ADOLESCENT SEXUAL BEHAVIOUR:

A STUDY OF NIGERIAN VILLAGES

Chukwudum Uche

University of the West Indies
Mona, kingston, jamaica

And

Gloria Vincent-Osaghae

University of benin
Benin city, nigeria

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Abstract

Adolescent Sexual Behaviour: A Study of Nigerian Villages

Chukwudum Uche and Gloria Vincent-Osaghae

Two villages, Ichi (Anambra State) and Baranyonwa Dere (Rivers), in Eastern Nigeria were chosen for study. A combination of methods was used: ethnographic survey, focus groups and demographic survey of randomly selected heads of households and adolescents aged 12-19.

The data showed that parent-child communication in sexual matters is non-existent or negative. Contraception is rare in traditional society. Most heads never discussed family life education nor shared any information about STIs with adolescents.

A third of the adolescents are sexually experienced with a mean age of initiation being 15.5 years, but only 11 percent are currently using contraceptives. The adolescents displayed a high level of ignorance of the AIDS virus. Less than half correctly identified preventive actions against contracting HIV. Older adolescents (16-19) and those who had lived in urban areas before age 12 are more likely to be sexually experienced, while having fathers in professional/skilled occupations decreased the odds. Also, males are more likely than females to be current contraceptive users.

Programmes dealing with cultural practices and providing information and youth-friendly services are needed.

Adolescent Sexual Behaviour: A Study of Nigerian Villages

Context

The pre-eminence of Nigeria demographically in Subsaharan Africa is well known. Nigeria's 1991 population of 89 million is projected to reach 134 million in 2005 and 236 million by 2025 (NPC, 1998, p. 334, 338).

The adolescent age group (10-19 years of age) constitutes about 23 per cent of Nigeria's population and this proportion is projected to remain virtually unchanged in the immediate future. There is evidence to confirm that these adolescents are sexually active. The Nigeria Demographic and Health Survey (DHS) 1990 found that the age-specific fertility rate for three years preceding the survey was 144 per 1,000 for women aged 15-19. Also, the 1991 Nigeria population census found that almost 10 per cent of births in the preceding 12 months before the count were born to young women aged 15-19 years. These adolescents rarely use contraceptives as only 2 per cent of women aged 15-19 years were current users of modern contraceptive methods. (Federal Office of Statistics, 1992, pp. 41-42)

It has been estimated that about 2.6 million adults and 120,000 children under 15 in Nigeria were living with HIV/AIDS at the end of 1999 (UNAIDS/WHO, 2000). This situation demands that programmes targetting the youth must be developed and implemented because the most vulnerable age group (the 20-39 age category) would have contracted the virus in their teenage and young adult years, given the incubation period of the virus. The study reported below was undertaken in two Nigerian villages to assist in gathering data needed for such programmes.

Objectives

The major objective of this study is to investigate the sexual behaviour, knowledge and use of contraceptives, and awareness of STDs, including AIDS, of adolescents (12-19 years of age) in two rural settings in Eastern Nigeria. This objective was executed using ethnographic and demographic surveys and focus group discussions.

The ethnographic survey had two objectives:

(i) to describe the context of sexual behaviour through a study of the family system, especially betrothal practices, marriage procedures and types, marital instability and child socialization in sexual practices.

(ii) on the basis of the results obtained in (i) above to design relevant research instruments for a demographic survey of adolescents' sexual behaviour.

The demographic survey involved both heads of households and their children. The objectives of the survey included:

(i) to explore the knowledge of, attitude towards, access to and use of contraceptives, by heads of households and their children.

(ii) to explore the knowledge of and attitudes towards Sexually Transmitted Diseases, including AIDS, of heads of households and their children.

(iii) to explore current sexual activity of adolescents and reasons for non-use of contraceptives, if not using.

Methods

This study used a combination of methods: an ethnographic study of two selected villages in Eastern Nigeria, focus group discussions and a demographic survey of a random sample of census enumeration districts in the villages.

The two communities are Ichi town (1991 estimated population, 25,000) in Anambra State, and Baranyonwa Dere (1991 estimated population, 15,000) in Rivers State of Eastern Nigeria, the region with the highest fertility in the country.

The informants used in the ethnographic fieldwork were the ward or lineage chief, the oldest male and female and the chief priest/priestess of the local deities in each of the 17 wards in Ichi and 12 in Baranyonwa Dere. In all, 41 informants were used at Ichi while 32 provided information at Baranyonwa Dere. The mean age of informants was over 70 years (Ichi) and over 65 years (Baranyonwa Dere). Fieldwork was conducted at Ichi between January and June, 1995 and at Baranyonwa Dere between February and July, 1995. As indicated above, the objective of the ethnographic study was an analysis of the family system. The same topic was the subject of focus group discussions involving young to middle aged professionals indigenous to these communities. The results of the ethnographic study and focus group provided the context for the demographic study and interpretation of adolescent behaviour in present day rural society.

Ichi and Baranyonwa Dere had 31 and 19 enumeration areas respectively in the 1991 Nigeria Census. A 20 per cent sample of the enumeration areas, or 10, was drawn and assigned proportionately to Ichi (6) and Baranyonwa Dere (4).

Two questionnaires, head of household and adolescent schedules, were used. In both villages, all houses/compounds in the sampled enumeration areas were canvassed. With parental consent, adolescents were interviewed using their own schedule. In all 468 heads of households and 333 adolescents were interviewed in both villages.

Literature Review

Studies of adolescent sexual behaviour in Nigeria have concentrated on urban areas of the country, though the country is still predominantly rural.

The median age at first intercourse for urban adolescents has ranged between 16 and 18 years (Ladipo, 1986, Makinwa 1991, Odiase, 1983). The Nigeria Demographic and Health Survey 1990 confirmed these results. It found that the median age at first sexual experience for females aged 20-24 was 16.6 years (Federal Office of Statistics, 1992, p. 63)

Nigerian adolescents have an active sexual life as demonstrated by their age-specific fertility rates (ASFR). The 1981/82 Nigeria Fertility Survey found that the ASFR for females aged 15-19 was 173 per 1,000; (WFS, 1984, p. 76). These figures remained almost unchanged for almost a decade as the 1990 DHS found that the ASFR for females 15-19 years of age was 178 per 1,000.

One of the major factors accounting for the high fertility rates is the low level of contraception by adolescents. The 1990 DHS found that only 4 per cent of females aged 15-19 years ever used modern methods of contraception; for current use of modern contraception this proportion declined to a mere 2 per cent. Reasons for non-use of contraceptives by adolescents include ignorance of methods, assumed impossibility of

pregnancy at first intercourse, moral reasons or the fear of possible impairment of health or future childbearing (Ladipo et al. 1986, Oronsaye and Odiase 1983, Oyeka, 1986, Makinwa-Adebusoye, 1991).

Results

(a) Ethnographic Survey

The ethnographic study affirmed that in traditional society sexual activity had one objective, that is, procreation, not pleasure. Parent-child communication in sexual matters was either non-existent or negative before maturity, which for girls is at age of menarche. The negative communication concentrated on the possibility of pregnancy and the dangers associated with it, including shame for the girl and the family. Though contemporary village society is more open and sex is being more freely discussed, communication in sexual matters between parent and child remains minimal.

Contraceptives in the form of herbs and traditional preparations were not commonly used. Abstinence was the only approved method of contraception for girls and any of them suspected of using any other form of contraception was ridiculed. Abortion was regarded as murder and required ritual cleansing for social and personal harmony. Prostitution was never part of traditional life; this is still the position in the villages studied. Concubinage still exists in Baranyonwa Dere as a mechanism to deal with the sexual needs of a husband with a wife who is lactating, during which period it was taboo to engage her in any sexual intercourse. However, aspects of traditional life are changing due to the forces of socio-economic development: education for girls,

increased mobility of persons, goods and services, increasing urbanization, and, more than ever before, young persons are assuming greater responsibilities for themselves.

(b) Heads of Households

More than four out of every five of the heads of households at Ichi and three out of every four in B. Dere are married, and more than four out of five heads in both communities live in monogamous unions. Almost all the heads of households in both communities were born and now reside in rural areas. This rural origin and residence would influence their views in matters relating to children's socialization and sexuality. The median age of heads at Ichi is 45.6 years but 47.6 years in B. Dere, while the median number of years of education of heads is 7.4 years at Ichi and 7.2 years at B. Dere.

Analysis of the data from heads of households shows that their current use of contraceptives is low. In Baranyonwa Dere, 40 per cent of heads of households are current users of contraceptives while at Ichi the proportion is only 27 per cent. In Ichi, the preferred methods by current users are rhythm, condom and withdrawal in that order; in B. Dere the methods of choice are pill, condom, withdrawal and rhythm.

In terms of modern methods only, 43 per cent of the women in the total sample claim to be currently using the pill while 14 per cent of the men are current users of the condom. These figures are higher than national figures (Federal Office of Statistics, 1992, pp. 41-42), and therefore suspect.

Heads of households are knowledgeable about sexually transmitted diseases such as gonorrhea, syphilis, herpes and AIDS. Eighty-seven per cent of the heads at Ichi and 76 per cent of those at B. Dere have heard of AIDS. Concerning syphilis, only 46 per

cent of the heads at Ichi have heard of it; at B. Dere 78 per cent of the heads have heard of it. The least known of the sexually transmitted diseases is herpes; only 25 per cent of the heads at Ichi and 39 per cent at B. Dere have heard of it. The major sources of information for heads of households are health professionals and the electronic and print media. Parents and relatives are rarely mentioned as secondary sources. Given their own experiences, these parents are not likely to play the role of information givers to their children in such matters as sexually transmitted diseases. This assertion is borne out by the data. Only 38 per cent of the heads at Ichi and 57 per cent at B. Dere claimed to have told their children about any of the sexually transmitted diseases. Finally, 16 per cent of the heads at Ichi and 60 per cent of the heads at B. Dere know someone who had contracted one of the STDs.

Heads of households in both communities are opposed to adolescent sexual activity. Ninety-seven per cent of the heads at Ichi and 60 per cent of those at B. Dere either disagree or strongly disagree with adolescent sex. The phrasing of this question was varied but their opposition strengthened. Ninety-seven per cent of the heads at Ichi and 80 per cent of those at B. Dere do not support an adolescent (boy or girl) having sex with a partner he/she does not intend to marry. Finally, ninety-six per cent of the heads at Ichi and 75 per cent at B. Dere do not think that it is "necessary for a girl having premarital sex". With such overwhelming level of opposition, these parents cannot be expected to facilitate adolescents acquiring knowledge that may be relevant in this area of life. Sixty-six per cent of the heads at Ichi and 59 per cent of those at B. Dere have never discussed family life education, that is, responsible parenthood or sex education, with their children. The reasons adduced by these parents for this lack of communication

include cultural or religious injunctions and that the young persons would know when they become adults. The minority of parents who discussed family life education with their children did so to ensure that the children got the correct information. Heads of households' attitudes toward adolescent sexuality understandably reflect the community's norms that they were socialized by during their childhood days. Our data bear this out as 96 per cent of the heads at Ichi and 93 per cent at B. Dere report that their communities disapproved of adolescents engaging in sex when they were growing up. The situation has not improved much in contemporary times as 94 per cent of the heads at Ichi and 78 per cent at B. Dere report that current community attitude still disapproves of adolescent sex. To enforce community's opposition to premarital sex, 60 per cent of the heads of households at Ichi and 27 per cent at B. Dere report that reliance is placed on parents to take whatever action is required. The predominant action is preventive, that is, to advise young persons not to engage in sexual intercourse. However, the community is not entirely powerless to discipline the youth. Twenty per cent of the heads at Ichi and 56 per cent of those at B. Dere report that communal action that can be taken range from gossip and social isolation to making it difficult for the youth to find an eligible marriage partner locally.

To identify the possible roots of the strong opposition to premarital sex in these communities, we asked the heads of households to identify any changes in sexual behaviour of young people when they were growing up as compared to the contemporary situation. Eighty-two per cent of the heads at both Ichi and B. Dere report a more permissive environment of sexual behaviour in contemporary times than when they were growing up. In spite of this situation, there exists almost a universal wish to marry

virgins, as 96 per cent of the heads at Ichi and 87 per cent at B. Dere wish their daughters to be virgins at the time of marriage. The major reason fanning this desire is that such a daughter brings honour and respect to herself and the family. Should a young girl become pregnant, abortion is not an option legally or culturally. Options explored include letting the girl have the baby, negotiating some settlement with family of the male partner, and withdrawal of affection. For a boy who puts a girl in the family way, the major option is to insist that the young man marries the girl.

To summarize, only a minority of the heads of households in the communities studied currently use contraceptives, that is, pill, condom, withdrawal and rhythm method. They are aware of sexually transmitted diseases, know modern health facilities for treatment and about two in five know someone who had contracted one of the sexually transmitted diseases. The primary sources of information for the heads with respect to contraceptives and sexually transmitted diseases were extra-familial and this also impacted on their experiences with their children. Only a minority of the heads shared information concerning contraceptives, family life education and STDs with their children. Communal and parental disapproval of adolescent sexual activity is very strong and, despite evidence to the contrary, almost all heads of households wish to give away (or receive) virgins in marriage, an event that traditionally confers much honour and respect to both the girl and her family.

Adolescents' Survey – Univariate Analysis

Forty per cent of the 333 adolescents studied are males and 60 per cent females; forty per cent are between 12 and 15, and 60 per cent between 16 and 19 years of age. Eighty-five per cent of the adolescents at Ichi and 77 per cent at B. Dere are still in school, predominantly at the secondary level. These adolescents seem to live in stable family units. Ninety-four per cent of the adolescents at Ichi and 77 per cent of those at B. Dere report that both parents are alive with 82 per cent of parents at Ichi and 76 per cent at B. Dere living in monogamous unions. Furthermore, 84 per cent of the adolescents at Ichi and 77 per cent at B. Dere live with both parents. Very few are married (3 per cent at Ichi, 15 per cent at B. Dere) and have children.

Menstruation is an experience which every girl will not fail to notice and which indicates a turning point in the developmental process of an adolescent girl. The median age at menarche for B. Dere adolescents is 14 years and 15 years for Ichi girls. These figures are consistent with the median age of 14 years for the onset of menstruation reported by the Nigeria Fertility Survey 1981/82 for all women (World Fertility Survey, 1984, p. 138). The source of information about menstruation for these adolescents, in rank order, included close relatives (mothers, aunts and sisters), friends, school teachers and counsellors. The principal information obtained by 79 per cent of the girls at Ichi and 65 per cent at B. Dere is that menstruation is a normal experience of a grown woman or one becoming an adult. Adolescents at B. Dere seemed to have had more sexual experiences than those at Ichi before age 14. For example, while half of them claimed that someone attempted to force them to have sex, in Ichi only 5 per cent of the adolescents made such a claim.

We next explored sexual experiences of the adolescents since age 14. Two per cent of the adolescents at Ichi and 35 per cent of those at B. Dere claimed that someone had tried to rape them. In the area of sexual experience, 8 per cent of the adolescents at Ichi and 62 per cent of those at B. Dere claimed that someone had approached them for sex. In all, seven per cent of the adolescents at Ichi and 55 per cent of those at B. Dere are sexually experienced, that is, had ever had sexual activity. The mean age of sexual initiation for Ichi adolescents was 15.7 years and 15.4 years for those at B. Dere. The mean age of the partners at Ichi was 15.7 years, exactly the same as the adolescents, but the mean age at B. Dere was 16.7 years, about a year older than the B. Dere adolescents whose mean was 15.4 years. These partners in both study locations were generally husband or wife, fiance or fiancee or steady boy or girl friend. Only in B. Dere do we find that a fifth of the partners was either a casual acquaintance or friend. The major reason for the first sexual activity by adolescents in both study sites was curiosity, that is, the adolescents wanted to find out how sex felt.

Contraceptive use at first sexual encounter was minimal; only about 8 per cent of the adolescents at Ichi and 34 per cent of those at B. Dere used contraceptives. The major reason for non-use at Ichi was that the adolescent felt that the time was within her 'safe' period during which she could not get pregnant. In B. Dere the major reasons were ignorance of any methods and that the adolescent was not expecting to have sexual intercourse at the time and so was unprepared. Most of the adolescents affirmed that they were not pressured to have their first sexual intercourse. Seventy-five per cent of the adolescents at Ichi and 52 per cent of those at B. Dere who had had sexual intercourse agreed that no force or pressure was applied on them to engage in the initial act. Also, all

the adolescents at Ichi and 47 per cent of those at B. Dere affirmed that they did not force their partners to have the first sexual intercousre.

Only a third of the sexually experienced adolescents at Ichi and two-fifths of their B. Dere counterparts are currently sexually active, that is, had sexual intercourse in the last 30 days. More than a quarter (27 per cent) of the adolescents at B. Dere have more than one sexual partner and major factors underlying such behaviours are economic, adventure, spousal absence, and peer influence.

Table 1 displays the percentages of adolescents who have ever heard of the various contraceptive methods.

Table 1: Percentage Distribution of Adolescents who have ever heard of various Contraceptive Methods by Study Villages

Method	Ichi	B. Dere
Female Sterilization (Tubal Ligation)	9.21	39.78
Male Sterilization (Vascectomy)	7.24	34.25
Implants (Norplant)	3.95	28.73
Pill	10.53	42.54
IUD, Coil, Loop	4.61	27.62
Condoms, Rubber	11.84	64.64
Foaming Tablets	3.95	36.26
Creams, Jellies	1.97	32.04
Diaphragm	3.29	26.52
Withdrawal	7.24	46.41
Rhythm, Safe Period	9.87	42.54
Billings Method	2.63	26.52
Abstinence	13.82	37.02
Traditional Methods (roots, herbs, charms)	0.65	22.10

Note: n for Ichi percentages is 152; B. Dere, 181.
Source: Fieldwork data.

Table 1 shows that the adolescents, especially at Ichi, have a very low level of knowledge of contraceptives. It is only with respect to the Pill, Condom and Abstinence that 11 to 14 per cent of Ichi adolescents claim some knowledge. Adolescents at B. Dere are more knowledgeable than Ichi counterparts, but even here, it is only with the condom that 50 per cent or more of the subsample claim some knowledge. With such a low level of knowledge, current use is bound to be lower. It turns out that only 38 of the 333 adolescents (3 at Ichi, 35 at B. Dere) or 11 per cent are currently using a contraceptive, with the condom being the preferred modern method. Current users know the source of supply and their mean estimated cost per month at the time of the study was N75 or a little less than US$1.00 at the prevailing rate of exchange.

Table 2 explores adolescents' knowledge of the menstrual cycle. It demonstrates that there is a high level of ignorance here as well.

Table 2: Percentage Distribution of Adolescents' Opinion on the most likely period for a Woman to get pregnant by Study Villages

When Pregnancy Occurs	Ichi	B. Dere
During her period (menstruation)	1.97	16.02
At the end of the period	5.26	13.81
In the middle of the period	18.42	18.79
Just before her period ends	25.66	25.41
At any other time	4.61	1.11
Blank, no response, don't know	44.08	24.86
	100.00	100.00
n	152	181

Source: Fieldwork data.

Less than a fifth of the adolescents (18 per cent at Ichi, 19 per cent at B. Dere) correctly identified the middle of the menstrual cycle as the time that a woman has the greatest chance of becoming pregnant. Also, the large percentage of non-response may indeed indicate ignorance.

Abortion is illegal in Nigeria and so we expect persons not to own up to any abortions or to underestimate their experiences substantially. However, a total of 28 adolescents (1 in Ichi and 27 in B. Dere) agreed that they have ever had abortions. For B. Dere the figure represents 15 per cent of the sample of 181 respondents. For these respondents the major reason for aborting the foetus is that the adolescent never wanted the child; the parent's or partner's wish counted for much less. Most of the parents did not know about the abortion and a majority of those who knew opposed it.

We next consider the level of knowledge that adolescents have of the AIDS virus. Table 3 deals with transmission modes.

Table 3: Percentage Distribution of Adolescents who mentioned Activity as a Source of getting the AIDS virus by Study Villages

Activity	Ichi (%)	B. Dere (%)
Shaking hands	14.47	0.55
Sharing hypodermic needles**	73.68	43.65
Sharing apartment, home or living quarters	22.37	3.87
Sharing office or classroom	20.39	4.42
Receiving a blood transfusion**	74.34	50.28
Having sex with homosexual or bisexual men**	53.29	32.04
Having heterosexual sex**	80.26	51.93
Giving a blood donation	60.53	34.87
Insect bites	46.71	17.13
Sharing dishes, toilets	36.84	7.18

Note: n for Ichi percentages is 152; B. Dere, 181.
** Correct source for spreading HIV.
Source: Fieldwork data.

Two things stand out in Table 3. The first is that there is a lot of misinformation or ignorance about the sources of contracting the AIDS virus. This is why every source mentioned was chosen. Secondly, even the correct sources are not well-known, which explains why only about 70 per cent (Ichi) and less than 50 per cent (B. Dere) of the adolescents know them.

Table 4 deals with preventive actions, what individuals should do to avoid contracting HIV and the perceived level of protection each activity offers.

Table 4: Adolescents' Assessment of the Level of Protection offered by Various Actions to Prevent AIDS by Study Villages

Activity	Level of Protection offered: % of responses selecting fairly or very effective	
	Ichi	**B. Dere**
Avoid kisisng people not well known	34.21	46.41
Refusing blood donation	(57.24)	(63.54)
Avoid using public toilets	28.95	25.97
Avoid mosquito or insect bites	32.89	32.04
Avoid sex with unclean people	19.08	46.41
Using a condom during sex	(48.03)	(57.46)
Abstaining from sex entirely	(38.82)	(58.01)
Avoiding someone who has AIDS virus	51.97	66.30
Avoid shooting drugs with needles	(44.08)	(43.09)
Stick to one faithful partner	(42.11)	(57.46)
Avoid sex with homosexuals, bisexuals	30.26	49.17
Avoid sex with strangers	(37.50)	(60.22)
Avoid sex with prostitutes	(46.71)	(65.19)
Avoid blood donation	19.08	38.12
Avoid sex with person with AIDS virus	(49.34)	(77.35)

Note: Correct preventive actions enclosed in brackets.
n for Ichi percentages is Ichi 152; B. Dere, 181.
Source: Fieldwork data.

Again, as noted for transmission modes, there is a high level of ignorance in the area of preventive actions. The correct preventive actions were selected and assessed as fairly or very effective by 38 to 57 per cent of the adolescents at Ichi and by 43 to 77 per cent of those at B. Dere. All actions that were not preventive were chosen, especially 'avoiding someone who has AIDS virus', which was chosen by 52 per cent of the adolescents at Ichi and 66 per cent of those at B. Dere.

Finally, we examine the extent of family life or sex education (FLE) available to these adolescents in their villages. Less than a quarter (23 per cent) of the adolescents at Ichi and less than a half (48 per cent) of those at B. Dere have ever had family life or sex education classes in school. The locus for this instruction is the secondary educational institution as more than two-thirds (68 per cent) of the adolescents in each of the study villages who had had an FLE class claimed that they were at the secondary level of education at the time the class occurred. Seventy-eight per cent of the instructors of the FLE classes at Ichi and 66 per cent at B. Dere were school teachers. Health professionals, that is, medical practitioners and nurses, came a distant second, with 14 per cent at Ichi and 24 per cent at B. Dere. Table 5 shows the content of the FLE class in school. This table shows that the proportion of students who got instruction in specific aspects of FLE was very low, 5 - 15 per cent at Ichi and 28 - 55 per cent in B. Dere. T he most deficient content area in both locations is services for adolescents.

Table 5: Percentage Distribution of Adolescents who had Various Components of Family Life or Sex Education Classes in School by Study Villages

Contents of Class	Ichi % had class	B. Dere % had Class
Human Reproductive System	15.13	54.70
Menstrual Cycle or Period	13.82	39.23
Pregnancy	11.84	39.78
Modern Contraceptives	9.21	29.28
Sexually Transmitted Diseases	11.84	33.70
AIDS	8.55	27.62
Services for Adolescents	5.26	27.62

Note: n for Ichi percentages is 152; B. Dere, 181.

Adolescent Results – Multivariate Analysis

In this section we wish to explore, with multivariate techniques, the factors influencing whether an adolescent is sexually experienced or not, and currently uses contraceptives or not, and his/her level of knowledge of AIDS. Table 6 shows the logistic regression results for sexual experience.

Table 6: Logistic Regression Results for the Regression of Sexual Experience on Various Variables

Variables	B (Additive Estimate)	Standard Error	Level of Significance	Exp (B) (Odds Ratio)
Gender	.6507	.3372	.0536	1.9
Age	.7169	.3530	.0423	2.1
Father's Occupation	-1.0321	.3339	.0020	0.4
Residence before Age 12	.7960	.3699	.0314	2.2
Intercept	-1.2507	.4006	.0018	-

The table shows that age, residence, and father's occupation are statistically significant ($p < .05$). Older adolescents (aged 16-19), and those who lived in urban areas before the age of 12 years are more likely to be sexually experienced than younger adolescents (aged 12-15) and those who had a rural background. However, adolescents whose fathers belong to professional/skilled occupations are less likely to be sexually experienced than those whose parents have farming/unskilled occupations.

As noted earlier, the level of current use of contraceptives by these adolescents is very low; only 11.4 per cent claim that they or their partners are current users of any method. Table 7 shows the results of the logistic regression of current use of contraceptives by respondent or partner on gender, age, residence, and father's occupation.

Table 7: Logistic Regression for the Regression of Current Use of Contraception on Various Variables

Variables	B (Additive Estimate)	Standard Error	Level of Significance	Exp (B) (Odds Ratio)
Gender	1.2791	.4934	.0095	3.6
Age	.2879	.5210	.5805	1.3
Residence	.3681	.5166	.4761	1.4
Father's Occupation	-.5158	.4867	.2892	0.6
Intercept	-2.2228	.5861	.0001	-

Only the coefficient for gender is statistically significant ($p < .01$). Adolescent males are by far more likely (odds ratio of 3.6) to be current users than adolescent females, other factors remaining constant.

Our earlier analysis of our respondents' knowledge of AIDS revealed very limited detailed knowledge and an abundance of myths concerning modes of transmission and

preventive actions. In this multivariate analysis we dichotomized the adolescents into those who know one to two modes and those who know three or four modes of contracting AIDS. The modes used in the study included: sharing hypodermic needles, receiving blood transfusions, having sex with a homosexual or bisexual, and heterosexual sex. Forty-one per cent of the 276 adolescents who responded knew one to two modes while 59 per cent knew three to four modes. Table 8 shows the result of the logistic regression of the level of knowledge of the modes of transmission of AIDS on various factors.

Table 8: Logistic Regression Results for the Regression of Level of Knowledge of Modes of Transmission of AIDS on Various Variables

Variables	B (Additive Estimate)	Standard Error	Level of Significance	Exp (B) (Odds Ratio)
Gender	.1307	.3258	.6883	1.1
Age	.5470	.3294	.0968	1.7
Residence	-.7080	.3688	.0549	0.5
Father's Occupation	-.0080	.3421	.9814	1.0
Sexual Experience	-0.148	.3621	.0051	0.4
Intercept	.5721	.3908	.1432	-

Only the coefficient on sexual experience is statistically significant ($p < .01$) and the effect is negative, indicating that those adolescents who are sexually experienced are more likely to have less knowledge of modes of transmitting AIDS virus than adolescents who are sexually inexperienced.

We summarize the multivariate analysis as follows: On the issue of being sexually experienced, that is, if the adolescent has ever had sexual intercourse, we found that the older adolescent (16-19) or the one who has had an urban residence before age 12 has higher odds of being sexually experienced than otherwise. However, the more

professional/skilled the occupation of the father, the less the odds that the adolescent would be sexually experienced. On current use of contraceptives by adolescent or his/her partner, we note that the odds of being a current user overwhelmingly favour male adolescents. Finally, most of the adolescents in the study know at least one of the sources of contracting AIDS. However, being sexually experienced does not confer any advantage; it actually reduces the odds of having a higher level of knowledge of the sources of contracting AIDS.

Conclusion and Recommendations

This study has demonstrated that socialization of youth in contemporary village societies continues to be determined by the cultural experiences of parents and grand parents, experiences that stretch back to the early decades of the 20th century. Though changes have occurred in many areas of traditional life, this study shows that in intimate matters such parent-child communication, sexual behaviour, contraceptives and HIV/AIDS, traditional cultural imperatives are dominant. Parents and guardians not only need information on reproductive biology, contraceptive technology and sexually transmitted infections, including HIV/AIDS, but also must be encouraged to share these with their children. The adolescents were found to be ignorant or misinformed about HIV/AIDS. They are sexually active but scarcely use contraceptives. We found that facilities for family life education are negligible and adolescent services non-existent.

To tackle the scourge of HIV/AIDS in sub-Saharan Africa, programmes are needed for parents, guardians and young persons. For parents and guardians, we recommend:

(i) Programmes to encourage parents and guardians to maintain and enhance existing bonds with their spouses, children and wards.

(ii) Programmes to encourage parent-child communication generally and especially on personal and sensitive matters such as menstruation, sexual behaviour, contraceptives and their use, STIs including HIV/AIDS.

(iii) Programmes giving parents and guardians basic information on human biology, contraceptive methods and their use, and STIs, including HIV/AIDS.

For adolescents and young persons in general, we suggest the following programmes:

(i) Introduction of family life or sex education curriculum into the formal school syllabus or revision and updating of any existing one. These courses should start from the upper primary level.

(ii) Training programmes for teachers and counsellors to be able to deliver the new or improved curriculum.

(iii) Provision of out-of-school classes for family life or sex education for young persons who are no longer in school.

(iv) Provision of youth-friendly facilities where adolescents and other young persons can feel free and confident to go for information and services.

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