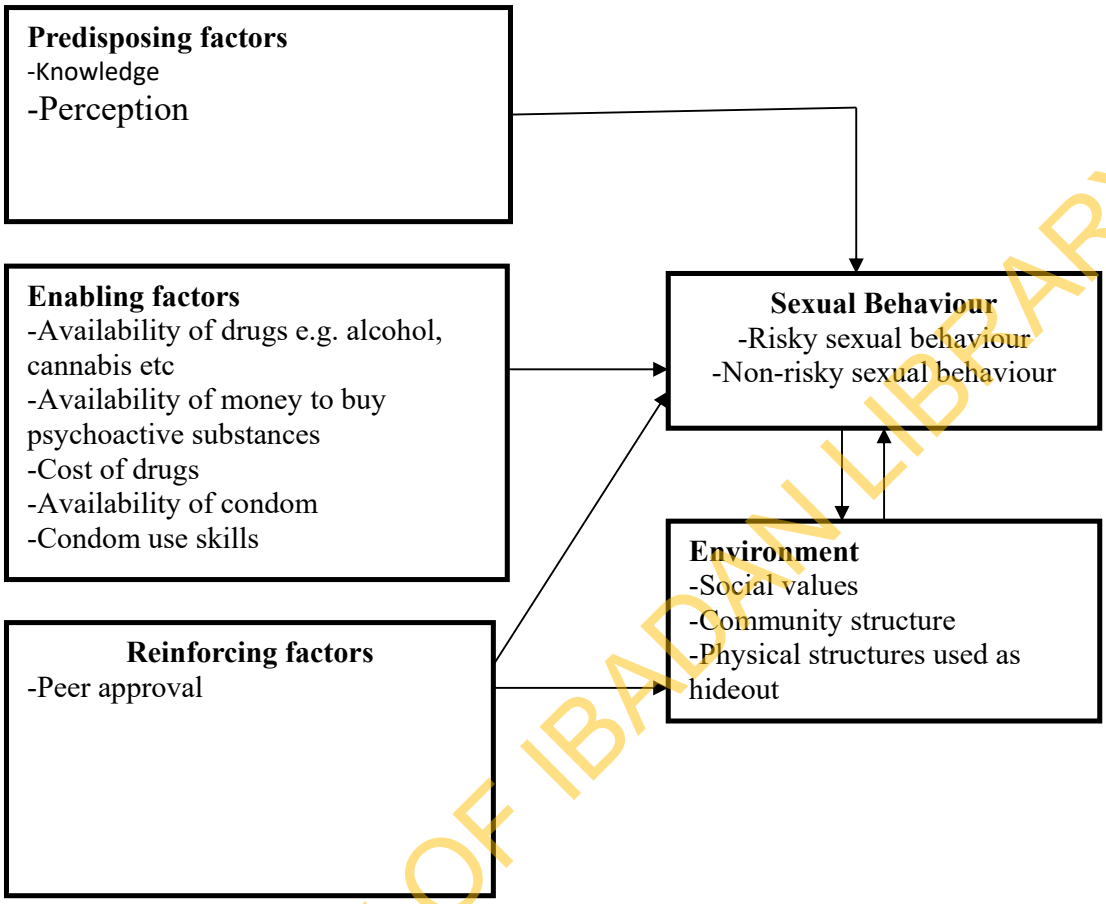

Fig 2.1: PRECEDE framework adapted to the study of risky sexual practices among youths who indulge in the abuse of psychoactive substances in selected inner core areas of Ibadan Oyo state Nigeria

Source: Green and Kreuter (2005)

CHAPTER THREE

METHODOLOGY

The study design

This study is a descriptive cross-sectional survey designed to explore the sexual practices among psychoactive drug using youths in selected inner-core areas of Ibadan.

Description of the study Areas

The study took place among psychoactive drug using youths in Beere, and its environs. The slum communities adjacent to Beere that were also studied are *Oja-Oba, Oranyan* and *Kudeti*. All the communities are located in the southern part of Ibadan North-West Local Government Area. These areas are among the major slums in Ibadan metropolis. The communities are characterized by the oldest (19th century) and lowest quality residential buildings which have undergone severe deterioration. Each of the communities have high population density, and inadequate social facilities. The communities are predominantly inhabited by the indigenous Ibadan people.

The environmental sanitation and drainage systems in the communities are poor. Most houses in the four communities are constructed very close to one another with little or no space for ventilation. Each of the communities has special locations called "*joints*" by psychoactive drug users which serve as social rendezvous for drug dependent young people. The "*joints*" could be back of houses, make-shift structures, uncompleted buildings and hidden corners surrounded by bushes. Most of the spaces used as joints are usually closed to the "*joints*" owners' houses. A joint owner, usually a male is theh one who owns and regulates the usage of a psychoactive drug "*joint*". A joint owner selld psychoactive substances and protects them from intimidation and arrests by law enforcement agents.

Study population

All the psychoactive drug using youths in the study communities were purposively targeted for this study. This consists majorly of male youths aged 15 to 24 years.

Sample size determination

The postulated prevalence of risky sexual behaviour among out of school youths is stated at 40.8% (Fagbamigbe, et al., 2011)

The sample size (n) for this study was determined using the Leslie Kish formula for single proportion for descriptive studies.

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

Where n = minimum sample size

Z = Standard normal deviation set at 1.96 normal interval

p = prevalence, 0.408 is the prevalence of risky sexual behaviour among out of school youths is stated at 40.8% (Fagbamigbe, et.al, 2011)

q = proportions that does not have the characteristics being investigated q= 1-0.408= 0.592

d = Level of significance set at 0.05 (precision set at 5%)

$$n = \frac{1.96^2 \times 0.408 \times 0.592}{0.07 \times 0.07} = 189.4$$

A non-response rate of 10% was added to get 207.9 respondents which was subsequently increased to 215

Therefore, the number of respondents for this studies was 215.

Sampling technique

A community diagnosis was conducted to identify key "joints" where drug users come together to use and share psychoactive substances. The population of drug using youths in the study settings was not known; therefore it was difficult to use a proportionate sampling method to determine the population of the respondents to study in each community. Consequently, the 215 respondents were shared equally among the communities.

A rehabilitated male drug dependent young person was recruited and trained to serve as a guide and research assistant. His role included helping to identify and link the investigator up with the respondents for interview using the snowballing technique. The place of interview of respondents was dictated by individual respondent because of the highly sensitive nature of the study.

Inclusion and exclusion criteria

Inclusion criteria: Eligibility to participate in the study was based on being:

1. A psychoactive drug using youth that resides in Beere, Kudeti, Oja-Oba and Oranyan.
2. A youth aged 15-24 years

Exclusion criteria: Individuals were not eligible to participate in the study if:

1. Any of the inclusion criteria were not met

2. An individual was currently enrolled in any formal training or is a recent graduate of a tertiary institution at the time of the study

Methods and instruments for data collection

A combination of qualitative and quantitative methods was used to facilitate data collection. The qualitative method used was Focus Group Discussion (FGD) while the quantitative method was the semi-structured interview.

Focus Group Discussion

FGD was conducted first. Data gathered from the FGD were used to edit and modify the semi-structured questionnaire. The FGD guide was used to conduct the FGD included the following issues:

1. The challenges faced by young people in Ibadan;
2. Young people's sexual needs and the use of psychoactive drugs to promote the enjoyment of sex;
3. The frequency of sexual intercourse among young people who us psychoactive drugs;
4. Categories of people that psychoactive drug using youths have sexual intercourse with while under the influence of alcohol and other drugs.;
5. Practice of having several sexual partners among psychoactive drug using youths;
6. Practice of having sex with fellow males among the drug using youths;
7. Practice of taking alcohol and other drugs before having sex among drug using youths;
8. Prevalence and pattern of condom use among young people who use alcohol and other drugs.

It was designed guided by the outcome of the review of related literature. The FGD guide contains questions which dovetail into the content of the questionnaire. The FGD guide is presented in appendix ii.

Semi-Structured Interview

The semi structured interview was conducted with the aid of a questionnaire which is organized into the following:

Section A: Socio-demographic characteristics;

Section B.1: Sexual behaviours;

Section B.2: Knowledge related to condom use;

Section C: Pattern of drug use;

Section D: Influence of drug on sexual behaviour;

The FGD guide and the questionnaire used are shown in appendix II and appendix III respectively.

Validity of instrument

The following steps were taken to ensure the validity of the instrument for data collection. Recent relevant literature was reviewed and used for the design of the semi-structured questionnaire and FGD guide with special reference to the theoretical framework adopted. The draft FGD guide and questionnaire were subjected to review and comments by my project supervisor and experts in mental health and reproductive health based at the University College Hospital and college of medicine, Ibadan. The instruments were translated to Yoruba, the most common language spoken at the study area. The Yoruba version was again given to another translator who is versed in English and Yoruba to translate the instrument into English. This was done to avoid error in translation.

Reliability of instrument

One of the steps taken to enhance the reliability of the study instrument was the pretesting of the FGD guide and questionnaire in Kaara, a slum community which is adjacent to Bodija, Ibadan.

The FGD guide was pretested among one group of young people which were drug dependent and necessary corrections were effected. Copies of the questionnaires were administered to 21 respondents which represent 10% of the total sample size. The copies of the questionnaire were edited, coded and entered into the computer facilitated by the use of an administered coding guide. The collected data were analysed facilitated by the use of Statistical Package for Social Sciences version 21 (SPSS). The Cronbach alpha coefficient analysis was also used to establish the reliability of the instrument. In this approach a Cronbach alpha score of 0.5 and above implies that the instrument is reliable.

The closer the value of the instrument is to 1 the more reliable the instrument is adjusted to be. In this study, the Cronbach alpha coefficient score obtained was 0.9 which shows that the instrument was highly reliable. The result of the FGD was used to edit and modify the draft questionnaire.

Recruitment and training of Research Assistant

Research Assistants (RA) were recruited to facilitate the conduct of the FGDs and the interviews. They were trained on issues relating to the nature and objectives of the study, the content of the FGD guide and the questionnaire; interviewer skills, how to establish rapport with the discussants or interviewees; ethical issues involved in the study and how to deal with them. The RAs were involved in the conduct of the pretest to enable them to acquire practical knowledge relating to the study.

Data collection procedure

Focus Group Discussion

The FGDs were the first to be conducted with the aid of the trained research assistants. Joints owners in the communities in the various communities place were approached to obtain permission to allow young people in their joints to take part in the study. After permission has been granted, suitable locations where the FGD and interviews could be conducted were agreed upon in collaboration with some of the study participants. The venues were places free from distractions and considered safe by the participants and joint owners. These were local halls and health care facilities.

The FGD sessions were conducted with the aid of two research assistants, with one serving as the moderator and the other serving as the note taker and audio recorder. Participants in a group were recruited from the same joint. Six FGDs were conducted in the mini hall located at Oja-Oba. Participants from Beere, Oja-Oba and Oranyan had their FGDs there while the last two FGDs took place in the community hospital participants from Kudeti. Each group comprised of a minimum of six participants and a maximum of eight.

The seats were arranged in a semicircular manner with the moderator and recorder/note

taker facing the group. Moderating and recording were done by one of the trained research assistants. The moderator explained the aims, objectives and importance of the study to the participants prior to the commencement. He also went on to explain that their participation in the study was voluntary and that they were not obligated to take part in the study if they did not want to do so. Permission and informed consent of participants were obtained before the commence of each of the FGD sessions. The conduct of each sessions lasted for 35 - 50 minutes. A total of eight FGD were conducted (i.e., two per community)

Semi-Structured Interview

Before the conduct of the interviews, permission was sought from the joint to pave the way for easy access to the target population. The snowballing approach was used to recruit eligible respondents for the interview. Data collections took place around the location where the FGDs were conducted as we were only allowed to enter one joint which was located in Oja-Oba. Respondents were usually brought from the joints by the joint owners to the sites where the FGD took place in so that we can interview them. Some other respondents were also recruited by their peers who had participated in the study. Consent of the participants was sought before administration of the questionnaire. The purpose of the research, time that would be spent to complete the questions and importance of the research were also communicated to the participants by the research assistants before the interviews started. Data collection was done during the week and weekends for about a week.

Data management and analysis

The tape-recorded FGDs were listened to and are transcribed. The eight FGD were analyzed using the thematic approach. Views that cut across the eight FGDs or views that were peculiar to one or more groups were noted.

The questionnaires were collated and edited by the researcher. Copies of the questionnaire were serially numbered from 1-215 for control and recall purposes. Data collected were checked and verified for completeness of information and accuracy. Responses provided by respondents were coded by the researcher with the use of a coding guide. The data were entered into a computer using the SPSS software version 25.

Frequency counts and other descriptive statistics were used to the analyze the data.

Subsequently, inferential statistics involving the use of ANOVA, Chi-square, and t-test statistical tools were used. The knowledge of respondents on condom was determined and their knowledge scores categorized as poor or good. Knowledge score ranging from 0-2 were classified as poor while scores of 3-5 were categorized as good.

The results of the analyzed data are presented in tables and charts in chapter four.

Ethical Consideration

The ethical issues guiding the use of human participants in research was taken into consideration in the design and conduct of the study. Ethical approval was granted by the University of Ibadan Social Science Ethics committee (UI/SSHREC). Permission was also obtained from "Joint" owners in the various communities. Participation in the study was made voluntary, and informed consent was obtained from each participant involved in the study (See appendix I). Each participant was provided with information about the purpose of the study, its objectives, methodology, inconveniences that might be experienced and the potential benefits of the study. No identifier was required and all pieces of information collected were kept confidential. Copies of the questionnaire have been stored in a place that is safe from destruction by fire, elements of weather and unauthorized persons.

Limitations of the Study

Limitations that were faced during this study are as follow

- The research participants were unwilling to take part in the study without incentives. This is because previous research group or organizations that visited them for one study or the other induced them with money to participate in their studies. To overcome this, monetary incentives had to be provided.
- Due to the sensitive nature of the study, participants were hard to reach. This challenge was addressed by going through an organization that has already been working with them before this study. In addition, recovery drug dependent youths who were familiar with the concerns of the drug dependent youth groups in the study areas was hired as a research assistant to facilitate the establishment of rapport with the study participants.

CHAPTER FOUR

RESULTS

Socio-demographic information

Table 1 presents the socio-demographic characteristics of the 215 respondents that were studied. The respondents were all males with their ages ranging from 15-24 years with a mean age of 22.2 ± 2.3 years. The ages of majority of the respondents (87.9%) ranged from 20-24 years. The respondents were predominantly Yoruba (99.1) while the remaining (0.9%) were Hausas. The highest level of education for most was secondary school (83.3%), followed by primary school (9.8%) and tertiary education (6.5%). Many were either learning a trade (33.0%) or were artisans (31.2%) while 13.0% respondents were unemployed. Some (43.3%) were living alone followed by 31.2% who stay with their parents. Majority (67.8%) were single followed by 27.4% were married.

The challenges faced by drug dependent young persons in Ibadan

The challenges endured by the drug dependent young persons were documented using focus group discussions. The discussants were asked about the equality of life generally and the challenges they were facing in particular. Life in the city was perceived by nearly all respondents as being tough. They enumerated four challenges which young people face in the city. Most discussants across the FGD reported that unemployment was the major problem faced by them.

The following quotes reflect their views and concerns:

- *"…In a nutshell, we need jobs; let jobs be provided for the young people to be doing because it is these jobs that will provide money."*
- *"The challenge of unemployment tops the list of our problems…"*
- *"…An idle hand is the devil's workshop, if the hand is gainfully employed the devil will not come to such people."*
- *"A lot of youths (young persons), do not have a job; they are searching for jobs but no jobs."*
- *"…if someone doesn't have a job, there is nothing one can do"*
- *"…they (government) should provide us with employment… …we need jobs…"*
- *"…most of our youths in our area do not have jobs…"*

Poverty was the second major issue of concern. The consensus of opinion among the discussants across the groups is that poverty is as a result of unemployment. The following quotes summarize their views related to poverty:

"…its money; if there is no money, one wouldn't live life well"

"…economy in the country is bad…"

"young people are hungry; we are starving in this area…"

"Things are getting expensive every day; people do not have money to purchase daily needs…"

"…people are suffering…"

"The number one thing that young people need, if God provides, is money to live a comfortable life…"

A third challenge listed and discussed by the participants was the issue of bad governance. Bad governance was blamed by the discussants on political leaders who do not care about the people. They were accused of not taking into consideration the condition of the masses in the ghettoes (slum areas) with special reference to the youths. The consensus of opinion across the groups was that unemployment and poverty were due to bad governance. According to some discussants:

"…Our government promised before election to do something about the situation but after election, nothing has been done; people are hungry…"

"…those that are our leaders do not think about us the youths…"

"It's our government in power that is not considerate about people; they do not remember them…"

A fourth challenge revealed by the drug using youth relates to occasional harassment by law enforcement agents or officers. According to two discussants, policemen come to their neighborhoods to arrest people indiscriminately. The discussants complained about the brutality of the law enforcement agents. The following quotes reflected participants concern relating to harassment:

"They do come every day to pack or arrest both offenders and non-offenders…"

"The police will come and 'collect' from us; the national road safety will come and 'collect' from us…"

"What can be said to be our problem is that law enforcement agents ride us a lot… … the policemen, are doing what they are not meant to be doing…"

Table 1: Respondents' Socio-demographic characteristics

N=215

Socio-demography characteristics	No	%
Age* (in years)		
15-19	26	12.1
20-24	189	87.9
Ethnicity		
Hausa	2	0.9
Yoruba	213	99.1
Marital status		
Single	150	67.8
Married	59	27.4
Divorced	6	2.8
Religion		
Muslim	195	90.7
Christian	19	8.8
Traditional religion	1	0.5
Highest level of education		
Non-formal education	1	0.5
Primary	21	9.8
Secondary	179	83.3
Tertiary	14	6.5
Type of tertiary institution		
University	1	7.1
Polytechnic	2	14.3
No response	11	78.6
Person living with		
Father only	7	3.3
Mother only	16	7.4
Both parents	67	31.2
Relatives	16	7.4
Self/living alone	93	43.3
Friends	10	4.7
On the street	4	1.9
Occupation		
Unemployed	28	13.0
Artisan	67	31.2
Employed	46	21.4
Learning trade/apprentice	71	33.0

***Mean = 22.2 ± 2.3 years**

Sexual behaviours and condom use practices

Table 2 highlights the age at which respondents first had sexual intercourse. The age at which respondents first had sex range from 1 to 25 years with a mean age of 16.3±3.4 years. Majority of them (60..7%) had their sexual debut, at ages which ranged from15-19 years. A total of 18.9% had their first sexual debut at 14 years or less. (See table for details).

The FGD participants were asked about the age at which young people start to have sex. The views are not fundamentally different from the quantitative result. According to them majority of the participants stated that young people nowadays start having sex very early. According to them many young people start to have sex as early as ages 8-11 years. Some stated that some young people start having sex even earlier with some stating as early as 6 years old. Most youths are said to start having sex during their teens. Some participants stated that some people start having sex between ages 15-18 years. Few discussants stated that some people start having sex later than 18 years. What cuts across the FGD was that girls tend to start having sex earlier than their male counterparts. This they linked to the fact that girls tend to develop (get more sexually mature) earlier than boys and so attract sexual attention. The discussants views are presented in the following quotes:

"...the age of having sexual partners is eleven years for males and at least 13 years for females in this area."

"At 8-10 years they have started having sex; for females, you will see some whose boobs are big... ... such girls want the breast to grow, so that males will be rushing at them."

"Young people start to have sex at 7 or 8 years."

"Children of 6 years old are having sex..."

"...for males the age of onset of sexual intercourse starts from 15-16 year;, but females its around 13 years"

Table 3 are respondents' responses on the number of sexual partners as at the time of the study. The mean number of sexual partners was 3.8 ± 3.5 with majority (85.7) having 1 – 5 sexual partners. Few respondents (10.5%) had 6-10 partners while very few had ≥ 11 sexual partners.

The issue of the number of sexual partners young people tend to have was raised during

the FGD. Majority of the participants stated that most young people have multiple sexual partners. It was revealed in three groups that there are still some young people who have only one sexual partner. It was disclosed that the number of sexual partners a young man possesses is often dependent on resources at the disposal of such young man.

A summary of views can be gleaned from the following quotations:

"I have just three; I still want more when I have enough money"

"Some have up to twenty, depending on his strength (money at his disposal)"

"Each young man has like four or five"

FGD participants were asked about the prevalence of having several sexual partners among drug users. The practice was stated to be generally very common. Two main reasons were adduced for the practice; these were availability of different women to choose from as a result of availability of money and the need to satisfy ones sexual urge. It was disclosed that, when a young person has money, girls tend to come to him and he keeps them. It was also revealed that in order not to be "sexually stranded", one has to keep multiple partners so that when one girlfriend is not available, the others can easily be contacted.

The quotes from the FGD which tend to justify the practice of having multiple partners are as follow:

"There is no limit to the number of girlfriends that one can't have if there is money. No money, no girlfriend."

"If you call one and she said she is not around, then you will go to the next one."

"...if a man has like 4, if he calls the first one and she is not available, calls the second and not available, then the third will be available, if the third now says she is not available, one of them will still be available..."

Table 4 shows the number of times respondents had sexual intercourse in the month preceding the study. The number of times varies from one to more than 25 times with a mean of 4.6 ± 4.5 times. Majority (80.3%) of the respondents reported that they had intercourse 1-5 time(s), followed by those who experience sex 6-10 times. The other details are contained in the table.

Figure 1presents the prevalence of sexual intercourse with casual sexual partners among the respondents. The practice of having sex with casual partners was 63.0%.

The pattern of condom use among respondents is shown in table 5. Majority of the

respondents (73%) had ever used condom with majority (68.2) using condoms with girlfriends. Many respondents(25.5) would proceed with sex without using condom if sexual partner refuses to use condom. A majority of the respondents were still using condom. The main reason for sustained condom use was to avoid STIs/STDs (67.5%). A majority (80.9%) used one condom for a round of sexual episode. Over half (59.2%) would stop having sex when condom gets torn and resume sex after changing it.

The prevalence of condom use among youths, was raised for discussion during the FGDs. Opinion was divided on pattern of condom use among the drug using youths. While about half said the practice was common, another half stated that condom was rarely used.

In four out of the eight groups, the consensus of opinion was that condom was a common practice among the youth. It is only in one group that majority stated that condom use was not common.

The diverse quotes that highlight issues relating to the use of condom are hereby highlighted:

"Condoms!!! if they are selling it, it will not sell well in our area"

"I don't know o but whosoever uses it, I might not greet the person again because I don't like it"

"Its very common, a lot of young people use it…"

"What is now the sex if condom is used?"

"condom is common where we have prostitutes, It is not very common here; condom is used anywhere one has an urge. However it is not every person that uses it."

"Yes people use condom; young people do use it here. I also use it."

"On that condom issue, it's common among we men. If sex is brought to someone at home he won't even be looking for condom; he will first do it without condom. Even our ladies are funny, they don't think of condom"

"I do it directly without condom; some girls might run away if you say you want to go and buy condom"

There was a further probe into the categories of people condoms are used with by young people. The most frequently mentioned category of people was the commercial sex workers; they were mentioned in five of the groups. A participant went ahead to state that condom use is usually common in places where prostitutes are many.

Another category of persons young people use condom with are girls that are perceived to be "loose" (i.e. have multiple sexual partners).

The following quotations throw light on the categories of persons that drug using youths use condom with:

"...nowadays bastards are very many on the streets and I don't want to give birth to one., If someone does it (i.e. have sex) without condom she will come in a month's time to say that she's pregnant; but someone I used condom with, how will she now come to say she is pregnant?"

"As for me, I use condom, only if I want to have sex with a prostitute..."

"the time I think about condom is when I want to do ut with a prostitute (Omooloso). I also use it with my old time girlfriends whom I have not seen for a long time because I cannot predict what may have happened to them, so I can use it for them"

"Girls who behave like prostitutes have mixed with a lot of guys; so we use condoms for those kind of girls because of the kind of people that sleeps I with them"

The participants were requested to discuss more why young people use condom. The two most common reasons adduced in the various groups were to prevent pregnancy and to prevent sexually transmitted diseases. A majority of the discussants in seven groups stated that condoms help to prevent one STD or the other including the most commonly mentioned one which is HIV/AIDS. Mention of use of condom to prevent unwanted pregnancy cuts across a majority of discussants in five groups.

The rationale behind condom use among drug using drugs are summarized in the following quotes:

"...there are some girls who after having sex with them and one contacts one disease or the other, one might spend over N30,000..."

"Condoms are used to prevent unwanted pregnancy and contacting diseases from women."

"The reason why I use condom is because of HIV and Syphilis. Some women have syphilis and they will not know."

"The reason why young drug dependent persons use condom is to prevent contracting diseases such as gonorrhea, HIV, and syphilis..."

"Some people buy and keep condom at home and use because they don't want to have children yet..."

"Condom helps to protects one from contracting illnesses"

Table 6 highlights how respondents acquired knowledge and skill relating to the use of condom. Learning from peers (32.0%) and learning by oneself (32.8%) were the two leading ways listed by the respondents. Other ways of acquiring knowledge and skills were media (14.1%) and advocacy/intervention programmes (11.7%).

Figure 2 displays the responses of respondents when asked if they enjoy sex while using condom. Majority (64%) of the respondents said that they do not enjoy sex with condom.

Questions were asked to probe into respondents' practice of homosexuality and condom use. Their responses are contained in Table 7. Very few (9.4%) had ever had sex with a fellow male. Among respondents who had ever done so, 60.0% used condom.

The FGD participants were asked about the prevalence of homosexuality, among young people in their community. Two groups out-rightly stated they were not aware of any of such sexual practice. Many participants in some other groups declared that they were aware of the practice in their communities but that it is a practice that is more common among girls. Only participants in two groups declared that homosexuality is common. Some participants in this two groups however said they had had the experience. A participant in one group disclosed that the practice was however on the increase in the community.

The quotes which highlights on awareness and prevalence of the practice are as follows:

"I have seen in this area among women or ladies. In this practice, the woman behaves like the man to her fellow woman. Those women even toasts fellow females"

"Yes, females who have sex with females are here. I heard that they finger themselves."

"No, we don't understand all these talks of homosexuality you are talking about…"

"I have never heard of it before."

"There is no such thing in this area…"

"Homosexuality is an old practice… …males have sex with males…"

"It is an age long practice but it is becoming common in Nigeria…"

Participants were asked why young people engage in the act of homosexuality. The most common answer that cuts across three groups was that some indulge in the practice for ritual purpose. Two other reasons that cut across two groups were that some people indulge in it for money while some people who are confined like those in prison or

boarding houses indulge in it.

The following quotes highlight some of the array of reasons adduced for indulgence in the practice:

"…What promotes it is love for money; some people are enticed and deceived with money to indulge in it… …For instance, if they tell someone that he will get an alert of one million naira on his phone, wouldn't he do such thing?"

"Maybe some do it for money ritual purposes."

"…there is a secret behind it that people don't know."

"…homosexuality or male to male sex happens among those who are not opportune to see the outside world(i.e. those in prison or confined environments)"

"…Some people especially the rich men enjoy it just like that…"

"There are some that use it for something diabolical, big men indulge in it with boys and pay them."

The FGD participants were asked whether homosexuals use condoms. Most participants across most of the groups stated that most homosexuals do not use condom. Some went further to state that since they are of the same gender/sex, most do not use because they feel it is not needed. Some participants said that they would not even remember to use condom since they will be under the influence of drugs.

A few participants stated that some homosexuals sometimes use condoms to avoid diseases. Some of the quotes that reflect views on condom use among homosexuals are hereby presented:

"They use it but it's not common. Once they're 'high' on drugs they hardly remember to use it."

"Its only someone that has hidden agenda that will remember to use condom because he wants to go and use the sperm for diabolical purpose"

"it has never happen for 'male to male' to use condom… …because the males have the same reproductive organ"

"Male to male do use condom for themselves."

"homosexuality is present here but they don't use condoms"

Table 2: Respondents' age at first sexual intercourse

n=211

Age* (in years)	No	%
<10 years	5	2.3
10-14	35	16.6
15-19	128	60.7
20-24	44	20.4

***Mean = 16.3 ± 3.4 years**

Table 3: Respondents' current number of sexual partners

n=210

Number of sexual partners*	No	%
1-5	180	85.7
6-10	22	10.5
11-15	4	1.9
16-20	2	1.0
21-25	1	0.5
≥ 25	1	0.5

***Mean = 3.8 ± 3.5 sexual partners**

Table 4: Number of sexual intercourse experienced by respondents within the last one month preceding the study

n=208

Number of sexual intercourse*	Frequency	%
1-5	167	80.3
6-10	22	10.6
11-15	11	5.3
16-20	6	2.9
21-25	0	0
≥ 25	2	1.0

***Mean = 4.6 ± 4.5**

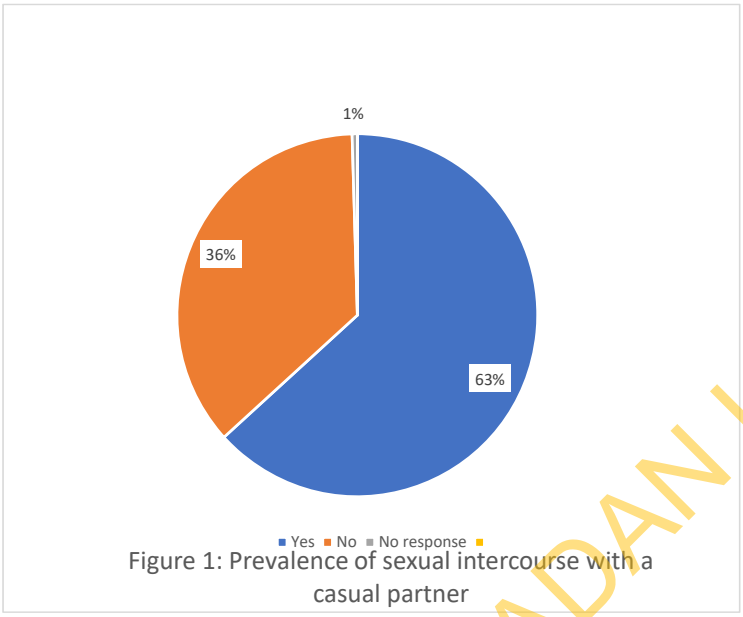

Figure 1: Prevalence of sexual intercourse with a casual partner

Table 5: Pattern of condom use among respondents

Pattern of condom use	No	%
Ever had sex using condom (N=215)		
Yes	157	73.0
No	58	27.0
Categories of people used condom with (n=157)		
Wife	16	10.2
Girlfriend	107	68.2
Concubine	49	31.2
Prostitute	56	35.7
What done when sexual partner refuses condom (n=157)		
Proceed without condom	40	25.5
Do not proceed	72	45.9
No response	45	28.7
Whether still use condom (n=157)		
Yes	128	85.5
No	25	15.9
Reasons for sustained condom use (n=128)		
Protect from STIs and STDs	100	67.5
Prevent pregnancy	17	12.1
No response	11	14.6
Pattern of condom use during sex (n=157)		
One for one round	127	80.9
One for more than one round	11	7.0
Two or more per round	5	3.2
No response	58	36.9
What done when condom gets torn while having sex (n=157)		
Continue sex with the torn condom	29	18.5
Stop sex and change it	93	59.2
No response	35	22.3
Frequency of condom use (n=157)		
Always	63	40.1
Frequently	28	17.8
Occasionally	21	13.4
Rarely	39	24.8
No response	6	3.8

Table 6: How respondents acquire condom use knowledge and skills

n=128

How condom use knowledge and skill was acquired	No	%
Peers	41	32.0
Media	18	14.1
Advocacy	15	11.7
Self-taught	42	32.8
Elder brother	12	9.4

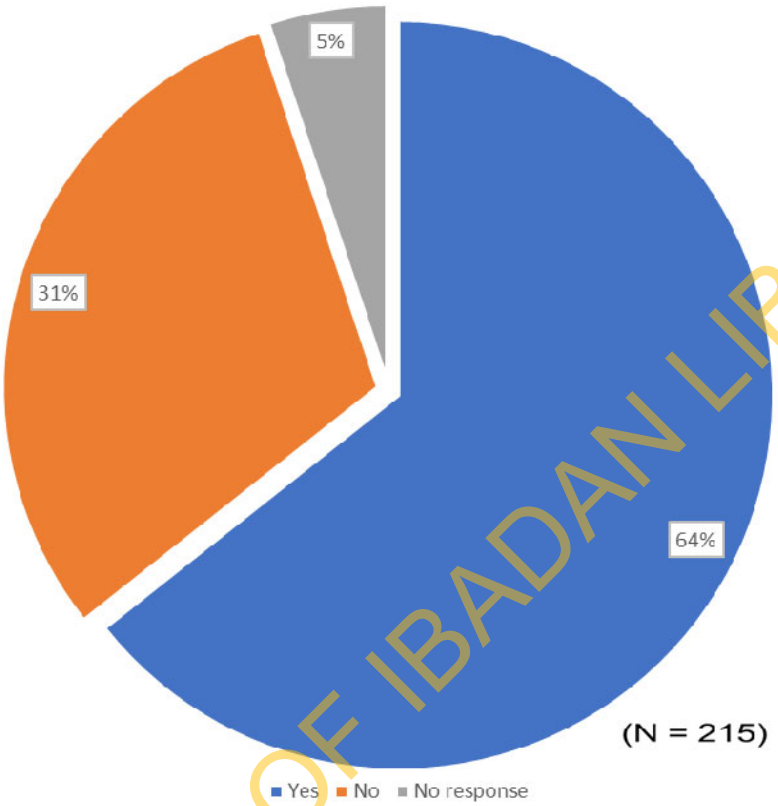

Figure 2 : Whether enjoy sex while using condom

Table 7: Practice of homosexuality and condom use among respondents

Practice of homosexuality and condom use	No	%
Ever had sex with a fellow male **(n=212)**		
Yes	20	9.4
No	192	90.5
Whether used condom if yes above **(n=20)**		
Yes	12	60.0
No	5	25.0
No response	3	15.0

Circumstances under which respondents ever had sexual intercourse and respondents knowledge of condom

The circumstances or conditions under which respondents ever indulge in sexual intercourse are presented in Table 8. Slightly over half (51.2%) had experienced sex while under the influence of one drug or the other. Nearly half (48.8%) had ever had sex while under the influence of alcohol. Less than half (47.0%) had ever been paid to have sex. The proportion of those who had ever raped someone is 20%. (See table for other details).

Table 9 presents the result of respondents' knowledge of condom. The areas of knowledge of condom assessed were limited to the following efficiency of condom in STI prevention; the STI which condom can prevent and other uses of condom. Majority (81.99) of the respondents were aware that condom can prevent STI. Majority of the respondents were knowledgeable about the efficiency of condom in the prevention of HIV (81.4%) and gonorrhea (66.0%). *Magun* is a supernatural culturally perceived STI. Only 1.4% stated that condom can prevent *magun*. Few respondents 35.8% stated that condom can be used to prevent unwanted pregnancy.

Highlighted in Table 10 is the distribution of respondents' condom knowledge scores. The mean score was 2.8± 1.3 with majority (62.8%) scoring 3-4 points. Only 5.1% had maximum score of 5, while 9.8% scored zero. See table for more details.

Table 8: Circumstances or conditions under which respondents ever had sexual intercourse

N=215

Circumstances or conditions	No	%
Pay someone to have sex	101	47.0
Ever been forced to have sex	35	16.3
Ever forced someone to have sex	45	20.0
Sex while under the influence of alcohol	105	48.8
Sex while under the influence of drugs (before or during sex)	110	51.2

Table 9: Respondents' knowledge of condom

N=215

Knowledge of condom	Yes (%)	No (%)	No response (%)
Knowledge of whether condom prevents STI	176 (81.9)	30 (14.0)	9 (4.2)
STI condom prevents			
HIV	175 (81.4)	16 (7.4)	24 (11.2)
Gonorrhea	142 (66.0)	50 (23.3)	23 (10.7)
Staphylococcus	11 (5.1)	181 (84.2)	23 (10.7)
Cancer	13 (6.0)	179 (83.3)	23 (10.7)
Magun	3 (1.4)	189 (87.9)	23 (10.7)
Other things condom can be used for			
Prevention of unwanted pregnancy	77 (35.8)	138 (64.2)	
Treatment of pimples	9 (4.2)	206 (95.8)	

Mean= 2.8 +/- 1.3

Table 10: Distribution of respondents' condom knowledge scores

Score in points	No	%
0	21	9.8
1	16	7.4
2	32	14.9
3	78	36.3
4	57	26.5
5	11	5.1

Mean = 2.8 ± 1.3

Pattern of use of psychoactive substances

Table 11 presents the pattern of drug use among respondents. Drugs that had ever been used or abused were mostly alcohol (78.1%), Marijuana (68.4%), Tramadol (65.1%), Skunk(60.9%), Skushi (60.5%), codeine (56.7%), caffeine (48.8%) and rohypnol (48.4%). The psychoactive substances which were used one week preceding the study are also shown in the table. The most commonly used ones included alcohol. Tramadol, *skunk*, marijuana and *skushi*.

The pattern of using psychoactive substances to enjoy sex is highlighted in table 12. The respondents were asked if they had ever taken drugs or alcohol to have good sex. Majority (71.2%) of them had ever done so. It was noted that 88.2% still take drugs and alcohol to have good sex as at the time of the study.

Participants in the FGDs were asked to discuss the practice of using drugs to enjoy sex. Majority of the participants across the 8 groups stated that the practice was very common. Some participants stated that alcohol and other drugs are used to gain energy needed to indulge in sexual intercourse and to perform other tasks generally. Many participants said that due to the excess energy gotten from the drugs taken, young people tend to indulge in a lot of sex.

Typical quotes from the FGDs are as follow:

- *"We cannot say exactly how common… … it is anytime…"*
- *"I like to use tramol (tramadol) if I want to have sex and I have it everyday."*
- *"It is when a man is horny he will be looking for a lady to pour into, some young people use drugs because of woman."*
- *"It is common among those who take alcohol. You know some people would have taken something that will make them high and may not be able to curtail their sexual urge again, so any girl that he gets at that time he must have sex with her."*
- *"…for some people, once they have taken anything that contains alcohol, until they have had sex with a female, they wouldn't calm down"*

The type of sexual partners young people use drugs to have sex with was probed into. Many participants stated that the practice is adopted to have sex with anybody. Few participants said that drugs are not normally used to have sex with wives but only on strangers, girlfriends or sex workers. Some claimed that some men however use drugs

because of the need to satisfy their wives sexually and prevent them from cheating on them. It was disclosed that the practice was common because of the high sex drive stimulated by the use of drugs. Drug users tend to have multiple sexual partners to satisfy their sexual urge. One participant reported that this can even lead them to having sex with old women or children.

- *"...some ladies like to be sexed very well. It is so common among married women…"*
- *"There is nobody they (young drug-users) cannot use it for… …they will have sex with their wife for four to five times; this is because if he does not satisfy his wife very well, she may begin to commit adultery outside…"*
- *"There is nobody one cannot use it with even you can use it with your wife…"*
- *"Some, after they take the drug may not even get their size, (young ladies) so they will go after old women."*
- *"Some can even have sex with children after they have taken drugs."*

Figure 3 displays the frequency of use of alcohol and other drugs to enjoy sex among young people. When asked how common the practice of using drug or alcohol to enhance sexual experience, majority (60.9%) said it was very common while 17.7% said that the practice was a bit common. (See table for details).

The psychoactive substances which youths generally use to have sex are shown in Table 13. Tramadol (71.6%) tops the list of the drugs mostly used by the youths to have or enjoy sex. This is followed distantly by alcohol (38.6%).

The FGD participants were requested to discuss how common the practice of using alcohol or any other drugs to have sex was among the youths. It was stated across all the FGD sessions that the practice was very common.

Tramadol was the most frequently mentioned drug used to enjoy sex. Tramadol was mentioned in 6 out of the eight groups followed by mention of the use of *rohypnol*. The most common type of alcohol said to be used to enjoy sex was beer. Different types of beer were mentioned across all the groups. The next most common type of alcoholic beverage mentioned by the participants in six groups was local mixtures "*origin", "baby oku", "alomo", "action bitters"*. Other alcoholic beverages used to enjoy sex were spirits such as gin. Gin was however mentioned in one group. The common alcohol and other drugs used by participants to enjoy sex are highlighted in the following quotes:

- *"The practice of using alcohol and other drugs to enjoy sex is common…"*
- *"It is very common; (use of psychoactive drug is common now even among kids).If you see 10 years old kids now they start with weed."*
- *"There are some people who cannot perform actively (have sex well) because after one round of sex they will be tired. They therefore procure drugs which they use to perform actively"*
- *"Some of the drugs used contains alcohol and they include "Kick n Start", "Bebeoku", "Agbara"…"*
- *"various psychoactive substances are used depending on what is compatible with ones health; examples are, "Rev", "Strong""*
- *"Some young people take larger beer such as trophy, Goldberg, powerhorse"*
- *"There are several types of psychoactive substances. They include the ones that can destroy one's life such that when one uses it, the person will just be looking like a dummy and any female that one gets hold of such a lady's life will be destroyed. We have "Emel-Dowell" or "Mac- Dowell"; and they are good if you take them without mixing. We also have "Sabina" which is another type of alcohol…"*
- *"some people take drugs like "Tramadol", "Rev""*
- *"Ogidiga, Bajinotu, Goldberg, Guiness, Stout, Climax, Hennessey, are alcoholic beverages people take"*

Presented in table 14 are psychoactive substances respondents have ever taken to have good sex. Alcohol (45.6%) and tramadol (44.2%) topped the psychoactive substances mostly used by respondents to have good sex. Other drugs reportedly used to have good sex indulged herbal mixtures (19.1%), pawpaw (13.0%), Tutolin (7.0%), Pacalin (6.5%) and Cocaine (2.3%).

The perceived effects of psychoactive substances on respondents' sexual experience are presented in table 15. The two effects on sexual experience that respondents reported were "increase in energy" and "delay of ejaculation". The four drugs that topped the list of those used to boost energy to have sex were codeine (83.3%), cocaine (81.3%), alcohol (70%) and pawpaw (68%).

Table 16 presents the typologies of sexual practices ever experienced by respondents while not under the influence of any psychoactive substances. Slightly over half (51.6%) had ever had casual sex. Many (47.0%) they had paid someone in exchange for sex; 33%

reported that they had ever had anal sex; Many (32.1%) respondents had ever been involved in an "orgy" (i.e. having sex in a group) and 30.2% had been paid to be involved in sex. (See table for typologies of sexual practices).

The typologies of sexual practices ever experienced by respondents while under the influence of alcohol and other drugs are highlighted in table 17. Many respondents had ever had casual sex (47.0%), paid someone to have sex with (41.9%) and participated in an orgy (31.2%). Fewer respondents had ever been involved in other sexual practices such as oral sex (26.0%), forced someone to have sex with (20.9%) or being forced by someone to have sex (15.8%).

During the FGD sessions various forms of sexual intercourse adapted by drug using youths were discussed. Most participants across the 8 groups stated that what was common was normal sex is (i.e. sex involving penis and vagina). The next common sexual practice adopted by many young people is sex with casual partners. Many participants stated that young drug dependent people can have sex with anybody that they meet. While some participants attributed the practice to drug use, others stated it is due to high libido.

Opinion was divided on how common oral sex was among young people. Those who states that young people do engage in it stated however that most males will not have a female genital in their mouth. They noted that females tend to suck or put the genitals of their sexual partner in their mouth more often and some females enjoy it. In the case of anal sex, many participants stated that the practice is absurd. The few who reported that the practice exists said those practicing it seems to enjoy it.

The quotes which reflect the participants views on the various forms of sexual intercourse include the following:

- *"it is the sex between a male to male that is bad."*
- *"Oral sex is dangerous because people have different diseases. Some women don't like to put the penis in their mouth…"*
- *"…I usually do anal sex. I don't like oral sex I don't know the type of disease I also have so that I will not transfer it to the female.."*
- *."Ah, a guy must not lick a lady's vagina; somebody that licks a lady's vagina is not normal; something is about to happen to the person"*

- *"…the most common one is that some men allow ladies to put their penis in their mouth… …for me I can't let a lady put my penis in her mouth, but I can do all other style for her…"*
- *"I can give her all the forms; as for the oral sex, I like it "OOO!" there's no place I can't use for penetration"*
- *"It is the normal one that I'll do i.e. entry from the vaginal that is the only one I do."*
- *"As I am, if I go to a party any girl that I meet, I have sex with them there and we don't meet again"*

Participants were asked about the dangers drug users expose themselves to by using drugs, some participants stated in most groups that there is no danger in using drugs. Most people across all groups noted that danger arises only when one uses too much of drugs. According to some, due to individual differences, people tend to react differently to psychoactive drugs and the tolerance level of individuals varies. Mental illness or death were stated to be the common adverse effect of drug use/abuse.

Many FGD participants stated that while under the influence of drugs, people tend to misbehave and this can lead them to getting into trouble or developing behaviours that can pose dangers to them or others around them.

When probed further on the effects of drugs on having relationship, most discussants disclosed that drug use pose minimal effect on relationships among people in the community. Some discussants noted that that rather than pose any dangers, drug use even helps strengthen relationships among young people.

Below are typical quotes which reflect participants views:

- *"The dangers are plenty, we that uses them know that there are lots of dangers to it but since we are into it already, there's nothing we can do, I smoke weed well, I believe that anything can happen and if something happens we'll settle it. I can use a whole sachet of tramadol, there's no day I can't take it"*
- *"I've been smoking weed since I was a kid, and I don't have brain diseases, I've been taking drugs since a kid"*
- *"You know they say, weed make people mad, it's a lie; only thing is if users use witchcraft in addition to what he/she is smoking, the person will run mad, We have our rich people who smoke it; why don't they run mad?"*

- *"The main adverse effect of alcohol and other drugs is on the heart, because if the drugs are too much the heart will be spoilt…."*
- *"Some people if they take this alcohol even if they take one crate of bottle of alcohol you will not know he has taken something while some will just take a bottle or two and they will be misbehaving all around."*
- *"It is not good to consume something (alcohol/ drugs) too much; it can cause self-destruction for someone. Drugs can lead to mental illness.*

Table 11: Pattern of use of psychoactive substance use among respondents

N=215

Psychoactive substance used	Ever used		Used in the week preceding the study	
	Yes (%)	No (%)	Yes (%)	No (%)
Depressants				
Alcohol	168(78.1)	47(21.9)	133(61.9)	82(38.1)
Valium	67(31.2)	147(68.4)	34(15.8)	181(84.2)
Rohypnol {refnol)	104(48.4)	110(51.2)	75(34.9)	140(65.1)
Pentazocine (injection)	47(21.9)	168(78.1)	26(12.1)	188(87.4)
Diazepam D5	51(23.7)	164(76.3)	35(16.3)	180(83.7)
Heroin	72(33.5)	143(66.5)	39(18.1)	176(81.9)
Morphine	48(22.3)	167(77.7)	29(13.5)	186(86.5)
Codeine	122(56.7)	92(42.8)	85(39.5)	130(60.5)
Swinol	29(13.5)	186(86.5)	20(9.3)	195(90.7)
Emzolyn	33(15.3)	182(84.7)	22(10.2)	193(89.8)
Uniplex	28(13.0)	187(87.0)	18(8.4)	197(91.6)
Tutolin	28(13.0)	187(87.0)	21(9.8)	194(90.2)
Coflin	23(10.7)	192(89.3)	16(7.4)	199(92.6)
Pacalin	74(34.4)	141(65.6)	48(22.3)	166(77.2)
Stimulants				
Skunk	131(60.9)	83(38.6)	105(48.8)	110(51.2)
Caffeine (coffee)	105(48.8)	110(51.2)	69(32.1)	146(67.9)
Cocaine	46(21.4)	169(78.6)	21(9.8)	194(90.2)
Tramadol	140(65.1)	75(34.9)	108(50.2)	107(49.8)
Marijuana	147(68.4)	68(31.6)	121(56.3)	94(43.7)
Colorado	23(10.7)	192(89.3)	17(7.9)	198(92.1)
Hallucinogens				
Ecstasy (MDMA)	47(21.9)	168(78.1)	27(12.6)	188(87.4)
Local Mixtures and others				
Herb/local mixtures	29(13.5)	186(86.5)	22(10.2)	193(89.8)
Pawpaw	27(12.6)	187(87.0)	20(9.3)	195(90.7)
White	26(12.1)	189(87.9)	21(9.8)	194(90.2)
**Skushi	130(60.5)	85(39.5)	101(47.0)	114(53.0)
Inhalant				
Glue		152(70.7)	39(18.1)	176(81.9)

**** A mixture of tramadol, marijuana, codeine, gin and other assorted substances influence of drugs on sexual behaviour**

Table 12: Pattern of using psychoactive drugs to enjoy sex

N=215

Pattern of use of psychoactive substance to enjoy sex	No	%
Ever taken drugs or alcohol to have good sex		
Yes	153	71.2
No	61	28.4
No response	1	0.5
Whether still take drugs or alcohol to enjoy sex (n=153)		
Yes	135	88.2
No	18	11.8

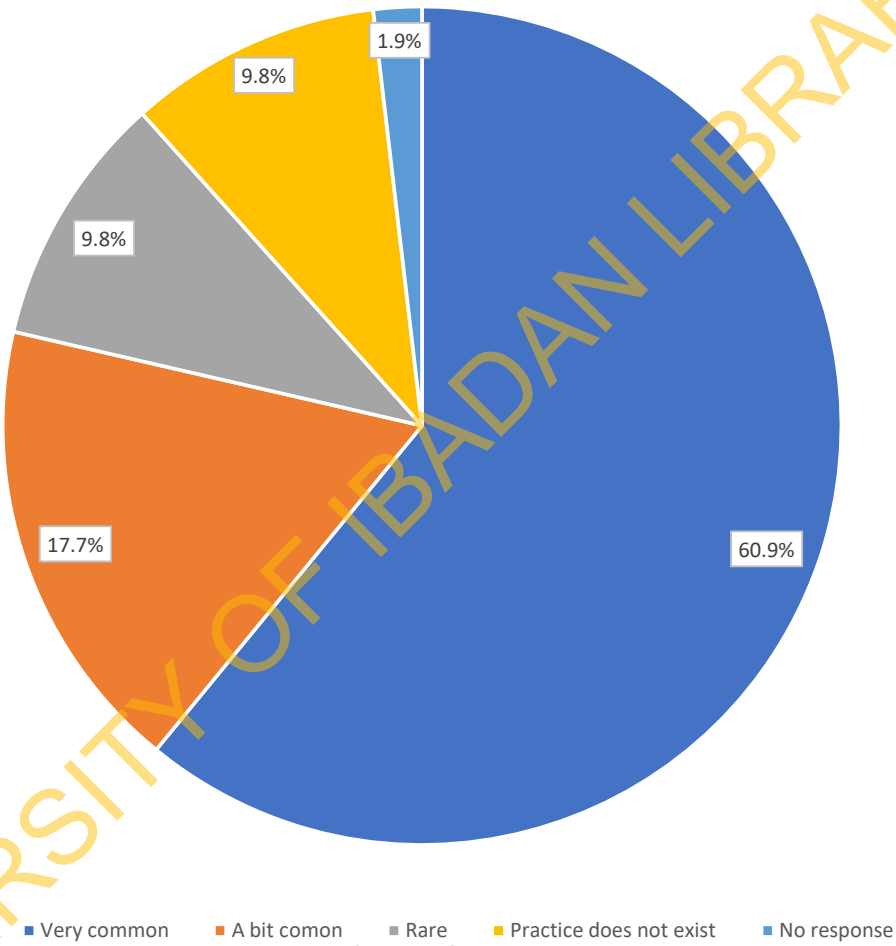

Figure 3: Frequency of use of alcohol or drugs to enjoy sex among young people

Table 13: Psychoactive substances generally used by the youth to have good sex

N=215

Psychoactive substance	Yes (%)	No (%)	No response (%)
Tramadol	154(71.6)	39(18.1)	22(10.2)
Alcohol	83(38.6)	111(51.6)	21(9.8)
Codeine	52(24.2)	142(66.0)	21(9.8)
Marijuana	21(7.0)	179(83.3)	21(9.8)

Table 14: Psychoactive substances ever taken by respondents to have good sex

N=215

Psychoactive substance	Yes (%)	No (%)	No response (%)
Alcohol	98(45.6)	98(45.6)	19(9.8)
Tramadol	95(44.2)	100(46.5)	20(9.3)
Codeine	41(19.1)	153(71.2)	21(9.8)
Herbal mixtures	32(14.9)	162(75.3)	21(9.8)
Pawpaw	28(13.0)	166(77.2)	21(9.8)
Tutolin	15(7.0)	179(83.3)	21(9.8)
Pacalin	14(6.5)	180(83.7)	21(9.3)
Cocaine	5(2.3)	188(87.4)	22(10.2)

Table 15: Perceived effects of psychoactive substances on respondents' sexual Experience

Psychoactive drugs used to have sex	Perceived effect on sexual experience	
	Gives energy / makes one active (%)	Delays ejaculation (%)
Alcohol	65(70.7)	32(33.0)
Tramadol	58(59.8)	33(36.3)
Codeine	40(83.3)	8(16.7)
Pawpaw	17(68.0)	8(32.0)
Herbal mixtures	14(53.8)	12(46.2)
Cocaine	13(81.3)	3(18.8)
Tutolin	10(55.6)	8(44.4)
Pacalin	9(60.0)	6(40.0)

Table 16: Typologies of sexual practices ever experienced while not under the influence of psychoactive substances

N=215

Typologies	Whether ever experienced		
	Yes (%)	No (%)	No response (%)
Casual sex	111(51.6)	103(47.9)	1(0.5)
Pay someone to have sex	101(47.0)	111(51.3)	3(1.4)
Anal sex	71(33.0)	139(64.7)	5(2.3)
Orgy	69(32.1)	145(67.4)	1(0.5)
Got paid to have sex	65(30.2)	147(68.4)	3(1.4)
Oral sex	64(29.8)	151(70.2)	0
Forced someone to have sex	57(26.5)	157(73.0)	1(0.5)
Was forced to have sex	39(18.1)	174(80.9)	2(0.9)

Table 17: Typologies of sexual practices ever experienced while under the influence of psychoactive substances

N=215

Typologies	Whether ever experienced		
	Yes (%)	No (%)	No response (%)
Casual sex	101(47.0)	109(50.7)	5(2.3)
Pay someone to have sex	90(41.9)	120(55.8)	5(2.3)
Anal sex	73(34.0)	137(63.7)	5(2.3)
Orgy	67(31.2)	139(64.7)	9(4.2)
Got paid to have sex	59(27.4)	152(70.7)	4(1.9)
Oral sex	56(26.0)	156(72.6)	3(1.4)
Forced someone to have sex	45(20.9)	167(77.7)	3(1.4)
Was forced to have sex	34(15.8)	177(82.3)	4(1.9)

Comparison of sexual practices by socio-demographic characteristics

Table 18 summarizes the comparison of prevalence of homosexual practices of respondents by socio-demographic characteristics. The result shows a statistically significant association between homosexual practices and occupation. The association between homosexual practices and other socio-demographic parameters are not significant. Details are contained in the table

Presented in table 19 is the comparison of the association between prevalence paying to have sex by their socio-demographic characteristics. There was no significant association between paying someone to have sex by their socio-demographic characteristics. See details in the table

Highlighted in table 20 is the association between people who has ever been paid to have sex and their socio-demographic characteristics. No statistically significant association was established between ever being paid to have sex by socio-demographic characteristics. See details in table.

The association between the prevalence of ever forcing someone to have sex and by socio-demographic characteristics is presented in table 21. There was no significant association between ever forcing someone to have sex by socio-demographic characteristics. See detail s in table.

Table 22 contains the association between ever had sex under the influence of drugs or alcohol by socio-demographic characteristics. No significant association was recorded between people who has had sex under influence and their socio-demographic characteristics. Details are contained in the table.

Table 23 shows the association between being involved in orgy by socio-demographic characteristics. There was no significant association between ever being involved in orgy and their demographic characteristic. See table for more details

The association between ever been involved in anal sex by socio-demographic characteristics are presented in table 24. A significant association was recorded between ever being involved in anal sex and by occupation. Other socio-demographic characteristics had no significant association with ever being involved in anal sex. See details in the table.

Table 25 shows the association between ever being involved in the practice of oral sex and by socio-demographic characteristics. A significant association was observed between ever had oral sex by ethnicity. No significant association was observed between other socio-demographic parameters and the practice of oral sex. See table for details

Highlighted in table 26 is the association between ever had casual sex and socio-demographic characteristics. There is no significant association between ever had casual sex and socio-demographic characteristic. See table for details

Association between people ever been forced to have sex and socio-demographic characteristics are shown in table 27. A statistically significant association was recorded between ever been forced to have sex and marital status. A statistically significant association was also recorded between ever been forced to have sex and occupation. Other socio-demographic characteristics has no statistical association with ever been forced to have sex. See table for details

Present in table 28 is the association between people who still use alcohol or drugs to have sex and their socio-demographic characteristics. A statistically significant association was established between people who still use alcohol and drugs to have sex and their occupation. No association was established between other socio-demographic characteristics and people who still use alcohol or drugs to have sex.

Table 18 Association between prevalence of homosexual practices and socio-demographic characteristics

Socio-Demography	Ever has sex with fellow male		X^2	df	P. Value
	Yes	No			
Age* (n=212)					
15-19	2	24	0.5	2	0.8
20-24	18	168			
Ethnicity (n=40)					
Hausa	1	1	3.9	2	0.1
Yoruba	19	19			
Marital status (n=212)					
Single	17	131			
Married	3	55	2.7	4	0.6
Divorced	0	6			
Religion (n=212)					
Muslim	19	173			
Christian	1	18	0.9	4	0.9
Traditional religion	0	1			
Person living with (n=212)					
Father only	1	6			
Mother only	1	15			
Both parents	11	55			
Relatives	2	13	18.3	14	0.2
Self/living alone	3	89			
Friends	0	10			
On the street	1	3			
Occupation (n=212)					
Unemployed	5	22			
Artisan	2	65			
Employed	9	37	16.5	8	0.03
Learning trade/apprentice	4	65			

Mean = 22.2 ± 2.3

Table 19 Association between prevalence of paying someone to have sex and socio-demographic characteristics

Socio-Demography	Ever paid someone to have sex		X^2	df	P. Value
	Yes	No			
Age*(n=212)					
15-19	16	10	3.5	2	0.2
20-24	85	101			
Ethnicity (n=212)					
Hausa	1	1	0.03	2	1.0
Yoruba	100	110			
Marital status (n=212)					
Single	63	85			
Married	32	26	9.7	4	0.05
Divorced	6	0			
Religion (n=212)					
Muslim	91	101			
Christian	9	10	1.4	4	0.8
Traditional religion	1	0			
Person living with (n=212)					
Father only	7	0			
Mother only	6	10			
Both parents	22	44			
Relatives	9	6	23.1	14	0.06
Self/living alone	51	41			
Friends	5	5			
On the street	1	3			
Occupation(n=212)					
Unemployed	10	16			
Artisan	38	29			
Employed	25	21	14.8	8	0.06
Learning trade/apprentice	27	43			

Mean = 22.2 ± 2.3

Table 20 Association between prevalence of being paid to have sex by socio-demographic characteristics

Socio-Demography	Ever been paid to have sex		X^2	df	P. Value
	Yes	No			
Age*(n=212)					
15-19	9	16	2.0	2	0.4
20-24	56	131			
Ethnicity (n=212)					
Hausa	1	1	0.4	2	0.8
Yoruba	64	146			
Marital status (n=212)					
Single	40	107			
Married	21	38	6.5	4	0.1
Divorced	4	2			
Religion (n=212)					
Muslim	56	136			
Christian	8	11	4.0	4	0.4
Traditional religion	1	0			
Person living with (n=212)					
Father only	2	5			
Mother only	4	12			
Both parents	17	48			
Relatives	7	9	8.9	14	0.8
Self/living alone	30	62			
Friends	5	5			
On the street	0	4			
Occupation(n=212)					
Unemployed	4	23			
Artisan	21	45			
Employed	17	29	7.2	8	0.5
Learning trade/apprentice	23	47			

Mean = 22.2 ± 2.3

Table 21 Association between prevalence of people who forced someone to have sex and socio-demographic characteristics

Socio-Demography	Force someone to have sex		X^2	df	P. Value
	Yes	No			
Age*(n=209)					
15-19	9	15	4.5	2	0.1
20-24	35	150			
Ethnicity (n=209)					
Hausa	0	2	0.6	2	0.7
Yoruba	45	162			
Marital status (n=209)					
Single	31	113			
Married	13	46	2.8	4	0.6
Divorced	1	5			
Religion (n=209)					
Muslim	41	149			
Christian	3	15	4.5	4	0.3
Traditional religion	1	0			
Person living with (n=209)					
Father only	1	6			
Mother only	3	13			
Both parents	13	51			
Relatives	4	11	8.8	14	0.8
Self/living alone	19	73			
Friends	2	7			
On the street	2	2			
Occupation(n=209)					
Unemployed	7	18			
Artisan	11	55			
Employed	13	33	12.0	8	0.2
Learning trade/apprentice	14	55			

Mean = 22.2 ± 2.3

Table 22Association between prevalence of people have had sex under the influence of alcohol or drugs and socio-demographic characteristics

Socio-Demography	Sex under the influence of alcohol or drugs		X^2	df	P. Value
	Yes	No			
Age*(n=214)					
15-19	21	5	1.1	2	0.5
20-24	132	56			
Ethnicity (n=214)					
Hausa	2	0	0.8	2	0.7
Yoruba	151	61			
Marital status (n=214)					
Single	107	42	1.9	4	0.8
Married	43	16			
Divorced	3	3			
Religion (n=214)					
Muslim	142	52	4.1	4	0.4
Christian	10	9			
Traditional religion	1	0			
Person living with (n=214)					
Father only	7	0	14.2	14	0.4
Mother only	10	6			
Both parents	40	26			
Relatives	14	2			
Self/living alone	69	24			
Friends	8	2			
On the street	4	0			
Occupation(n=214)					
Unemployed	16	11	12.8	8	0.1
Artisan	47	20			
Employed	33	13			
Learning trade/apprentice	56	15			

Mean = 22.2 ± 2.3

Table 23 Association between prevalence of people who have been involved in orgy and socio-demographic characteristics

Socio-Demography	Involved in orgy		X^2	df	P. Value
	Yes	No			
Age*(n=214)					
15-19	8	18	1.5	2	0.5
20-24	61	127			
Ethnicity (n=214)					
Hausa	2	0	4.3	2	0.1
Yoruba	67	145			
Marital status (n=214)					
Single	45	104			
Married	23	36	2.6	4	0.6
Divorced	1	5			
Religion (n=214)					
Muslim	63	131			
Christian	6	13	0.6	4	1.0
Traditional religion	0	1			
Person living with (n=214)					
Father only	5	2			
Mother only	4	12			
Both parents	17	49			
Relatives	4	12	11.5	14	0.7
Self/living alone	33	60			
Friends	4	6			
On the street	2	2			
Occupation(n=214)					
Unemployed	6	21			
Artisan	24	43			
Employed	17	29	10.3	8	0.2
Learning trade/apprentice	22	49			

Mean = 22.2 ± 2.3

Table 24 Association between prevalence of people who have been involved in anal sex and socio-demographic characteristics

Socio-Demography	Involved in anal sex		X^2	df	P. Value
	Yes	No			
Age*(n=210)					
15-19	12	14	3.3	2	0.2
20-24	59	125			
Ethnicity (n=210)					
Hausa	1	1	0.3	2	0.9
Yoruba	70	138			
Marital status (n=210)					
Single	48	97			
Married	20	39	3.0	4	0.6
Divorced	3	3			
Religion (n=210)					
Muslim	62	128			
Christian	8	11	3.24	4	0.5
Traditional religion	1	0			
Person living with (n=210)					
Father only	6	1			
Mother only	0	15			
Both parents	16	49			
Relatives	8	8	39.3	14	0
Self/living alone	33	59			
Friends	7	3			
On the street	1	2			
Occupation(n=210)					
Unemployed	6	19			
Artisan	26	41			
Employed	19	25	19.0	8	0.02
Learning trade/apprentice	20	51			

Mean = 22.2 ± 2.3

.

Table 25 Association between prevalence of people who have been involved in oral sex and socio-demographic characteristics

Socio-Demography	Involved in oral sex		X^2	df	P. Value
	Yes	No			
Age*(n=215)					
15-19	7	19	0.04	1	0.8
20-24	57	132			
Ethnicity (n=215)					
Hausa	2	0	4.8	1	0.03
Yoruba	62	151			
Marital status (n=215)					
Single	45	105			
Married	16	43	1.4	2	0.5
Divorced	3	3			
Religion (n=215)					
Muslim	56	139			
Christian	7	12	2.9	2	0.2
Traditional religion	1	0			
Person living with (n=215)					
Father only	5	2			
Mother only	5	11			
Both parents	18	49			
Relatives	5	11	9.2	7	0.2
Self/living alone	27	66			
Friends	4	6			
On the street	0	4			
Occupation(n=215)					
Unemployed	9	19			
Artisan	17	50			
Employed	13	33	3.0	4	0.6
Learning trade/apprentice	25	46			

Mean = 22.2 ± 2.3

Table 26 Association between prevalence of people who have been involved in casual sex and socio-demographic characteristics

Socio-Demography	Involved in casual sex		X^2	df	P. Value
	Yes	No			
Age*(n=214)					
15-19	19	7	1.8	2	0.4
20-24	117	71			
Ethnicity (n=214)					
Hausa	2	0	1.2	2	0.6
Yoruba	134	78			
Marital status (n=214)					
Single	98	51			
Married	35	24	1.7	4	0.8
Divorced	3	3			
Religion (n=214)					
Muslim	128	66			
Christian	8	11	6.1	4	0.2
Traditional religion	0	1			
Person living with (n=214)					
Father only	5	2			
Mother only	9	7			
Both parents	46	20			
Relatives	10	6	5.2	14	1.0
Self/living alone	58	35			
Friends	5	5			
On the street	2	2			
Occupation(n=214)					
Unemployed	15	12			
Artisan	42	25			
Employed	31	15	9.2	8	0.3
Learning trade/apprentice	47	24			

Mean = 22.2 ± 2.3

Table 27 Association between prevalence of people who have been forced to have sex and socio-demographic characteristics

Socio-Demography	Been forced to have sex		X^2	df	P. Value
	Yes	No			
Age*(n=213)					
15-19	7	18	0.9	2	0.6
20-24	42	144			
Ethnicity (n=213)					
Hausa	1	1	1.4	2	0.5
Yoruba	38	173			
Marital status (n=213)					
Single	25	123			
Married	10	49	10.6	4	0.03
Divorced	4	2			
Religion					
Muslim	34	159			
Christian	4	15	4.9	4	0.3
Traditional religion	1	0			
Person living with (n=213)					
Father only	2	5			
Mother only	4	12			
Both parents	16	50			
Relatives	4	12	8.5	14	0.9
Self/living alone	13	79			
Friends	0	10			
On the street	0	4			
Occupation(n=213)					
Unemployed	5	21			
Artisan	7	60			
Employed	12	34	19.2	8	0.01
Learning trade/apprentice	15	56			

Mean = 22.2 ± 2.3

Table 28 Association between prevalence of people who still use drugs or alcohol to have sex and socio-demographic characteristics

Socio-Demography	Whether still use alcohol or drugs to have sex		X^2	df	P. Value
	Yes	No			
Age*(n=153)					
15-19	18	3	1.2	3	0.7
20-24	117	15			
Ethnicity (n=153)					
Hausa	2	0	1.2	3	0.8
Yoruba	133	18			
Marital status (n=153)					
Single	95	12			
Married	38	5	2.8	6	0.8
Divorced	2	1			
Religion (n=153)					
Muslim	126	16			
Christian	8	2	4.8	6	0.6
Traditional religion	1	0			
Person living with (n=153)					
Father only	5	2			
Mother only	10	0			
Both parents	33	7			
Relatives	12	2	26.7	21	0.2
Self/living alone	64	5			
Friends	7	1			
On the street	4	0			
Occupation(n=153)					
Unemployed	11	5			
Artisan	44	3			
Employed	32	1	22.4	12	0.03
Learning trade/apprentice	47	9			

Mean = 22.2 ± 2.3

CHAPTER FIVE

DISSCUSSION, CONCLUSION AND RECOMMENDATIONS

Socio-demographic characteristics of respondents

The age of respondents ranged from 14-24 years with a mean of 22.2±2.3 years while majority of them were aged 20-24 years. The age profile indicates that the drug abuse phenomenon cuts across early adolescence, mid-adolescence, late adolescence and early adulthood. This age cum developmental categories share some common behavioural characteristics such as being adventurous and being prone to experimentation with innovations. Most (67.8%) of the respondents were either single or divorced. This is not surprising because of the pervasive unemployment and poverty among them. A study conducted elsewhere among adolescents relating to psychoactive substance use revealed that drug abuse adversely affects the chances of marriage among males and females. (Mesaco & Blair, 2014).

It was noted in this study that respondents had low level of education. This study was not designed to determine the effects of drug abuse on young people's educational development or advancement. However, a study conducted to determine the effect of drug abuse on youth revealed that the phenomenon had negative impact on their learning, memory, school attendance, concentration, academic performance or achievement. (Ibrahim, Mahmud, Abubakar, Harazimi and Abdulkadir, 2016). Based on this, it can be inferred that drug abuse may have been one of the factors which led to the low level of education observed among participants in the study. That the respondents are Yoruba is not contrary to expectation. This is because the study was conducted in the inner-core slum areas that are predominantly inhabited by indigenous Yoruba speaking people of Ibadan.

The aforementioned socio-demographic characteristics of the respondents discussed have implications for the design of educational interventions aimed at rehabilitating the drug abusing youths. The characteristics should be taken into consideration to ensure that educational interventions are appropriate to their peculiarities.

Challenges facing drug-using youths in Ibadan

The major challenges of the respondents which were well articulated in the FGDs were unemployment and poverty. These factors have potential for making it difficult for one to address his basic needs such as getting married and meeting the demands of marriage. The issue of unemployment has been raised by the national report released in December 2018 by the National Bureau of Statistics – NBS (NBS, 2018).It was noted in the report that in Nigeria, unemployment increased from 18.1% as recorded by the end of 2017 to 23.1% by September of 2018. The Brooklings Institute (2018) recently declared Nigeria as the poverty capital of the world, a situation that surpassed India as the country with the largest number of people in extreme poverty. Unemployment naturally leads to poverty in most cases. Either unemployment or poverty or both have great potential for leading to drug abuse. One is tempted to hypothesize based on the qualitative results that there is a triangular relationship among unemployment, poverty and drug abuse among the study population; So addressing one and leaving the others could be counterproductive.

The respondents noted that their economic woes are partly linked to bad governance by political leaders. When this is taken into consideration, then one can safely say that there is a cyclical relationship between unemployment, poverty, drug abuse and bad governance. Bad governance can be fuelled by corruption. A major social pathology in Nigeria is the issue of corruption. Nigeria has been ranked 144thout of the 180 countries based on the corruption index used by Transparency International (TI) (TI, 2018).

Sexual practices among the youths including use of drugs to enjoy sex

The survey results showed that the age of sexual debut among majority of the respondents' ranged from 15-19 years while FGD participants disclosed that experimentation with sex could start as early as 8-11 years. A study conducted among adolescents elsewhere has shown that adolescents and other young people who regularly abuse psychoactive substances are more likely to become sexually active at an early age (Madkour, Farhat, Halpern, Godeau, & Gabhainn, 2010). Many participants in this study have multiple sexual partners. A previous study has shown that people who regularly abuse psychoactive substances are more likely to have multiple sexual partners (Connell, Gilreath, & Hansen, 2009).

Many of the respondents stated that they had ever had sex with casual partners. Molobe (2016) also noted a similar sexual practice among young people. Majority of the study population reported condom use; many often disclosed that they would however proceed to have sex without condom if their sexual partner refuses to accept it. Majority of the respondents in this study are knowledgeable about the usefulness of condom. They rightly reported that it could be used to prevent STI and pregnancy. This is contrary to what Tanaka et al. (2017) earlier noted. According to them, young people usually have insufficient knowledge relating to the prevention of STI. The differences in the environmental situations in which the two studies took place (this and that of Tanaka et al. (2017)) may have accounted for their difference. There are several governmental and non-governmental organizations which aggressively target young people with educational interventions on HIV other STIs and related risky practices. In addition, Ibadan ia an urban area which is blessed with numerous educational institutions as well as print and electronic media which are involved in one health related public enlightenment activity or the other. These resources may have played a role in upgrading respondents' knowledge relating to STI in Ibadan.

There were reports of homosexual practices among some of the drug users. Homosexuals are viewed as social deviants in the Nigerian society. Yet the practice of homosexuality is on the increase in Nigeria in spite of the fact that it is socially unacceptable and has even been criminalized. The prevalence of the practice as revealed in the study is, however, low. This practice attracts high social stigmatization and discrimination. It is likely that many homosexual drug dependent young persons studied would not, therefore, wish to disclose their sexual orientation as a result of this. The prevalence documented in the study should therefore, be regarded as a tip of the ice-berg. The study has shown that there are several risky sexual practices among the participants. These other risky sexual practices include early age of sexual debut, multiple sexual partners, sex without use of condom and use of drugs to promote the enjoyment of sex. The aforementioned sexual practices have very high potential for the transmission of STI including HIV, Hepatitis B and blood-borne infections. A high level of alcohol and drug abuse has been reported among homosexuals elsewhere (McKirnan, Peterson, 1989).

The psychoactive substances commonly abused by respondents in the study included alcohol, marijuana, codeine, tramadol, rohypnol and several herbal mixtures or concoction. High prevalence of use of marijuana is reported worldwide among young

people (Weier, 2016). The use of alcohol, marijuana and other psychoactive substance poses serious health challenges to users worldwide (Oshodi, Aina & Onajole, 2010). As noted in a previous study, most young people start by experimenting with alcohol and later progress to the abuse of other substances such as marijuana (Abiodunet al., 1989).

Both qualitative and quantitative results revealed the prevalence of use of psychoactive substances to promote the enjoyment of sex. Psychoactive drugs are said to be primarily used to boost sexual performance and delay ejaculation. This drug use trend can catalyse the emergence of dependence. A similar pattern of use of psychoactive substances has been documented by Molobe, (2016). Tramadol was reported to be the drug mostly used to prolong sex. Alcohol, marijuana and rohypnol were also reported to be used to boost sexual performance. Cook, (2010) has similarly documented wide use of tramadol and alcohol among young people to boost sexual performance and delay ejaculation. According to Molobe (2016) marijuana is used by young people to promote sexual performance. Rohypnol has been associated with the practice of date rape among young people. (Howard et al., 2003).

Implication of results for Health Education and Social Policy

Health education focuses on the modification of peoples behaviours and behavioural antecedents (Green &Kreuter, 1991). It is, therefore, concerned with helping people develop practices that promote peoples wellbeing (WHO, 1988). Health education principles and strategies can be used to address the risky practices and challenges noted in this study.

There is the need for health promotion and education programs targeted at drug dependent youths in the study area. Health education interventions are needed to upgrade the study populations' knowledge relating to the physical, psychology and social adverse effects of the abuse of psychoactive substances. Community based health education interventions such as peer education, public enlightenment and peer-resistant educational intervention hold great promise in this regard.

Several studies and programs have demonstrated the positive effects of health promotion and education on improving peoples reproductive health and reducing the prevalence of

drug abuse among youths. This study documents the high prevalence of early sexual debut among the respondents. The effectiveness of health education strategies in curbing the prevalence of drug has also been documented. A high school-based health education programme conducted in Iran to promote drug abuse prevention revealed that video clip- and lecture-based methods were very effective and efficient in changing the attitudes of the participants toward drug abuse.

A previous study has shown that health education is effective in tackling early sexual debut. In Jos for instance, a study conducted among secondary school students to investigate the impact of health education on sexual risk behaviours showed that health education delayed sexual debut among students who were sexually naïve or inexperienced but had no effect on the sexual activity of those who were already sexually experienced. Another study conducted in Portugal revealed that sex education helps protect the youth from risky sexual behaviours (Marta, Lúcia, Margarida & José, 2011).Some researchers have recently documented the contribution of delayed sexual initiation and improved contraceptive use to decreased teen pregnancy rate (Mueller, Gavin & Kulkarni, 2008).

Public enlightenment is a useful health education strategy which has the potential for reaching a large number of people through the use of the multi-media approach. The strategy can be employed to create awareness, influence perceptions and practices as well as foster political will for action (Whitaker, Baker and Arias, 2007). Findings from this study revealed that the mass media was the third most popular source of information when it comes to learning how to use condoms. This is a measure of the popularity of the mass media among the study population. Public enlightenment can also be creatively used to address the risky sexual practices noted among the respondents.

Advocacy targeted at policy makers has a pivotal role to play role in the formulation of social policies geared towards the promotion of healthy sexual practices and reduction of the prevalence of drug abuse in urban slums. Social and economic policies aimed at creating jobs for the drug dependent young people are crucial. Advocacy interventions are needed to influence law enforcement agents to employ behavioural change intervention measures aimed at controlling the prevalence of drug abuse among the study population. Law enforcement done which involves arrest, detention and other coercive approaches could be counterproductive.

The risky behaviours relating to drug abuse and sexual intercourse identified in this study are complex. Therefore no one strategy can be used to address them. Multiple strategies are needed so that the strengths of one can compensate for the weakness of the others.

Conclusion

It was noted that respondents were sexually active and the practice cuts across various categories of the study population. The study also revealed high prevalence of risky sexual practices among the respondents. An emerging risky sexual practice noted among them is the use of drugs to boost sexual performance; a wide variety of psychoactive substances were used to achieve this. Knowledge and practice of using condom was noted to be high among respondents with avoidance of STI being the primary reason for using condom.

The psychoactive substances commonly abused by respondents were mainly stimulants and depressants. The drugs commonly abused include alcohol, marijuana, codeine, rohypnol and tramadol. This pattern of use may be linked to their ready availability and availability (low prices) compared to others. Alcohol which is the most abused psychoactive substance is readily available to all ages at bars and regular stalls or shops. This is due to the lax law on the substance in addition to the fact that it is socially acceptable. Tramadol and codeine on the other hand could be obtained from the local pharmacies in spite of the fact that they have become controlled substances in Nigeria. The drugs are still readily available for consumption by the respondents at the various joints in the study communities. Unemployment and poverty are major challenges among the respondents. Their persistence have high potential for the sustenance of risky sexual and psychoactive drug related practices.

Recommendations

The recommendations based on the findings of this study are as follow:

1. Entrepreneurial training interventions and the provision of economic incentives needed to be self-employed should be used to tackle the challenges posed by unemployment and poverty among the study population. This is because unemployment and poverty could lead to indulgence in drug abuse.
2. Community-based educational interventions should be used to upgrade or reinforce the study populations' knowledge relating to the adverse effects of the abuse of psychoactive substances.
3. Group and individual counselling interventions are needed to address the prevalence of risky sexual practices and indulgence in drug abuse among the study population. This is because drug abuse/dependence is often characterized by physical, psychological and social adverse effects which require these interventions to ameliorate.
4. Law enforcement agents who operate in the study area should be re-orientated to adopt appropriate educational interventions aimed at influencing the study populations to discontinue the abuse of psychoactive substances instead of relying absolutely on raiding and indiscriminate arrest.
5. The abuse of psychoactive substances in the study areas is primarily sustained by joint owners who make the drugs readily available at an affordable price. They should, therefore, be supported to take up more lucrative legal businesses instead of indulgence in illegal community-based drug trafficking targeted at vulnerable young persons.
6. The use of psychoactive substances to enjoy sex is an emerging sexual practice that urgently needs to be prevented because of the associated adverse health effects. More studies are needed to explore the prevalence of the phenomenon at the national level with a view to yielding results for guiding social policy formulation and anti-drug abuse programming.

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APPENDICES

APPENDIX I

INFORMED CONSENT FORM FOR RISKY SEXUAL PRACTICES OF PSYCHOACTIVE DRUG-USING YOUTHS IN SELECTED INNER CORE AREAS OF IBADAN, NIGERIA

This approval will elapse on:

Title of research: Risky sexual practices of out-of-school drug using youths in selected inner-core areas of Ibadan.

Name of researcher: This study is being conducted by Jegede Tolulope a postgraduate student in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine University of Ibadan.

Purpose of research: The purpose of this study is to investigate ***the risky sexual behaviour of out of school drug-using youths located in selected inner core areas of Ibadan, Nigeria.***

Sample size and procedure for data collection: A total of 410 male youths in selected communities would be recruited for this study.

Expected duration of the research and participant(s) involvement: This process of this study will last for one month. You are to provide answers to the questions contained in the questionnaire. The questionnaire is expected to last about 30 minutes to complete.

Risk(s): There is no physical risks in participating in this study. However, there are some sensitive questions on sexual practices and indulgence in psychoactive drug use which some respondent would find it uncomfortable to answer.

Cost to participating of joining the research: Participation will cost you nothing. It will however take a little of your time.

Benefit: At the end of the research, findings will be useful in the design of interventions or strategies among drug using youths in Ibadan.

Confidentiality: All information collected in this study will be given coded numbers. Names of participants will not be written on the questions. In addition, your name or any other identifiers will not be used in any publication or report emancipating from this study.

Voluntariness: Your participation in this research is entirely voluntary.

Consequences of participants' decision to withdraw from the research and procedure for orderly termination of participant: You can choose to withdraw from the research at any time without any penalty. Please also note that some of the information that has been

obtained about you before you choose to withdraw may have been used in reports and publications.

Statement of Person Obtaining Inform Consent

I have fully explained the nature and scope of the research to _____and have provided sufficient information to him/her which is needed by him/her to make informed decision

Date_____ **Signature** _____

Name _____

Statement of Person Giving Consent

I have read the description of the research and the research has been explained to me in a language I understand or have been translated into a language I understand. I understand that my participation is voluntary. I know enough about the purpose, methods, risk, and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. Finally, I have received a copy of this consent form and additional information sheet to keep for myself.

Date _____ **Signature** _____

Name _____

APPENDIX II

Focus Group Discussion Guide
Sexual practices of out-of-school drug-using youths in selected Inner-core areas of Ibadan

Introduction:

I am _____ and my colleagues are _____.

1. We are students in the College of Medicine, University of Ibadan. I thank you for agreeing to take part in this discussion.
2. The discussion focuses on the health concerns of out-of-school drug users with special reference to their sexual behaviour/practices. The purpose of this study is to investigate their sexual practices of young persons who use one drug or the other in Ibadan.
3. The types of drugs we are interested in are those that make people feel high.
4. We have specially invited you to come and share your views with us because of your wealth of experience.
5. We crave your indulgence to use a tape recorder because there is a limit to what the brain can remember and we do not want to forget the useful experiences you are here to share.
6. We assure you that what we discuss here will not be used in any way against any one. All what will be discussed will be kept confidential.
7. Please do not mention anyone's name while the discussion is going on so that the name will not be recorded. We do not want to know who and who has said what. All we want are your ideas or views. Thank you.

Questions:

S/N	MAIN QUESTION	FOLLOW UP QUESTIONS
1	Generally, how is life treating young people in Ibadan nowadays?	• What are the general needs or concerns of young people in Ibadan? • Specifically, what are the special challenges of young people who use one drug or the other to feel high?
2	One of the important needs of every normal human being is to have sex. Now, do the young people who take alcohol or use drug to feel high have sex?	• If yes, how many sexual partners on the average do young people who use drugs have sex with? • If they do not like having sex, why? • How early in life do young people start having sex
3	Now let us discuss the frequency of sex among young people who use drugs. How often do young people who use alcohol or other drugs have sex?	Probe for when taken: • Always • Frequently • Sometimes • Or rarely Probe for the settings or places where young people usually take drugs
	What are the categories or group of people that young people who use drugs usually have sex with?	Probe for • Girlfriends • Casual friends • Prostitute or people who want sex for money • Fellow boy/man • Girl or lady who also uses drug
	How common is the practice of having several sexual partners among young people who abuse alcohol and drugs?	• Why do young people have several sexual patners?
4	Some young people who use drugs have sex with fellow men or boys. • How common is this practice in your area or in Ibadan? • Why do they prefer fellow men to ladies or women	• What are the drug used by these persons who have sex with fellow men poor boys? • Do they use condom when having sex with fellow men or boys?
5	• How common is the	• What types of alcohol do they take?

	practice of taking alcohol or any other drug before having sex among drug using young people? • How does alcohol and other drugs affect sex among young people?	• What types of drugs do they take?
6	How common is the use of condom among young people who use alcohol or other drugs?	Probe for • Feeling or opinions relating to drug use • Categories of people they use condom with • Importance of condom (probe for prevention of STI/STD if not mentioned)
7	There are different styles of sexual intercourse among young people who use alcohol and other drugs. I will list some of them and then request you to discuss how common each one of them is. They are: • Oral sex • Sex with somebody one doesn't know well (casual sex) • Normal sex involving penis and vagina • Anal sex • Sex with fellow man or boy	
8	What are the consequences of using alcohol or any other drugs among young people?	Probe for • Physical consequence e.g. forms of ill-health they can cause • Psychological effects e.g. what they do to peoples minds or feelings • Social effects e.g. how they affect users relationship with other people

APPENDIX III

Serial No:

Sexual practices of out-of-school drug-using youths in major slums in Ibadan South-East Local Government area

Dear Respondent,

I ama Post-graduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to investigate the sexual practices of out-of-school drug-using youths selected communities in Ibadan. Some of the questions that will be asked in this study are about sensitive issues. Let us assure you that your answers will be kept very confidential or secret. Your name will not be written in this questionnaire or anywhere. The information you provide will be used to help in developing strategies for protecting the health of young people who use drugs to feel high. Participation in this study is totally voluntary and you always reserve the right to withdraw from participating in the study if you so wish at any time.

(Akekoileiweekoseiseguntiileeko giga unifasitiilu Ibadan niwa. Mo dupe pe a gbalatikopaninuijiroroyi. Iwadiyi da loriasaibalopolarinawonodoti ko siniileiwe tin won nloogunoloro. Awonibeerekanti a beerelowo yin ninuiforowanilenuwoyi lee ma rorunlatidahun. A fi daa yin loju wipe a ko ni lo ohunkohunti e ba so ninuijiroroyinionatiyio pa yin lara. Gbogboohunti e ba so ni a maapamofinifini. Idahun yin siawonibeerewa lee se anfani fun idagbasoke fun aaboawonodo. Awonoogunti a nseiwadiniawonoogunti o maanjekieniyanmaa hu iwa bi eniti ko niisorolehinti won ba loo tan. E jowo e ma se da orukoenikenininuipejopoyikiforan ma bakaasile. A ko femoenikeniti o so ohunkantabiomiran. E nietolatiyanlatikopatabi ma kopamoniakokoti o bafeniipeleiforowanilenuwoyi.)

Kindly tick the appropriate box below*(Jowo fi amiti o ye siinuapotiti o waniisaleyi)*:

Would you want to participate in the study? YES ☐ NO ☐

***(Se o fekopa)*?**

Thank you very much *(E se ganan ni)*.

Section A: Socio-demographic characteristics *(Abala A: Ajuweawonoludahun)*
Please tick (√) any of the responses or options that apply to you in the boxes provided or complete the blank spaces provided. (Jowo fi amin (√) siibiidahunti o ba jo moidahun re niawonapotiti a pese fun ibeere)

1. **Gender/Sex** *(Akon'babo)*
   1. Male (Ako) ☐ 2. Female*(Abo)* ☐

2. **Age as at last birthday (in years)** _____
   (Ojoori (Odun)

3. **Ethnicity *(Eya re)*:**
   1. Hausa ☐ 2. Yoruba ☐ 3. Igbo ☐

   4. Others (Please specify) _____

   4. **Marital status**

      1. Single *(Apon)* ☐ 2. Married *(Lokolaya)* ☐ 3.Widowed (Opo) ☐

      4. Divorced *(Dalemosu)* ☐ 5. Others (Please specify) _____

5. **Religion (*Esin*):**
   1. Muslim *(musulumi)*2. Christian*(Igbagbo)*

   3. Traditional African religion *(EsinAbalaye)*

   4. Others (Please specify): _____

6. **The highest level of education *(Eko ti o ga ju)***
   1. Never attended school/non-formal education ☐ 2. Primary ☐
   Ko lo ile iwe rara *Ile iwe alako bere*
   3. Secondary ☐ 4.a. Tertiary ☐
   Ile iwe girama *Ile iwe giga*
   4.b. Type of tertiary _____
   5. Others (Please specify): _____
   Iru ile iwe giga *Omiran (So oruko re)*

7. **Who are you living with?** ***(Ta ni o nbagbe)***

1. Father only ☐ **2. Mother only** ☐ **3. Both parents**

Baba nikanIyanikanAwon obi mejeji

4. Relatives ☐ **5. Self (living alone)** ☐
Awonebi ***Emi nikan***

6. Living with friend ☐ **7. Living on the street** ☐
Awon ore ***Igboro***
8. Others (Please specify) ***(Omiran. So oruko re)*****:** _____

8. **Occupation** ***(Ise)*** ☐

1. Unemployed ☐ 2. Artisan3. Employed ☐

4. Learning trade ☐ 5Others (Please specify): _____

Section B.1: Sexual behaviours

Please tick (√) any of the responses that apply to you in the boxes provided or complete the blank spaces provided.

9. How old were you when you first had sex? _____
Ki niojoori re niigbati o niigbaakokoti o niibalopo?

10. How many sexual partners do you have now? _____
Iyeolubalopomeloni o nibayi?

11. How **many times** have you had sex within the last one month? _____
Igbameloni o niibaloponiosukansehin?

12. How **many sexual partners**did you havesex within the last one month? _____
Eniyanmeloni o baniibaloponiosukansehin?

13. Has there been any time when you had sex with someone you didn't know well or is not your regular girl friend?
1. Yes *Beeni* ☐ 2. No *Beeko* ☐

14. Have you ever had sex using a condom?
1. Yes *Beeni* ☐ 2. No *Beeko* ☐

15. Which group of people do you use condom with? (List them below)
Ti o bati lo robaidaaboboniibalopo, iruawoneniyan wo ni o loo pelu?
(Ko iruawoneniyan bee siisaleyi)
1.People used condom with _____

Awonti e nlorobaidabobopelu

2. Not applicable/Never u☐

16. How did you learn how to use condom?
Bawoni o se ko lilorobaidaabobo?

1. _____
2. Not applicable/Never used *(Mi lo ri)* ☐

17. What do you do when your sexual partner refuses to use condom?
Ba ni o se niigbatiolubalopo re ni o ko ferobaidaabobo?

1. _____
2. Not applicable/Never used *(Mi lo ri)* ☐

18. Do you enjoy sex while using condom?
Nje o gbadunrobaidaaboboniigbati o loo?

1. Yes ☐ 2. No ☐ 3. Not applicable/Never used *(Mi lo ri)* ☐

19. Do you still use condom? *(Nje o si tun nlorobaidaabobobayi?)*

1. Yes ☐ 2. No ☐ 3. Never used condom *(Mi lo ri)* ☐

20. If you still use condom, tell us why you still use it *(Ti o basinlorobaidaabobo, so iditi o si fi nloo?)*

1._____
_____
_____
_____
2. Never used condom*(Mi lo ri)*

21. Which of the following indicates how you use condom? *(Iruewoni o so bi o seenlorobaidaabobo?)*

1. one condom for a round of sex*obaidaabobokan fun ibalopoleekan* ☐
2. one condom for two or more rounds of sex*Robaidaabobokan fun ibaloponiigbamejitabiju be lo* ☐
3. two condoms for one round of sex*Robaidaabobomeji fun ibalopoleekan* ☐
4. never used condom*Mi o lo ri* ☐

22. What do you do if you are having sex and the condom gets torn?*(Kini a ma nsetirobaidaabobobayaniigbati o bawaloriibalopo?)*

1._____

3. Never used condom ☐

23. Have you ever had sex with someone of the same sex with you? (i.e. with a fellow man/boy)

Nje o tibaokunrin bi tire lopori?

1. Yes*Beeni* ☐ 2. No*Beeko* ☐

24. Did you use condom when having sex with a fellow man/boy?

nje o lo robaidaabobopeluokunrinnati o baniibalopo?

1. Yes ☐ 2. No ☐ 3. Not applicable/Never had such sex ☐

25. Have you ever had forced intercourse with someone (i.e. when the partner is not willing)?

Nje o ti fi ipabaenikeni lo po ri? (niigbatieninaa ko fe)

1. Yes ☐ 2. No ☐

26. Has someone ever had intercourse with you when you were not willing to do so?

Njeenkeniti fi ipaba o loponiigbati o ko ri?

1. Yes ☐ 2. No ☐

27 If yes, who is this person?

Ti o ba je beeni, ta nieninaa?

1. Girlfriend ☐ 2. Fellow male ☐

3. Not applicable/Never ☐ 4. Others (Please specify) _____

28. How often do you make use of condom when having sex?

Bi igbameloni o ti lo robaidaaboboniigbati o niibalopo?

1. Always/Each time youhave sex ☐ 2. Frequently (but not always) ☐

3. Occasionally ☐ 4. Rarely ☐ 5. Never ☐

29. **Table 1*contains a description of the conditions under which some people have sex. For each condition, thick 'Yes' if it applies to you or tick 'No' if it does not apply to you. Awonnkanti o wan ninuapotiyiniawoniditiawoneniyankanmaanniibalopo. Fun idikooka, fi ami 'beeni' ti o ba jo mo o tabi 'beeko' ti o ba je mo o.***

Table 1

S/N	Circumstance/condition under which you have ever had sex	Yes	No
29.1	Use gift to have sex*Lo ebunlati fi niajosepo*		
29.2	Pay to have sex *Mo san owolatiniibalopeo*		
29.3	Someone ever had forced intercourse with you *Enikan fi ipaba mi lopo*		
S/N	**Circumstance/condition under which you have ever had sex**	**Yes**	**No**
29.4	Had forced intercourse with someone (i.e. when the partner is not willing) *Mo fi ipabaenikan lo po*		
29.5	When you were under the influence of alcohol *Ni abeakosootilile*		
29.6	When you were under the influence of drugs that make people feel high		

	Niabeakosoooguoloro		

SECTION B.2: Knowledge related to condom use

30. Can condom help prevent Sexually Transmitted Diseases (S.T.D.) or Sexually Transmitted Infections (S.T.I.)?

Njerobaidaabobo lee denaarunibalopo?

1. Yes ☐ 2. No ☐

31. If yes, name three (3) STIs/STDs which condom can help prevent

so orukoawonarunibalopo metatirobaidaabobo le dena

1. _____
2. _____
3. _____

32. Apart from preventing diseases, what else can condom be used to do? _____

Section C: Pattern of drug use

33. **Table 2*contains a list of drugs you may have used and when you might have used them last. For each period, thick 'Yes' if it applies to you or 'No' if it does not Awonnkanti o wan ninuapotiyiniawoneyaoogunoloroti lo atiigbati o loo won gbehin. Fun igbakooka, fi ami 'beeni' ti o ba jo mo o tabi 'beeko' ti o ba je mo o.***

Table 2

S/N	Substances	Ever used		Used in the last one week	
		Yes	No	Yes	No
33.1	Alcohol*otilile*				
33.2	Valium				
33.3	Skushi				
33.4	Rohypnol {Refnol)				
33.5	Fortwin (injection)				
33.6	Skunk				
33.7	Caffeine (coffee)				
33.8	Cocaine				
S/N	**Substances**	**Ever used**		**Used in the last one week**	

		Yes	No	Yes	No
33.9	D5				
33.10	Ecstasy (MDMA)				
33.11	Heroin				
33.12	Morphine				
33.13	Glue				
33.14	Tramadol				
33.15	Codeine				
33.16	Marijuana				
33.17	Pacalin				
Please tell me some other substances which you might have ever used but is/are not listed above					
33.18					
33.19					
33.20					

Section D:Influence of drugon sexual behaviour

Abala D: Ibasepo larin lilo oogun oloro ati iwa ibalopo

34. Have you ever taken alcohol or any other drug in order to enjoy sex?

*Nje o ti mu otililetabi lo oogunolorori tori ki o baa lee niibalopoti o**Sl'orin**?*

1. Yes ☐ 2. No ☐

35. Do you currently takenalcohol or any other drugs to make you strong enough to enjoy sex?

Nje o maanmuotililetabi lo oogunoloromiranlatijeki o lee niibalopoti o lorin

1. Yes ☐ 2. No ☐ 3. Not applicable/Never *Mi o lo ri* ☐

36. How common is the practice of taking alcohol or other drugs so as to have good sex among young people?

*Bawonimimuotililetabililoooogunolorolati lee niibalopoti**o l'orin**.*

1. Very common ☐ 2. A bit common ☐ 3. Rare ☐

4. Practice does not exist ☐

37. Which drugs do young people use to have good sex which are you aware of? (Please list as many as you can remember)

_____

_____

38. **Which drugs have you ever taken so that you can have good sex? For each drug, please tell me how it helps you have good sex. USE TABLE 3** ***(First itemize the drug/alcohol before completing how it is used to enjoy sex)***
Oogunoloro wo ni o ti lo rilati je ki o lee niibalopoti ol'orin.

Table 3

S/N	Alcohol and any other drug ever taken to enjoy sex *Otilileatiioogunolorolatigbadunibalopo?*	How does the drug help you to have good sex? *Bawonioogunoloronaa se ran o lowosilatigbadunibalopo?*
38.1		
38.2		
38.3		
38.4		
38.5		

39. **Table 4** ***contains a list of sexual practices which some people indulge in. For each tick (v) whether you have ever experienced it while you were sober (i.e. NOT under the influence of one drug or the other)***
Awonasaibalopotiawoneniyanmaansewaninupoti 4 yi. Fi amisieyiti o batiniiriri re ri, ki o si so iditi o fi ba o ninu je (i.e. Ko siniabeakosoogunolorokantabiomiran)

Table 4

S/N	Sexual activities ever experienced	Yes	No
39.1	Sex without condom		

	Ibalopolaisirobaidaabobo		
39.2	Oral sex (i.e. licking genitals or sex organ of partner) *Ibalopolatienu (i.e. lilaojuaraobirin)*		
393	Orgy (sexual intercourse with many people at a time) (*Ibalopopeluopolopoeniyanleekannaa*)		
39.4	Anal sex (Sex through the anus) *Ibalopolatiibitieniyantinyagbe*		
39.5	Casual sex (Sex with someone you don't know well or is not your regular friend) *Ibalopopelueniti o ko modaradara*		
39.6	Pay someone to have sex *Sanwo fun ibalopo*		
39.7	Got paid to have sex *Won sanwo fun mi fun ibalopo*		
39.8	Forced/coerce someone to have sex with you *Mo fi ipabaenikan lo po*		
39.9	Forced or unwanted sex in the hands of someone *Won fi ipaba mi lo po*		
39.10	Sex without condom *Ibalopolaisirobaidaabobo*		

40. **Table 5*contains a list of sexual practices which some people indulge in. For each tick (v) whether you have ever experienced it under the <u>INFLUENCE OF ONE</u>drug or the other***

Awonasaibalopotiawoneniyanmaansewaninupoti 4 yi. Fi amisieyiti o batiniiriri re ri, ki o si so iditi o fi ba o ninu je (i.e. Ko siniabeakosoogunolorokantabiomiran)

Table 5

S/N	Sexual activities ever experienced under the influence of alcohol or any other drugs	Yes	No	Drugs used
40.1	Sex without condom *Ibalopolaisirobaidaabobo*			
40.2	Oral sex (i.e. licking genitals or sex organ of partner) *Ibalopolatienu (i.e. lilaojuaraobirin)*			
40.3	Orgy (sexual intercourse with many people at a time) (*Ibalopopeluopolopoeniyanleekannaa*)			
40.4	Anal sex (Sex through the anus) *Ibalopolatiibitieniyantinyagbe*			
40.5	Casual sex (Sex with someone you don't know well or is not your regular friend) *Ibalopopelueniti o ko modaradara*			

40.6	Pay someone to have sex *Sanwo fun ibalopo*			
40.7	Got paid to have sex *Won sanwo fun mi fun ibalopo*			
40.8	Forced/coerce someone to have sex with you *Mo fi ipabaenikan lo po*			
40.9	Forced or unwanted sex in the hands of someone *Won fi ipaba mi lo po*			
40.10	Sex without condom *Ibalopolaisirobaidaabobo*			

APPENDIX IV

Sexual Practices of out-of-school drug using youths in selected Inner-core areas of Ibadan

Coding guide

ITEMS	VARIABLES	CODE
Q2	**Age**	Actual figure
Q3	**Ethnicity:**	
	Hausa	1
	Yoruba	2
	Igbo	3
	No Response	99
Q4	**Marital Status:**	
	Single	1
	Married	2
	Widowed	3
	Divorced	4
	No Response	99
Q5	**Religion:**	
	Muslim	1
	Christian	2
	Traditional African Religion	3
	No Response	99
Q6	**Highest Level of Education:**	
	Non-formal education	1
	Primary	2
	Secondary	3
	Tertiary	4
	No Response	99
Q6b	**Type of tertiary institution:**	
	University	1
	College of Education	2
	Polytechnic	3
	No response	99
Q7	**Who are you living with:**	
	Father only	1
	Mother only	2
	Both Parents	3
	Relatives	4
	Self	5
	Friends	6

	On the Street No Response	7 99
Q8	**Occupation:** Unemployed Artisan Employed Learning trade/Apprentice No Response	 1 2 3 4 9
	SECTION B: SEXUAL BEHAVIOUR	
Q9	**Age at first sexual intercourse**	Actual figure
Q10	**Number of sexual partners you have now**	Actual figure
Q11	**Number of sexual intercourse in the last one month**	Actual figure
Q12	**Number of sexual partners in the last one month**	Actual figure
Q13	**Have you ever had sexual intercourse with a casual partner** Yes No No response	 1 2 99
Q14	**Ever had sex using condom** Yes No No response	 1 2 99
Q15a	**Wife** Yes No Not applicable (i.e. No to Q14) No response	 1 2 3 77 99
Q15b	**Girlfriend** Yes No Not applicable (i.e. No to Q14) No response	 1 2 3 77 99
Q15c	**Concubine** Yes No Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q15d	**Prostitute** Yes No	 1 2

	Not applicable (i.e. No to Q14) No response	77 99
Q16	**How did you learn to use condom:** Peers Media Advocacy Not applicable (i.e. No to Q14) No respose	 1 2 3 77 99
Q17	**What you do when your sexual partner refuses condom use:** Proceed without condom Do not proceed Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q18	**Do you enjoy sex while using condom** Yes No Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q19	**Do you still use condom** Yes No Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q20	**Why you still use condom**: Protect from STIs and STDs Prevent pregnancy Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q21	**Which of the following indicates how you use condom**: One for one round One for more than one round Two or more per round Not applicable (i.e. No to Q14) No response	 1 2 3 77 99
Q22	**What you do if condom gets torn while having sex**: Continue with the torn condom Stop and change it Not applicable (i.e. No to Q14) No response	 1 2 77 99
Q23	**Have you had sex with a fellow male** Yes No	 1 2

	No response	99
Q24	**If yes, did you use condom while having sex with them**	
	Yes	1
	No	2
	Not applicable (i.e. No to Q23)	77
	No response	99
Q25	**Have you forced someone to have sex with you**	
	Yes	1
	No	2
	No response	99
Q26	**Has anyone forced you to have sex**	
	Yes	1
	No	2
	No response	99
Q27	**Who forced you to have sex**:	
	Girlfriend	1
	Fellow male	2
	Female	3
	Wife	4
	Not applicable (i.e. No to Q26)	77
	No response	99
Q28	**How often do you use condom**:	
	Always	1
	Frequently	2
	Occasionally	3
	Rarely	4
	Never	5
	Not applicable (i.e. No to Q14)	77
	No response	99

Q29	**Circumstances under which you have ever had sex**	
Q29.1	**Had sex willingly**	(for each) Yes = 1 No = 2 No Response =99
Q29.2	**Paid to have sex**	
Q29.3	**You were forced to have sex**	
Q29.4	**You forced someone to have sex**	
Q29.5	**Under influence of alcohol**	
Q29.6	**Under influence of drugs/take one psychoactive drug before or during sex**	

SECTION B.2: KNOWLEDGE RELATED TO CONDOM USE

Q30	**Does condom prevent STD**:	
	Yes	1
	No	2

	No response	99
Q31a	**HIV/AIDS**: Yes No No response	 1 2 99
Q31b	**Gonorrhea (Atosi):** Yes No No response	 1 2 99
Q31c	**Staphylococcus**: Yes No No response	 1 2 99
Q31d	**Cancer (Jejere)**: Yes No No response	 1 2 99
Q31e	**Magun**: Yes No No response	 1 2 99
Q32	**What else is condom useful for**; Prevent unwanted pregnancy Treat pimples No response	 1 2 99
Q41	Q41 Knowledge score	Actual figure
SECTION C: PATTERN OF DRUG USE		
Q33a	**Substances ever used**	
Q33a.1	**Alcohol**	(for each) Yes = 1 No = 2 No Response =99
Q33a.2	**Valium**	
Q33a.3	**Skushi**	
Q33a.4	**Rohypnol {Refnol)**	
Q33a.5	**Pentazocine (injection)**	
Q33a.6	**Skunk**	
Q33a.7	**Caffeine (coffee)**	
Q33a.8	**Cocaine**	
Q33a.9	**D5**	
Q33a.10	**Ecstasy (MDMA)**	
Q33a.11	**Heroin**	
Q33a.12	**Morphine**	
Q33a.13	**Glue**	
Q33a.14	**Tramadol**	

Q33a.15	**Codeine**	
Q33a.16	**Marijuana**	
Q33a.17	**Pacalin**	
Q33a.18	**Swinol**	
Q33a.19	**Emzolyn**	
Q33a.20	**Uniplex**	
Q33a.21	**White**	
Q33a.22	**Tutolin**	
Q33a.23	**Coflin**	
Q33a.24	**Pawpaw**	
Q33a.25	**Colorado**	
Q33a.26	**Herb/local mixtures**	
Q34b	**Substances used in the last 1 week**	
Q33b.1	**Alcohol**	(for each) Yes = 1 No = 2 No Response =99
Q33b.2	**Valium**	
Q33b.3	**Skushi**	
Q33b.4	**Rohypnol {Refnol)**	
Q33b.5	**Pentazocine (injection)**	
Q33b.6	**Skunk**	
Q33b.7	**Caffeine (coffee)**	
Q33b.8	**Cocaine**	
Q33b.9	**D5**	
Q33b.10	**Ecstasy (MDMA)**	
Q33b.11	**Heroin**	
Q33b.12	**Morphine**	
Q33b.13	**Glue**	
Q33b.14	**Tramadol**	
Q33b.15	**Codeine**	
Q33b.16	**Marijuana**	
Q33b.17	**Pacalin**	
Q33b.18	**Swinol**	
Q33b.19	**Emzolyn**	
Q33b.20	**Uniplex**	
Q33b.21	**White**	
Q33b.22	**Tutolin**	
Q33b.23	**Coflin**	
Q33b.24	**Pawpaw**	
Q33b.25	**Colorado**	
Q33b.26	**Herb/local mixtures**	

SECTION D: INFLUENCE OF DRUGS ON SEXUAL BEHAVIOUR

Q34	**Have you taken drugs or alcohol to have good**sex Yes No No response	 1 2 99
Q35	**Do you currently do it** Yes No No response	 1 2 99
Q36	**How common is the use of alcohol or drugs for sex** Very common A bit common Rare Practice do not exist No response	 1 2 3 4 99
Q37a	**Drugs youths use to have good sex (Tramadol)** Yes No No response	 1 2 99
Q37b	**Q37b Drugs youths use to have good sex (Alcoho)** Yes No No response	 1 2 99
Q37c	**Q37c Drugs youths use to have good sex (Codeine)** Yes No No response	{ 1 2 99
Q37d	**Q37d Drugs youths use to have good sex (Marijuana)** Yes No No response	 1 2 99
Q38a	**Q38a.1 Drugs used to have sex (Codeine)** Yes No No response	 1 2 99
Q38a	**Q38a.2 Drugs used to have sex (Alcohol)** Yes No No response	 1 2 99
Q38a	**Q38a.3 Drugs used to have sex (Cocaine)**	{

	Yes	1
	No	2
	No response	99
Q38a	**Q38a.4 Drugs used to have sex (Tramadol)**	
	Yes	1
	No	2
	No response	99
Q38a	**Q38a.5 Drugs used to have sex (Pacalin)**	
	Yes	1
	No	2
	No response	99
Q38a	**Q38a.6 Drugs used to have sex (Tutolin)**	
	Yes	1
	No	2
	No response	99
Q38a	**Q38a.7 Drugs used to have sex (Herbal Mixture)**	
	Yes	1
	No	2
	No response	99
Q38a	**Q38a.8 Drugs used to have sex (Pawpaw)**	
	Yes	1
	No	2
	No response	99
Q38b	**Effects of drugs used to have good sex**	
Q38b.1	**Q38b.1 Codeine**	
	Energy booster/ make me more active	1
	Holds sperm/ Prolongs ejaculation	2
	No response	99
Q38b.2	**Q38b.2 Alcohol**	
	Energy booster/ make me more active	1
	Holds sperm/ Prolongs ejaculation	2
	No response	99
Q38b.3	**Q38b.3 Cocaine**	
	Energy booster/ make me more active	1
	Holds sperm/ Prolongs ejaculation	2
	No response	99
Q38b.4	**Q38b.4 Tramadol**	
	Energy booster/ make me more active	1
	Holds sperm/ Prolongs ejaculation	2
	No response	99
Q38b.5	**Q38b.5 Pacalin**	
	Energy booster/ make me more active	1

	Holds sperm/ Prolongs ejaculation No response	2 99
Q38b.6	**Q38b.6 Tutolin** Energy booster/ make me more active Holds sperm/ Prolongs ejaculation No response	 1 2 99
Q38b.7	**Q38b.7 Herb/Local mixture** Energy booster/ make me more active Holds sperm/ Prolongs ejaculation No response	 1 2 99
Q38b.8	**Q38b.8 Pawpaw** Energy booster/ make me more active Holds sperm/ Prolongs ejaculation No response	 1 2 99
Q39	**Sexual activities ever experienced while sober**	
Q39.1	Sex without condom	(for each) Yes = 1 No = 2 No Response =99
Q39.2	Oral sex	
Q39.3	Orgy	
Q39.4	Anal sex	
Q39.5	Casual sex	
Q39.6	Pay someone to have sex	
Q39.7	Got paid to have sex	
Q39.8	Forced someone to have sex (crosscheck Q25	
Q39.9	Was forced to have sex (crosscheck Q26)	
Q40	**Sexual activities experienced while under the influence of drugs**	
Q40.1	Sex without condom	(for each) Yes = 1 No = 2 No Response =99
Q40.2	Oral sex	
Q40.3	Orgy	
Q40.4	Anal sex	
Q40.5	Casual sex	
Q40.6	Pay someone to have sex	
Q40.7	Got paid to have sex	
Q40.8	Forced someone to have sex (crosscheck Q25)	
Q40.9	Was forced to have sex (crosscheck Q26)	

APPENDIX V

UNIVERSITY OF IBADAN

Chairman: Prof. A.S. Jegede, B.Sc, M.Sc.(Ife), MHSc (Toronto), Ph.D (Ibadan)
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NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Sexual practices of out of School drug-using youths selected inner core areas in Ibadan, Oyo state, Nigeria

UI/Social Sciences Ethics committee assigned number: UI/SSHREC/2018/0050

Name of Principal Investigator: **Jegede, Tolulope J.**
Address of Principal Investigator: Department of Health Promotion & Education
Faculty of Public Health
University of Ibadan
Date of receipt of valid application: 22/10/2018
Date of meeting when final determination on ethical approval was made: 30/10/2018

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the SSHREC Committee.

The approval dates from **30/10/2017 to 29/10/2019.** If there is delay in starting the research, please inform the SSHRE Committee so that dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the SSHE Committee assigned number and duration of SSHRE Committee approval of the study. It is expected that you submit your annual request for the project renewal to the SSHRE Committee early in order to obtain renewal of your approval to avoid disruption of your research.

Note: the National code for research ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the SSHREC. No changes are permitted in the research without prior approval by the SSHREC except in circumstances outlined in the Code. The SSHRE reserves the right to conduct compliance visit to your research site without previous notification.

Prof. A.S. Jegede