

Sexual Behaviour And Contraceptive Use Among Female Students In A Rural Community In South South Nigeria.

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ABSTRACT

Each year an estimated 333 million new cases of curable sexually transmitted infections (STIs) occur worldwide with the highest rates among young people. Risk behavior and subsequent STIs, unwanted pregnancies and subsequent criminal abortions are fuelling the already excessive maternal mortality and morbidity rates in developing countries. Yet only a minority of young people have access to any acceptable and affordable adolescent health services. A total of 300 pre-tested semi structured questionnaires were administered to female JSS2 to SSS2 students selected by multistage sampling in August 2014. It contained questions on the socio demographic characteristics of respondents and their knowledge of sexually transmitted infections (STIs) and contraceptives and their patterns of sexual activity and contraceptive use. Majority (80.2%) of respondents had heard about contraception, their commonest source of information being radio (57.4%) and television (43.4%). The commonest contraceptive known was the condom (88.1%) and the contraceptive prevalence rate was 24.67%. Most respondents were sexually exposed (42.6%) with 84.3% of these previous 6 months. Mean age at first sexual debut was 12.0 ± 2.8 years. The prevalence of condom use at first and most recent sexual encounters were 31.3% and 57.8% respectively ($p < 0.005$). The commonest reasons for not using contraceptives in both first and most recent encounters were ignorance (67.5%) and the partners dislike for it (17.5%). The inclusion of sex education into the school health programme for secondary school students as well as provision of guidance and counselling services by trained and retrained personnel and motivation of home based information and guidance for adolescents is recommended.

INTRODUCTION

Adolescence is a period between the ages 10-19 years which is characterized by progression from appearance of sexual characteristics to sexual and reproductive maturity. They constitute about 20 percent of the world population with about 85 percent in developing countries.

Human sexual behavior is the manner in which human experience and express their sexuality¹ it refers to the way someone is sexually attracted to another person which is determined by sexual orientation. Interest in sexual activity typically increases when an individual reaches puberty, the process of physical change from the body of a child into that of an adult. Adolescents are usually adventurous in all spheres of human endeavors including sexual practices and when sexual behaviours are identified as harmful, it is essential to think about why the child or young person is exhibiting the behaviour¹.

Risk behaviour among them commonly results in sexually transmitted infections (including human immunodeficiency virus(HIV) and acquired immunodeficiency syndrome(AIDS), unwanted pregnancies and unsafe abortions. Studies within Africa including Nigeria has demonstrated an increasing rate of premarital sex and decline in age of sexual debut among adolescents contrary to our moral and cultural values. Some of the reasons for this trend include high poverty level, adoption of western norms/values, lack of parental control, mass media, urbanization and tourism. Adolescent health was identified as a major public health problem especially among developing countries.

Nigeria has reported a high rate of parental aversion to discussing sexuality issues with their children. This has resulted in Nigeria adolescents being vulnerable to all forms of sexually acquired health problems with their attendant complications.²

Each year an estimated 333 million new cases of curable sexually transmitted infections (STIs) occur worldwide with the highest rates among 20-24 year olds, followed by 15-19 year olds. One in 20 young persons is believed to contract an STI each year excluding HIV and other viral infections and yet only a minority of adolescents have access to any acceptable and affordable STI services.³

The current prevalence rate of contraceptive use in Nigeria is approximately 11% - 13%.⁴ The rate is very low in spite of the high rate of sexual activity and wide spread awareness of the various contraceptive methods among Nigerian adolescents and youths⁴. While there is variation in estimates of contraceptive prevalence, statistics generally suggest that the overall use of contraception is extremely low; one 2005 study found contraceptive prevalence to be 14.8 percent overall and 13 percent among married women aged 15-49.⁵

Low rates of contraceptive use have resulted in high rates of unintended pregnancy and according to a 2004 study, the percentage of unintended births among Nigerian women is on the rise⁶ and contributes to a maternal mortality ratio (MMR) that is among the highest in the world, estimated at 545 maternal deaths for every 100,000 live births.⁷

The aim of the study was to determine the pattern of sexual behavior among secondary school students, assess their level of awareness of STIs and contraception as well as the contraceptive prevalence rate among them.

MATERIALS AND METHODS

This study was a descriptive cross sectional study carried out in August 2014 among female students from JSS2 to SSS2 in Elele, Ikwerre Local Government Area, Rivers State in South South Nigeria. Sample size was determined using the formular $n = z^2 pq/d^2 = 162$ where n, z, p and d represented the standard normal deviate at 95 confidence intervals (1.96), contraceptive prevalence (12%) from a previous study and minimum degree of error (5%) respectively. Multistage sampling was done. Stage 1 involved stratification into private and public schools. In stage 2, 2 private and 2 public schools were selected by balloting. Using proportionate sampling at a ratio of

57%:43% based on population size, 181 and 139 students were selected from public and private schools respectively. Data collection was carried out using semi structured questionnaires comprising 3 sections; personal data of respondents, their patterns of sexual behavior and contraceptive use and their knowledge of STIs. Data was cleaned and analysed with SPSS software version 17. Chi-square test of association between variables was used with p-value set at 0.05 level of significance. Ethical approval was gotten from the Department of Community Medicine, Madonna university Elele, Rivers state as well as from the principal of each school. Informed verbal consent was obtained from students before questionnaires were administered to them.

RESULTS

Three hundred and twenty questionnaires were administered in this survey. Only three hundred were correctly filled giving a response rate of 93.8%. Table 1 shows the sociodemographic features of the study population. The mean and modal age of respondents were 14.2 and 14.4 respectively, with the age group of 14-16 years (51.0%) having the highest frequency and age group greater than 20 years (4.0%) having the least frequency. Their classes were evenly distributed with most of them being Catholics (40.7%) and Pentecostals (37.0%). Majority of them were of Ikwere (52.3%) and Igbo tribes (41.7%) and from monogamous families (51.3%). Most of their parents were traders (38.3%), farmers (23.0%) and civil servants (20.3%).

Majority (80.2%) of respondents had heard about contraception. Their commonest source of information was radio (57.4%) followed by television (43.4%) and news papers (12.3%) while the least source of information was from friends/ relatives (4.7%). The commonest contraceptive known was the condom (88.1%). Others were injectables (26.8%), pills (23.0%) and natural methods (38.7%). Interestingly, none of the respondents knew about surgical methods, spermicides, creams or diaphragm.

Majority of respondents (93.6%) knew

about sexually transmitted infections and the most commonly mentioned were HIV/AIDS (95.4%) and gonorrhoea (19.7%) while the least mentioned was Chlamydia infection (1.9%). None of them mentioned Herpes, Chancroid, Trichomonas vaginalis and Bacterial vaginosis.

A sizeable proportion 128(42.6%) have had sex before. Out of this number, 84.3% have been sexually active in the previous 6 months. Mean age at first sexual debut was 12.0 ± 2.8 years of age with majority of them having their first sex within the ages of 14-16 years (31.5%) and 11-13 years (28.3%). The major reasons for having sex were to please partners (27.6%), curiosity(23.6%) and rape (13.7%). None of them had sex because of financial reasons. The major form of sexual activity was penile/vaginal intercourse (84.3%). Fifty five

(43.3%) of sexually active respondents in this survey had 2 or more sexual partners.

Contraceptive prevalence rate among the total population was (24.67%) and among sexually active respondents was (69.2%). The prevalence of condom use at first and most recent sexual encounters were (31.3% and 57.8%) respectively. The commonest reasons for not using contraceptives in both first and most recent encounters were ignorance (67.5% and 27.0% respectively) and the partners dislike for it (17.5% and 27.0% respectively). As much as (43.8%) of respondents have had STIs in the past. The commonest known methods of preventing sexually transmitted infections were by use of condoms(46.6%) and drugs (31.3%) while the major benefits of contraception as perceived by respondents were to prevent pregnancy (66.0%) and infections (19.1%).

Table 1: Socio demographic characteristics of respondents.

Variable	freq	%
Age group(years)		
8 – 10	16	5.3
11 – 13	79	25.5
14-16	153	51.0
18 – 20	40	13.3
=20	12	4.0
Mean(SD)=14.2(2.7); Mode=14.4		
Educational level		
JSS 2	95	31.7
SS 1	103	34.3
SS 2	102	34.0
Religion		
Catholic	122	40.7
Pentecostal	111	37.0
Orthodox	46	15.3
Muslim	6	2.0
Others eg. Eckankar, Traditional Religion	15	5.0
Tribe		
Ikwerre	157	52.3
Ibo	125	41.7
Others eg. Hausa, Isoko, Yoruba	18	6.0
Family type		
Monogamous	196	65.3
Polygamous	104	34.7
Parent's occupation		
Trading	121	40.3
Farmer	74	24.7
Civil servant	66	22.0
Artisan	39	13.0
SD = Standard deviation		

Table 2: Knowledge of contraceptives and STIs, sources of information about contraception

Variable	Frequency	(%)	
Prior Knowledge of contraception n=300	Yes	241	80.2
	No	59	19.8
Source of information about contraception n=235*			
	Radio	134	57.4
	TV	102	43.4
	Posters	12	5.1
	Health personnel	12	5.1
	Parents/relations	11	4.7
	Newspapers	29	12.3
Types of contraception known* n=235			
	Condom	207	88.1
	Injection	63	26.8
	Pills	54	23.0
	Natural method	91	38.7
	Implants	19	8.0
	IUCD	17	7.2
	Others eg spermicides	0	0.0
Ever heard about STIs n=300			
	Yes	281	93.6
	No	19	6.4
Type of STIs known* n=281			
	HIV/AIDS	268	95.4
	Gonorrhoea	55	19.7
	Syphilis	41	14.5
	Hepatitis B virus	17	6.1
	Chlamydia	5	1.9
	Others eg Herpes	0	0.0

*Multiple response applicable

Table 3: Sexual behaviour and practice among respondents

Variable		Frequency	(%)
Had sex before?(n=300)	Yes	128	42.6
	No	172	57.4
Current sexual activity; had sex in past 6 months?(n=128)	Yes	108	84.4
	No	20	15.6
Age(yrs) at first sexual exposure	5-7	9	7.0
	8-10	24	18.9
	11 -13	40	31.5
	14-16	44	34.6
	>17	10	7.9
Mean(SD): 12.0(2.8), Median: 12.6			
Reason for having sex	To please partner	36	27.6
	curiosity	30	23.6
	Just wanted to	18	14.2
	Rape	17	13.7
	Was in Love	9	7.1
	Peer pressure	9	7.1
	Pleasure	7	5.5
	Incest	2	1.6
Type of sexual activity	Penile/vaginal	107	84.3
	Oral	17	13.4
	Fingering/fondling of genitalia	3	2.6
Number of sexual partners	1	72	56.7
	2 or more	55	43.3

Table 4: Pattern of contraceptive use.

Variable		Frequency	(%)
Currently using any contraceptive?n=108	Yes	74	69.2
	No	33	30.8
Condom use at first sexual debut? n=128	Yes	40	31.3
	No	80	62.6
	Can't remember	8	6.3
Condom use in last sexual experience ? n=128	Yes	74	57.8
	No	52	40.6
	Can't remember	1	0.7
Reason for not using condom at sexual debut n=80	Partner doesn't like it	21	26.3
	Ignorance	54	67.5
	Decreases pleasure	5	6.3
Reason for not using condom at last encounter n=52	Partner doesn't like it	19	
	Ignorance	19	
	Decreases pleasure	8	
	I don't care	6	
Previous history of STI? n= 300	Yes	131	43.8
	No	169	56.2
Methods of STI prevention[*]n=262	Abstinence	51	19.5
	Condom	122	46.6
	Drugs	82	31.3
	Others eg. Prayers	7	2.7
Benefits of contraception n=235	Prevents pregnancy	155	66.0
	Prevents infection	45	19.1
	Saves money	21	9.0
	Enables family spacing	12	5.1
	Saves lives	2	0.9

DISCUSSION

The socio demographic characteristics of respondents in this study are similar to those of previous studies conducted in Nigeria¹. Majority of the respondents were Christians(93%) and this is because the South-South region of Nigeria is dominated by Christians. Few others were muslims about 2% which is similar to a study done in Anambra State, Nigeria¹. The study showed that majority(78.3%)of the respondents have heard about contraception. Of this number, the commonest sources of information were from Radio(57.4%) and Television(43.4%) implying that the mass media is the major source of information for this demographic group who may not visit health facilities often. It is also important to note that none of the respondents who were all students got their information within the school system. This is probably due to the fact that sexuality education is not taught in an overwhelming majority of Nigerian schools despite recommendations in the past.⁸

This trend differs from findings in Anambra State, South East Nigeria, which had the greatest sources of information from friends and peer groups(47.2%) and television(30.0%) and parents(10.4%). This may be due to the rural/urban as well as cultural differences in the locations of these studies.

The most commonly known contraceptive methods were condoms(88.1%) and Injectables (26.8%) while the least known methods were Implants(8.0%) and IUCDs (7.2%).No respondent knew about surgical methods like tubal ligation, vasectomy, spermicidal creams or diaphragm. The main reasons mentioned for contraceptive use were to prevent pregnancy(66.0%)and to prevent sexually transmitted infections(19.1%). These are similar to findings in a study by Orji E done in among school girls in South south Nigeria⁵. The study also showed that (42.6%) were sexually exposed with (88.4%) of this group sexually active in the preceding 6 months. The mean age at first exposure and highest period of exposure were 12 years and 14-16 years (37.4%) respectively. More than a quarter(25.9%) of girls were sexually active before age 11 years with 43.3% having more

than 1 sexual partner. Again this is similar to the findings of Orji E⁵ and Duru BC et al¹ but is lower than findings in Ilesha, Southwest Nigeria which showed age group of 15-19years being the predominant age group of sexually active teenagers (86.7%)⁵. The influence of culture may play a part in the earlier sexual exposure observed here. Poor parental control, exposure to pornographic movies or papers, curiosity and cultural differences are factors associated with the decreasing age at first sexual intercourse. As seen in other similar studies¹ the predominant sexual practice was vaginal/penile sex (84.3%).

Contraceptive use among the sexually active respondents was(31.5%) at first sexual exposure but rose to (58.3%) at their most recent last exposure. The difference in contraceptive use between these periods was found to be statistically significant ($p < 0.005$). Compared with findings in developed countries with better levels of education and adolescent health services and where figures of 86.5% are being recorded⁹, one can understand why ignorance (67.5%) and the partner's dislike (26.3%) were the major reasons for non-use of contraception in our respondents.

The implications of these observed trends are that with early sexual exposure and poor contraceptive use among young, ignorant, sexually active girls, many of whom are in multiple sexual relationships the incidence of complications of this high risk behaviour such as STIs (including HIV/AIDS), unwanted pregnancies, criminal abortions, abandonment of education and ultimately maternal morbidities and mortalities may not abate soon. The inclusion of sex education into the school health programme for secondary school students as well as provision of guidance and counselling services by trained and retrained personnel and motivation of home based information and guidance for adolescents is therefore recommended..

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