SEXUAL BEHAVIOUR IN THE ERA OF HIV/AIDS AMONG IN-SCHOOL FEMALE ADOLESCENTS IN SABON GARI LOCAL GOVERNMENT AREA, KADUNA STATE

BY

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DECLARATION

I hereby declare that this thesis was written by me and it is a record of my research work carried out under the supervision of Dr. K. Sabitu. I solemnly declare that no part of the thesis has been submitted elsewhere for a higher degree. The work of other researchers are acknowledged and referred to accordingly.

Udoh, Geoffrey Calix

28/2/2001
Date

CERTIFICATION

This thesis entitled "Sexual Behaviour in the Era of HIV/AIDS among in-school female adolescents in Sabon Gari Local Government Area, Kaduna State" by **Udoh,** Geoffrey Calix meets the regulations governing the award of masters degree of Ahmadu Bello University, Zaria and is approved for its scholarly contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to my dear wife, Mrs. Tinuola H. Udoh, who has been very encouraging and supportive of my Post – Graduate studies.

ACKNOWLEDGEMENT

First and foremost, I thank God for helping me to complete this work successfully. I wish to acknowledge and deeply appreciate the encouragement, guidance and patience of my supervisor, Dr. K. Sabitu.

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ABSTRACT

A cross sectional study of 400 randomly selected in-school female adolescents in Sabon Gari Local Government Area, Kaduna State, to determine their level of knowledge about AIDS and the influence of such knowledge on their sexual behaviour. Structured questionnaire and Focus Group Discussions (FGD) were used to collect data.

93.3% of the respondents were aware of AIDS, 93% knew HIV could be transmitted through sexual intercourse. 33% of the respondents were sexually exposed. FGDs revealed poverty as a major socio - economic factor pre - disposing in-school female adolescents to premarital sex.

There was no significant association between knowledge of sexual means of HIV transmission and use of condom. However, there was a significant positive association between knowledge of the protective effect of condom against sexual transmission of HIV and regular use of condom. (X^2=5.25, P=<0.05).

The study reveals an adolescent female population that is vulnerable and at risk of HIV infection as a result of their sexual behaviour. Public health measures are urgently needed to educate and positively change the attitudes of female adolescents towards condom.

TABLE OF CONTENTS

TITLE PAGE.....i

DECLARATION.....ii

CERTIFICATION.....iii

DEDICATION.....iv

ACKNOWLEDGEMENT.....v

ABSTRACT.....vi

TABLE OF CONTENTS.....vii

CHAPTER ONE.....1

1.1 INTRODUCTION.....1

1.2 JUSTIFICATION.....4

1.3 OBJECTIVE.....5

CHAPTER TWO.....7

2.1 LITERATURE REVIEW.....7

CHAPTER THREE.....17

3.1 HISTORICAL BACKGROUND.....17

3.2 MATERIALS AND METHOD.....19

3.3 LIMITATIONS.....22

KASHIM IBRA

CHAPTER FOUR 23

4.0 RESULTS 23

4.1 DEMOGRAPHIC CHARACTERISTICS 23

4.2 KNOWLEDGE OF AIDS/SEXUALITY 24

4.3 ATTITUDE OF RESPONDENT ABOUT AIDS/SEXUALITY 30

4.4 SEXUAL BEHAVIOUR 31

4.5 RELATIONSHIP BETWEEN KNOWELDGE OF AIDS SEXUALITY AND SEXUAL BEHAVIOUR 38

4.6 FINDINGS OF THE FOCUS GROUP DISCUSSIONS ON AIDS 40

CHAPTER FIVE 44

5.1 DISCUSSIONS 44

5.2 CONCLUSIONS 54

5.3 RECOMMENDATION 54

REFERENCES 56

APPENDIX 61

CHAPTER ONE

1.1 INTRODUCTION

Adolescence is a culturally defined term. Most cultures relate the beginning of adolescence to the onset of puberty, though when adolescence ends differ widely.[1] At the 1974 World Health Organisation meeting on pregnancy and Abortion in Adolescence, the consensus of opinion was that adolescent period is when.

(i) The individual progresses from the point of the initial appearance of the secondary sexual characteristics to that of sexual maturity.

(ii) The individual's Psychological process and patterns of identification develop from those of child to those of an adult.

(iii) A transition is made from the state of total socio-economic dependence to one of relative independence.

Chronologically, WHO defines adolescent age as the second decade of life, between 10-19 years. This age limit is, however, often extended to 24 years, when the youth's concerns are also taken into consideration as the concept are also overlapping; consisting of late adolescence and early adulthood - that is ages 15-24 years.[1]

Adolescence is a period of life that has come to be regarded as a time of intense sexual drive, sex and drug experimentation.[2]

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The trend in adolescent sexuality and sexual behaviour can be attributed to three main factors.

Firstly, there is a widening gap between age at sexual maturity and age at marriage; this is evident in the decreasing age at menarche.[3,4] The early age at menarche has been ascribed to improved general health, nutrition and living conditions. On the other hand, the age at first marriage has been increased in recent times as a result of schooling and Vocational training. The economic problems have also forced men to defer marriage.

Secondly, the effect of rural – urban drift of adolescents and young people, increasing modernization and exposure to foreign ideas and changes in societal moral values. These conditions have weakened traditional family centred constraints on sexual behaviour and the traditional requirement of premarital chastity.[5,6]

Thirdly, the economic hardship faced by many adolescents as a result of reduced family income, diminished employment opportunities and high cost of living. In the present of few options, female adolescents tend to trade sex for job and financial gains.[7]

Early sexual debut, multiple sexual partners, non use of health/ family planning services including condoms are risky behaviours that have predisposed adolescents to infection with human immunodeficiency Virus (HIV) causing Acquired immunodeficiency Syndrome (AIDS.).[7]

AIDS is ranked the fourth biggest killer worldwide and has claimed about 18.8million people since 1983.[8] The infection is transmitted through sexual intercourse, blood transfusion, contaminated hypodermic needles/ instruments and from mother to child (vertical transmission).[9]

In sub-Saharan Africa, the sexual route is the predominant means of transmission.[7] This route accounts for 80% of HIV transmission in Nigeria. Adolescents, therefore, are a vulnerable group at risk of contracting HIV/AIDS. Indeed, the first case of HIV/AIDS seen in Nigeria in 1984 was in a sexually active 13-year-old pregnant girl.[10] Since then, the epidemic has been increasing and a trend of growing epidemic has already been established. The proportion of people infected with AIDS virus has increased from 1.8% in 1990 to 3.8% in 1993, from 4.3% in 1995 to 5.4% in 1999.[11] Nigeria now ranks fourth after India, South Africa and Ethiopia on the list of the worst affected countries in the world. [12]

In Nigeria, campaign against AIDS was officially launched in 1987, the press had created public awareness about AIDS. A national AIDS committee was set-up to spearhead AIDS control programmes. Presently, this committee is headed by the President of the Federal Republic of Nigeria, this underscores the perception by the government of the threat AIDS poses to the Nigerian socio-economic structures. However, in spite of all the AIDS preventive measures mounted by the Nigerian government and the local NGOs, AIDS is still ravaging our people especially the adolescents. In 1998 alone, 60% of the 20,334 confirmed cases were within the age of 15-24 years.[11]

1.2 JUSTIFICATION

The rate of newly acquired HIV infection in sub-Saharan Africa is highest among adolescents 15-19 years old, with most of the infections in 15-19 years old occurring to females (AIDSCAP, et al 1996).[13]

80% of females are said to experience sexual intercourse by the age of 20.[14] In Nigeria, where 80% of AIDS is transmitted through the sexual route, female adolescents constitutes an at risk population. Also there is a greater male to female transmission of HIV, a phenomenon explained by the larger mucosal surface of the vagina, the higher incidence and prevalence of STD in women.[15]

The socio-economic conditions of the female adolescents are also factors that increase their risk to HIV infection.[7] Royce et al in an epidemiological review article stated that the sexual transmission of HIV will not be prevented by using any single intervention approach. The authors call for preventive strategies that combine knowledge of the epidemiology of the spread of HIV, the biology of the virus and the sociology of the affected groups.[13]

Already much have been known about the epidemiology of the spread of HIV and the biology of the virus. This study therefore focuses on the sociology of the female adolescents.

With no specific cure for AIDS and no developed vaccines, preventive measures based on information and education programmes remain the mainstay for tackling HIV/AIDS and its associated problems.

1.3 OBJECTIVES

The general objective of the research is to study the sexual behavioural response of in-school female adolescents to HIV/AIDS epidemic.

The specific objectives include:

(i) Determining the level of knowledge and attitude of in-school female adolescents towards HIV/AIDS.

(ii) Determining the sources of information about AIDS/sexuality among the in-school female adolescents.

(iii) To determine the level of knowledge of condom as effective protective method for sexually active people among in-school female adolescents.

(iv) To determine the level of sexual activity among the in-school female adolescents.

(v) To test the hypothesis that correct knowledge of sexual means of HIV transmission will lead to use of condom among the sexually active adolescent girls.

(vi) In the light of the findings above, recommend useful measures that could reduce HIV infection among adolescent girls.

CHAPTER TWO

2.1 LITERATURE REVIEW

Many studies have been done on sexual behaviour of young people around the world. [5, 6, 7,12]

From available data, a high proportion of adolescents are sexually active.[14,16] Nichols et al in his Ibadan study found that 38.4% of the adolescents were sexually exposed. He also found a pattern of condom usage among adolescents, 47.9% of the adolescents who had sexual intercourse once or twice in a month used condoms as against 20.5% of them who had sexual intercourse 3 or more times per month. [16]

Odujinrin in a survey of 950 secondary school students in Lagos in 1990, found 29% of the students sexually active, only 21% had ever practised any form of contraception.[17] The proportion of sexually active adolescents found in other studies in Nigeria ranges from 40% in Anambra to 77% in Benin City. [2,18,19] Between 20-49% of unmarried adolescents aged 15-19 years in Ghana, Kenya, Liberia, Togo and The Gambia have reported being sexually active. [1,20,21]

In general, the average age of sexual debut ranges between 15 and 17 years.[1] The 1990 national demographic and health survey of females within reproductive age group found the median age at first intercourse to be just over 16 years.[1] In a research interview of 3,485 women in Kinshasa, Zaire, the mean age at first intercourse was 16 years, while 14 years was found for both sexes

in Cameroon.[1] Amazigo U. et al in their study in Anambra and Enugu States noticed that the proportion of sexually active students rose with age, however, he found no difference in sexual activity by gender or school location (urban or rural).[18] However, in a study done in Ilorin, Kwara State among adolescents aged 15-24 years in the university, Araoye found a difference between the proportions of sexually active adolescents by gender, 52% of females compared to 73% males.[22]

In a comparative study on the influence of discipline of study on the sexual behaviour of in-school female students in eastern Nigeria, Brian-D Adinna et al found that there was no significant difference in the mean age at first intercourse between the medical and non-medical students. However, there were significant higher sexual exposure and increased frequency of sexual intercourse in the non-medical group. They explained, that absence of long vacations in the medical disciplines left little time for idleness, which often expose students to thoughts of sexual exploits and also that their behaviour may have been influenced by interaction with very ill patients and those dying of AIDS in the hospital.[19]

Attitudes and practice of barrier method vary among females. In a study conducted in Benin City by Temin et al, female adolescents expressed dislike for condoms because of diminishing sexual pleasure and fear that the condom will break thereby causing health problems. Some associated condom use with mistrust between sexual partners.[23]

Of the 77% of the girls who were sexually active in Unuigbe et al study in Benin City, only 29.9% practised use of condom during sexual intercourse.[2] In the Ilorin study, among the adolescents females who used condom as contraceptives, only 31% of them used it regularly.[22]

Amazigo et al also found that the use of condom increases with age, in his study whereas no sexually active 14-year-old used condom, 9% of the 15 years old did and the proportion climbed to 27% among the19 years old.[18]

In Guinea, a study revealed that while 65% of teenagers 15-19 years and 83% of 20-24 years age groups identified condom as effective method of contraception, only 29% in each group ever used condom as a contraceptive method.[24]

Condom use was more prevalent among students who had multiple sexual partners than those with one partner in the Anambra and Enugu study.[18] Stigum H. et al found that low frequency of sexual intercourse, high education, one life partner and late sexual debut were predictors for condom use and that condoms were used primarily as contraceptive.[21]

In The Gambian study, 37% of the 14-24 years age group ever used condom. Lack of information about contraception and limited access to family methods were significant obstacles to the use of contraceptive methods among single women.[20]

While adolescents usually start romantic relationship, which might include sex because of physical attraction with their fellow students, the desire

for material and financial gain is the primary motivation for sexual relationship with older partners.[23] This explains the mean age difference between adolescent females and their partners. In Guinea, mean age difference of 3.1years was found for adolescents aged 15-19 years compared with 6.1 years for age group 20-24 years.[24] The cultural reluctance of parents to discuss sexual matters with their children, let alone give them sex education, ill prepares adolescents to face the challenges of social life, when they leave home for studies or to seek job opportunities in the urban areas. [16,26]

Sexual permissiveness, therefore, predisposes the youths to HIV infection/AIDS. A review of KAP studies on HIV/AIDS has revealed a high knowledge about STDs/AIDS among adolescents. [22,23] Over 80% of respondents in studies in Nigeria and Kenya were aware of AIDS, however, few reported indebt knowledge of modes of transmission of the infection.[22]

Umoh and Okesina in their study entitled knowledge of AIDS among rural adolescents in Kwara State of Nigeria found that only 37% of the respondents knew that AIDS is caused by a virus. 65% of respondents were able to explain the symptoms correctly and 72% knew that AIDS could be transmitted from one person to another. 31% perceived AIDS is transmitted through blood transfusion, 20.9% mentioned sexual contact with an infected person, 19.8% of respondents mentioned piercing skin with sharp blades or needles, while 28.2% of the respondents had misconception about the mode of transmission, some mentioned witchcraft, a curse and eating in dreams.[27]

In another study conducted in Benin City, Unuigbe and Osafu found that 94% of the study population were aware of AIDS. 64% of the respondents knew that AIDS could be transmitted through sex, 81% knew that the disease is incurable, while only 8.7% knew that AIDS is caused by a virus. 13% of the respondents wrongly ascribed AIDS transmission to casual kissing and sharing of utensils. 40% knew the use of condom could prevent AIDS.[2] Temin et al using Focus Group Discussion (FGD) to study perception of Sexually Transmitted Diseases (STDs) among secondary school students in Benin City found a high awareness of AIDS among their study population.[23] The participants agreed that condoms were the best method of STDs prevention, abstinence was thought to be the next most commonly used method of prevention followed by monogamy. Girls mentioned abstinence and monogamy frequently.

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Although the group considered condoms the best way to avoid STDs, the reported prevalence of condom use showed a gap between knowledge and practice. In fact, the students felt that contracting STDs was inevitable for sexually active young people.[23]

Gary Barker and Susan Rich using FGD to study influences on adolescent sexuality in Nigeria found in Gabari, a semi-rural suburb of Zaria that young women were aware of AIDS and knew that the disease is transmitted through sexual contact. Participants agreed that the best way of prevention was mutual monogamy. The young men were however, curious

about whether AIDS was truly fatal.In Zaria, young men knew AIDS is fatal and said it was acquired from prostitutes, nearly all agreed that young people could acquire AIDS, the majority admitted worrying about AIDS.[26]

There are two main types of Human Immunodeficiency Virus (HIV). HIV type –1 (HIV-1) is more common around the world. HIV type – 2 (HIV-2) is found predominantly in West Africa.[28] Dual infections with HIV-1 and HIV-2 is possible, although it has been suggested that HIV-2 infection may confer some protection against HIV-1 acquisition.[29] HIV has been isolated from blood, semen, saliva, vaginal secretion, tears, breast milk and urine. However, only blood, blood products, semen and vaginal secretion seem to be important sources of transmission.[28]

The mechanisms of HIV transmission are limited: sexual intercourse, exposure to contaminated blood products/body fluids, the use of contaminated needle for injection, vertical transmission from an infected mother to her child prior to or at delivery and breast feeding are the known routes of transmission.[30]

Estimates of the efficiency for each route vary from 0.1% per sexual contact to over 90% for blood-borne transmission via transfusion. However, wide regional variation occurs for reasons that remain unclear. For example, in Thailand, there is a much higher risk of 3-6% per heterosexual contact compared with the estimate of 0.1% in North America.[9]

The very efficient routes include.[31]

(a) *Blood transfusion*: It is at least 90% efficient

(b) *Needles shared by drug abusers.*

(c) *Penetrative sexual intercourse*: Heterosexual transmission accounts for an estimated 70%-80% of global transmission of HIV. The male is a more efficient transmitter than the female. The rectum is more vulnerable than the vagina. In both sexes, the presence of classical STDs has been shown to facilitate the acquisition and transmission of HIV infections. An increase of 4–10 fold risk of HIV transmission has been associated with ulcerative genital infections such as chancroids, syphilis and genital herpes, while a 2–4 fold increase had been associated with STDs characterised by vaginal and urethral discharge, such as gonorrhoea, chlamydial infection and trichomoniasis.[32] Traumatic bleeding classically caused by the first intercourse also promote the heterosexual transmission of HIV.

Genital ulcer disease is one reason why vaginal intercourse seems to be a more efficient route in sub-Saharan Africa.

(d) *From mother to child*: 90% of infection in children result from mother-to-children transmission. Reported rates of transmission from mother to child range from 15% to over 40% in the absence of anti-retroviral treatment and vary across countries.[29] Transmission could occur in-utero, during labour and postpartum through breast milk. The use of short regimen of zidovudine, which is started late in pregnancy and

continued until delivery or into postpartum period appears to decrease transmission risk by 40 to 50%.

Fairly efficient routes include:-

(a) Improper sterilized equipment, needles and canullae

(b) Sex of any kind with condom; it is important to know that condom reduces the risk of HIV transmission, but does not eliminate it. Therefore condom use only makes sex "safer" but certainly it is not a safe sex.

The inefficient routes include:

(a) Needle stick injuries to health workers, there is about 0.5% risk of HIV transmission per episode of needle stick injury.

(b) Breast-feeding when a mother was infected before or during pregnancy.

Dry kissing, ordinary family contact, contact at school and work, shaking hands, insect bites, droplet infection by coughing and sneezing carry no risk of HIV transmission.[28,30,31] Heterosexual sex, particularly with multiple sexual partners, homosexuality, intravenous drug use, transfusion of blood and blood products are therefore recognised risk factors in the transmission of HIV/AIDS.

Traditional practices and customs such as "dry sex" and vaginal douching with non-antiseptic solutions increase the risk of HIV infection by

causing excoriation and inflammation. Female Genital Mutilation (FGM) also constitutes a risk factor for HIV infection.[13]

John Stover and Mario Bravo in their study on the impact of AIDS on knowledge and attitude about condoms as a contraceptive method, in urban Mexico reported that AIDS information campaigns are likely to lead to an increase in knowledge of the condom, as a method of AIDS prevention and a method of family planning.[33]

Women may be monogamous, but are still at very high risk of HIV infection due to the sexual behaviour of the male partners. Despite their high risk of infection, cultural practices and pressures often prevent women from taking the necessary precautions to guard against infection, because the rules that govern sexual practices in most African cultures reflect an awareness of strict sex roles in which the women are only subservient to men and have fewer privileges and therefore are unable to negotiate condom use for prevention of sexually transmitted diseases.[30]

Studies in some West African and East African countries report that many unmarried people have shown some sexual behavioural changes in response to AIDS.[34]Behavioural changes reported include, beginning to use condom, restricting sex to one partner, delayed first sex, abstinence from sex, restricting to fewer partners, asking partners to be faithful, learning the histories of one's partner and avoiding sex with prostitute. Other non sexual behaviour mentioned was avoiding use of unsterilized instruments.

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In a study on the attitudes of Zambian students towards risky sexual behaviour, 92% of the respondents answered "NO" to the question, Is it safe to have sex with more than one partner? 74% disagreed with the statement that to be truly African one should have more than one sexual partner, while 74.4% of the respondents answered "NO" to the question, should peoples have sex before marriage?[35]

CHAPTER THREE

3.1 HISTORICAL BACKGROUND.

Sabon Gari Local Government area was created in August, 1991. Historically, as a town, it has existed since 1906 as a settlement area for the colonial masters and the non – indigene Nigerian workers who constructed the railway lines in the then Northern protectorate.

The town has undergone rapid growth over the years, it has an estimated population of about 200,000 people. The town shows an impressive mix of religious and ethnic groups typical of a fast growing urban community .It has a mixed population of Hausa/Fulani, Igbo, Yoruba, other Nigerian minority ethnic groups and foreigners from the neighbouring West African Countries. The Hausa – Fulani are mainly Moslems, while the rest of the other ethnic groups are mainly Christians.

The town has experienced rapid change in norms, values and gender roles compared with Zaria city. It attracts many young people from the surrounding rural areas with learning and earning opportunities. The major occupations of the people are trading, farming and civil service.

The socio – economic situation in the area is poor. Many families cannot afford to provide the needs of their children in schools. With the recent increment in school fees, indigent students will have to look for other sources of income.

Also, the socio – economic hardship in the country as a whole weakens the extended family's capacity to help financially. This socio-economic situation makes the female adolescents very vulnerable to sexual exploitation, especially the indigent ones, who are vulnerable to sugar daddies.[26]

Sugar daddy is an established phenomenon in our society. The term is used for older men who offer gifts of money and other materials to females in exchange for sexual favours. Many of these adolescent poor girls who have been deprived of the basic necessities of life at home look out for such men, who will buy them gift items and ultimately enter into a sexual relationship for material gains.[8,23,26]

Young girls often lack knowledge of "safer sex" practices. Sex educations are not taught in most schools and parents are reluctant to discuss sexual matters with their children. [8, 26] Therefore, in this era of HIV/AIDS and particularly in Kaduna State which is a hotspot with HIV prevalence of 11.5%, female adolescents who indulge in casual sex are risking HIV infection.

The choice of Sabon Gari Local Government area for this study is as a result of,

1. It's mixed population in terms of religion and ethnic groups,
2. The rapid change in norms, values and gender roles the area has experienced over the years.
3. The socio – economic situation predisposing young adolescents to sexual exploitation.

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1. It's mixed population in terms of religion and ethnic groups,
2. The rapid change in norms, values and gender roles the area has experienced over the years.
3. The socio – economic situation predisposing young adolescents to sexual exploitation.

4. The sexual permissiveness of the area, this is evidenced by the number of brothels that are scattered around the Local Government area.

3.2 MATERIALS AND METHOD

A cross sectional study of sexual behaviour among female adolescents attending senior secondary schools was carried out in Sabon Gari Local Government Area of Kaduna State. 384 students was the minimum sample size for the study calculated from the formula[36]

$$\text{Minimum Sample Size (n)} = \frac{Pq}{\left(\frac{E}{1.96}\right)^2}$$

Using 52% as the highest proportion for sexual exposure among female adolescents in Northern Nigeria.[22] The calculated minimum sample size allowed for 5% sampling error, giving a 95% confidence interval. However, 400 students were randomly selected for the study, making allowance for the non-response encountered during the study.

Permission to carry out the study was obtained from the zonal Director of Education for Sabon Gari LGA, who also gave me a letter of introduction to the principals of the selected schools.

The primary sampling units for the study consisted of the co-educational and female schools in the Sabon Gari LGA, totalling 24 in number, from which the following schools were randomly selected.

1. GGSS Dogon Bauchi
2. GGSS Chindit
3. GGSS Samaru
4. Comprehensive College Railway Quarters

The secondary sampling units consisted of the female adolescents in the Selected schools. Students selection was done by stratified random sampling with equal allocation to the different school grades. The list of unmarried female adolescents in each school grade constituted the sample frame for that grade (e.g. SS1). 100 students were randomly selected from each of the four schools.

The study was explained in detail to the principals of the selected schools, in each school a teacher designated as the study co-ordinator helped in selecting the students and also described the research to them. Questionnaires and Focus Group Discussions (FGDs) were used to collect data.

A Pre-tested questionnaire with 34 closed and open-ended items designed to elicit data in Demography, knowledge about AIDS/Sexuality, attitude about AIDS/Sexuality and sexual behaviour was administered during normal class periods by trained female research assistants.

In each school, the teacher, designated as study co-ordinator chose the student participants and made arrangements for the focus groups. The students who were selected to participate in the group discussions were those perceived

by the teacher as likely to provide the most information. 3-4 students from each school grade were selected to constitute the focus group with a total number of 9-12 students in each school.

The author served as a facilitator, while the trained female research assistants served as recorders in the focus group discussions. We were permitted by the participants to tape record the discussions, the recorder also took notes. The participants did not know the research team, this arrangement encouraged free discussions among the participants. The focus groups were conducted in English, the language used by the teachers and students in the schools.

The focus group discussions centered on AIDS, situations that can predispose young people to HIV infection, measures to prevent of HIV Infection and effective means of reaching youths with information on AIDS and sexuality.

Data from the questionnaires were processed and presented in the form of simple percentages, cross-tabulations, bar and pie charts for analysis. Chi-square test was used to establish significance, while coefficient of association was used to establish the strength of relationship between two variables. Tape recordings and notes from the FGDs were studied through content analysis.

LIMITATIONS

1. Only four schools were randomly selected for the study in Sabon Gari LGA because of time constraint.
2. The zonal Directorate for Education in Sabon Gari LGA did not sanction the inclusion of Junior Secondary School female adolescents in the study.
3. A few students found the research topic very sensitive and did not respond to some of the items in the questionnaire.

CHAPTER FOUR

4.0 RESULTS

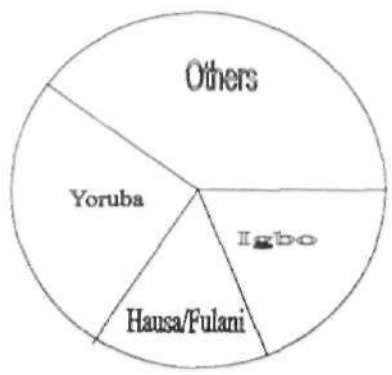
4.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

TABLE 1.1 DISTRIBUTION OF RESPONDENTS BY AGE AND CLASS

AGE	SS1	SS2	SS3	TOTAL
10-14	12	9	-	21
15-19	119	121	126	366
20-24	2	3	8	13
TOTAL	**133**	**133**	**134**	**400**

Table 1.1 shows the distribution of the respondents by age group. They were selected by stratified sampling with equal allocation to each school level. Majority of the respondents (91.5%) are in the 15-19 years age group

FIGURE 1.1 DISTRIBUTION OF RESPONDENTS BY ETHNIC GROUP



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A pie chart showing the distribution of the three major ethnic groups. 48 minority tribes were grouped together and represented as "others" in the above figure. The Yorubas were the largest single ethnic group (30%) in the sample.

TABLE 1.2 DISTRIBUTION OF RESPONDENTS BY RELIGION AND ETHNICITY

ETHNIC GROUP	CHRISTIANITY	ISLAM	TOTAL	%
HAUSA– FULANI	3	51	54	14
IGBO	59	-	59	15
YORUBA	67	53	120	30
OTHERS	117	43	160	41
TOTAL	**246**	**147**	**393**	**100**

Non-responses were observed; therefore, the total is less than 400. The sample reflects the mix of ethnic groups typical of an urban area. The Hausa-Fulani were predominantly Moslems, while the Igbos were all Christians. The Yorubas were mixed in religion.

4.2 KNOWLEDGE OF AIDS/SEXUALITY

TABLE 2.1 DISTRIBUTIONS OF RESPONDENTS BY AWARENESS OF AIDS

AWARENESS	NUMBER	%
AWARE	373	93.3
UNAWARE	27	6.7
TOTAL	**400**	**100**

The table shows the percentage of respondents who were aware of AIDS. Majority of the respondents (93.3%) had heard of AIDS. 6.7% of the respondents said they had not heard of AIDS. On the whole, the students were highly aware of AIDS.

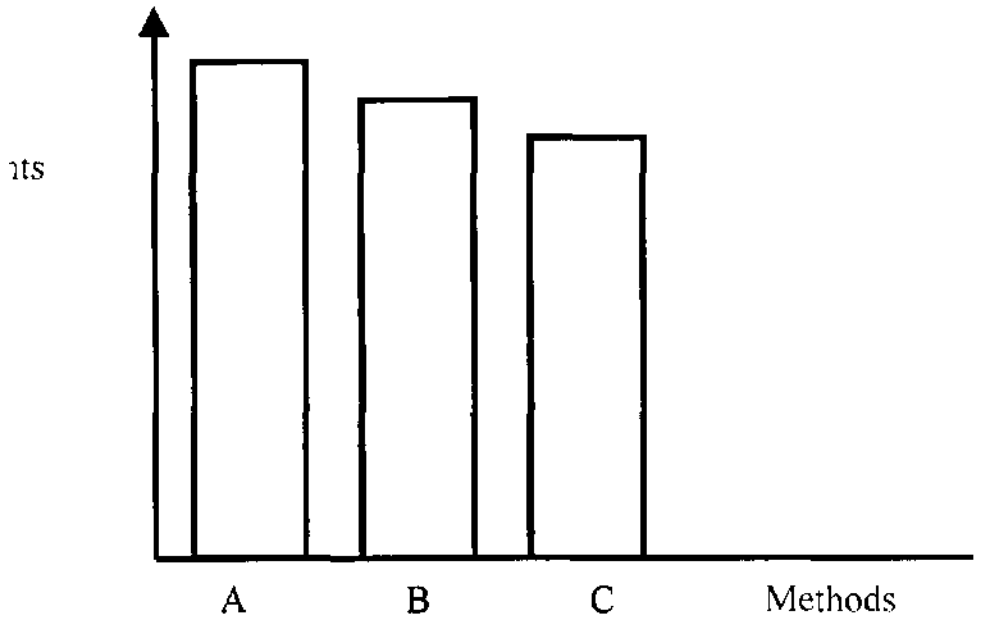
TABLE 2.2 DISTRIBUTION OF RESPONDENTS BY KNOWLEDGE OF THE CAUSATIVE AGENT OF AIDS AND CLASS

KNOWLEDGE	SS1	SS2	SS3	TOTAL
CORRECT	56 (68.8)	78(68.8)	73(69.3)	207
INCORRECT	25(13.6)	7(13.6)	9(13.7)	41
DON'T KNOW.	52(50.5)	48 (50.5)	52(50.9)	152
TOTAL	**133**	**133**	**134**	**400**

$x^2 = 18.36$, $df = 4$, $P = <0.01$

207 (51.75%) of the respondents had correct knowledge of the viral nature of the causative agent of AIDS. There were significant higher proportions of respondents in SS2 & SS3, who knew the viral nature of the causative agent of AIDS than those in SS1. 38% of the respondents said they didn't know what causes AIDS.

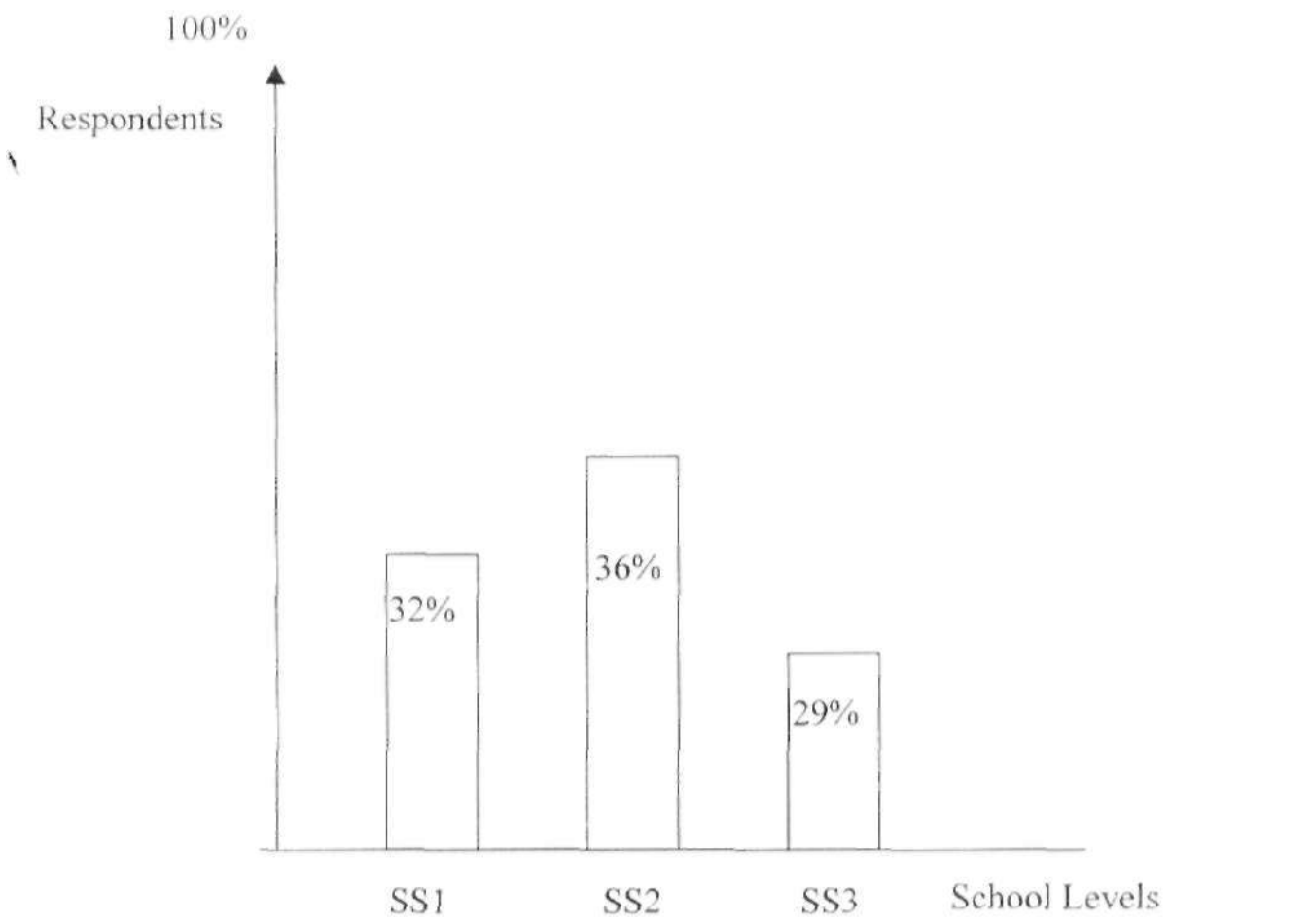
FIGURE 2.1 DISTRIBUTION OF RESPONDENTS BY KNOWLEDGE OF THE METHODS OF TRANSMISSION OF AIDS



KEY: A = Sexual Intercourse
B = Sharing of Needles
C = Mother to baby

The bar chart shows the percentage of respondents by knowledge of the methods of AIDS Transmission. A greater proportion (93%) knew the sexual method of AIDS transmission. 88% knew sharing needles could transmit AIDS, while 85% of respondents were knowledgeable about the vertical method of AIDS transmission.

FIGURE 2.2 DISTRIBUTION OF RESPONDENTS WHO SAID AIDS IS CURABLE BY LEVEL OF EDUCATION



The bar chart shows proportion of respondents in the 3 levels of Education who said AIDS has cure. There was no marked difference in the proportions of the respondents who said AIDS has cure by level of education. On the whole, 33% of the respondents said AIDS has cure, the majority 67% knew AIDS has no cure..

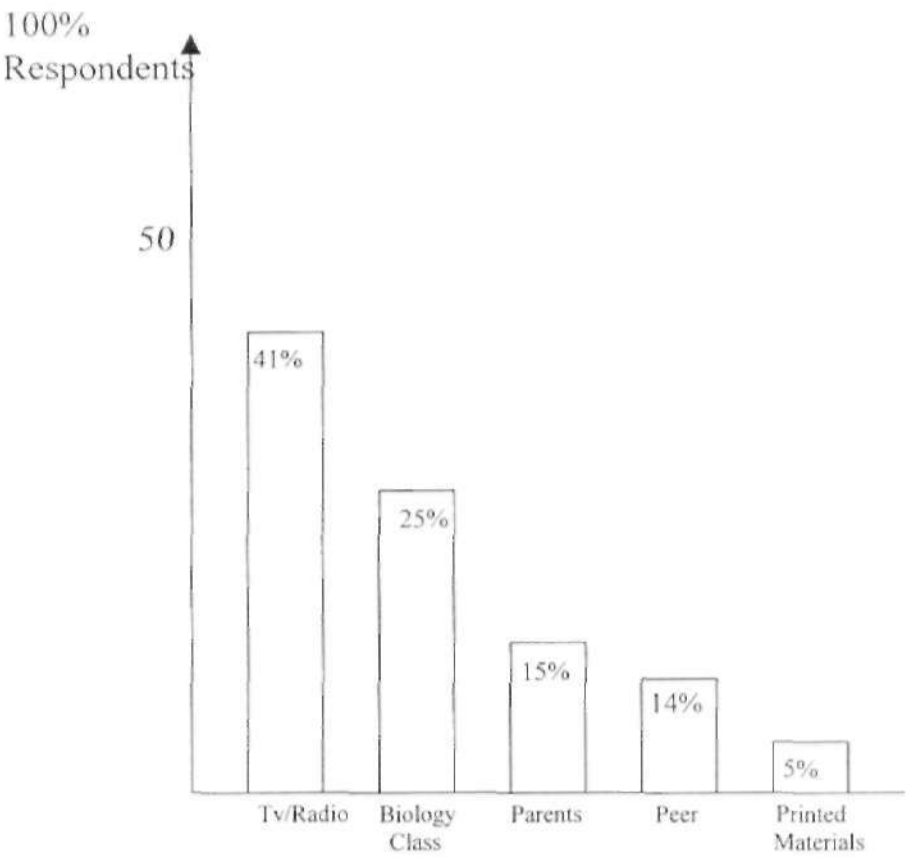
TABLE 2.3 **DISTRIBUTIONS OF RESPONDENTS BY KNOWLEDGE OF CONDOM'S PROTECTIVE EFFECT AGAINST AIDS AND LEVEL OF EDUCATION**

KNOWLEDGE	SS1	SS2	SS3	TOTAL
CORRECT	83 (77.7)	74 (76.5)	75 (77.7)	232
IN CORRECT	49 (54.3)	56 (53.5)	57(54.3)	162
TOTAL	**132**	**130**	**132**	**394**

$X^2=1.33$, $df=2$, $p=>0.05$

Non-responses were observed, therefore total are less than 400. The results were statistically tested to see if there was association between knowledge of the protective effect of condom and level of education. No significant association was found between knowledge of the protective effect of condom and respondent's level of secondary education.

FIGURE 2.3 DISTRIBUTION OF RESPONDENTS BY SOURCES OF INFORMATION ON AIDS/SEXUALITY



Bar chart showing distribution of respondents by source of information on AIDS/Sexuality. TV/Radio, Biology Class and Parents were the 3 major sources of information to students. Electronic media (41%) was the most important source of information.

4.3 ATTITUDES OF RESPONDENTS ABOUT AIDS/SEXUALITY

TABLE 3.1 DISTRIBUTION OF RESPONDENTS BY ATTITUDES ABOUT AIDS

S/NO	ATTITUDE	NO	%
1.	Feels AIDS is a serious health problem.	374	93.5
2.	Feels there is much to be done to prevent AIDS.	258	65
3.	Feels at risk of catching AIDS.	169	45
4.	Feels sorry for a baby with AIDS.	347	90
5.	Feels sorry for a prostitute with AIDS.	141	35
6.	Feels Safer not sitting close to AIDS victims.	221	59

Above table shows percentage of respondents with different attitudes about AIDS. Majority of the respondents (93.5%) appreciate the serious health problems posed by AIDS, 65% felt much can still be done to prevent it. 55% of the respondents did not feel being at risk of catching the disease. Their attitudes were mixed towards victims of AIDS, while 90% of the respondents would feel sorry for a baby with AIDS, 65% of them were negative to prostitutes with AIDS and 59% would feel safer not sitting close to AIDS victims.

TABLE 3.2 DISTRIBUTION OF RESPONDENTS BY THEIR ATTITUDES ABOUT SEXUALITY

S/NO	ATTITUDE	NO	%
1.	Feels it is good to have sexual intercourse before marriage	50	13
2.	Feels it is OK to have sex with anyone as long as there is no cheating on someone else	53	13
3.	Feels it is alright to have sex in exchange for gifts	31	8
4.	Feels condom can cause health problems to a girl	251	67

Non – responses were observed in some questions. Majority of the respondents (87%) did not approve of premarital sexual intercourse. 13% of respondents approve of multiple sexual relationships, while 8% felt it was alright to trade sex for financial/material gain. 67% of respondents felt negative about condom, they felt its use could cause health problems to girls.

1.4 SEXUAL BEHAVIOUR

TABLE 4.1 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY AGE

AGE	FREQUENCY	%
10-14	4	3
15-19	125	93
20-24	6	4
TOTAL	**135**	**100**

Above is a simple percentage table showing distribution of sexually exposed respondents by age. Majority of the sexually exposed respondents were in the 15-19 years age group. The mean age at first sexual intercourse was 13.4 years.

TABLE 4.2 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY RELIGION

RELIGION	EXPOSED	NOT-EXPOSED	TOTAL
CHRISTIANITY	80 (82.6)	166 (163.4)	246
ISLAM	52 (49.4)	95 (97.6)	147
TOTAL	132	261	393

X^2=0.33, d*f*=1, P=>0.05

Majority (62.5) of the respondents were Christians, while only 37.4% were Moslems. 20.4% of the Christian respondents were exposed sexually, while 13.2% of the Moslems were sexually exposed. Test statistics show no association between sexual exposure and religion.

TABLE 4.3 DISTRIBUTIONS OF SEXUALLY EXPOSED RESPONDENTS BY ETHNIC GROUP

ETHNIC GROUP	EXPOSED	NOT EXPOSED	TOTAL
HAUSA FULANI	15 (8.3)	39 (35.2)	54
YORUBA	42 (40.6)	78 (79.4)	120
IGBO	14 (19.96)	45 (39.0)	59
OTHERS	62 (54)	98 (105.8)	160
TOTAL	**133**	**260**	**393**

X^2 = 5.41, d*f* = 3, P =>0.05

The sample was heterogeneous in ethnicity. Statistical test using Chi square test was done to see if there was an association between sexual exposure and ethnicity. Results show no significant association between ethnicity and sexual exposure.

TABLE 4.4 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY TYPE OF FAMILY BACKGROUND

TYPE OF FAMILY	EXPOSED	NOT EXPOSED	TOTAL
POLYGAMOUS	45 (38.9)	77 (77.1)	116
MONOGAMOUS	89 (95.1)	195 (188.9)	284
TOTAL	**134**	**266**	**400**

$X^2 = 2.03$, $df = 1$, $p => 0.05$

38.7% of respondents from polygamous family background were sexually exposed, while only 31.3% of the respondents from monogamous background were sexually exposed. Statistical analysis using Chi square test shows no association between sexual exposure and polygamous family background.

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TABLE 4.5 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY PARENTS STATE OF MARRIAGE UNION.

STATE OF MARRIAGE	EXPOSED	NOT EXPOSED	TOTAL
TOGETHER	112 (112.05)	224 (224.95)	337
SEPARATED	18 (17.75)	36 (36.05)	54
TOTAL	**130**	**261**	**391**

$X^2 = 0.0002$, $df = 1$, $p => 0.05$

33.2% of the respondents from stable family background were sexually exposed as against 33.3% sexually exposed respondents from separated family background. There is almost no difference between the two proportions. Statistical test with Chi square test shows no association between sexual exposures and separated family background.

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TABLE 4.6 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY FAMILY SIZE

FAMILY SIZE	EXPOSED	NOT EXPOSED	TOTAL
SMALL (1-4CHILDREN)	20 (21.78)	45 (43.2)	65
LARGE (5-9 CHILDREN)	81 (80.7)	160 (160.2)	241
VERY LARGE (10+ CHILDREN)	28 (26.5)	51 (52.5)	79
TOTAL	**129**	**256**	**385**

$X^2 = 0.35$, df=2, p=>0.05

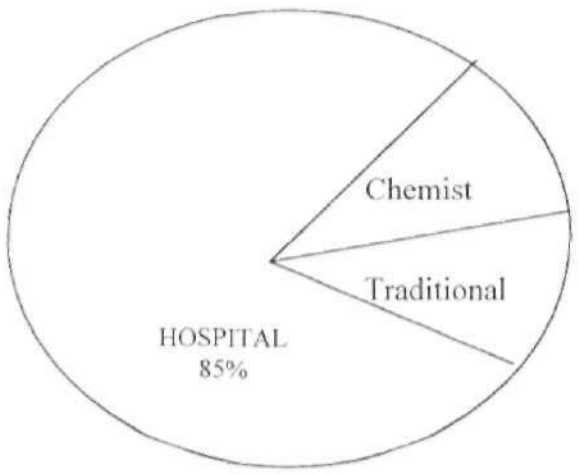
Above table shows distribution of sexually exposed respondents by family size. 30.7% of the respondents from small sized family background were sexually exposed, as against 33.6% and 35.4% respondents who were sexually exposed from large and very large sized family respectively. However, statistical analysis shows no association between sexual exposure and family size.

TABLE 4.7 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY FREQUENCY OF SEXUAL INTERCOURSE

FREQUENCY/MONTH	NO	%
1	30	22.7
2	8	6.1
3	3	2.3
4	30	22.7
5+	21	15.9
OCCASIONALLY	40	30.3
TOTAL	**132**	**100**

Above is a simple percentage table, showing the distribution of sexually exposed respondents by frequency of sexual intercourse per month. 69.7% of the sexually exposed respondents have sexual intercourse every month, while the rest (30.3%) have sexual intercourse occasionally.

FIGURE 4.1 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS B Y CHOICE OF PLACE FOR STD TREATMENT



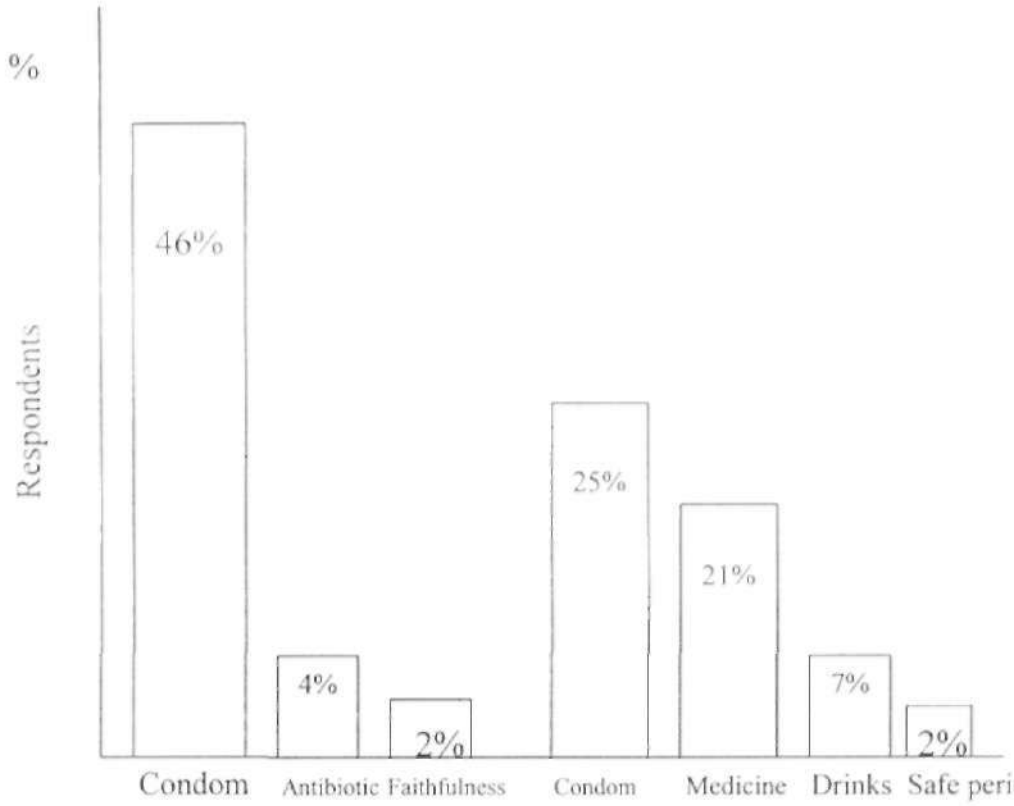
A pie chart showing the distribution of sexually exposed respondents by choice of place for treatment of sexually transmitted diseases. 85% of the respondents said they would treat STDs in a hospital. On the whole, majority of the respondents had a good health seeking behaviour.

TABLE 4.8 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY NUMBER OF SEXUAL PARTNERS.

NO OF PARTNERS	FREQUENCY	%
1	91	68.9
2	24	18.1
3	10	7.5
4	3	2.3
5	1	0.8
6	1	0.8
7	-	-
8	1	0.8
9	-	-
10	1	0.8
TOTAL	**132**	**100**

Above is a simple percentage table showing the distribution of sexually exposed respondents by number of sexual partners. 91(69%) of the sexually exposed respondents had only one sexual partner, while 41(31%) had had more than one sexual partner. The mean life partner was 1.6 for the sexually exposed respondents.

FIGURE 4.2 **DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY PRACTICE OF STD/PREGNANCY PREVENTION.**



Only 53% of the sexually exposed respondents had heard of contraceptives. Many unconventional practices were used for pregnancy prevention. Some of those who mentioned safe period had no clear understanding of how it is practised.

46% of the respondents mention condom for STD prevention as against 25% who mentioned condom for pregnancy prevention.

4.5 RELATIONSHIP BETWEEN KNOWLEDGE OF AIDS/SEXUALITY AND SEXUAL BEHAVIOUR

TABLE 5.1 DISTRIBUTION OF SEXUALLY EXPOSED RESPONDENTS BY KNOWLEDGE OF SEXUAL ROUTE OF HIV TRANSMISSION AND USE OF CONDOM

KNOWLEDGE	USES CONDOM	NEVER USE CONDOM	TOTAL
CORRECT	69(67.5)	48(49.5)	117
IN CORRECT	6(7.5)	7(5.5)	13
TOTAL	**75**	**55**	**130**

$X^2 = 0.78$, $df = 1$, $p = >0.05$

Above is a 2 x 2 contingency table showing distribution of sexually exposed respondents by knowledge of sexual route of HIV transmission and use of condom. 58.9% of respondents with correct knowledge of sexual route of HIV transmission used condom as against 46.2% of those with incorrect knowledge about sexual route of transmission.

There was no significant association between knowledge of sexual means of HIV transmission and use of condom by the respondents.

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TABLE 5.2 DISTRIBSUTION OF SEXUALLY EXPOSED RESPONDENTS BY KNOWLEDGE OF CONDOM'S PROTECTIVE EFFECT AGAINST AIDS AND USE OF CONDOM.

Knowledge	Uses Condom Regularly	Never/Irregular Use Condom	Total
CORRECT	30(24.4)	57(62.6)	87
IN CORRECT	7(12.6)	38(32.4)	45
TOTAL	**37**	**95**	**132**

$X^2 = 5.25$, $df = 1$, $p = <0.05$

Above is a 2 x 2 contingency table showing distribution of students by knowledge of condom's protective effect against AIDS and use of condom.

34.5% of the respondents who had correct knowledge used condom regularly as against 15.6% of those who lacked knowledge of the protective effect of condom against AIDS.

There was a significant positive association between knowledge of condom's protective effect against AIDS and regular use of condom.

4.6 FINDINGS OF THE FOCUS GROUP DISCUSSIONS ON AIDS

There was a general agreement that AIDS is real. Some participants claimed to have seen AIDS patients in the hospital, others said on the television. Majority of the participants said AIDS is incurable, a few said AIDS, especially HIV infection has cure, they cited Dr. Abalaka's and other's claims in the newspapers.

(a) SITUATIONS THAT PREDISPOSE YOUNG PEOPLE TO HIV/AIDS

Premarital sexual intercourse was identified as a major activity predisposing young girls to HIV infection. The participants agreed that sexual activity was common among their school mates. A participant remarked that some girls are never satisfied with sex, she called them "nymphomaniac", everyone laughed. She explained that such girls go from one man to another looking for sexual satisfaction, other participants agreed with her.

Some of the contributory factors to premarital sex identified are the following:

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- Lack of contentment,
- desire to be in vogue,
- inability of parents to provide for their children,
- poverty,
- broken homes with resultant neglect of children.

These factors were said to force female adolescents into establishing sexual relationships for financial and material gains.

Bad parental influence was also raised, a participant observe that some housewives not only indulge in extra-marital affairs but also encourage their daughters to go out with men.

Zobo drinks contaminated with HIV positive blood was discussed in all the four groups. A recent one was said to have occurred in Sabon-Gari, Zaria in which a woman infected with HIV deliberately contaminated Zobo drinks with her blood and sold it to the school children.

Other predisposing factors discussed included, Abortion, injections, haircuts and manicure, these factors expose young people to contaminated instruments.

(b) MEASURES TO PREVENT HIV INFECTION

(i) Many participants suggested abstinence from premarital sex, use of condom was recommended for those who wish to continue sexual relationship. There were, however, expressed dislike of condom by some of the student participants. A participant in the Dogon Bauchi group remarked that in their school "wise girls" don't use condom, everyone laughed, she went further to say that "wise girls" prefer the warm temperature feeling of unprotected sex and that only "foolish girls" use condom. Also a participant in another group said "condom may protect

can these kind of condoms protect?" Asked if girls would use condom if the have access to good quality ones, the response was mixed. Some said yes, while other said no.

Generally participants expressed beliefs among girls that condoms are for prostitutes and that use of condom in a relationship was a sign of mistrust. The skills of their male partners at wearing condoms were also discussed. A participant said even if good quality condoms are provided, improper use will still cause it to burst. Some participants claimed that burst condom in the vagina could cause health problems.

(ii) ISOLATION OF AIDS PATENTS

Participants generally suggested that government should isolate and treat AIDS patients. Two participants in Samaru School group suggested that doctors should "inject them to die", other participants disagreed with them, however, one of them insisted it was better for AIDS patients to be killed than be allowed to spread the infection. An account of a man who engaged in sexual intercourse with intention to spread the disease was cited. He was said to have approached a school girl for sex, the girl in turn negotiated sex for money, which the man agreed and that the man took her to Jim Harrison's Hotel along Kaduna Bye-pass. He was said

to have given the girl twenty five thousand Naira after the affairs and also told her that he was HIV positive. The girl was said to have cried uncontrollably which attracted other people's attention to the incidence. Other participants nodded knowingly to this account.

(iii) Alleviation of poverty, a participant said "Government should settle poor parents and meet their financial needs, so that they too can take care of their children.

(iv) Inquiry into the past history of would be sexual partner and also HIV screening test before establishing a marriage relationship.

(v) Use of sterile equipment

STUDENTS BEST MEANS OF RECEIVING INFORMATION ON AIDS AND SEXUAL MATTERS

Generally the participants preferred Television/Radio and Talks by medical doctors.

CHAPTER FIVE

5.1 DISCUSSIONS

Majority of the respondents (91.5%) were in the age group 15-19 years (see Table 1.1). For a female, this is the most vulnerable period to HIV infection, as most of the infections in this age group occur to the females.[13] The study group was heterogeneous in ethnicity, it consisted of the three major Nigerian ethnic groups namely the Hausa-Fulani (14%), the Yorubas (30%) and the Igbos (15%). There were 48 minority tribes grouped together as "others" (see fig.1.1 and Table 1.2). The sample was also mixed in terms of religious faith, 62.6% were Christians while 37.4% were Moslems. The heterogeneous nature of the sample is expected in studies done in urban areas and agrees with the findings of other workers within and outside the country, Gorgen et al in his study in Guinea and Kane et al in Gambia reported similar findings.[18,20]

93.3% of the respondents were aware of AIDS (see table 2.1). Also there was more than average knowledge of the different methods of transmission of the disease, 93% of the respondents were knowledgeable about the sexual route of transmission, 88% knew about the method of blood inoculation through sharing of needles and 85% knew about the vertical means of transmission from mother to baby (see fig 2.1). The high level of awareness recorded in my study is consistent with results of studies done in other parts of

the country and Kenya; where over 80% of the respondents were reported to be aware of AIDS.[22]

Unuigbe and Osafu, who conducted their study in Benin City reported that 94% of their study population were aware of AIDS and that 64% of them knew about the sexual means of transmission.[2] Umoh and Okesina working among adolescents from rural communities in Kwara State also reported high awareness, 72% of their respondents knew how AIDS can be transmitted, while 65% of them correctly explained the symptoms of AIDS.[27]

52% of the respondents in my study knew the viral nature of the causative agent of AIDS, while 33% of them said AIDS is curable (see table 2.2 and figure 2.2). During Focus Group Discussions (FGDs), those who said AIDS is curable cited Dr. Abalaka's claims and other traditional healers, who claimed to have cured AIDS(see results 4.6). This underscores the important role the mass media play in informing and educating the public, mass media have potentials to correctly or incorrectly inform the public, therefore, there is need for censorship on what is made pubic to people as regards HIV/AIDS.

However, many participants were not agreeable to such claims. FGD also revealed some misconception about the spread of AIDS through coughing and sneezing by AIDS patients.

Table 2.2 shows distribution of respondents by knowledge of the causative agent of AIDS and class; the respondents in the higher classes (SS2 & SS3) demonstrated a significant higher level of knowledge than those in

SSI. This higher level of knowledge may have resulted from more exposure to AIDS talk in school or due to knowledge gained in biology class about classification of micro-organisms over the school years.

The proportion of respondents who knew the viral nature of the causative agent of AIDS in my study was much higher than findings from previous studies. The explanation for this may be as a result of increased enlightenment campaign embarked upon by the government and other organisations in recent times. In the study conducted in Benin only 8.7% of the respondents knew that AIDS is caused by a virus, while in Ilorin study only 39% of the respondents had correct knowledge that AIDS is caused by a virus.[2,27]

On the other hand, only a few respondents (7.1%) in Benin study said AIDS is curable as against 33% in the author's study who said AIDS is curable (see Fig 2.2)

59% of the respondents knew that condoms could prevent AIDS (see Table 2.3). This finding shows increased public knowledge about AIDS among students in Sabon Gari LGA. In the Benin study only 40 % knew that condom can prevent the spread of AIDS, while only 32% in the Kwara State study mentioned sound health education with emphasis on safer sex as preventive measure.[2, 27]

The major sources of information on AIDS and sexuality were the electronic media (TV/RADIO) and Biology class (see figure 2.3). Amazigo u.

et al obtained a similar result in the Eastern Nigeria.[18] In contrast, the major source of information in the Benin studies were school mates (22.4%), friends (19.9%) followed by school teachers (16.9%). The news media (5.9%) was the least mentioned source of information.

During the FGDs participants preferred to be reached with AIDS/sexuality information through the electronic media and health talks by medical doctors, participants seized the opportunity provided by the FGD to ask the author many questions about HIV/AIDS that had bothered their minds.

93.5% of the respondents felt that AIDS is a very serious health problems, 65% of them felt that much can still be done to prevent the disease (see Table 3.1), this attitude was very positive. However, while the respondents (90%) would feel sorry for a baby with AIDS, they were very negative about adults with AIDS. 65% would not feel sorry for a prostitute with AIDS, while 59% would feel safer not sitting close to AIDS victims.

During FGD a few participants suggested isolation of AIDS victims, 2 participants in one of the groups expressed a very negative feeling, they would like AIDS patients to be "injected to die" using their words.

They suggested this measure to stop HIV infected people from intentionally spreading the disease. An instance of a woman in Sabon Gari was cited, who contaminated Zobo drinks with her infected blood and sold it to the public, also another instance was cited of how a man approached a student for sex, the girl in turned negotiated sex for money, which the man agreed and

took her to Jim Harrison's Hotel, after the sexual relationship, he gave the girl Twenty five thousand Naira (₦25,000.00) and announced to her his HIV positive status. The girl was said to have wept uncontrollably, which attracted other people's attention. These two instances of people spreading AIDS intentionally seem to be common knowledge to the other participants who nodded knowingly during the discussions and was mentioned in other groups.

Temin et al using FGDs to study the perception of sexual behaviour and knowledge about sexually transmitted diseases among adolescents in Benin city have also reported similar findings, that people intentionally spread STDs especially HIV infection, many of the students in their study thought that getting an STD was inevitable, a perception that can discourage them from taking preventive measures.[23] This attitude also contrasts the positive feeling expressed by the respondents in my study, that much can still be done to prevent the spread of AIDS.

Other workers have also reported negative attitudes towards HIV infected persons. Umoh and Okesina in their study in Kwara State reported that 11.6% of their respondents suggested castrating sexually active HIV positive individuals, while 10.7% suggested quaranting AIDS patients in a special hospital in other to control the spread of the disease.[27]

Attitudes towards sexuality were very positive (see Table 3.2), only few respondents (13%) felt it was good to have sex before marriage, the rest (87%) of the respondents disapproved of premarital sex and multiple sexual partners.

Also only a few respondents (8%) felt it was alright for a girl to exchange sexual favours for financial gains, 92% of the respondents disapproved of it. Nichols et al in their study in Ibadan also reported few respondents (18.7%) approving of premarital sex.[21] My finding also agrees with the results of the study conducted in Zambia to assess the impact of AIDS on students, majority of the students (92%) said it was not safe to have sex with more than one partner, while 74% answered "NO" to the question should people have sex before marriage?. [35]

FGD revealed healthy attitudes towards sexuality such as wanting to know the past histories of would-be sexual partner and going for HIV screening test before establishing a marriage relationship.

67% of the respondents felt that condom could cause health problems to a girl (see table 3.2). FGDs revealed negative attitudes towards condoms, one of the participants stated "condom may protect against AIDS, but according to my research, our people sell fake and expired condoms in the market, that easily burst in the vagina, how can these kind of condoms protect?" Asked if girls would use condoms, if the government ensures the supply of good quality ones, a girl expressed worry about the skills of male partners wearing the condom, she said even with good quality condoms, improper use will still cause it to burst and that no girl likes it to burst inside her.

Condom use was also associated with prostitution and mistrust between sexual partners. There was also the observation that condom decreases sexual

pleasures. A participant explained that the warm temperature feeling that is felt during sexual intercourse is reduced by wearing a condom. In one of the groups, girls were said to be classified into 2 groups based on the use of condom, "wise" girls were said to be the ones that don't use condoms, while the "foolish" ones use condoms, the "wise girls" prefer the warm sensation feeling of unprotected sex.

The findings of negative attitudes towards the use of condoms agree with the findings of Temin et al in Benin.[23] There is therefore an urgent need for these attitudes to be addressed with a view to changing them through condom promotion.

33% of the respondents were sexually exposed, 93% of the sexually exposed respondents were in the age group 15 – 19 years old (see table 4.1).

The mean age at first sexual intercourse was 13.4 years. The proportion of sexually exposed respondents found in my study was low compared with the results of other studies done in some parts of the country. Nicholas et al in 1986 reported 38.4% of sexual exposure among their study population in Ibadan.[16]

Amazigo el al reported 40% sexual exposure in their Anambra and Enugu States study.[18] Araoye reported 52% among the undergraduates in Ilorin aged 15 – 24 years. [22] Unuigbe and Osafu reported 77% sexual exposure among the female adolescents in their Benin City study in 1999. [2]

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Between 20 – 46% of unmarried teenagers aged 15–19 years in Ghana, Kenya, Guinea, Gambia, Liberia and Togo reported being sexually active. [1,20,21,24] The reason for the low prevalence of sexual exposure recorded in my study compared with results of other studies done in Nigeria may be due to the restrictive social norms obtainable here in the north as against the permissive societal norms found in the South.

The mean age at first sexual intercourse was 13.4 years, compared with results of studies within and outside the country, this mean age is early. Brian–D Adinma et al reported 18 ± 1.2 years for adolescents 10–19 years in Anambra and Enugu States.[19] In the Guinea study 15.4 year was reported as mean age at first sexual intercourse for the age group 15–19 years. 16 years was reported for females in Kinshasa, Zaire, while 14 years was reported among school children 11-16 years in Cameroon.[2] Unprotected sexual intercourse is reported to be common with early sexual debut.[16]

There was no significant association between sexual exposure, religion and ethnicity (see table 4.2 and 4.3). Amazigo et al also reported no association between sexual exposure and religion.[18]

Respondents from polygamous family background, large family size and separated homes were not significantly exposed sexually (see Tables 4.4, 4.5 & 4.6), however, during FGDs participants identified inability of parents to provide for their children, marital separation leaving the children uncared for, as contributory factors to the sexual exposure of some of the girls.

Table 4.7 shows the distribution of sexually exposed respondents by frequency of sexual intercourse, 30.3% of the respondents have sexual intercourse occasionally, while the rest (69.7%) have sexual intercourse every month. The majority (68.9%) of the sexually exposed respondents had only one sexual partner; the rest (31.7%) had multiple sexual partners (see Table 4.8). In the Benin study, 90.9% of the sexually exposed respondents had sex occasionally; only 9.1% of them had sexual intercourse monthly. 35% of the respondents reported multiple sexual partners. [2]

In comparison, the sexually exposed female adolescents in my study were more sexually active than their colleagues in the Benin study judging from the frequency of sexual intercourse, there is no marked difference in the proportions of multiple sexual relationships in these two studies.

The mean lifetime partner was 1.6, this finding agrees with the results of the Guinea study for female adolescents 15–19 years age group. [24]

Figure 4.2 shows the distribution of sexually exposed respondents by practice of STD/Pregnancy prevention. 46% of the respondents mentioned condom for STD prevention as against 25% who mentioned condom for pregnancy prevention.

This result is not consistent with the finding of Stigum H. et al that condom is used primarily as contraceptive by girls.[25] However, my finding agrees with the prediction of Stover and Bravo who reported from their study in Mexico, that AIDS prevention campaigns are likely to lead to increase in

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knowledge of the condom as a method of AIDS prevention.[34] Many unconventional preparations were mentioned for pregnancy prevention, such as drinking Andrew Liver Salts and Mixtures of Potash and Lime, some respondents mentioned drinking soft drinks such as Krests, Tonic Fanta and Bitter Lemon "to wash out pregnancy". Those who mentioned safe period had no clear understanding of how safe period is practiced. Pills, Menstrogen, Postinor, overdose of Vitamin C and Vitamin K were also mentioned for pregnancy prevention. Antibiotics such as Ampiclox and Flagyl were mentioned for STD prevention. The finding of unconventional preparations and drinks used for pregnancy preparation is consistent with the results of previous studies conducted in Benin, Enugu and Anambra States. [18,23]

57.6% of the sexually exposed respondents had used condom, of this, however, only 28% used condom regularly (see table 5.1 & 5.2). This finding does not differ much from results of other studies, Unuigbe and Osafu in Benin reported that 26.9% of their sexually exposed students used condom regularly.[2] In Ilorin, Araoye reported that only 31% of the sexually active females used condom regularly. [22] In The Gambian study 37% of the 14–24 years age group had ever used condom. [20]

Table 5.1 shows the distribution of sexually exposed respondents by knowledge of sexual route of HIV transmission and use of condom, the Coefficient of Associations (Q) is 0.25, however, statistical test with chi-square test shows no significant association.

Table 5.2 shows the distribution of sexually exposed respondents by knowledge of condom's protective effect against AIDS and use of condom. The Coefficient of Association (Q) for these variables was 0.48, statistical test using chi square test shows a significant positive association.

The relevance of this finding is that, if many youths are made to know that condom really offers protection against sexually acquired HIV infection, they are more likely to use condom regularly.

5.2 CONCLUSION

This study reveals an adolescent female population that is vulnerable and at risk of HIV infection as a result of their sexual behaviour. It also reveals that the knowledge of condom's protection against sexual transmission of HIV/AIDS is significantly associated with regular use of condom.

Public health measures are therefore urgently needed to educate and positively change the attitudes of female adolescents towards condom.

5.3 RECOMMENDATION

1. There is need to educate in-school female adolescents in Sabon Gari Local Government Area, Kaduna State about ways that are not associated with the spread of AIDS. This is to disabuse their minds of the misconceptions they already have about such ways.

2. There is an urgent need for sex education to be taught in Senior Secondary Schools, preferably JSS3 should be included. The curriculum should include contraceptives, this will make the in-school female adolescents in Sabon Gari LGA knowledgeable about the conventional ways of STD and pregnancy prevention.
3. The image of condom needs to be promoted through Health Talks, its protective effect against STD especially AIDS should be emphasized. The unrealistic fears of in-school female adolescents in Sabon Gari LGA should be addressed during such condom promotions.
4. The electronic media (TV/Radio) and health talks by Medical Doctors should be used to reach in-school female adolescents in Sabon Gari LGA, Kaduna State, with information on AID/sexuality.
5. A comprehensive approach is needed for the control of AIDS in Sabon Gari LGA, Kaduna State; Socio-economic factors that predispose people to HIV infection such as poverty should be eliminated. It is hoped that the Poverty Alleviation Programme of the present government will assist in this regards. Also sound moral teachings are needed both at schools and homes. Teachers and parents also have a role to play by leading exemplary lives. Religious leaders have a duty to teach and help these in- school female adolescents to obey God's commandments.

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QUSTIONNAIRE ON SEXUAL BEHAVIOURS IN THE ERA OF HIV/AIDS AMONG IN-SCHOOL FEMALE ADOLESCENTS IN SABON-GARI L.G.A. ZARIA

INSTRUCTIONS:

i. Do not write your name on the questionnaire.
ii. If boxes are provided, mark X in the appropriate box.
iii. Please read carefully and answer all questions.

I DEMOGRAPHIC CHARACTERISTICS

1. What class are you? SS1 ☐ SS2 ☐ SS3 ☐
2. How old are you? _____
3. What is your tribe? _____
4. What religion do you belong to? Christianity ☐ Islam ☐
5. Are your parents staying together? Yes ☐ No ☐
6. How many children does your father have? .....
7. Does your father have more than one wife? Yes ☐ No ☐

II KNOWLEDGE ABOUT AIDS AND SEXUALITY

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1. Have you heard of AIDS? Yes ☐ No ☐
2. What type of germ causes AIDS? Virus ☐ Bacteria ☐ I don't know ☐
3. Can AIDS spread through sexual intercourse? Yes ☐ No ☐
4. Can one catch AIDS through sharing needles for injection? Yes ☐ No ☐
5. Can the germ that causes AIDS pass from the mother to her baby? Yes ☐ No ☐
6. Is there a cure for AIDS? Yes ☐ No ☐
7. Have you ever heard of contraceptives (Methods of pregnancy prevention)? Yes ☐ No ☐
8. Can the use of condom prevent people who have sexual intercourse from catching AIDS? Yes ☐ No ☐
9. What is your major source of information on AIDS and sexual matter?

   Biology Class ☐ Friends ☐ Parents ☐ TV/Radio ☐

   Printed material (Leaflet and posters) ☐