

**RURAL -URBAN DIFFERENCES IN SEXUAL BEHAVIOUR
AND MALE CONDOM USE AMONG NEVER MARRIED
YOUTH IN NIGERIA**

BY

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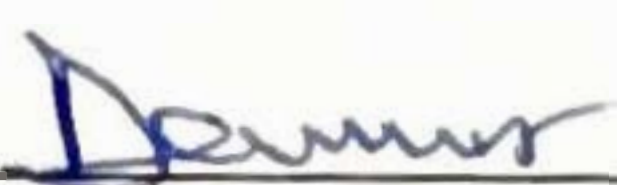
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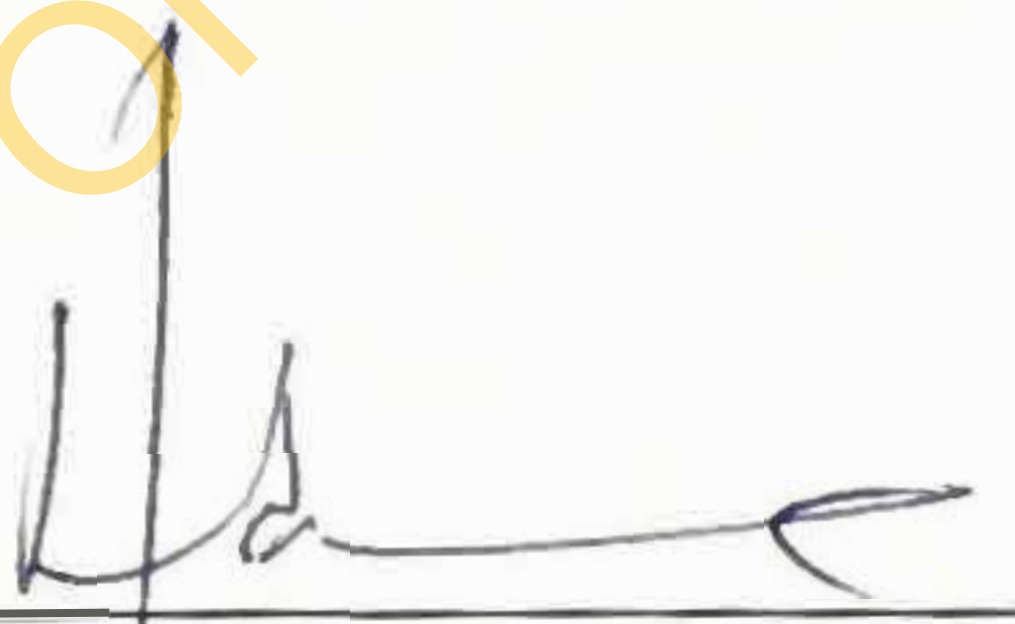
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CERTIFICATION

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DEDICATION

This work is dedicated to God Almighty, the giver of life and knowledge and to my parents Mr. and Mrs. Ojigho for their dedicated interest to enhance my progress in life.

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ABSTRACT

The Acquired Immune Deficiency syndrome (AIDS) crisis, the increase in other sexually transmitted diseases (STDs) and the continuing problem of unwanted pregnancies, necessitated new methods of barrier protection. Youths in Nigeria are engaged in risky sexual behaviour and are not quick at taking actions that would prevent or reduce the risk of STD and AIDS/HIV transmission. This study aimed at comparing sexual behaviour and condom use among never married youths in rural and urban areas using population based data from 2007 National HIV/AIDS and reproductive health survey (NARHS, 2007).

It was a comparative cross sectional population based study and involved 3,046 never married youths aged 15-24 years living in rural and urban areas in Nigeria, selected from the study population of the NARHS, 2007. The primary survey was a national one, involving the 36 states and the Federal Capital Territory Abuja. Secondary data analysis were done using descriptive, chi-square and logistic regression statistic with the aid of SPSS statistical software.

The total number of rural respondents was 2015 and urban respondents was 1311. There were more rural males (66.5%) than urban males (58.5%) and less females (33.5%) in rural areas than urban areas (41.1%). Regarding sexual behaviour, there were rural urban differences. Rural dwellers tend to initiate sexual relation (16.34 ± 2.69) earlier than urban dwellers (17.06 ± 2.64) and tend to have less multiple sexual partners (26.6%) compared to their urban counterparts (27.7%). Cross tabulation of variables on multiple sexual partners showed that education ($p=0.0001$), Religion ($p=0.030$), ethnicity ($p=0.001$) and access to information ($p=0.001$) were significantly associated with having more than one sexual partners. There were also rural-urban differences in ever-used and heard of the male condom among respondents. Less proportion (68.0%) of rural dwellers compared with (84.9%) of urban dwellers have ever heard of the male condom while (15.6%) of rural dwellers compared with (23.3%) of urban variables have ever used the male condom. Relationship between socio demographic variables and ever used the male condom showed that all variables were significant ($p < 0.05$) except for sex and religion ($p > 0.05$). Relationship between socio demographic variables and ever heard of the male condom revealed that all variables were significant ($p > 0.05$) except for age ($p < 0.05$). Logistic regression analysis of ever use of male condom on variables revealed that rural youths with poor access to information were 5 times less likely to have ever used the male condom than urban youths. Also regression awareness on ever heard of male condom showed that rural youths who have secondary education were 2.5 times less likely than urban youths. The major reason for using the male condom was to protect from HIV/AIDS and unwanted pregnancy with (66.1%, 168) in rural areas compared with (60.3%, 40) in urban areas; while the major reason for not using the male condom by rural youths (58.9%, 28) was because they did not enjoy using the device compared with urban youths (34.2%, 25) who gave other reason for not using the device.

From this study it is important to publicize the male condom which help youths overcome the initial barriers and motivate them to use the device. In addition programmes geared towards behavioural change should be organized in the society. Such programmes should entail making the youths feel and perceive the risk of involving in certain risky sexual behaviour like unprotected sex.

Key words: Youths, Rural/urban areas, Sexual behaviour, Condom use

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GLOSSARY OF TERMS

AIDS	Acquired Immune Deficiency Syndrome
FHI	Family Health International
FMH	Federal Ministry of Health
HIV	Human Immuno-deficiency Virus
NDHS	Nigerian Demographic Health Survey
RHC	Reproductive Health Coordinator
SAPC	State's AIDS Programme Coordinator
SMC	Survey Management Committee
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TC	Technical Committee
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNFPA	United Nations Populations Funds
WHO	World Health Organizations

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND INFORMATION

According to the World Health Organization adolescents cover the age of 10-19 years. "Youths" are defined as belonging to the age group of 15-24 years while the terminology "young people" covers the age of 10-24 years (WHO, 2005).

Studies of reproductive health behaviour of young people indicate that many adolescents and youths initiate sexual intercourse at an early age and engage in high risk sexual behaviours. Such risky behaviours include having unprotected sex and multiple partners with the resultant effect of high rate of unwanted pregnancy, illegal abortions and sexually transmitted disease including HIV (human immunodeficiency virus) that causes AIDS (acquired Immune deficiency syndrome) which is the most complicated and complex health problem confronting the world today (Agweda et al., 2010; Okonkwo et al., 2005; and Dibua et al., 2010). The National commission on AIDS in 1991, classified Aids as the most deadly sexually transmitted disease ever to confront humanity.

According to UNAIDS (2001), AIDS kills ten times more people in a year than wars. Current statistics on HIV/AIDS in Nigeria provide evidence as to the relatively higher risk that young adults (within the age bracket of undergraduate) face with respect to HIV transmission. The 2007 national survey for example recorded a minimum of 6 percent seroprevalence level for different categories of young people (6.5% for 25-29 years, 6.0% for 20-24 years and 6.1% for 15-19 years as compared to other age categories, none of which had a seroprevalence rate of above 5% (Federal Ministry of health, 2002).

One of the widely accepted methods of prevention of HIV/STI's is the use of condom. Population report (1999) explains that in order to avoid AIDS, sexually active males and females who are not monogamous must know about AIDS and know how to prevent AIDS using condoms and how to use them correctly.

It is as a result of the effectiveness of condom in preventing the spread of HIV that Imhonde et al (2005) contend that all known primary interventions for HIV have endorsed the use of condom as one of the sure ways of not contracting the HIV virus in heterosexual intercourse.

Many studies have supported the efficacy of condom in reducing the risk of HIV/AIDS transmission in heterosexual intercourse (Imhondel et al., 2005; Kwabena, 2007; Tinuola, 2006;

and Onyekanmi, 1994). In their research, Daroch and Bankole (2000) observed that the decline in HIV prevalence in Uganda among young men and women aged between 15-49 years, was as a result of condom use among the unmarried sexually active population. As a result of the effectiveness of condoms in preventing HIV transmission, many countries have seen an increase in condom use in recent years. The distribution of condom to countries in sub-Saharan African has increased. In 2004, the number of condom provided to Sub-Saharan region by donors was equivalent to 10 for every man compared to 4.6 for every man in 2007 (Kaisernetwork.org, 2005).

In studies carried out between 2001 and 2005 eight out of eleven countries in Sub-Saharan Africa reported an increase in condom use (UNAIDS, 2006).

Several hypotheses have been offered to explain the high rates of sexual activity among young Nigerians. Social environment plays an important role in the health related behaviour of young people and this include their friends and peers, sexual partners, family member as well as the community, school and other youth serving institution . (Okonkwo et al., 2005; Okunlola et al., 2006; and WHO, 1999).

The impact of peers on reproductive and sexual behaviour of young people has particularly been documented to be strong (Stanton et al., 2002). Among others, beliefs of young people as regarding the behaviour of their peers have shown to have impact on their actions in various spheres of health behaviour. Some studies have shown that young people who believed that their peers were using condoms were more likely to use condoms compared to those who had contrary beliefs.

In a cross sectional study of 350 out-of-school youth aged 15-24 years in a local government area of Nigeri, those who had ever had sexual intercourse were 74.9%,and of these, 56.5% used no protection while 29.0% used condoms.Up to 78.6% have had sex within the preceding 12 months with 38.9% condom use. The commonest reason for non-condom use was that it reduces sexual enjoyment. Those who believed a single unprotected sexual exposure may result in HIV infection reported more condom use than those who believed otherwise (42% vs. 27.2%). Those who had prior discussion with their partners on HIV/AIDS reported more condom use compared to those who had not (50% vs. 25%). Also, those who had sexual intercourse occurring as a spontaneous event reported less condom use compared to those who have previously discussed about the possibility of having sex (68.0% vs. 51.8%) (Adchiyi and Asuzu, 2009)

In a study of 593 students of which 344 were females and 249 males, only 3.6% of male urban and 28.1% of female urban respondents indicated that they used condoms. Only 2% of rural subjects had ever used a condom. The major reason for the use of condoms is to prevent pregnancy (Donatus, 1995).

In their research, Miriam J. Temin et al (1999) observed that Nigerian's deteriorating socio economic situation, the erosion of traditional African values, early onset of menarche, a widening gap between age at menarche and age at marriage and decreased value placed on virginity account for high rate of sexual activity and STD infection among Nigerian adolescents. Population reports (2007) explains that the social bonds and tradition that use to shape people's behaviour and help them to transform to adulthood in Africa have weakened in the face of urbanization, new attitude towards sexuality and the breakdown of the extended family. Thus many people are sexually active and without adequate information to protect themselves.

1.2 STATEMENT OF PROBLEM

There appears to be a consensus among Nigerian Researchers and observers that many traditional values are changing rapidly for the worse (Naswen, 2001; Ezeh, 2001; Arumala, 2005; and Eruesegbefe, 2005). One area of life in which the decline of traditional values is obvious is in the area of sexuality.

Osisioma (1998) lamented that in Nigeria, culture no longer has a grip on the youth as our society seems to be plagued with decayed moral codes and value and so the sense of right and wrong is eroded. This seems to affect the youth, adolescent inclusive, more than any other group as this is manifested in the acceptance of sex before marriage, homosexual behaviour, lesbianism, abortion and indecent dressing. The problems of adolescent unprotected sexual activity, low contraceptive use, rising pregnancy rates and reliance on clandestine abortion has become readily apparent. The gravity of the problem is highlighted by results of the 1990 demographic and health survey (DHS). At the time of the survey, nearly 40% of adolescent women in Nigeria either had given birth or were expecting their first child (Amazigo, 1997). Information on reproductive tract infection and clandestine abortion confirm that a real problem exists. For example in a study of reproductive tract infections among adolescent in a rural community, 80% of women aged 17-19 years interviewed said they were sexually active, and 29% of those younger than 19 years had an induced abortion, physical examinations revealed

that 40% of women younger than 19 had a reproductive tract infection(Nancy Silver,1997). A ministerial inquiry on maternal health in Nigeria reported that an estimated 500,000 *clandestine induced abortions occurred in 1980 and that such procedures were the main cause* of death among unmarried women between the ages of 15-24years (Obikezie et al., 1997). Other consequences of sexuality and non use of condoms among the youth as experienced in Nigeria include STDs, HIV/AIDS, as well as psychological/emotional problems. Each of these has a number of social, economic, and health implications for our youth and the entire society. Unwanted pregnancies leads to shame, and rejection by parents, peer (friends)and society, a young girl being forced to untimely marriage to an older, often unfit man. Social and economic consequences such as dropping out school or other vocational training abruptly; poor financial status; low status in society and low quality of life. The psychological /emotional problems include guilt and permanent regret; loss of self esteem; fear of the future (Owuamanem,1997;Achal,1998;Bimbola and Akanle,2008;and Ankomah et al.,2006).

1.3 RATIONALE OF THE STUDY

A study of sexual behaviour and condom use among young Nigerians is important not only because of the health, social and economic repercussions of their sexuality but because of their sheer size and contribution to overall fertility. Globally the youth proportion of the population is increasing. In Nigeria it is estimated that youths aged 15-24 years make up approximately 20% of the estimated 130 million population (Ejembi and Otu, 2004). About one person out of every five in Nigeria is currently between aged 10 and 19. From 1980-1990 the number of young people aged 10-19 increased by about 42%, from 18.5million to a little over 26million (Makinwa-Adebusoye, 1997). Estimate by the national population commission (NPC,1998)reported that 84million Nigerians are currently under age 25.

According to the Nigeria fertility survey (NFS) conducted in 1981-1982, the contribution of the young to overall fertility is high. Women aged 15-19years representing 21.6% of all sampled women aged 15-49years contributed 13.7% of reported births. The age specific-fertility rate among 15-19 year old (173.3 births per 1,000) was one of the highest in the world. Moreover this group accounted for 10.4% of all females pregnant at the time of the NFS (Makinwa-Adebusoye, 1997).

The NFS revealed that these young women's knowledge of contraception was very low. About 70% of those aged 15-19 and 61% of those aged 20-24 had not heard of any method. Only 4-5% of women in these age groups had used one or more effective methods.

Such data indicate that further information is needed on sexual behaviour, reproductive knowledge and condom use, which is one of the contraceptive tools among young Nigerians, to guide policy makers on youth specific programs.

Young people are extremely at risk of contracting and transmitting HIV/AIDS/STD because they are among the most sexually active segment of the population (Achal, 1998). It has been reported that every day 5,000-6,000 young people (ages 15-24) contract HIV and about one third of all STD occur in the 15-24 years age group with the females being more affected than males (Bimbola and Akande, 2008)

Risky sexual behaviours such as unprotected heterosexual intercourse is one of the major channels of transmission (Agweda T.O et al., 2010). One of the widely acknowledge ways of preventing the contraction of HIV/AIDS and all forms of sexually transmitted diseases is the use of condom (Anyanwagu, 2010).

Thus a study of this nature will help to determine reasons for use and non-use of condom among youths aged 15-24, and it can enable the government, non-government organization and other service providers, to embark on programmes geared towards encouraging the sexually active people in the society, especially youths, to engage in safe sexual activities that will reduce their exposure to HIV/AIDS/STD.

Majority of university students are unmarried youths. On entry into universities, they acquire independence from parental and secondary school restrictions. This increase in autonomy manifests in very permissive attitude and increased sexual experimentation, replete with risky sexual practices. (Ejembi and Otu, 2004). Because of their social positions, university students serve as role models to other youth and thus, these negative tendencies may impact on other youths.

The prevalence of risky sexual behavior is high among students in tertiary institutions despite a high level of knowledge about reproductive health issues. Indeed the environment in higher institutions of learning in Nigeria, like that in many other parts of the world is characterized by high level of personal freedom and social interactions, Socially, the typical university environment in Nigeria offers opportunities for high level of sexual networking and the

“freedom” that characterizes the higher institutions permits permissive lifestyles (Fatusi,2005; Araoye and Fakeye,1998; and WHO,1995).

The government and development partners have unfortunately neglected the university environment. There is now a great need to direct attention to the reproductive health behaviour of young people in Nigeria tertiary who are role models to other youths in the society in terms of both research and intervention.

1.3 BROAD OBJECTIVE

To compare sexual behaviour and condom use among never married youths aged 15-24 in rural and urban areas using population based data from 2007 National HIV/AIDS and reproductive health survey.

1.4 SPECIFIC OBJECTIVES

1. To identify the number of sexual partners among rural-urban youths
2. To identify the age at sexual debut among rural –urban youths
3. To identify ever heard and use of condoms among rural-urban youths
4. To identify factors associated with condom use among rural -urban youths

1.5 RESEARCH QUESTIONS

1. What are the differences in sexual behaviour and condom use among rural and urban Nigeria youths aged 15-24?
2. What is the age at sexual debut among rural- urban youths?
3. What are the factors associated with condom use among rural- urban youths?
4. What are the effects of socio-demographic characteristics on sexual behaviour and use of condoms?

1.6 HYPOTHESES OF THE STUDY

The hypotheses of this study are as follows.....

The socio demographic characteristics of rural and urban Nigeria youths aged 15-24, have no effect on their sexual behaviour.

There is no association between the socio -demographic characteristics of rural-urban youths on their use of condom.

There is no significant association between social behaviour and condom use among rural –urban youths

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CHAPTER TWO

LITERATURE REVIEW

The review of literature in this chapter is divided into sections relating to the characteristics, sexuality, reproductive health problems, pattern of sexual behaviour and condom use among rural and urban Nigeria youths aged 15-24. Thus the review is under the following headings;

1. Youth's and sexuality
2. Reproductive health problems affecting youths
3. Sexual behaviour and condom use among rural urban Nigeria youths aged 15-24

2.1 YOUTH AND SEXUALITY

The Oxford Dictionary of Current English defines youth as being young. It is a period that is characterized with vigour, enthusiasm and inexperience. This is a critical stage in the development of gender roles, in the perceptions of the self and others. The biological and social growth, which occurs in this life cycle stage, forms the foundation for a healthy and productive adult life of a generation. (Amazigo, et. al., 1997; Katz, 2006; Ozumba, 1992; Amaechi, 1992)

Sexuality on the other hand refers to the entire gamut of attitudes, thoughts and behaviours concerning sexual activity, it can be penetrative or non-penetrative, coercive or voluntary.

Different people perceive sexuality in different contexts. Generally, a four dimension framework of sexuality has been proposed for analyzing and understanding the issues involved in sexuality.

Sexuality is seen as a comprehensive concept that encompasses the physical capacity for sexual arousal and pleasure as well as personalized and shared social meaning attached to the formation of sexual identities. (Amazigo, et. al., 1997; Katz, 2006; Ozumba, 1992; Amaechi, 1992). As a

biological concept, heavily influenced by culture, sexuality becomes a social product, that is a representation and interpretation of natural functions in hierarchical social relationships. The first

two dimensions of the framework, sexual partnership, and social construction (meaning) of sexuality are primarily behavioural and objective, the last two dimensions are physiological or

cultural and importantly, subjective. (Amazigo, et. al., 1997; Katz, 2006; Ozumba, 1992; Amaechi, 1992)

2.1.1 Formation of sexual partners among the youth

Primary on the list of the sexuality framework is the concern for the number of sexual partners, current and past that a person has. Put differently, it focuses on concern for each person's level of involvement, whether knowingly or unknowingly in sexual networks. It also addresses issues of timing and duration of sexual partnership throughout the person's lifetime; the identity imposed; as well as the rate and conditions of change of partners. (Amazigo ,et.al., 1997; Katz, 2006; Ozumba, 1992; Amaechi, 1992)

What is considered most crucial is a girl's ability to choose where, when and with whom to have sexual relations or to engage in a particular sexual act. Pecuniary forces, rather than any elements of voluntarism, often drive young girls into sexuality. Survey of school girls facing adverse circumstances show that they are increasingly engaging in sexual networking in exchange for economic or personal support. Many girls traded sexual favours for some form of assistance withheld by their parents. On the other hand, the schoolboys boast of the number of girls they keep in school as a mark of achievement and being "a happening guy" (Amazigo ,et.al., 1997; Katz, 2006; Ozumba, 1992; Amaechi, 1992).

The problem here is that the schoolgirls and boys do these without knowing that their sex partners have other sexual partners. These other sex partners of their partners may be carriers of the deadly AIDS virus without betraying it in any form. Many schoolgirls are known to maintain relationships with boys who help them with their schoolwork while having men friends who support them financially. These schoolgirls may contract any of the STDs from their out of school friends and transmit same, unknowingly to their in-school young boy friends. (Amazigo et al; 1997; Katz, 2006; and Ozumba 1992 Amaechi, 1992).

2.1.2. Social Construction of Meaning of Sexuality

This refers to the process by which sexual thoughts, behaviours and conditions (for instance sexual chastity and virginity) are interpreted and ascribed cultural meaning (Katz, 2006). This incorporates collective and individual beliefs about the nature of the body; about what is considered erotic or offensive; and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or talk about sexuality. (Katz, 2006). Ideologies of sexuality in some culture stress females resistance, male aggression and mutual antagonism in sex act, whereas in others they stress reciprocity and

mutual pleasure. While the young girls are expected to exhibit no knowledge of sex, the boys on the other hand are allowed to flaunt and even boast of their sexual exploits. (Katz, 2006). The question is with whom do they experiment? This double standard promotes confusion among the youth, as boys put pressure on the seemingly ignorant girls to achieve their selfish ego boosting. Sex is here defined as the index of measuring love and a medium of exchange for social, academic or financial supports. Thus our youths try to define their growth by their sexual exploits, unmindful of the dangers they may be exposing themselves to. (Katz, 2006).

2.1.3 Sexual Acts

This refers to the nature, frequency and conditions of choice of specific sexual practices in which individuals and couples engage. This goes beyond the mere focus on reproduction, which characterizes the conventional demographic conception of sex as a voluntary heterosexual intercourse with vaginal penetration and ejaculation. It extends to cover different acts of sexuality, such as rape, or milder forms of coerced or forced sex, the use of pleasure-enhancing devices or techniques (some of which may be physically damaging, for example, the use of drying or tightening vaginal astringents) or other forms of sexual practices. (Amazigo et al; 1997; Katz, 2006; and Ozumba 1992 Amaechi, 1992).

The frequency and forms of sexual depression people engage often come in as important elements of sexual and reproductive health. Some sexual acts, no doubt, negate the need for safe practices and contraception. In sexual practices that go beyond reproduction to the male enjoyment, there is strong resistance for contraceptive devices like condoms. These are considered interference with the sexual fruition of the males and their strong sexual manhood expressions. The man often needs body to body contact (BBC). This is seen as a proof of love. Here, schoolgirls, who are expected to satisfy their partners, find it difficult to negotiate safe sex even when they face the threat of unwanted pregnancy. Worse still, these young girls are led into considerable risk by practices which are accepted as necessary for 'good sex' or at least satisfying the men. This involves inserting of tissue paper and herbs into the vagina or even douching with Dettol to ensure dry sex for the man's enjoyment. (Amazigo et al; 1997; Katz, 2006; and Ozumba 1992 Amaechi, 1992).

There are also the cases of violent sex, which appear to be endemic in many of our schools, in the face of obvious physical evidence of harm, and threat of unwanted pregnancy, if they are

frightened or ashamed. It must be added that in such cases the females rather than the males are usually the ones to be derided. It must be added that in such cases the females rather than the males are usually the ones to be derided. In some cases, female youth are even powerless to of being beaten and accusation of not being in love/infidelity. (Amazigo et al; 1997; Katz, 2006; and Ozumba 1992 Amaechi, 1992).

2.1.4 Sexual Drive and Enjoyment

This encompasses the physiological and socio-psychological aspects of sexuality which, interact to produce varying levels of arousability and orgasmic capacity that differ generally and situational among individuals and that change over the course of lifetime. (Amazigo et al; 1997; Katz, 2006; and Ozumba 1992 Amaechi, 1992). This element includes women and men's knowledge of the body's sexual and reproductive capabilities and the ability to obtain physical and emotional pleasure from fantasy, sexual encounters, or self stimulation. (Ozumba & Amaechi, 1992).

The youths in most cases get involved in so many acts that expose them to unhealthy levels of arousability and orgasmic capacities. This is seen in the gangs they keep, dressing patterns and even drunkenness and drug addiction. When a young is under the influence of alcohol or hard drugs, that youth loses self control and ventures into dangerous experiments. (Ozumba & Amaechi, 1992).

2.2 REPRODUCTIVE HEALTH PROBLEMS AFFECTING YOUTHS

The major reproductive health problems affecting youths are pregnancy, abortion, STD including HIV/AIDS and sexual abuse.

Premarital pregnancies among the youths have been the concern of health workers as well as religious leaders. Teen births are growing social problems in Africa as neglect and abandonment increases. School drop out of pregnant students negatively affects their socio-economic standing. For example, in Kenya, 10 percent of female students leave secondary schools annually because of pregnancy (WHO, 2002). In Zimbabwe, one study found that 46 percent of premarital sexually active women ages 11 to 19 had been pregnant (WHO, 2002).

In Nigeria, a study conducted by Makinwa-Adebusoye, (1997) among some youths in five cities in Nigeria, 100 women or 21 percent of those who reported first pregnancies stated that nearly half of the female students (in both secondary and university level) in the survey have been pregnant in the past. This showed that some sexually active university students in Nigeria have been pregnant in the past. Early pregnancy for youths generally bears negative consequences particularly for girls. In some cultures, premarital pregnancy is a source of stigma and pregnant girls may be ostracized from their families and communities.

Faced with unintended pregnancy, many young women turn to abortion. Estimates of abortion among women under age 20 in developing countries range from 1million to 4.4million a year. Most of these abortions, are unsafe, and for some , unsafe abortions results in life-long disability, infertility or death (omoregie , 2002)

In Nigeria, abortion is illegal except to save a woman's life (United Nations, 1995). Nigeria's abortion legislation is an unrevised colonial legacy which is highly restrictive. Abortion is only permissible on narrow medical grounds, that is when pregnancy becomes a threat to a woman's life (Makinwa – Adebusoye 1997).

Inspite of this legal restriction on abortion however, various studies show that abortion is very common among youths in Nigeria. Teens account for 80 percent of unsafe abortion complications treated in hospitals (F.M.H, 1994). A study activity among adolescent females in lagos showed that 24 percent of sexually active respondents have had at least one abortion. Only 48 percent had the procedure performed by a doctor (Odujirin, 1991).

Factors underlying high teen abortion rates include continuing schooling, economic insecurity, and the thought about the consequences of pregnancy earlier discussed. Some of the complications that might occur as a result of unsafe abortion are hemorrhage, anemia, cervical and vaginal lacerations, perforations of the uterus or bowels and secondary sterility. In many cases, these complications lead to death.

Meeting the contraceptive needs of sexually experienced youths is one of the most effective ways of lowering the incidence of pregnancy and hence the need for non punitive, high quality post abortion care which includes contraceptive information and counseling for girls and their partners will improve the health of youths as well as lower the incidence of repeat abortion.

Millions of women worldwide suffer from STIs- all of which are preventable, but many of which are not curable. Almost half of the 39million adults around the world infected with HIV are

women – up from about one –third in 1985 (UNAIDS et al.,2006). Young women are most at risk.Half of all new HIV infections occur in young people (15 to 24 years old). Other STIs also take a toll worldwide, and some can make those infected more vulnerable to HIV infection. According to the latest World Health Organization (WHO) estimates, 340million new cases of curable STIs occur every year.

Biology, gender roles, sexual norms and inequalities in access to resources and decision making power put women and girls at greater risk of infection than men and boys. Many women have insufficient information about sexual and reproductive health and do not understand the risks associated with their own or their partners' sexual behaviors. Many of those who do recognize their vulnerability are powerless to protect themselves. Women who receive informations and counseling and who learn to use the female condom, can protect themselves even if their partners refuse to use a male condom.

As the global HIV/AIDS epidemic has evolved, so too have the populations at risk. About three of every four HIV infections in developing countries are transmitted through heterosexual intercourse.

Current statistics on HIV/AIDS in Nigeria provide evidence as to the relatively higher risk that young adults (within the age bracket of undergraduates) face with respect to HIV transmission. The 2001 national survey, for example , recorded a minimum of 6percent sero-prevalence level for different categories of young people (6.5% for 25-29 yearsm 6.0% for 20-24 years, and 6.1% for 15-19) as compared to all other age categories none of which had a sero-prevalence rate of above 5.0% (Federal Ministry of Health, 2002). This situation makes it necessary to increase measures of prevention, which targets youths favouring empowerment and providing innovative tools.

2.3 SEXUAL BEHAVIOUR AMONG RURAL URBAN YOUTH

Studies on adolescents sexuality suggest that Nigeria youths are becoming sexually active at an earlier age (Makinwa-Adebusoye, 1997; Oyediran et. al, 2002; Isiugo-Abanihe,2004)According to the 2003 NDHS, 75.5 percent of women aged 25-49 had sexual intercourse by age 20 and 39.5percent of men aged 25-29 had sexual intercourse by age 20. In a related analysis of the 1999 NDHS, Isiugo- Abanihe and Oyediran (2004) found that 31.5% of unmarried female youth (15-24 years) were sexually experience d and the median age of sexual debut was 16.6 years.

Rural residents from various studies tend to initiate sexual relation earlier from those in urban areas and are slightly more sexually experienced. The median age at first sexual experience by rural dwellers ranges between 16-17.9 years while that of urban dwellers ranges between 18-18.9 years with the males more sexually active than the females. (NPC, 2000; NDHS, 1999; NDHS, 2003; NDHS, 1991; Ejembi & Otu, 2004; Oladokun et. al., 2008; FMH, 2003).

In a study carried out by Ejembi and Otu (2004) among 400 youths aged 15-24 years in Zaria town, the median age for both sexes at sexual debut was 18 years. Another study carried out in Ekiti among 593 students, showed that a greater percentage (13.2%) of females dwelling in urban areas had their sexual debut at the age of 18 years while their rural counterparts had their sexual debut before 20 years of age (Donatus, 1995).

There are also differentials in sexual partners maintained among urban and rural youths. Studies have shown that urban Nigeria youths tend to have more sexual partners than Rural Youths (Ejembi and Out, 2004; Oladokun et al 2008).

Donatus (1995) in his research among student in secondary and tertiary institution in Ekiti observed that female urban subjects had as many as four sexual partners while one male urban respondent indicated having as many as 23 compared to their Rural counterparts who had none.

Makinwa -Adebusoye (1992) carried out a study among young urban Nigerians and observed that both males and females were currently sexually active, as many as 78% of males and 86% of females aged 20-24. According to the survey of more than 5,500 males and females aged 12-24, sexual intercourse appear to be sporadic and unstable, and many of these young people, particularly males had more than one sexual partners (Makinwa_Adebusoye, 1992).

In another study carried out by Owuamanam (1995) among 593 students in secondary and higher institutions in rural and urban communities in Ondo State, it was discovered that differences exist between rural and urban youths with regards to who they had their first sexual encounter with.

As regards the female subjects, 79.4% of urban and 24.5% of rural girls had their first encounter with boyfriends while 5.4% of urban and 6.1% of rural girls had it with others including relatives (Owumanam, 1995).

According to the research, the most common situation which brought partners together for sexual contact was love and affection, 40.3% for female urban respondents, 48.2% for male urban and 22.4% for rural respondent.

Major factors influencing attitudes of urban youths towards sexual practices are exposure to pornographic films and peer pressure.

(Egbochukwo & Ekanem, 2008 Makinwa – Adebusoye 1992, Okonkwo et al, 2005). Miriam et al 1999), while the major factor influencing rural youths is poverty. (Isiugo Abanihe and Oyediran, 2004).

Booyesen and Summerton (2002) have observed for South Africa that poverty increases the vulnerability of women to HIV infection by resulting among other things, in unsafe sexual practices, often due to a lack of knowledge, lack of access to means of protection and inability to negotiate condom use with sexual partners as a result of entrenched gender roles and power relations.

2.4 CONDOM USE AMONG RURAL URBAN YOUTHS

A condom is a barrier device most commonly used during sexual intercourse to reduce the probability of pregnancy and spreading sexually transmitted diseases (STDs such as gonorrhea, syphilis and HIV). As a method of birth control the male latex condom have the advantage of being inexpensive, easy to use, having few side effects and is the single, most efficient available technology to reduce sexual transmission of HIV and other sexually transmitted infections (WHO/UNAIDS, 2004; WHO 2007; NIH 2000). Laboratory studies show that the male latex condoms are impermeable to infectious agents contained in genital secretions (WHO/UNAIDS; 2001; Twa-Twa et al 2008).

A female condom is also available, most often made of polyurethane. Studies have shown high level of condom use among urban youths compared to their rural counterparts (Isiugo-Abanihe and Oyediran 2004; Donatus 1995; NDHS 2003; Ashley Fraser et al, 2005). According to the national demographic health survey (2003) among 827 never married men aged 15-24 years, condom use at first sexual initiation and during last sex were higher among urban dwellers than those residing in the rural areas. (273%, 54.1%) of urban dwellers and (11.1%, 276%) of rural dwellers reported condom use at first and last sexual intercourse.

In a study carried out by Owuamanem (1995) among 593 students in secondary and higher institutions in Ondo State, 3.6% of Male and 28.1% of female urban respondents indicated that the condom was used by them. Only 2 percent of the rural subjects reported ever using condom.

Higher level of Education, information and socio-economic status are major factors that account for the high level of condom use among urban youths compared to their rural counterparts (NDHS 2003; Isiugo-Abanihe 2004; Oyediran 2004; Donatus 1995). According to NDHS (2003) report among unmarried men aged 15-24 years, (63.7%, 86.6%) of the youths with tertiary education reported condom use at first and last sexual intercourse compared (17%, 43%) and (88%, 18.1%) of their counterparts with secondary and primary health education.

In a study carried out in an urban area in Edo State, 95% of the youths included in the study were favourably disposed to the use of condom in heterosexual intercourse (Agweda et al, 2010).

Isiugo-Abanihe and Oyediran (2004) in their research among 1,831 never married females aged 15-24, observed that 24.5% of the adolescents with a high level of access to information have ever used condom as against 7.3% of their counterparts with low access of information and about 20% of the adolescents who are living in household with high socio economic status reported ever used of condom while 12.8% of their counterparts in Low Socio Economic status had ever used condom.

CHAPTER THREE

METHODOLOGY

3.1 STUDY DESIGN

This is a secondary data analysis of data from 2007 National HIV/AIDS and Reproductive Health Survey (NARHS). The major objective of NARHS plus (2007) was to obtain accurate HIV prevalence estimates and information on risk factors related to HIV infection at the National, Zonal and to some extent at state Levels (NARHS, 2007).

It is a comparative Cross sectional population based study.

3.2 STUDY AREA

The primary survey (NARHS PLUS) was a national study involving the thirty six states and the Federal Capital Territory, Abuja.

3.3 STUDY POPULATION

The population of the 2007 national HIV/AIDS and reproductive Health Survey (NARHS) consisted of all females aged between 15-49 years and males aged 15-64 years living in rural and urban areas in Nigeria.

For this study, never married youths aged 15-24 years living in urban and rural areas will be considered from the study population of the NARHS 2007.

3.4 SAMPLING PROCEDURE

The survey (NARHS, 2007) used probability sampling technique. The sampling procedure (four levels) was a multi stage eligible sampling aimed at selecting eligible persons with known probability.

Stage 1: This involved the selection of rural and urban localities

Stage 2: This involved the selection of Enumeration Area (EA) within the selected rural and urban localities.

Stage 3: Listing of eligible individuals within households was done

Stage 4: Selection of actual respondent for interview and testing was conducted.

Overall 11,822 respondents were selected for interview of which 11,521 were successfully interviewed resulting in a 2.5% non response rate.

3.5 DATA COLLECTION

The primary data were collected by personal interview method using structured and semi structured questionnaire which included socio demographic characteristics such as age, sex, education, religion, ethnicity, access to information,

Number of sexual partners, condom knowledge, reasons for use and non use of male condom, ever used and heard of condom. For this study however, the secondary data will be managed using SPSS version 16.0 for windows and analyzed using descriptive and bivariate statistics and the result will be presented using tables and graphs.

Independent variables:

Age, sex, access to information, education length of time in the community, ethnicity, religion.

Dependent variables:

Condom use, sexual behavior by location

3.6 DESCRIPTION OF THE NARHS 2007

The survey was a cross sectional survey that captured the following broad themes: Socio demographic characteristics; sexual behavior, condom accessibility and use

The survey team in each state consisted of two supervisors and six interviewers. The respondents were assured that all information and discussions remained confidential, that no personal identifiers would be recorded and that their participation was voluntary. Participants were asked questions regarding numbers of sexual partners, condom use, ever heard of condoms, age at sexual debut as well as reasons for use and non use of condoms. A pilot study was conducted in 2 states (Nassarawa and Lagos) by visiting one urban and one rural cluster in each state to test the instruments and other aspects of the survey. The pilot assisted in determining problems that could arise during the survey and discovering problems in the questionnaire.

Two key committees managed the survey. The day to day technical management of the survey was carried out by a technical committee (TC). Oversight of the survey was provided by a larger Central Survey Management Committee (SMC). The latter was a multi disciplinary committee drawn from all relevant stake holders; including development partners, NGOS, Government institutions and technical experts, from academic institutions.

Independent reviews of the entire survey process and questionnaire was undertaken by technical advisors (through WHO). The training of survey personnel was at 2 levels. Central training and

state level training. A comprehensive training manual was developed & finalized for the purposes of both central and state level training.

A three day central training involved NPC staff, SAPCs, RHCs, State laboratory scientists, one state counselor, research agency supervisors, quality as well as technical committee members.

Training was on sample selection and all aspects of field work. State level training was undertaken by the centrally trained supervisor, SAPCs, RHCs, NPC officer and a member of the survey technical group. The training of field staff included a detailed discussing of the contents of the questionnaire, how to complete the questionnaire and interviewing techniques with respect to data collection and was conducted by members of the survey technical committee (TC).

3.7 DATA MANAGEMENT

Summary descriptive statistic (mean, median, standard deviation, range) will be used for quantitative variables while frequency distribution will be used for categorical variables. Bivariate analytic tools such as chi square will be used to establish relationship between sexual behavior, condom use and socio demographic variables. Logistic regression will be used to show strength of association between independent and dependent variables.

3.8 LIMITATION OF STUDY

1. Recall bias with respect to many of the participant not been able to remember issues especially about their sexual life in the past years.
2. In sincere response to the questions by participant with respect to the sensitivity of the issues on sex and sexual behavior in our society.
3. Accuracy of the dataset been used.

CHAPTER FOUR

RESULTS

The total number of never married youths aged 15-24 years from the data set was 3,406 (valid number = 3,406, missing number = 0).

Table 1; shows the distribution of socio-demographic characteristics between rural and urban youths. There were more rural males 66.5% than urban males 58.5%, and less females 33.5% in the rural areas than urban areas 41.1%. Respondents within the age group 15-19 years were more in the rural areas 63.8% than in the urban areas 57.6% compared to respondents within the age group 20-24, less in the rural areas 36.2% than in the urban areas 42.2%.

The highest level of education attained among respondents was secondary with 64.1% from rural areas and 70.8% from urban areas.

This was followed by Primary Level 23.3% for rural youths and higher level 14.8% for urban youths.

The lowest level of education attained was higher for rural dwellers 4.1% and primary for urban dwellers 12.4%.

Overall 8.5% of rural youths and 2.8% of urban youths gave no response. The longest number of years spent among respondents in their locality was between 15-29 years with 49.9% from rural areas and 37.4% from urban areas, while the least number of years spent was between 10-14 years with 7.1% from rural areas and 9.8% from urban areas.

Christianity was the predominant religion. There were less Christians in the rural areas 54.6% than urban areas 58.7%. This was followed by Islam with 44.8% from rural areas and 40.8% from urban areas.

Overall 0.6% rural youths and 0.5% urban youths reported other religion.

There were more Hausa youths from rural areas 34.0% compared to urban areas 19.5% followed by other ethnic groups with 32.4% from rural areas and 29.9% from urban areas.

Overall 18.9% of respondents from rural areas and 28.6% from urban areas were Yoruba while 14.7% from rural areas and 22.0% from urban areas were Igbo.

A total number of 1,734 and 1,672 respondents reported poor access and Covid access to information, 67.4% of rural youths and 24.5% of urban youths reported poor access to information while 32.6% of rural youths and 75.5% of urban youths reported good access to information.

TABLE 1: SOCIAL DEMOGRAPHIC CHARACTERISTICS BETWEEN RURAL AND URBAN YOUTHS

Variable	Rural N(%)	UrbanN(%)	P value
Sex of Respondent			
Male	1393 (66.5)	772(58.9)	0.001
Female	702 (33.5)	539 (41.1)	
Age			
15-19	1337 (63.8)	755 (57.6)	0.001
20-24	758 (36.2)	556 (42.4)	
Education			
Primary	489(23.3)	163(12.4)	0.001
Secondary	1342 (64.1)	928 (70.8)	
Higher	86 (4.1)	194 (14.8)	
No response	178(8.5)	26(2.0)	
Length of time in Community(years)			
0-4	240(11.5)	255 (19.5)	0.001
5-9	168 (8.0)	172 (13.1)	
10-14	148(7.1)	128 (9.8)	
15-19	493 (23.5)	490 (37.4)	
20-24	1046 (49.9)	266 (20.2)	
Religion			
Islam	938 (44.8)	535 (40.8)	0.057
Christianity	1144 (54.6)	770 (58.7)	
Other Religion	13(0.6)	6(0.5)	
Ethnic Group			
Yoruba	397(18.9)	375 (28.6)	0.000
Igbo	309 (14.7)	288 (22.0)	
Hausa	711 (34.0)	255 (19.5)	
Others	678 (32.4)	393 (29.9)	
Access to information			
Poor Access	1413(67.4)	321(24.5)	0.000
Good Access	682(32.6)	990(75.5)	

Majority of the respondents reported having heard of the male condoms (N=2,517) as shown in Table 2.

There were Rural-Urban differences with 82.0% in the rural areas and 84.9% in the urban areas. A greater proportion of rural youths 12.0% compared to 15.1% of urban youths had never heard of the male condoms.

Overall 78.0% of rural youths and 73.3% of urban youths thought condoms were affordable while 5.0% of rural youths compared to 2.4% of urban youths thought condoms were not affordable.

When respondents were asked if the male condoms were affordable with 26.8% from rural areas and 23.0% from urban areas.

TABLE 2: PERCENTAGE DISTRIBUTION OF EVER HEARD OF MALE CONDOMS BETWEEN RURAL AND URBAN YOUTH

Variable	Rural N(%)	Urban N(%)	P-value
Have you ever heard of male condoms			
Yes	1427 (82.0)	1112 (84.9)	0.000
No	317 (18.0)	198 (15.1)	
Would you use male condoms if affordable			
Yes	927 (78.3)	816 (73.3)	0.075
No	258 (21.7)	292 (26.7)	
Don't know	178 (16.4)	200 (21.0)	

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A total number of 631 respondents had ever used the male condom. About 15.6% of rural youths and 23.3% of urban youths reported ever used the male condom.

There were also rural-urban differences among respondents (N=1890) who had never used the male condom, with 52.5% from the rural areas and 61.1% from urban areas.

Overall 32.4% of rural youths and 15.6% of urban youths gave no response if ever used the male condom.

A large proportion of rural youths 77.9% compared to 76.1% of urban youths reported using the male condom as at the time of the survey while 22.1% of rural youths and 23.9% of urban youths reported not using the male condom as at the time of the survey.

TABLE 3: PERCENTAGE DISTRIBUTION OF CONDOM USED BETWEEN RURAL AND URBAN YOUTHS

Variable	Rural N(%)	Urban N(%)	P Value
Have you ever used male condoms			
Yes	326(15.6)	305(23.3)	0.000
No	1089(52.0)	801(61.1)	
No response	680(32.4)	205(15.6)	
Are you currently using a male condom			0.658
Yes	254(77.9)	232(76.1)	
No	72(22.1)	73(23.9)	

Table 4 showed main reason for using male condom. Most respondents considered male condoms to be effective in protecting HIV/STI's with 23.6% from rural areas and 27.6% from urban areas; preventing unwanted pregnancy with 10.2% from rural areas and 12.1% from urban areas; Protecting HIV/STI's and unwanted pregnancy with 66.1% from rural areas and 60.0% from urban areas.

TABLE 4: PERCENTAGE DISTRIBUTION OF REASON FOR USING MALE CONDOMS BETWEEN RURAL AND URBAN YOUTHS

Variable	Rural N(%)	Urban N(%)	P Value
Main Reason for using male condoms			
To protect yourself from HIV/STI's	60(23.6)	64(27.6)	0.416
To prevent unwanted pregnancy	26(10.2)	28(12.1)	
To protect yourself from both HIV/STI's and unwanted pregnancy	168(66.1)	140(60.3)	

Respondents gave reasons why they stop using the male condom; (38.9%) of rural youths and (28.8%) of urban youths didn't enjoy using condoms; while (4.2%) of rural youths and (1.4%) of urban dwellers desiring a child, were given as main reasons.

Rural youths (13.9%) and urban youths (12.3%) reported partner opposing condoms while (12.5%) of rural youths compared to (23.3%) of urban youths gave religious reasons why the use of condoms were stopped.

Respondents from rural areas (30.6%) and urban areas (34.2%) gave other reasons why they stop using condoms.

TABLE 5: PERCENTAGE DISTRIBUTION OF REASON FOR STOP USING MALE CONDOMS BETWEEN RURAL AND URBAN YOUTHS

Variable	Rural N(%)	Urban N(%)	P Value
Reason for stop using condoms			
Didn't enjoy using condoms	28(38.9)	21 (28.8)	0.320
Wanted a child	22 (30.6)	1 (1.4)	
Partner opposed	9 (12.5)	9(12.3)	
Religious reasons	10 (13.9)	17 (23.3)	
Others	3 (4.2)	25 (34.2)	

Table 6 shows where condom can be obtained. A greater number of respondents (N=1955) reported the chemist as where condom can be obtained with 54.4% in the rural areas and 45.6% in the urban areas. This was followed by pharmacy (N=975) with 44.4% in the rural areas and 55.6% in the urban areas.

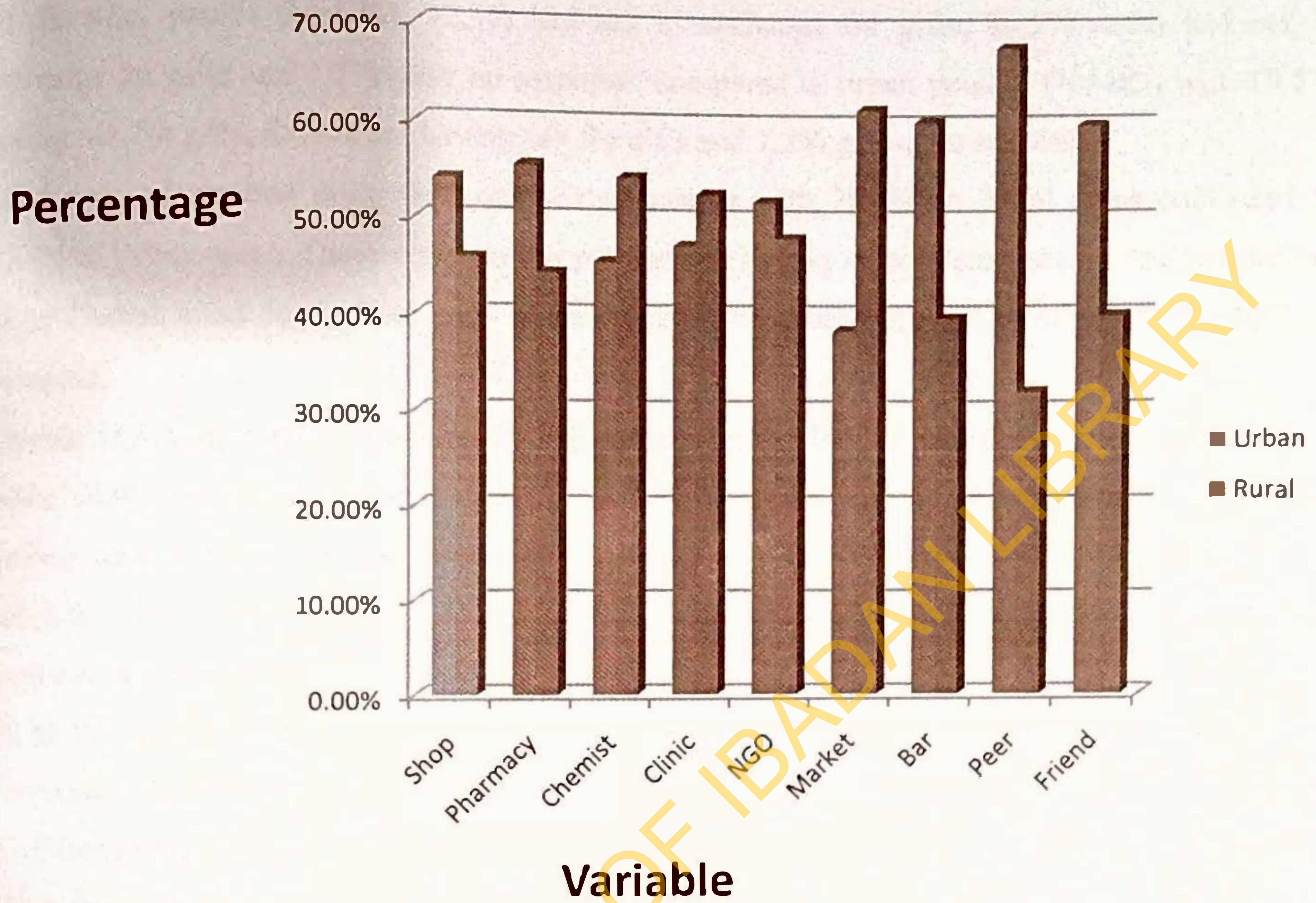
The least number of respondents (N=25) reported peer group as where condom can be obtained with 32.0% from rural youths and 68.0% from urban youths. This was followed by Bar (N=28); 37.7% of respondents from Rural areas compared to 60.3, reported the Bar as a source of obtaining condom.

TABLE 6: PERCENTAGE DISTRIBUTION OF SOURCES OF CONDOM.

Variable	Rural N (%)	Urban N (%)	Total
Shop	247(45.9)	291(54.1)	538 (100.0)
Pharmacy	432(44.4)	542(55.6)	974(100)
Chemist	1064(54.4)	891(45.6)	1955(100)
Clinic	277(52.7)	249(47.3)	526(100.0)
NGO	37(48.1)	40(51.9)	77(100.0)
Market	98 (61.6)	61(38.4)	159(100.0)
Bar	23(39.7)	35(60.3)	58(100.0)
Peer	8(32.0)	17(68.0)	25(100.0)
Friend	38(40.0)	57(60.0)	95(100.0)

CHART 1: PERCENTAGE DISTRIBUTION OF SOURCES OF CONDOM

Where Condom can be obtained



Difference in sexual behavior between Rural and Urban youths is shown in **Table 7**. Rural Subjects tend to initiate sexual activity earlier than Urban subjects. Age at first sexual intercourse was 16.34 ± 2.69 for Rural subjects and 17.06 ± 2.64 for urban subjects.

Of the rural youths (N=676), 12.3% had sex in exchange for gifts, 86.5% never had sex in exchange for gifts and 1.2% gave no response, compared to urban youths (N=483) with 10.8% having sex for gifts, 88.0% not having sex for gifts and 1.2% giving no response.

Most respondents had more than one sexual partner with 26.6% in Rural areas compared to 27.7% in Urban areas. There were similar proportions among respondents having one sex partner in rural/urban areas 70.6. About 2.8% of rural youths compared to 1.7% of urban youths gave no response.

Overall 76.0% of rural youths and 73.5% had sex in the last 12 months preceding the survey while 24.0% and 26.5% never had sex. Sex with Boy/girlfriend or casual partners was higher among rural subjects 98.6% compared to urban subjects 98.0%. A lesser proportion of rural subjects 1.2% compared to urban subjects 2.0% never had sex with boy/girlfriend or casual partners. About 0.2% of rural youths gave no response.

Of all the respondents who had sex with boy/girlfriend or casual partner, 38.5% of Rural youths compared with 57.5% of urban youths used condom in last sex while 61.5% of rural youths and 42.5% of urban youths reported never using condom in last sex.

Most respondents used condom in last sex for protection from HIV/STIs with 21.5% in rural areas and 27.5% in Urban areas, to prevent unwanted pregnancy with 11.3% from rural areas and 12.0% from urban areas; For protection from HIV/STIs and unwanted pregnancy with 66.2% from Rural areas and 60.5% from urban areas. About 1.0% of rural dwellers gave no response.

Respondents who had sex in the last 12 months preceding the survey reported more than one sexual partner with 28.8% in rural areas compared with 25.4% in urban areas, while 66.5% in rural areas and 69.9% in urban areas reported one sexual partners.

TABLE 7: SEX & IB BEHAVIOUR BETWEEN RURAL AND URBAN YOUTHS

Variable	Rural N (%)	Urban N (%)	P value
Did you have sex in exchange for gifts			
Yes	83(12.3)	52(10.8)	0.695
No	585(86.5)	425(88.0)	
No response	8(1.2)	6(1.2)	
Had more than one sex partner			
Yes	180(26.6)	134(27.7)	0.000
No	477(70.6)	341(70.6)	
No response	19(2.8)	8(1.7)	
Have you had sexual intercourse in the last 12 months			
Yes	514(76.0)	355(73.5)	0.501
No	162(24.0)	128(26.5)	
Did respondent have sex with boy/girlfriend or casual partner			
Yes	507(98.6)	348(98.0)	0.399
No	6(1.2)	7(2.0)	
No response	1(0.2)	0(0.0)	
Was condom use in last sex			
Yes	195(38.5)	200(57.5)	0.000
No	312(61.5)	148(42.5)	
What was the main reason you used a condom that time			
For protection from HIV/STI's	42(21.5)	55 (27.5)	0.375
To prevent unwanted pregnancy	22(11.3)	24(12.0)	
For protection from HIV/STI's and unwanted pregnancy	129(66.2)	121(60.5)	
No response	2(1.0)	0(0.0)	
How many sexual partners do you currently have including casual and commercial partners?			
No sexual Partner	18 (3.5)	14 (3.9)	0.507
One sexual Partner	342(66.5)	248(69.9)	
More than one sexual Partner	148(28.8)	90(25.4)	
No response	6(1.2)	3(0.8)	

Table 8 shows cross tabulations between social demographic characteristics and ever used of male condoms. There were significant results for age group ($p=0.025$), Education ($p=0.000$), Length of time in the community ($p=0.001$) Ethnicity (0.003) and access to information (0.000).

Rural youths (33.7%) within the age group 15-19 reported a higher proportion compared to urban youths (25.6%) while rural youths (66.3%) within the age group 20-24 reported a lesser proportion of ever used of male condom compared to urban youths (74.4%).

Respondent who attained a secondary level of education reported a higher proportion of ever used of male condom with 78.0% in rural areas and 65.0% in urban areas. There were also significant differences among respondents who attained a primary and a higher level of education with 9.6% & 12.4% in rural areas and 7.3% & 27.7% in urban areas reporting ever used condom. A high proportion of respondents who lived in their community within 20-24 years reported ever used condom with 36.2% in rural areas and 34% in urban areas. There were significant difference in ethnicity among rural and urban dwellers. About 50.3% of rural youths compared with 40.7% of urban youths from other ethnic groups reported ever used condom. Rural youths (49.1%) with good access to information reported a lesser proportion of ever used condom compared to urban youths (83.6%).

TABLE 8: Relationship between ever used condom and social demographic characteristics

Variables	Urban N (%)	Rural N (%)	P value
Sex of respondents			
Male	219 (71.8)	244 (74.8)	0.387
Female	86 (28.2)	82 (25.2)	
Age			
15-19	78 (25.6)	110 (33.7)	0.025
20-24	227 (74.4)	216 (66.3)	
Education			
Primary	22 (7.3)	31 (9.6)	0.000
Secondary	197 (65.0)	252 (78.0)	
Higher	84 (27.7)	40 (12.4)	
Length of time in Community			
0-4	80 (26.2)	49 (15.0)	0.001
5-9	41 (13.4)	38 (11.7)	
10-14	27 (8.9)	21 (6.4)	
15-19	52 (17.0)	100 (30.7)	
20-24	105 (34.4)	118 (36.2)	
Religion			
Islam	73 (23.9)	56 (17.2)	0.108
Christianity	2 (0.7)	268 (82.2)	
Others	230 (75.4)	2 (0.6)	
Ethnicity			
Hausa	18 (5.9)	34 (10.4)	0.003
Igbo	73 (23.9)	54 (16.6)	
Yoruba	90 (29.2)	74 (22.7)	
Others	124 (40.7)	164 (50.3)	
Access to information			
Poor Access	50 (16.4)	166 (50.9)	0.000
Good Access	255 (83.6)	160 (49.1)	

Table 9 shows Cross Tabulation between socio demographic characteristics and multiple sexual partners.

There were significant results for education ($p=0.0001$) religion ($p=0.030$), Ethnicity($p=0.007$) and access to information ($p=0.007$). A lesser proportion of rural dwellers 7.3% compared to urban dwellers 24.8% who attained a high level of Education reported more than one sexual partner. Christians reported a high proportion of multiple partners with 81.7% in rural areas and 69.4% in urban areas. This was followed by Islam, 17.2% in rural areas and 29.9% in urban areas.

Youths in rural areas 54.5% with poor access to information, reported a high proportion of multiple sexual partners compared to youths in urban areas 80.6% with good access to information.

There were significant differences among ethnic groups.

Yoruba and Igbo youths in rural areas reported a lesser proportion of multiple sexual partners 23.3% , 11.1% compared to urban areas 37.3%,19.4% while Hausa and youths from other tribes in rural areas reported a higher proportion of multiple sexual partners 11.1% , 54.5% compared to urban areas.

Table 9: Factors Associated with multiple sexual behaviour in rural and urban areas

Variables	Urban N (%)	Rural N (%)	P value
Sex of respondents			
Male	109(81.3)	144 (80.0)	0.766
Female	25 (18.7)	36 (20.0)	
Age			
15-19	37 (27.6)	67(37.2)	0.074
20-24	97 (72.4)	113(62.8)	
Education			
Primary	13(9.8)	25(14.0)	0.0001
Secondary	87(65.4)	141(78.8)	
Higher	33(24.8)	13(7.3)	
Length of time in Community(years)			
0-4	28(20.9)	22(12.2)	0.146
5-9	16(11.9)	21(11.7)	
10-14	15(11.2)	16(8.9)	
15-19	28(20.9)	55(30.6)	
20-24	47(35.1)	66(36.7)	
Religion			
Islam	40(29.9)	31(17.2)	0.030
Christianity	93(69.4)	147(81.7)	
Others	1(0.7)	2 (1.1)	
Ethnicity			
Hausa	9(6.7)	20(11.1)	0.001
Igbo	26(19.4)	20(11.1)	
Yoruba	50(37.3)	42(23.3)	
Others	49(36.6)	98(54.4)	
Access to information			
Poor Access	26 (19.4)	98(54.4)	0.001
Good Access	108 (80.6)	82 (45.6)	

Table 10 shows association between ever heard of male condom and socio-demographic characteristics. All variables were significant ($p < 0.005$) except for age ($p > 0.05$).

TABLE 10: FACTORS ASSOCIATED WITH EVER HEARD OF CONDOM IN RURAL AND URBAN AREAS

Variables	Rural N (%)	Urban N (%)	P-value
Age			
15-19	787(55.3)	587(52.7)	0.205
20-24	637(44.3)	526(47.3)	
Sex			
Male	969 (68.0)	680 (61.1)	0.000
Female	455 (32.0)	433 (38.9)	
Ethnicity			
Hausa	326 (22.9)	175 (15.7)	0.000
Yoruba	258(18.1)	262 (23.5)	
Igbo	237(16.6)	322 (28.9)	
Others	603(42.3)	354(31.8)	
Religion			
Islam	452 (31.7)	408 (36.7)	0.029
Christianity	961 (67.5)	699 (62.8)	
Others	11 (0.8)	6 (0.5)	
Education			
Primary	234 (16.4)	117 (10.5)	0.000
Secondary	1072 (75.3)	790 (71)	
Higher	118 (8.3)	206 (18.5)	
Access to information			
Poor Access	868 (61.0)	235 (21.1)	0.000
Good Access	556 (39.0)	878 (78.9)	

Logistic regression analysis of ever used male condom on variables showed that rural youths with poor access to information were 5 times less likely to ever used the male condoms than urban youths. (95% CI OR = 0.13 – 0.29) (table 11).

Respondents in rural areas who attained a secondary level of education were 2 times less likely than those in urban areas (95% CI OR = 0.32 – 0.80)(table 11). Igbo youths in rural areas were 1.8 times more likely to ever used the male condom than those in urban areas (95% CI OR = 1.15 – 2.96). Also rural youths that have stayed in their locality within the period of 0-4 years were 2.13 times more likely than urban youths (95% CI OR = 1.27 – 3.59). Respondent with poor access to information on ever used male condom were 5 times less likely than those with good access. (95% CI OR = 0.13 – 0.29). (table 11) Respondents who have secondary education were 2 times less likely than those with higher education. (95% CI OR = 0.32 – 0.80)(table 11). Respondents who are Igbo are 1.8 times more likely to ever used the male condom than those from other tribes (95% CI OR = 1.15 – 2.96).

Table 11: Logistic Regression Showing the odds of association between condom use and sociodemographic characteristics.

Variables	Odds ratio	95% Confidence Interval
Ethnicity		
Hausa	0.57	0.27-1.19
Igbo	1.84	1.15-2.96
Yoruba	1.01	0.64-1.59
Others*		
Access to information		
Poor Access	0.20	0.13-0.29
Good Access*		
Age		
15-19	0.92	0.56-1.51
20-24*		
Education		
Primary	0.52	0.24-1.12
Secondary	0.504	0.32-0.80
Higher*		
Length of time in Community		
0-4	2.13	1.27-3.59
5-9	1.50	0.82-2.73
10-14	1.94	0.94-4.02
15-19	0.76	0.42-1.36
20-24*		

* reference category

Regression Awareness On multiple Sexual partners on variables revealed that Igbo youths in rural areas were 2.41 times more likely than those in urban areas (95% CI OR = 1.14 – 5.11)(table 12). Rural dwellers with poor access to information were 4.2 times less likely to have more than one sexual partner than urban dwellers (95% CI OR = 0.34 – 0.43)(table 12).

Respondents in rural areas who attained a primary level of education were 3.2 times less likely than those in urban areas (95 % CI OR= 0.11 – 0.91). Also rural dwellers who attained a secondary level of education were 2.8 times less likely than urban dwellers (95% CI OR = 0.17 – 0.77). Respondents who are Igbo were 2.41 times more likely than those from other tribes. (95% CI OR = 1.14 – 5.11)(table 12). Respondents with poor access to information were 4.2 times less likely to have multiple sexual partners than those with good access to information. (95% CI OR = 0.34 – 0.43)(table 12). Respondent with primary education were 3.2 times less likely than those with higher education. (95 % CI OR= 0.11 – 0.91) Respondents with secondary education were 2.8 times less likely than those with higher education. (95% CI OR = 0.17 – 0.77).

Table 12: Logistic Regression Showing the odds of association between number of sexual partners and socio-demographic characteristics.

Variables	Odds ratio	95% Confidence Interval
Ethnicity		
Hausa	0.35	0.12-1.02
Igbo	2.41	1.14-5.11
Yoruba	1.13	0.59-2.18
Others*		
Access to information		
Poor Access	0.24	0.34-0.43
Good Access*		
Religion		
Islam	2.89	0.17-50.75
Christianity	0.90	0.56-14.64
Others*		
Education		
Primary	0.31	0.11-0.91
Secondary	0.36	0.17-0.77
Higher*		

* reference category

Logistic regression on ever heard of condom showed that Hausa youths in rural areas were 1.7 times less likely than those in urban areas (95% CI OR = 0.45-0.79)(table 13)

Igbo youths in rural areas were 1.6 times more likely than those in urban areas (95% CI OR = 1.33-2.17). Also Yoruba respondents in rural areas were 1.7 times more likely than those in urban areas (95% CI OR= 1.27-2.06)(table 13).

Rural dwellers with poor access to information were 1.2 times less likely to have ever heard of the male condom than urban dwellers (95% CI OR = 0.15-0.23)(table 13). Respondents in rural areas who attained a primary level of education were 2.6 times less likely than those in urban areas (95CL% OR = 0.260 – 0.564). Rural dwellers who attained a secondary level of education are 2.5 times less likely than urban dwellers (95% CI OR = 0.30-0.55)(table 13). Males in rural areas were 1.4 times less likely than those in urban areas (95CL% OR = 0.58-0.84). Rural dwellers that have stayed in their locality within the period of 10-14 years were 1.6 times more likely than urban dwellers (95% CI OR = 1.18-2.20).

Respondents that are males were 1.4 times than those that are females (95CL% OR = 0.58-0.84). Respondents that are Hausa were 1.7 times less likely than other tribes (95% CI OR = 0.45-0.79)(table 10). Respondents that are Yoruba were 1.6 times more likely than those from other tribes (95% CI OR= 1.27-2.06)(table 13). Respondents with poor access to information were 1.2 times less likely to have ever heard of male condom than those with good access to information. (95% CI OR = 0.15-0.23)(table 10). Respondents with primary education were 2.6 times less likely than those with higher education. (95CL% OR = 0.260 – 0.564). Respondents with secondary education were 2.5 times less likely than those with higher education. 95% CI OR = 0.30-0.55)(table 13).

TABLE 13: Logistic Regression showing the odds of association between ever heard of male condom and socio-demographic characteristics.

Variables	Odds ratio	95% Confidence interval
Sex		
Male	0.69	0.58 – 0.84
Female*		
Ethnicity		
Hausa	0.60	0.45 – 0.79
Yoruba	1.70	1.33 – 2.17
Igbo	1.62	1.27 – 2.06
Others*		
Religion		
Islam	1.69	0.52 – 5.49
Christianity	0.84	0.26 – 2.72
Others*		
Education		
Primary	0.38	0.26 – 0.56
Secondary	0.41	0.30 – 0.55
Higher*		
Access to information		
Poor	0.82	0.15 – 0.23
Good*		
Length of time in the community(years)		
0-4	1.99	1.55-2.57
5-9	1.77	1.34-2.34
10-14	1.61	1.18-2.20
15-19	1.00	0.82-1.23
20-24*		

CHAPTER FIVE

DISCUSSION

Designing an effective programme to promote responsible reproductive health behavior among youth adults in Nigeria requires a better understanding of the factors related to their sexual behaviors and contraceptive use. Although scholars have documented factors associated with reproductive health behavior among Nigerian youths (NDHS, 2003; Isiugo Abanihe and Oyediran, 2004; Owuamanam, 1995, Egbochukwu and Ekanem, 2008).

Few of these have examined rural-urban differences in sexual behavior and condom use. This study compared sexual behavior and condom use among never married youths aged 15-24 in rural and urban areas using population based data from 2007 National HIV/AIDS and reproductive health survey (NARHS, 2007).

The findings of this study confirm the high level of Premarital Sexual activity among Nigerian youths with rural dwellers (16.34+2.69) initiating sexual relation earlier than those in urban areas (17.06+2.64). This fact is supported by the 2003 National demographic health survey (NDHS, 2003) and a study carried out by Isiugo Abanihe and Oyediran (2004) among never married families aged 15-24 in Nigeria.

Childhood place of residence supports the notion of lower exposure activity among those who have some urban exposure and the folk life of the rural areas provides ample space for sexual mixing. More than the busy and crowded environment in urban areas (Isiugo Abanihe and Oyediran, 2004).

The result of this study showed that rural dwellers(26.6%)(N=110) tend to have less multiple sexual partners compared to their urban counterparts (27.7%) (N=134). This fact is supported by a study carried out by Owamanem (1995) among students in secondary and tertiary institution in Ekiti, it was observed that female urban subjects had as many as four sexual partners while one male urban respondent indicated having as many as 23 compared to their rural counterparts who had none (Owamanem, 1995).

The high percentage of subjects having multiple partners warns of a potential hazard for STD and AIDS/HIV transmission in youths particularly in the urban area (Owamanem 1995).

Relationship between respondents having multiple sexual partners and socio-demographic characteristics showed that level of education attain, good access to information, Ethnicity, type

of religion practiced and increase in age tend to be associated with an elevated likelihood of having multiple sexual partners.

About (78.8%) (N=141) of rural dwellers and (65.4%) (N=87) of urban dwellers who have secondary education reported multiple sexual partners compared with (9.8%) (N=13) of rural dwellers, compared with (14.0%) (N=25) of their urban counterparts who attained a primary level of education.

Level of access to information is positively related with the level sexual activity. Youths in rural areas (54.4%)(N=98) with poor access to information reported a lesser proportion of multiple sexual partners compared to their urban counterparts(80.6%)(N=1 108) with good access to information.

Religion is believed to have a profound impact on individual behavior and views. Even in the face of modernization and its consequences on cultural practices, religion seems to still hold a firm grip on moral values relating to sexual activity (Silver Koller et. al, 2008).

Therefore, youths who are more religious are more likely to hold types of beliefs that may discourage sexual activity. The relationship between religious affiliation and reproductive health behavior particularly sexuality is likely to be mediated by social and demographic factors such as education of the respondent. This study showed that Muslim respondents had less multiple sexual partners with (17.2%), in rural areas and (23.9%) in urban areas, compared to their Christian counterparts with (82.2%) in rural areas compared with (75.4%) in urban areas. This fact is supported by NDHS 2003 data where 37.7% of Muslim male adolescents in Nigeria reported being sexually experienced relative to 47.7% of their counterparts who are catholic. Condom use has been identified as one of the means of preventing the transmission of HIV and other sexually transmitted infections. The male latex condom is the single most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections (Johnson, 1994; WHO/UNAIDS, 2004).

Conclusive evidence from extensive research among heterosexual couples, in which one partner is infected with HIV, shows that correct and consistent condom use significantly reduces the risk of HIV transmission from both men to women and also from women to men (Holmas et. al, 2004). Despite a high level of sexual activity among Nigeria youths, the level of condom use is low. An indication of their high level of exposure to pregnancy and sexually transmitted infections. Only (15.6%) (N=326) of rural youths compared to (23.3%)(N=305) of urban youths admitted ever using the device.

This suggests that the male condom has not gained much acceptance as a contraceptive device in this part of the world.

The high proportion (52.0%) (N=108) of respondent in the rural areas compared with (61.1%) (N=801) in urban areas that indicated never used of the male condom may be an indication of inadequate awareness programme and communication about reproductive health issues and

practices, thus it is not unlikely that institutions in Nigeria, despite this general openness to new ideals, may still have some traces of the "culture of silence" that had traditionally surrounded sexual issues and personal reproductive health practices in our environment.

Relationship between ever used of male condom and socio demographic variables revealed that increase in age, education, ethnicity, access to information and exposure to an urban environment are significantly associated with ever used of the male condom. It also showed that older respondents with (66.3%) (N=216) in rural areas compared with (74.4%) (N=227) in urban areas used the device than younger respondents with (33.7%) (N=110) in rural areas compared with (25.6%) (N=78%) in urban areas suggesting they were more conscious of their reproductive health and considering the fact that older and more educated youths are usually better informed about the consequences of unprotected sex and the fact that accessibility to contraceptives is higher in the urban centres, the observed relationships between age, education, access to information, place of residence and ever used of the male condom are not unexpected.

This study also showed that rural males (68.0%) (N=969) compared with urban males (61.0%) (N=680) were more likely to have heard about the male condom than rural females (32.0%) (N=455) and urban females (38.9%) (N=433).

Population report (2001) and federal ministry of health survey (2003) have shown that young men are more knowledgeable about HIV/AIDS and other venereal diseases than young women. In most cases, young women often hesitate to challenge misinformation from their partners, so that they will not be seen to be too knowledgeable about sex (Population report, 2000). In many societies in Africa, parents, elders and peer group are more liberal in discussing sex related issues with young men than women and this must have accounted for their differences in knowledge about sexual behavior and contraceptive use. Factors associated with ever heard of condom are ethnicity, sex, education, religion, access to information and length of time in the community. The commonest reason for using the male condom was to protect from HIV/STDs and unwanted pregnancy with (66.1%) (N=168) in rural areas compared with (60.3%) (N=40) in urban areas; while the commonest reason for not using the male condom by rural youths (58.9%) (N=28) was that they did not enjoy using the device compared with urban youths (34.2%) (N=25) who gave other reason for not using the device.

5.2 CONCLUSION AND RECOMMENDATION

In this era of global crisis with an AIDS epidemic and variable availability of Reproductive Health (RH) services, it is critical that all of us become protectors of our nation's health. Unintended pregnancy and Sexually Transmitted Infections (STIs) yield poverty, infertility (post unsafe abortion), social upheaval, and at times, death.

Bringing about greater choice in youth barrier methods will mean militating for regulatory changes. The potential public health impact of integrating the male and female condom into national reproductive health programs is substantial and represents an opportunity for diminishing the present HIV/STD burden, one that was completely unanticipated 10 years ago. Few HIV/STD prevention approaches for youth have reported news this good. Considering youth's dire need for HIV/STD prevention strategies, we must now move immediately in applying what we know.

Using media campaigns to educate adolescents about risky behavior and condom use, educating parents about reproductive health and communication with adolescents, training medical providers in low cost diagnosis and treatment techniques and establishing youth friendly services that emphasize sensitivity and confidentiality would be helpful in reducing high risk sexual behavior and controlling the spread of STDs (including HIV and AIDS) among young people in Nigeria.

Programmes geared towards behavioural change, should be organized for youths in the society. Such programmes should entail making the youths feel and perceive the risk of involving in certain risky sexual behavior like unprotected sex. As Machel (2004) noted, one important prerequisite for transforming HIV knowledge into behavioural change, is a feelings of risk of infection. It is in view of this, that Schapink et al. (1992) assert that even though risk taking is a normal of adolescent behavior, a major component in motivating behavior and change is to have youths develop the perception that certain behavior puts them at risk. Such a behavior change, can be possible through proper education, including community leaders and opinion leader in the fight against HIV/AIDS and giving talks on the adverse consequences of involving in sexual risky behavior that can expose people to contracting the disease.

There should be open communication between youths and the community opinion leaders, counselors and other services providers on the implication of involving in unprotected sex. Such communication should be frank and culturally integrative. This is because in order to change behavior, one must change the underlying attitude or subjective norms which influence the behavior.

There should be integration of reproductive health programmes in the schools curricula that will cut across all disciplines of undergraduates in Nigerian institutions of higher learning.

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APPENDIX I

2007 NATIONAL HIV AND AIDS AND REPRODUCTIVE HEALTH SURVEY (NARHS PLUS)

NIGERIA

Paste Sticker Here

INDIVIDUAL INTERVIEW SCHEDULE FOR WOMEN AGED 15-49 YEARS AND MEN AGED 15-64 YEARS

STATE

CLUSTER

QUEST. ID

000 STATE _____

001 ZONE _____ CODE

002 LOCAL GOVT. AREA _____

003 LOCALITY _____

004 LOCATION (URBAN - 1 OR RURAL -

005 HOUSEHOLD NUMBER

Introduction: My name is..... I am working for the Federal Ministry of Health. We are interviewing people here in [NAME OF CITY, TOWN OR SITE] in order to find out about certain behaviors that affect people's health in this environment.

Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place all over the country. Your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. The information collected from you and people like you will help the government to find solution to some health problems affecting people in this environment. We would greatly appreciate your help in responding to this survey. My supervisor may come back later to verify this information.

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Interviewer visit

	Visit 1	Visit 2	Visit 3
Date			
Result			
Interviewer			

Result codes: 1...Completed; 2...Respondent not available; 3...Refused; 4...Partially completed; 5... Others (Specify).

006 INTERVIEWERS: Code | | | Name _____ Signature _____

007 DATE OF INTERVIEW: / / TIME INTERVIEW STARTED _____
DD MM YYYY

CHECKED BY SUPERVISOR _____ CODE | | | Date _____

Name of Coder _____ Signature _____ Date _____

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Section 2: Background characteristics

No	Question and filter	Filtering categories	Page #
Q101	RECORDS OR X OF THIS IS AVAILABLE?	State Female	
Q102	In what month and year was your Area?	Month () () Year () () () () Year () () () ()	
Q103	How old were you in the year last recorded?	Age in completed years () () ()	
Q104	What is your occupation in what kind of work do you usually do?	<ul style="list-style-type: none"> Director upper management Other management Self-employed independent business owner Professional free-lance Self-employed in own business Self-employed in other business/occupation Blue collar skilled & semi skilled Unskilled Child Child Home Producer/Farming/Mining Unemployed Retiree/Retired Unemployed Student Others specified 	
Q105	Have you ever attended school?	Yes No	
Q106	What is the highest level of school you attended (primary, high, secondary, university, etc)?	<ul style="list-style-type: none"> Quinary Primary Secondary Higher 	
Q107	What is the highest level of school you completed at that level?	Yes (through) From Certificate From Diploma	

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No.	Questions and filters	Coding categories	Skip to																																																																								
Q107	What languages can you READ with understanding? [DO NOT READ OUT OPTIONS ; PROBE FULLY]	<table border="1"> <thead> <tr> <th colspan="2"></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>1</td><td>Pidgin English</td><td>1</td><td>2</td></tr> <tr><td>2</td><td>English</td><td>1</td><td>2</td></tr> <tr><td>3</td><td>Hausa</td><td>1</td><td>2</td></tr> <tr><td>4</td><td>Arabic</td><td>1</td><td>2</td></tr> <tr><td>5</td><td>Igbo</td><td>1</td><td>2</td></tr> <tr><td>6</td><td>Yoruba</td><td>1</td><td>2</td></tr> <tr><td>7</td><td>Fulfude</td><td>1</td><td>2</td></tr> <tr><td>8</td><td>Edo</td><td>1</td><td>2</td></tr> <tr><td>9</td><td>Tiv</td><td>1</td><td>2</td></tr> <tr><td>10</td><td>Nupe</td><td>1</td><td>2</td></tr> <tr><td>11</td><td>Urhobo</td><td>1</td><td>2</td></tr> <tr><td>12</td><td>Ijaw</td><td>1</td><td>2</td></tr> <tr><td>13</td><td>Efik</td><td>1</td><td>2</td></tr> <tr><td>14</td><td>Kanuri</td><td>1</td><td>2</td></tr> <tr><td>15</td><td>Idoma</td><td>1</td><td>2</td></tr> <tr><td></td><td>None</td><td>1</td><td></td></tr> <tr><td></td><td>Others Specified [.....]</td><td></td><td></td></tr> </tbody> </table>			Yes	No	1	Pidgin English	1	2	2	English	1	2	3	Hausa	1	2	4	Arabic	1	2	5	Igbo	1	2	6	Yoruba	1	2	7	Fulfude	1	2	8	Edo	1	2	9	Tiv	1	2	10	Nupe	1	2	11	Urhobo	1	2	12	Ijaw	1	2	13	Efik	1	2	14	Kanuri	1	2	15	Idoma	1	2		None	1			Others Specified [.....]			
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Q109	How long have you been living continuously in this city/town/village?	Number of years [][] Record 00 if less than 1 year																																																																									
Q110	In the last 12 months have you been away from your home for more than one month altogether?	Yes 1 No 2																																																																									
Q111	What is your religion?	Islam 1 Protestant 2 Catholic 3 Traditional 4 No religion 5																																																																									

No.	Questions and filters	Coding categories	Skip to
		Others specify.[.....6 No Response.....9	
Q111A	How often do you attend religious congregational services?	Everyday.....1 More than once a week.....2 Once a week only3 Less than once a week.....4 Not at all.....5	
Q111B	How important is religion to you in helping you deal with problems?	Very important.....1 Somewhat important.....2 Not important.....3 Others Specify[.....4	
Q112	To which ethnic group do you belong?	Biom1 Bura2 Edo.....3 Efik.....4 Fulani5 Gwari.....6 Hausa.....7 Ibibio.....8 Igala.....9 Igbo.....10 Ijaw11 Ikwere.....12 Itsekiri.....13 Kaje.....14 Kanuri.....15 Okrika.....16 Nupe17 Shuwa-Arab.....18 Urhobo.....19 Tiv.....20 Yoruba.....21 Idoma.....22 Others specify[.....23	
Q113	[LOOK AND RECORD THE TYPE OF DWELLING STRUCTURE THE RESPONDENT LIVES IN]	Single family house.....1 Duplex.....2 2-3bedroom flat.....3 Mini flat.....4 Room and Parlour.....5 Single room.....6 Mud house with thatched roof.....7 Mud house with zinc roof.....8 Wood and makeshift structures.....9 Others Specify[.....10	

No.	Questions and filters	Coding categories	Skip to																																																																					
Q114	<p>Which of these items that I am going to read out do you have in your household?</p> <p>[MULTIPLE CODES POSSIBLE]</p>	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Fridge</td><td>1</td><td>2</td></tr> <tr><td>Radio</td><td>1</td><td>2</td></tr> <tr><td>TV</td><td>1</td><td>2</td></tr> <tr><td>Car</td><td>1</td><td>2</td></tr> <tr><td>Video</td><td>1</td><td>2</td></tr> <tr><td>Cable/Satellite dish</td><td>1</td><td>2</td></tr> <tr><td>Washing machine</td><td>1</td><td>2</td></tr> <tr><td>GSM Phone</td><td>1</td><td>2</td></tr> <tr><td>Telephone</td><td>1</td><td>2</td></tr> <tr><td>Generator</td><td>1</td><td>2</td></tr> <tr><td>Gas/electric cooker</td><td>1</td><td>2</td></tr> <tr><td>Electricity</td><td>1</td><td>2</td></tr> <tr><td>Grinding machine</td><td>1</td><td>2</td></tr> <tr><td>Motorcycle</td><td>1</td><td>2</td></tr> <tr><td>Bicycle</td><td>1</td><td>2</td></tr> <tr><td>Fan</td><td>1</td><td>2</td></tr> <tr><td>Kerosene stove</td><td>1</td><td>2</td></tr> <tr><td>Cow(s)</td><td>1</td><td>2</td></tr> <tr><td>Goat(s)</td><td>1</td><td>2</td></tr> <tr><td>Owns farmland</td><td>1</td><td>2</td></tr> <tr><td>Owns boat/ship/canoe</td><td>1</td><td>2</td></tr> <tr><td>Donkey/camel/horse</td><td>1</td><td>2</td></tr> </tbody> </table>		Yes	No	Fridge	1	2	Radio	1	2	TV	1	2	Car	1	2	Video	1	2	Cable/Satellite dish	1	2	Washing machine	1	2	GSM Phone	1	2	Telephone	1	2	Generator	1	2	Gas/electric cooker	1	2	Electricity	1	2	Grinding machine	1	2	Motorcycle	1	2	Bicycle	1	2	Fan	1	2	Kerosene stove	1	2	Cow(s)	1	2	Goat(s)	1	2	Owns farmland	1	2	Owns boat/ship/canoe	1	2	Donkey/camel/horse	1	2	
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Q115	<p>Where do you get your main source of water supply for domestic use (for drinking, cooking/washing utensils etc)?</p> <p>[SINGLE RESPONSE ONLY]</p>	<p>From the stream.....1</p> <p>From the well.....2</p> <p>From the street tap water.....3</p> <p>From the in-house tap.....4</p> <p>From a tanker.....5</p> <p>From the borehole.....6</p> <p>Rain water.....7</p> <p>Water vendors.....8</p> <p>Others Specify[]...9</p>																																																																						
Q116	<p>What is your main method for sewage disposal?</p>	<p>Bush/field/river.....1</p> <p>Pit toilet.....2</p> <p>Ventilated improved pit latrine.....3</p> <p>Bucket toilet.....4</p> <p>Water closet (WC).....5</p> <p>Others Specify[]...6</p>																																																																						
Q117	<p>How many meals per day can you AFFORD throughout an average month?</p> <p>[READ OUT OPTIONS]</p> <p>[SINGLE CODE ONLY. PLEASE STRESS THAT THE QUESTION IS FOR THE ENTIRE MONTH]</p>	<p>Cannot guarantee one meal a day throughout the month... 1</p> <p>Only afford one meal a day throughout the month..... 2</p> <p>Only afford two meals a day throughout the month3</p> <p>Afford three meals a day throughout the month..... 4</p> <p>Can afford three meals a day throughout the month3</p>																																																																						

No.	Questions and filters	Coding categories	Skip to																								
	<p>[PLEASE TELL THE RESPONDENT] I am going to ask you some sensitive and personal questions. Your answers are completely confidential and will not be divulged to anyone.</p>																										
Q117A	<p>Some people take alcohol, others don't. During the last 4 weeks how often have you had drinks containing alcohol?</p> <p>[SINGLE CODE ONLY]</p>	<p>Every day..... 1 At least once a week..... 2 Less than once a week..... 3 Never..... 4 Not Sure..... 8 No response..... 9</p>																									
Q118	<p>Some people have tried a range of different types of Psychoactive drugs (Drugs that make a person feel high). Which of the following, if any, have you tried?</p> <p>[READ OUT; PROBE FOR OTHERS; MULTIPLE CODES POSSIBLE]</p>	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>No response</th> </tr> </thead> <tbody> <tr> <td>Marijuana</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>Glue (Solution)</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>Cocaine</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>Heroin</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>Others specify[.....]</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	No response	Marijuana	1	2	9	Glue (Solution)	1	2	9	Cocaine	1	2	9	Heroin	1	2	9	Others specify[.....]				
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Q119	<p>Some people have tried INJECTING cocaine or heroin using a syringe and needle. Have you done this in the last 12 months?</p> <p>[DRUGS INJECTED FOR MEDICAL PURPOSES OR TREATMENT OF AN ILLNESS DO NOT COUNT]</p>	<p>Yes1 No.....2 No response9</p>																									

Section 3: Condom knowledge, access and use.

No.	Questions and filters	Coding categories	Skip to																																							
Q301	Before I started talking to you, have you ever heard of male condoms? [DESCRIBE WHAT MALE CONDOMS ARE TO THE RESPONDENT]	No..... 2 Yes.....1	→Go to Q401																																							
Q302	Please tell me if you agree or disagree with the following statements. [READ OUT OPTIONS]	<table border="1"> <thead> <tr> <th></th> <th>Agree</th> <th>Disagree</th> <th>Don't know</th> </tr> </thead> <tbody> <tr> <td>Male condoms protect against unplanned pregnancy</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Male condoms protect against the virus that causes AIDS</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Male condoms protect against diseases that are transmitted through sexual intercourse</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		Agree	Disagree	Don't know	Male condoms protect against unplanned pregnancy	1	2	8	Male condoms protect against the virus that causes AIDS	1	2	8	Male condoms protect against diseases that are transmitted through sexual intercourse	1	2	8																								
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Q303	Do you agree or disagree that male condoms are easy to obtain?	Agree.....1 Disagree.....2 Don't know.....8																																								
Q304	From which places or persons do you know of where you can obtain male condoms? [PROBE AND RECORD ALL ANSWERS; MULTIPLE CODES POSSIBLE; DO NOT READ OUT OPTIONS]	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Shop/Supermarket</td> <td>1</td> <td>2</td> </tr> <tr> <td>Pharmacy</td> <td>1</td> <td>2</td> </tr> <tr> <td>Patent medicine store PMS/Chemist</td> <td>1</td> <td>2</td> </tr> <tr> <td>Clinic/Hospital</td> <td>1</td> <td>2</td> </tr> <tr> <td>NGO/CHWs/CBD/CBOs</td> <td>1</td> <td>2</td> </tr> <tr> <td>Market</td> <td>1</td> <td>2</td> </tr> <tr> <td>Family planning center/PPFN</td> <td>1</td> <td>2</td> </tr> <tr> <td>Bar/guest house/hotel</td> <td>1</td> <td>2</td> </tr> <tr> <td>Peer educator</td> <td>1</td> <td>2</td> </tr> <tr> <td>Friend</td> <td>1</td> <td>2</td> </tr> <tr> <td>Other specify[.....]</td> <td>1</td> <td>2</td> </tr> <tr> <td>Don't know any place.....</td> <td>1</td> <td></td> </tr> </tbody> </table>		Yes	No	Shop/Supermarket	1	2	Pharmacy	1	2	Patent medicine store PMS/Chemist	1	2	Clinic/Hospital	1	2	NGO/CHWs/CBD/CBOs	1	2	Market	1	2	Family planning center/PPFN	1	2	Bar/guest house/hotel	1	2	Peer educator	1	2	Friend	1	2	Other specify[.....]	1	2	Don't know any place.....	1		→Go to Q306
	Yes	No																																								
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Don't know any place.....	1																																									
Q305	How long would it take you from your house to walk to the nearest place where you can obtain male condoms?	Less than 15 mins.....1 15 to 30mins.....2 31 mins to 1hr.....3 More than 1hr to 3hrs.....4 Over 3hrs.....5 Don't know.....8																																								
Q306	Would you say male condoms are affordable?	Yes.....1 No.....2 Don't Know.....8																																								
Q307	Do you agree/disagree that male condoms break OFTEN during sexual intercourse?	Agree.....1 Disagree.....2 Don't Know.....8																																								

No.	Questions and filters	Coding categories	Skip to
Q307A	Suppose you wanted to buy a male condom and some people were in the store. Would you..... [READ OUT]	Wait and buy it some other time?.....1 Try to hide the fact that you were buying condom?.....2 Buy the condom without hiding?.....3	
Q308	Have you ever used male condoms [OR IF FEMALE] Has your partner ever used a male condom with you?	Yes 1 No 2 No Response.....9	→Go to →Q315
Q308A A	Has a condom ever broken or gotten torn while you were using it during sex?	Yes.....1 No.....2 Cant remember/Don't know....8	→Go to →Q308A
Q308A B	How long ago was the last time a condom broke while you were using it? [RECORD ANSWER IN MONTHS]	Months Number [][] Cant Remember.....888 No Response.....999	
Q308A	Are you currently using male condoms? [IF FEMALE ASK] Is your partner currently using male condoms with you?	Yes.....1 No.....2	
Q309	How long ago did you start using male condoms for the first time? [IF RESPONSE IS GIVEN IN YEARS CONVERT TO MONTHS]	Months Number [][] Cant Remember.....888 No Response.....999	
Q310	Which of the following applies to you now? You have.... [READ OUT]	Been using male condoms for some time.....1 Used male condoms in the past but stopped.....2 Ever used, stopped but have resumed using.....3 Just started using for the first time.....4	→Go to Q314
Q311	What is the Main reason why you are using male condoms? Is it because you want... [READ OUT]	To protect yourself from HIV/STIs.....1 To prevent unwanted pregnancy.....2 To protect yourself from both HIV/STIs and unwanted pregnancy.....3 Others specify[].....4	
Q312	[FOR THOSE WHO HAVE RESUMED USING IN Q310. OTHERS GO TO Q313] How long ago did you RESUME using male condoms a gain?	Months Number [][]	

No.	Questions and filters	Coding categories	Skip to
Q313	<p>[ASK ONLY CURRENT CONDOM USERS IN Q310 (BEEN USING(option 1) OR RESUMED USAGE(option 3) OR JUST STARTED USING(option 4))</p> <p>What was the Brand of male condom you used MOST OFTEN in the last 3 months?</p> <p>[DO NOT READ OUT]</p>	<p>Durex.....1</p> <p>Romantic.....2</p> <p>Life style.....3</p> <p>Rough Rider.....4</p> <p>Gold circle.....5</p> <p>Cool.....6</p> <p>Play Girl.....7</p> <p>Alabama.....8</p> <p>Blue Panther.....9</p> <p>Lovers Plus.....10</p> <p>Protector.....11</p> <p>Prudence.....12</p> <p>Unbranded.....13</p> <p>Don't know name.....14</p> <p>No particular brand.....15</p> <p>Others specify[].....16</p>	<p>Go to ●315</p>
Q314	<p>[ONLY ASK IF STOPPED USING CONDOMS IN Q310 (OPTION 2)]</p> <p>What is the Main reason why you stopped using male condoms?</p>	<p>Did not enjoy using condoms... 1</p> <p>Wanted a child.....2</p> <p>Partner opposed.....3</p> <p>Religious reasons.....4</p> <p>Others specify[].....6</p>	
Q315	<p>Do you intend to start to use (OR IF CURRENTLY USING) continue to use male condoms in the next 12 months?</p>	<p>Yes.....1</p> <p>No..... 2</p> <p>Don't know.....8</p>	

Section 4 Sexual History: Number and Types of partners

No.	Questions and filters	Coding categories	Skip to
	<p>[TELL THE RESPONDENT] I need to ask you some personal questions about sexual activity in order to gain a better understanding of some family life issues.</p>		
Q401	<p>At what age did you first have sexual intercourse, if ever?</p>	<p>Age in years [][]</p> <p>Never.....87 Can't remember..... 88 No Response.....99</p>	→Go to Q901
Q401A	<p>Have you ever had sex in exchange for money/ favours or gifts?</p>	<p>Yes..... 1 No 2 No response.....9</p>	
Q402	<p>Surveys reveal that many people have had more than one sexual partner at the same time. Would you say this has ever happened to you?</p>	<p>Yes 1 No 2</p>	
Q403	<p>Have you had sexual intercourse in the last 12 months?</p>	<p>Yes 1 No 2 No Response.....9</p>	→Go to Q501
Q404	<p>How many sexual partners have you had in the past 12 months?</p>	<p>NUMBER [][] No Response.....99</p>	
Q405	<p>Think about the persons you have had sex with in the last 12 months.</p> <p>How many were:</p> <p>Your spouse(s) or partners who you were living together with</p> <p>Boy/girl friends</p> <p>Partners with whom you had commercial sex</p> <p>Partners you met on a casual basis</p> <p>[IF NONE FOR ANY OF THE PARTNER TYPES CODE '00']</p>	<p>MARITAL OR LIVING TOGETHER [][]</p> <p>BOY/GIRLFRIEND [][]</p> <p>COMMERCIAL [][]</p> <p>CASUAL [][]</p> <p>No Response.....99</p>	

No.	Questions and filters	Coding categories	Skip to
Q406	CHECK Q405 OPTION B, C AND D. DID RESPONDENT HAVE SEX WITH BOY/GIRLFRIEND AND/OR CASUAL PARTNER AND/OR COMERCIAL SEX PARTNER? Y/N→ ↓	→ → →	→Go to Q410
Q407	Think of your very last sex act with a non- marital, non-cohabiting partner. In that very last sex act, was a condom used?	Yes.....1 No.....2	→Go to Q408
Q407A	What was the MAIN reason why you used a condom that time? Was it [READ OUT]	For protection from HIV/STIs.....1 To prevent unwanted pregnancy....2 For protection from both HIV/STIs and unwanted pregnancy.....3 Others specify[.....4	
Q408	This partner with whom you had your last sex act, was he/she younger, about the same age or older than you?	Younger....1 About the same age.....2 Older than me.....3	→ Go to Q409A → Go to Q410
Q409	(If older,) do you think he/she was less than 10 years, or 10 or more years older than you?	Less than 10 years older.....1 10 or more years older...2 Don't know the difference....8	Go to Q410
Q409A	(If younger,) do you think he/she was less than 10 years, or 10 or more years younger than you?	Less than 10 years younger.....1 10 or more years younger...2 Don't know the difference...8	
Q410	[ASK ALL WHO HAVE HAD SEX IN THE LAST 12 MONTHS IN Q403] How many sexual partners do you currently have including casual and commercial partners?	Number [] No Response.....99	
Q411	Of all your current sexual partners, how many are your.... A. Spouse/ partners who you are living together with? B. Non marital and non-cohabiting partners? [IF NONE TO ANY CODE '00']	Number [] No Response.....99 Number [] No Response.....99	

APPENDIX II

VARIABLES

Key variables

Unmarried youths aged

15-24 years

Rural/urban areas

Sexual behaviour

Condom use

SECTION I

(Background/socio demographic characteristics)

Q101

Sex of the respondent

Q102

In what month and year were you born?

Q106

What is the highest level of school you attended?

Q109

How long have you been living continuously in this city/town/village?

Q111

What is your religion?

Q112

To which ethnic group do you belong?

SECTION 3

(Condom knowledge, access and use)

Q301

Ever heard of male condoms?

Q304

From which places or persons do you know of where you can obtain male condoms?

Q306

Would you say male condoms are affordable?

Q308

Have you ever used male condoms (or if female) Has your partner ever used a male condom with you?

Q308

Are you currently using male condoms? (if female ask) is your partner currently using male condoms with you?

Q311

What is the main reason why you are using male condoms?

Q314

What is the main reason why you stop using male condoms?

SECTION 4 SEXUAL BEHAVIOUR

- Q401 At what age did you first have sexual intercourse if ever?
- Q401A Have you ever had sex in exchange for money/favours or gifts?
- Q402 Surveys reveal that many people have had more than one sexual partner at the same time would you say this has ever happened to you?
- Q403 Have you had sexual intercourse in the last 12 months?
- Q404 How many sexual partners have you had in the past 12 months.
- Q406 Did respondent have sex with boy/girlfriend or casual partner?
- Q407 Was condom use in last sex?
- Q407A What was the main reason you used a condom that time
- Q410 How many sexual partners do you currently have including casual and commercial partners?