

**KNOWLEDGE AND USE OF CONTRACEPTIVE METHODS  
AMONG YOUTH IN ABUJA METROPOLIS**

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**TITLE PAGE**

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AMONG YOUTH IN ABUJA METROPOLIS**

**CERTIFICATION**

This is to certify that this project written by Mr. Henry N. Ugwu with Registration Number PG/M.Sc/08/48493. A postgraduate student in the Department of Sociology and Anthropology, has satisfactorily completed the requirement for the award of masters Degree of Science (M.Sc) in the Department of Sociology and Anthropology (Demography option). The research work embodied in this thesis is original and has not been submitted in part or in full for any other Diploma or Degree of this or any other University.

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**DEDICATION**

TO GOD ALMIGHTY FOR HIS LOVING KINDNESS

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## ABSTRACT

*Unwanted pregnancy followed by unsafe abortion can be avoided by using different contraceptive methods. Information on knowledge, attitude and practice of contraceptives among youth is particularly important because of high rates of teenage and unwanted pregnancies as well as soaring STI and HIV/AIDS rates. Unfortunately, in Nigeria, the case is not different as significant proportion of youth who engages in premarital sex, either lack basic knowledge of contraception, or are ignorant about contraceptive practices. This study examined the knowledge, and use of contraceptive method among youth in Abuja metropolis. A cross-sectional of five hundred (500) youth aged 15-25 years was carried out using instruments like other-administered structured interview schedule, in-depth interviews and informal conversation to collect data. The analysis of the data showed majority of the youth in Abuja metropolis are sexually experienced (58.2%) with most of the first sexual experiences occurring within the 15-19 years age group. There is a high level of knowledge (78.8%) of contraceptive methods available and where to get them but the level of contraceptive use is relatively lower (34.6%) even for the sexually active notwithstanding their level of education especially the students at higher institutions. This could be attributed to barriers to contraceptive use identified by them which includes embarrassment to buy, fear of side effect, disapproval by partner and lack of proper knowledge of contraceptive. Finally, it was concluded that there is a wide disparity between contraceptive knowledge and practice which need to be bridged. There is also need to review policies regarding reproductive health, sexuality and family life education among youth in Nigeria.*

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**LIST OF ABBREVIATIONS AND ACRONYMS**

AIDS	Acquired Immunodeficiency Syndrome
GFR	General Fertility Rate
HIV	Human Immunodeficiency Syndrome
ICONTTRACEPTIVED	International Conference of Population and Development
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organization
NPC	National Population Commission
STIs	Sexually Transmitted infections
STDs	Sexually Transmitted Diseases
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's fund
UNPD	United Nations Population Division
USAID	United States Agency for International Development
USA	United States of America
UK	United Kingdom
UN	United Nations
WHO	World Health Organization



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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study

Sexual and reproductive health is an important issue to every stakeholder in the global health sector particularly with regard to the youth and adolescents (Tien, 2006). A number of factors are responsible for the high level of importance attached to adolescents/youth's sexual and reproductive health. Various authors indicate that adolescent/youth's sexual and reproductive health for most countries is in bad shape. Attahir, Sufiyan, Abdukadir and Haruna (2010) found out that the health risk faced by adolescent girls during pregnancy is very high, accounting for 15% of the Global Burden of Disease (GBD) for maternal conditions and 13% of all maternal deaths. The cause of this degenerating health condition of adolescent girls, according to Tien (2006), is lack of knowledge and access to contraception. Consequently, Tayo, Akinola, Babatunde, Adewumi, Osinusi and Shittu (2010) suggested active and intensive promotion of sexuality education, and contraceptive use among the youth in the Sub-Saharan Africa as a way of addressing this anomaly.

In Nigeria, Harrison (2009) observed that the country's high maternal mortality ratio (MMR) is attributed to her youth's sexuality. The latter is characterized by low contraceptive usage by the youth, high incidence of illegal abortion amongst the youth, ignorance of contraception among the youth, and lack of sex education from parents and teachers. The situation in Nigeria is likely to be a reflection of the situation in the entire Africa. Such a situation made the World Health Organization Report (2010) to show that Africa's progress in meeting the number 5 Millennium Development Goals (MDG5), in which the target is 75% reduction in the maternal mortality ratio from the year 2000, to the year 2015 remains a major challenge to health systems worldwide.



Moreover, NPC and ICF Macro Report (2009), indicate that Nigeria is remarkably slow in its progress towards the MDGs set to be attained in 2015. As we move close to 2015, MMR in Nigeria is put at over 545 per 100,000 live births, compared with other societies that have made significant progress towards the MDGs goal 5, such as U.K with about 8 per 100,000 live births, Germany and Spain 7 per 100,000 live births and France with about 10 per 100,000 live births. Also, NPC and ICF Macro (2009) have attributed the high MMR in Nigeria to poor contraceptive usage and high rates of unwanted pregnancies, which invariably give rise to illegal and clandestine abortions.

World Health Organization Report (2010) on the statistics of contraceptive prevalence in 53 African countries, shows that Nigeria has 14.1% contraceptive prevalence rate, unlike other African countries like Mauritius with 75.8%, Morocco 63.0%, Algeria 61.4%, Cape Verde 61.3%, Egypt 60.3%, South Africa 60.3%, Tunisia 60.2%, Zimbabwe 60.2%, Namibia and Swaziland with 55.1% and 50.6% respectively. The concern here is that since the MDG were set in 2000, there have been steps deliberately taken by Nigerian government to reduce incidences of unwanted pregnancies, particularly among the youth. Promotion of contraceptive practices has also intensified yet with 14.1% contraceptive prevalence in Nigeria, it shows low usage of contraceptives among the youth necessitating enquiring into factors that could explain the trend.

According to Indongo (2007), one of the major factors is that youth often lack basic reproductive information on the consequences of sexual intercourse. In addition to the above mentioned information, youth also lack skills in negotiating sexual relationship, and knowledge about affordable confidential reproductive health services. Again many do not feel comfortable discussing sexual issues with parents or other key

adults with whom they can talk about their reproductive health concerns. Likewise, parents, healthcare workers, and educators frequently are unwilling or unable to provide complete and accurate age-appropriate reproductive health information to young people. This is often due to discomfort in discussing the subject or the false belief that providing the information will encourage increased sexual activity. This is because most youth enter into sexual relationships with very little knowledge on the consequences. The little knowledge they have is either got from their peers or from the media

The question then is why teenage pregnancy, maternal mortality ratio and premarital childbirth is on the increase in Nigeria despite efforts made by both private and public agencies in providing youth-friendly centers in public and private hospitals where contraceptive services could be accessed. This study is therefore designed to study the knowledge of contraception and use of contraceptives among sexually active youth in Abuja-Federal Capital Territory (FCT).

## **1.2 Statement of the Problem**

Despite dramatic declines in the percentage of youth who have ever had sexual intercourse, and reduced rates of teenage childbearing in developed societies, Ryan, Franzetta and Manlove (2007), noted that the youth remain inconsistent contraceptive users and are thus at high risk of unintended pregnancy and childbearing in United State of America (Abma, Martinez, Mosher & Dawson, 2004 cited in Ryan et al., 2007). Estimates of contraceptive consistency within teens' first sexual relationships show that 21% of teens use no method and 16% are inconsistent contraceptive users, using a method only occasionally (Manlove, Ryan & Franzetta, 2003 cited in Ryan et al., 2007). Moreover, youth who do not use contraception or who use contraception inconsistently

in their first sexual relationships are less likely to be consistent contraceptive users in later relationship (Manlove, Ryan and Franzelta, 2004 in Ryan et al., 2007).

Studies in Nigeria indicate high rate of sexual activities as well as limited knowledge and use of contraceptives among secondary school students/undergraduates (Ogbuji, 2005; Iyaniwura and Salako, 2005 cited in Nwaorah, Mbamara, Ugboaja, Ogelle and Akabuike, 2009). The resultant effect of this result is an increased rate of unwanted pregnancy, MMR, STI including HIV/AIDS etc. The increasing number of pregnancies, abortions, and sexually transmitted infections including HIV/AIDS among the youth in Sub-Saharan Africa indicates that successive efforts towards preventing the scourge remain inadequate in the continent (Atere, Shokoya, Akinwale and Oyenuga, 2010). It is obvious that many young people are sexually active with low level of contraceptive use. This is a factor contributing to the increasing spread of sexually transmitted infections and HIV/AIDS among the youth. Evidence from different studies continue to confirm the existence of increasing sexual activities among the youth globally, with those in developing countries perceived to be at greater risk because of their low level of access to medical facilities (Nwafor and Madu, 2002; Ghuman, 2005; Atere et al., 2010).

However, the age at which the youth engage in sexual activities varies considerably depending on the various socializing influences and the opportunities available for practicing sexual behaviours (Atere et al., 2010). Studies on adolescent sexual behaviour in several parts of Nigeria have shown that pre-marital sexual activities are quite common especially in the urban areas (Araoye and Adegoke, 1996; Atere et al., 2010). As a result, unintended pregnancy arises when sexually active women do not use contraceptive or use them incorrectly (Chung-Park, 2007). The tendency for adolescent and young adults to engage in sexual activity without the use of contraception, despite

exposure to educational programs, has led investigators to consider the potential predictors of contraceptive use (Chung-Park, 2007). These studies have indicated that multiple factors influence contraceptive decision-making, amongst them are perceived risk and benefits, values and personality factors (Sigman-Grant, 2002 cited in Chung-Park, 2007).

The inadequate contraceptive coverage is multifaceted social, ethical, and cost issues are focused on the consequence of unintended pregnancy; long-term consequences of unintended pregnancy are far reaching. For example, teenage pregnancy, out-of-wedlock birth, welfare dependency, child abuse, domestic violence, and abortion are some of the major social ramifications of unintended pregnancy (Judith and George, 2003). Research in Latin America has also shown that a relatively high proportion of teenagers are exposed to the risk of pregnancy (WHO, 2001). In Africa, studies have demonstrated that a large proportion of young women are exposed to the risk of conception, receive poor or no sex and contraceptive education and experience a high incidence of adolescent child birth (Muhwava, 1998; Burgard, 2004).

The Nigerian situation is similar to that prevailing in developing societies in Africa and Latin America. Although reports indicate a decline in teenage pregnancy, maternal mortality and morbidity, yet most of the premarital births still occur among young women aged 15-24 years, the majority of whom are neither economically nor emotionally ready to deal with parental responsibilities. Thus, improving reproductive health is keys to improving the situation of youth as well as the world's future generations (Creel and Perry, 2003).

In Federal Capital Territory (FCT) Abuja, teenage pregnancy, maternal mortality ratio and pre-marital childbirth, sexually transmitted disease including HIV/AIDS is a

major health and social problem and its occurrence is on the increase (Aderibigbe et al., 2011). In a study carried out by Aderibigbe et al. (2011) in north central Nigeria, indicates that 66.3% of all adolescent sexually active female has been pregnant only once while 33.3% have been pregnant more than once. On the other hand, 17% of all sexually active males had impregnated a girl once while the remaining has got a girl pregnant more than once. Based on the fore going, poor access to contraceptive information contributes to higher infant mortality, increased maternal mortality and morbidity among the youth and the spread of sexually transmitted infections including HIV/AIDS (Garenne, 1997; Aderibigbe et al., 2011). Furthermore, discrimination on part of young girls has subjected them to physical and sexual abuse which contributes to high level of diseases that are associated with non use of contraceptive methods. Based on these, this study aims at examining factors responsible for level of contraceptive use and practice among youth in Abuja metropolis.

### **1.3 Research Questions**

The following research questions are formulated to guide this study.

1. What is the level of youth's contraceptive use and practice in Abuja metropolis?
2. What factors are responsible for level of youth's contraceptive use and practice in Abuja metropolis?
3. How effective is contraceptive use and practice among youth in Abuja metropolis?
4. What is the youth's level of access to contraceptive methods in Abuja metropolis?
5. What are the problems youth's encounters in accessing contraceptive methods in Abuja metropolis?

### **1.4 Objectives of the Study**

#### **General Objective**

This research seeks to achieve a general objective of examining the level of contraceptive use and use of contraceptive methods among youth in Abuja metropolis

### **Specific Objectives**

1. To examine the level of youth's contraceptive use and practice in Abuja metropolis.
2. To identify factors responsible for level of youth's contraceptive use and practice in Abuja.
3. To find out how effective contraceptive use and practice among youth in Abuja metropolis are.
4. To find out the youth's level of accessibility to contraceptive methods in Abuja metropolis.
5. To know the problems youth's encounters in accessing contraceptive methods in Abuja metropolis.

### **1.5 Significance of the Study**

It is hoped that this study will have both theoretical and practical significance, since it is geared towards addressing an issue that is fundamental to the society at large.

Theoretically, this study will contribute to already existing literatures that will assist the youth in understanding the extent and consequences of ineffective use of contraceptives.

Practically, the data generated from the study will be used by future researchers to explore other ways of reducing unwanted pregnancy, maternal mortality and morbidity and sexually transmitted diseases. The knowledge that will be obtained from this study is intended to create public awareness on the importance and proper use of contraceptive method. However, feasible policy strategies that are going to enhance or

address youth sexual and reproductive health are likely to emanate from the study and will aid the young people and society at large, on the use of effective family planning methods. Thus, the youth becomes more of the importance of contraceptive, the sources of contraceptive methods and the use of contraception. A study of this nature will provoke policy debates aimed at awakening the government and its agencies on the importance of adequate inclusion of sexual and reproductive education on primary, secondary and tertiary institutionsø curricula. A good knowledge of contraception and reproductive health strategies will equally help in the management of population control and human resource development in Nigeria.

## **1.6 Operationalization of Concepts**

For more clarity and consistency of the use of concepts in this study, it is important to give meanings operationally to some of the key terms in this study. This is necessary to avoid conceptual confusion. The terms are as follows:-

### **Adolescents:**

In this study, adolescents refer to a distinct group in terms of their health needs and opportunities to reach them with preventive health programs. According to World Health Organization, adolescents are defined as those aged between 10 and 19 years of age.

### **Family planning:**

It can be conceptualized as to steps people take to have children by choice and not by chance. In this work it refers to steps taken by individual and couples to decide on attain their desired children and the spacing between births which could be achieved through contraception or treatment of involvement infertility.

**Contraception:**

It refers to artificial methods/techniques for prevent pregnancy through temporal or permanent means. Pernoll (1994) stated that contraception is practiced for many reasons, such as pregnancy planning, limiting the number of children, avoiding medical risks of pregnancy and controlling of world population.

**Contraceptive Methods:**

It refers to artificial device use for prevention of individual from both pregnancy and HIV/STIs.

**Abortion:**

This is the spontaneous or induced termination of pregnancy (TOP) before the foetus has attained viability i.e. becoming capable of independent extra uterine life.

**Clients:**

This refers to those individuals who approach the health care system for services and also those in the community who are in need of services.

**Fertility Regulation:**

Is the process by which individuals and couples regulates their fertility through, for example, use of contraception, treatment of infertility and termination of an unwanted pregnancy.

**Maternal Mortality:**



Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy or its management but not from accidental or incidental causes. It can also be called obstetrical death (WHO and UNICEF, 2005)

**Reproductive Health:**

This is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes (Germain and Kyte, 1995). The key element of reproductive health include people's ability to have a safe and satisfying sex life, capability to reproduce, and freedom of choice to decide if they want to reproduce as well as the freedom to decide the timing and frequency of reproduction. It also includes accessibility to health services that are affordable, safe and good quality.

**Unsafe Sex:**

This is the practice of sexual activities that carry a higher risk of negative consequences. In this work, it is activities that involve exchange or contact with semen, vaginal fluids, penile or vaginal discharges, or bloods at high risk.

**Youth:**

According to United Nations, youth is composed of individuals aged between 15 and 24 years. In this study, youth is conceptualized as those persons who normally would be completing their secondary schools or would either be in tertiary institutions such as university.

**Youth Friendly Centers:**

This is a place designed to encourage youth to seek sexual and reproductive health services and to enable them to use contraception to avoid unintended pregnancy and STIs, including HIV/AIDS. It is also referred to where public transportation is available and close to places where young people gather, such as schools, markets, and community centers. It is designed to create an atmosphere that is welcoming, youthful, informal, and culturally appropriate for all the youth using the services.

## **CHAPTER TWO**

## **LITERATURE REVIEW**

### **2.1 Empirical Literature**

In this literature review, efforts will be made to examine some of the previous studies related to the title of this work under the following sub-headings: Maternal mortality in developed and developing countries, maternal mortality in Nigeria, adolescent knowledge and use of contraceptives, trends in unwanted pregnancy, contraception in Nigeria, preventive factors affecting contraception etc.

#### **2.1.1 Maternal Mortality Ratio in Developed and Developing Countries.**

Maternal mortality is a public health issue in many countries especially in the developing countries, where an estimated 585000 women die everyday from pregnancy related deaths (Ali, 2009). Similarly, WHO (2010) report shows that, in developed and developing countries, maternal mortality adds up to 600,000 each year. And that every minute, at least one woman dies from complications arising from pregnancy and child birth. The report further shown that maternal mortality represents one of the widest health gaps between developed and developing nations, with 99% of all maternal deaths occurring in developing countries.

Report by United Nations Development Programme [UNDP], (2003) from a study conducted by Charles (2000) on Maternal Deaths in Europe, shown that in developed countries there are approximately 27 maternal deaths per 100,000 live birth each year, while in developing countries, the average is 18 times high, at 480 deaths per 100,000 live births. The majority of pregnancy related deaths occur after delivery is (61%), in comparison to 24% during pregnancy and 16% during delivery (USAID, 2010).

According to Esperanca (2009) maternal mortality has been an important public health problem, that is why its reduction has being included in the MDG goals. And spontaneous reporting and pregnancy registries were presented as examples of mechanisms that could and should be in place for reduction of maternal deaths in developing countries.

WHO (2007) survey using a Time-Series analysis in estimation of 586000 maternal deaths shows that developing countries accounted for 99% of maternal deaths. Thus, it was also observed from the survey that Sub-Saharan Africa and Asia accounted for 86% of global maternal deaths.

Moreover, Ali (2009) carried out a study on "Make Every Woman Count: Maternal Mortality" in Malawi, India and United Kingdom. The study used an ecological study design, which means to study the relationship between aggregated health data and exposing factors, for a geographical area and time period. The result shows that maternal mortality is highest in Malawi and India, while it is very low in the U.K. the result further shows that in Malawi and India, maternal mortality is caused by direct causes while in U.K it is mainly caused by indirect causes. It was also observed that preventive steps such as family planning, skilled attendance, obstetric emergency care and antenatal care can significantly reduce the maternal mortality rate.

Geubbels (2006) carried out a research on maternal deaths in three districts in the central region of Malawi. The result indicate that there were 28(65.1%) and 15(34.9%) deaths resulted from direct obstetric and indirect obstetric respectively. The study classified other causes of maternal deaths in Malawi, which include postpartum haemorrhage (25.6%), post partum sepsis (16.3), HIV/AIDS (16.3%), ruptured(4.7%), and eclampsia (4.7%). In the final analysis of the study, it was observed that four factors

have contributed to the maternal deaths in Malawi as a developing nation. They include: Health worker factor, administrative factor, patient/family factor and TBA factor.

Similarly, Salvi (2009) conducted a survey research on Health and Family welfare in India. The study was applied to 29 states in a sample of household. He examined that it is estimated that India has 28 million pregnancies annually and this high number is due to prevalent poverty, illiteracy and early marriages. The study further shows that most of the pregnancies lack medical services which result to high maternal mortality in the country.

### **2.1.2 Maternal Mortality Ratio in Nigeria**

High maternal mortality rates in most Sub-Saharan African countries are currently a major source of concern to policy makers through out the world (Okonofua, Abejide and Makanjuola, 1992). Out of the estimated 27 million women of reproductive age in Nigeria, one in thirteen die due to causes related to pregnancy (Odimegwu, 2002). Recent figures indicate that the maternal mortality ratio in the world despite decades of activities associated with the Safe Motherhood Initiatives (WHO, 2001; Odimegwu, 2002).

Odimegwu (2002) carried out a research on Emergency Obstetric Condition, Health Seeking Behaviour and Spousal Role in Southwest Nigeria: Mothers Perspectives. The research used 1998-1999 community-based Survey on men's role in emergency obstetric care in Osun state. The findings shows that the major causes of maternal mortality in Nigeria are due to complications such as haemorrhage which account for about a quarter of all maternal deaths.

Ezugwu ,Onah, Ezugwu and Okafor (2008) conducted a research on Maternal Mortality in Transitional Hospital in Enugu State. The study used a record of maternal deaths that occurred in the maternity unit of the hospital during the 5 year period, the case notes of the patients were retrieved from the medical records departments and studied. The findings shows there were 60 maternal deaths during the 5 year period. The result further shows that during the 5 ó year period, there were 7574 deliveries, 7146 live births and 60 maternal deaths giving an overall maternal mortality ratio (MMR) of 840/100,000 live births.

Okeibunor, Onyeneho and Okonofua (2010) carried out a study on Policy and Programs for Reducing Maternal Mortality in Enugu State, Nigeria. The study focused on describing and analyzing the extent to which the state government is committed to reducing maternal mortality rate (MMR) in the state. The results revealed that the reported MMR of about 1,400/100,000 live births in the state is attributable to preventable medical causes. The results further indicate that the high mortality rate in the state is fueled by socio-cultural factors, and poor access to skilled medical personnel.

Kamara (1991), presented results from focus-group discussions among rural women in Nigeria indicating that such features of transportation as the absence of vehicles, irregular traffic, bad roads, high fares, and unfriendly drivers effectively contribute to high mortality in Nigeria. The result also showed that these factors are likely to affect women of low economic status more severely, and they may explain the higher frequency of transportation difficulties in the group of maternal deaths in Ile-Ife, South Western Nigeria

According to AbouZahr (2004) maternal mortality is a huge problem in many developing countries, and unfortunately Nigeria is not an exception. In a study carried

out by AbouZahr (2004) only about 60% of women have access to prenatal care in Nigeria and fewer have access to family planning. According to Hajiya (2008), special assistance to the governor of Bauchi State, quotes that in Bauchi State alone, the maternal mortality rates worsened from 1350/100,000 of lives birth in 2003 to 1380/100,000 in 2006. She explained that only 43.8% women in the state received anti-natal care (ANC) during pregnancy, while 14.6% give birth in health facility with trained personnel, such as doctors, nurses, and mid wives attending to only about one third of the deliveries.

### **2.1.3 Adolescent knowledge and use of contraceptives**

Contraception is one of the essential elements of youth reproductive health. It allows youth to determine the timing and the number of their children and empowers them to manage their lives with respect and dignity. Adolescent reproductive health is increasingly being recognized as one of the major determinant of human development. Among the essential development concern about contraception or prevention of unwanted early pregnancies considered to have a significant potential in improving the status of youth

Knowledge and use of contraceptives among youth showed very wide variation among region of sub-saharan Africa than other regions of the world (Gadisa, 2004). In confirmation with this study among youth aged 15-19 in Ghana, revealed that 85% knows at least one method of contraception while only 17% of sexually active youth use contraceptives, the rate for any method was 27% (Gadisa, 2004). Similar study in Nigeria has revealed that over 60% of urban youth have heard of at least one method but only 4.7% of active youth practice contraceptives of which 3.5% of them practice modern methods (Ahmed, 2006). Another study in Kenya indicate that 90% of Kenyan

high school students knew at least one method, 49% of male and 43% of female student ever used contraceptives (Bekele, 2005). The same study also revealed an increase in contraceptive use from 25% versus 28% during the first to 31% versus 29% during the last intercourse among male and female students respectively. However, only 11% of ever users considered themselves as frequent users (Bekele, 2005). Knowledge of contraceptive method among youth in most countries of Latin America, the Caribbean, Asia, Near east and North Africa exceed 90% (Gadisa, 2004).

Knowledge of contraceptive method is the first step toward accepting a method (Khan and Mishra, 2008). In all regions, knowledge of any modern method of contraception is nearly universal among both young women and men. However, a considerable proportion of youth in Sub-Saharan Africa do not know of a modern method; Chad is the most notable examples- only 49% of this country's young women and 72% of its young men know of a modern method. Khan and Mishra (2008) further observed that other countries with low levels of knowledge of any contraceptive method include Madagascar, Mali and Nigeria. Overall, knowledge of any method is somewhat higher among young men than young women and knowledge levels are generally higher in countries outside Sub-Saharan Africa.

Report by National Research Council [NRC] (2005), indicates that knowledge of multiple methods of contraception measures how well-informed youth are about CONTRACEPTIVE. And as expected, in all countries with all-women samples, knowledge of three or more modern methods is lower than knowledge of any method. This is most apparent in Sub-Saharan Africa, about 80% or more of young people know of three or more modern methods in most countries outside Sub-Saharan Africa. Demographic and Health Survey [DHS] (2008) report, indicate that level of ever use of CONTRACEPTIVE among youth are low in most countries in all regions but vary



greatly across and within regions. Ever use of CONTRACEPTIVE is lower in most Sub-Saharan African countries than countries in other regions. In about half the countries in Sub-Saharan Africa, fewer than 20% of youth have ever used a modern method. This is also necessitated the relevance of this study, since it geared towards creating awareness on proper and effective use of CONTRACEPTIVE methods among youth in Nigeria and Africa in general.

#### **2.1.4 Trends in Unwanted Pregnancy**

Unintended pregnancy poses a major challenge to the reproductive health of young adults in developing countries. Harrison (1997) carried out a study on the effects of unwanted pregnancies among youths in USA. The study shows that some young women with unintended pregnancies in U.S.A obtain abortions and others carry their pregnancies to term, incurring risks of morbidity and mortality higher than those for adult women. Two studies carried out in Mexico and Nigeria by Marques (1991) and Okonofua (1995) found that adolescents who were employed were at least four times more likely to be pregnant than those who were not, the study also shows that having future goals and aspirations is also important to prevent adolescent from unwanted pregnancy (WHO, 2005). Two studies carried out in Brazil also shown that youth with lower future aspirations were much more likely to be at risk for unwanted pregnancy compared to those with higher aspirations and goals (Margues, 1991, Pick de Weiss, 1991). In fact, in, Ecuador, youth with higher levels of knowledge about contraception were nearly 14 times more likely to avoid being pregnant compared to those with low knowledge of contraception (Pick de Weiss, 1991; WHO 2005).

However, in China and province of Taiwan, three separate studies showed that smoking cigarettes and drinking alcohol significantly increased the risk of early

childbearing (Lee & Chon, 2001; Wang & Chon, 1999; Wang & Chou, 2001). Two studies found that where a teen has a friend who has been pregnant, her risk for pregnancy significantly increases (Marquess, 1991; Vindule, 2001). For example in South Africa, a study carried out by Vindule (2001) indicate that youth who said that most of their friends have been pregnant were more than four times more likely to be pregnant themselves.

In addition, a study carried out by Osakinle (2005) in South Western Nigeria revealed that most times, a youth that is not married usually go into unprotected sex for both maternal and monetary gains and this kind of activities makes them susceptible or vulnerable to sexually transmitted infections and unwanted pregnancies. The result further indicated that these unwanted pregnancies are either aborted or carried to term (Fasua, 2003).

Moreover, Eruesegbefe (2005) in his research on the effects of unwanted pregnancy in Nigeria, the result shows that the news of an unexpected pregnancy in South Western Nigeria is in most cases followed by the trauma of broken promises, emotional pursuits, shattered relationships and unfulfilled potentials. Similarly, Osakinle (2003) in his own study of unwanted pregnancy in Nigeria observed that it is always dangerous and risky when an adolescent below age become pregnant. His findings again shows that, 85% of youth pregnancies in South Western Nigeria are unintended, half end in birth, a third in clandestine abortion and the rest in miscarriage.

Furthermore, Okonofua (1997) in his study on adolescent pregnancy in Nigeria revealed that 80% of unwanted pregnancies to unmarried girls were unintended, compared to 6% of married girls. In spite of all these, a finding from Action health Incorporation (1999) shows that premarital sex among youth in Nigeria seems to be

regarded as fun. And these has lead many youth to get pregnant early either they died, or maimed through unsafe abortion. This is a great problem which demands an urgent attention; hence the need to arrest unwanted pregnancies (Osakinle, 2005).

#### **2.1.5 Contraception in Nigeria**

In developing countries, surveys have shown that the highest level of contraceptive use, are among unmarried, sexually active youth between the ages of 20 and 24 years, the lowest levels are among adolescent married women between the ages of 15 and 19 years (WHO, 2005). Consequently, from the survey, few married adolescents use contraception. For example, only 13% of married youth in this age group use contraception, among unmarried, sexually active adolescents in this same age group, the level of contraceptive use reaches 39% married women and 60% of unmarried, sexually active women between the ages of 15 and 19 years use contraception (Zlidar, 2003; WHO, 2005).

In Nigeria, Arowojolu and Adekile (2000) carried a study on Perception and Practice of Emergency Contraception in Nigeria. The result shows that being aware of contraception significantly increased the likelihood that youth will use emergency contraception. Their findings further shows that being young and Pentecostal also increased the likelihood of using contraception. Meanwhile, Makinwa (1992) in his research on sexual behavior among young urban Nigerians shows that ethnic origin, education and place of residence were all significant determinants in contraceptive use in Nigeria.

Similarly, Addai (1999) in his own study on Ethnicity and Contraceptive use in Sub-Sahara Africa which explored ethnic differences in contraceptive use among 6 groups. The results shows that ethnicity, having no education, no occupation, having a

husband with no education, and having no living children were all negatively associated with using contraceptive. The results also show that living in an urban area, was positively related to using contraceptives in Nigeria. Kiragu and Zabin (1995) carried out a study on contraceptive use among high school students and their result findings shows that for females, high socioeconomic status, high academic achievement and a favorable attitude toward contraception were the most important factors predicting use of contraception at first and last sex. The study further indicates that males who said their partner approved of contraception were twice as likely to have used a method at last sex.

Aso, Odimegwu (1995), opined that exposure to mass media family planning campaign increases contraception in Nigeria, Similarly, Adewuyi, Obadeyi and Rimi (1992) in their studies on changes in Nigerian's knowledge of and attitudes towards contraception and its use, shows that by 1990 the proportion of women who knew of specific methods of contraception has grown. Further more, 41% of married women who knew of specific contraceptive methods in Nigeria had discussed contraceptive with their husband.

#### **2.1.6 Factors affecting contraception**

Firstly, Oladeji (2008), in his study on Socio-Cultural and Norm Factors Influencing Family Choices and Contraceptive Use among Couples in Ibadan Metropolis, indicates that five factors affect contraceptive use, they include: social and cultural norms, gender roles, social networks, religion, and local beliefs. However, several qualitative studies have provided further evidence of the influence of external factors on young people's sexual behavior (Dixon-Meuller, 1999). For example, Holland (2001) in his study on the social construction of sexuality indicates that men and women's unequal power relations manifest themselves in young people's sexual lives,

thereby making it difficult for young women to insist on condom use should they wish to do so. Greenwell (1999) and Vickers (2000) supported this study from their research on sexual relations among youth in Sub-Saharan Africa, their results shows that the larger the differences in reproduction intentions within a community, the more likely that community norms supports youth contraceptive choices.

Cherkavoi (2001) and Barnett (2001) from their studies on factors of contraceptive use in Kenya indicated that most women use contraceptives because having smaller families is the norm. Jejebhoy (2004) in his study also shows that young people often decide not to use contraception because they do not want their parents or other adults to know that they are sexually active. In Kenya, studies also shows that when new client were ask to give a single reason for their choice of specific family planning method, most cited that the attributes of their spouse or their peers, or their religion or value. Jacobson (2000) in his own study shows that as women gain more autonomy, they are better able to claim their rights as individuals, including the rights to act to protect it, their own reproductive health. Rutenberg and Watkins (2000) in their study in Nigeria and other West African countries, indicate that some women reported that, it was difficult for them to use contraception because their relatives or friends were not using it. Godley (2001) in his study in urban Nigeria, found that the more widely used a contraceptive method, the more attractive it become to others in the cities and villages. Therefore, based on a review of various studies over the previous two decades, the results found that program have helped convert people's interest in having fewer children into a demand for contraception (Oladimeji, 2008)

## **2.2 Review of Relevant theories**

In the course of reviewing some theories/approaches of contraception, attempt will be made to show how these theories/approaches of contraception directly or indirectly relate to knowledge and use of contraceptive methods.

### **2.2.1 The Theory of Reasoned Action**

Theory of Reasoned Action was developed by Martin Fishbein and Icek Ajzen in 1975. The theory is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them. People consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behaviour, and that most actions of social relevance are under volitional control (Ajzen, 1980 cited in Rachel, 1999).

The theory of Reasoned Action specifically focuses on the role of personal intention in determining whether behavior will occur. The theory indicates that a person's intention is a function of two basic determinants. 1. Attitude toward the behaviour, and 2. Subjective norms. i.e. social influence. Normative beliefs play a central role in the theory, and generally focus on what an individual believes other people, specifically influential people would expect him/he to do. For example, for a person to start using contraceptives, his/her attitude might be 'having sex with contraceptive is just as good as having sex without contraceptives' and subjective norms or the normative belief could be that 'most of my peers are using contraceptives; they would expect me to do so as well'. Interventions using theory to guide activities focus on

attitudes about risk-reduction, response to social norms, and intentions to change risky behaviours.

### **2.2.2 Social Cognitive (or Learning) Theory**

Social Cognitive Theory is a theory that stemmed out of work in the area of social learning theory, proposed by N.E Miller and J. Dollard in 1941. Their position posits that if one were motivated to learn a particular behavior, then that particular behavior would be learned through clear observation. The premise of the Social Cognitive or Social Learning theory (SCT) states that new behaviours are learned either by modeling the behaviour of others or by direct experience. Social learning theory focuses on the important roles played by vicarious, symbolic, and self regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants (Bandura, 1977 in Rachel, 1999). Central tenets of the social cognitive theory are:

- Self-efficacy-the belief in the ability to implement the necessary behaviour (‘I know I can insist on contraceptive use with my partner’).
- Outcome expectancies ó belief that using contraceptive correctly will prevent HIV infection, STIs and unwanted pregnancies.

Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and contraceptive use, the positive and negative beliefs about adopting contraceptive use, and the types of environmental barriers to risk reduction.

### **2.2.3 Theory of Planned Behaviour**

The Theory of Planned Behaviour (TPB) propounded 1980 by Ajzen and fishbein aimed at explaining various health behaviours, such as smoking behaviours, diet and exercise behaviours, diabetic management and condom use (Glanz, Rimer, and Lewis, 2002). The Theory of Planned Behaviour, was a modification of the theory of reasoned action, was based on the rational and make systematic use of the information available to them (Ajzen and Fishbein, 1980). The theory contends that people estimate consequences of actions before deciding to engage or not engage (intent factor).

However, according to the Theory of Planned Behaviour, intention, devoid of unforeseen circumstances that limit individual control, will help predict future behaviour. A central factor in the Theory of Planned Behaviour is the individual's intention to perform a given behaviour. Intentions are assumed to capture the motivational factors that influence behaviour; they are indications of how an effort they are planning to exert, in order to perform the behaviour. Chakema (2007) states that the theory of planned behaviour can also help to understand why people have certain attitudes and subjective norms, since the belief that one holds about oneself and the world in which one lives, underlie attitudes, and the perception that salient others believe one should or should not perform the act underlie subjective norm.

### **2.2.4 Health Belief Model**

The theory of Health Belief Model (HBM) is a psychological model that attempt to explain and predict health behaviours. This is done by focusing on the attitudes and belief of individuals. The HBM was first developed in the 1950s by social psychologist Hochbaum, Rosenstock and Kegels, who were working in the US public health service.



The Health Belief Model, developed in the 1950s, holds that health behaviour is a function of individual socio-demographic characteristics, knowledge, and attitudes. According to this model, a person must hold the following beliefs in order to change behaviour:

1. perceived susceptibility to a particular health problem (‘am I at risk for HIV?’)
2. perceived seriousness of the condition (‘how serious is AIDS; how hard would my life be if I got it’)
3. belief in effectiveness of the new behaviour (‘contraceptions are effective against HIV transmission’).
4. cues to action (‘witnessing the death or illness of a close friend or relative due to AIDS/STIs’).
5. perceived benefits of preventive action (‘if I start using contraceptives, I can avoid HIV/AIDS infection or unwanted pregnancy’).
6. barriers to taking action (‘I don’t like using contraceptives’).

In this model, promoting action to change behaviour includes changing individual personal beliefs; individuals weigh the benefits against the perceived cost and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in effectiveness of contraceptive use and benefits of contraceptive use or delaying onset of sexual relations

### **2.3 Theoretical Framework**

The theoretical framework of this study hinged on the Health Belief Model and Theory of Planned Behaviour. These two approaches are indeed appropriate in this study for they stress the need for the use of contraceptives (Bongaarts and Johansson, 2000). Considering the value of the attitude, belief, behaviour, relationship and reproductive

health services, it is considered of importance to explore some belief of youth in Abuja regarding contraception, by adapting some ideas from health belief model and theory of planned behaviour on fertility regulations.

According to the Health Belief Model, individual perceptions such as perceived seriousness of pregnancy, benefits and barriers are more likely to affect the preventive actions such as using contraception which can prevent a specified condition such as unplanned pregnancy and perceived barriers such as difficult access to sexual and reproductive health services. Theory of planned behaviour provides framework for understanding the use of condoms in heterosexual intercourse to prevent AIDS. The theory further argues that intentions to use condoms with new sexual partners can be predicted from attitudes, subjective norms, and perceived behavioral control with respect to the behaviour.

The theories are chosen because they best explain the level of youth's contraceptive use and practice in Nigeria. The theories will contribute to the understanding of effective and ineffective use of contraceptive methods.

#### **2.4 Research Hypothesis**

- (1) Female youth approve of contraceptive use in sexual activities more than their male counterparts.
- (2) Youth in tertiary institutions are more aware of contraceptive methods than those in secondary schools.
- (3) The higher the knowledge of contraceptives, the more the use of contraceptives among youth.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Research Design.

This study adopted a cross-sectional survey design. May (2001) noted that the application of a cross-sectional survey method is appropriate in obtaining the behavioral pattern of a given population on the basis of their knowledge, opinion, attitude and perception concerning a given phenomenon?

#### 3.2 Study Area.

This study was carried out in Abuja Federal Capital Territory (FCT) in Nigeria. Abuja is the capital city of Nigeria, comprising five districts and several surrounding towns and villages. It is one of the six council development Areas in the Federal Capital Territory (FCT), the others being Bwari, Kwali, Kuje, Gwagwalada and Abaji. It is a place of remarkable beauty, well planned and peaceful. Abuja is the capital of Nigeria, established by a military decree in 1976 to be a place centrally located and free of ethnic domination by any cultural or religious group. By 1991, it had become the official capital (seat of Government) having most of all federal agencies based in or completely relocated to it from the former capital Lagos. The projected population figure of FCT in 2006 was 1, 405201 million people and the youth (aged 15-24yrs) was 268,891 people, representing 19.1% of the total population in the FCT (NPC, 2006).

The capital has several monuments, some of which attract visitors from all over the world. Some of these monuments include the Aso rock and Aso presidential villa, the New National Stadium, Economic Community of West African States (ECOWAS) Secretariat, the National Assembly Complex, Wonderland, the Ecumenical Centre and

the Ship house among many others. However there is also the strong presence of private sector based workers in the city including contractors, construction staff, business consultants and professionals in many fields. The two major religions are Christianity and Islam with Christians being slightly more in number than Muslims.

Social life is relatively expensive when compared with most other cities of Nigeria. Night clubs, eateries, entertainment centers like Cinemas and other relaxation sports are located in areas distant from residences. On a normal day social outings could cost a couple a minimum of \$100 (#15,000).

Infrastructure is the best in all of Nigeria. These are good road networks, electricity supply, and other infrastructures in the city than most parts of Nigeria. Also security services are efficient. Accommodation is expensive as the city has not many residencies since it has a master plan which makes it difficult for residential house to be constructed without government approval and a tiresome process. English is the official language. Other languages spoken in the territory include Hausa, Yoruba, Igbo and Fulani etc.

### **3.3 Study Population**

The study population consists of youth between the ages of 15-24 years in Abuja metropolis. While the target population includes youth aged 15-24 years from the Higher Institutions and Secondary Schools, Traders and Artisans in Abuja metropolis. Students, traders and artisans are chosen for this study since other social categories like Okada riders, Hawkers, and Motor Park touts etc, which may also be relevant to the study, are strictly and highly restricted from operating in the metropolis.

### **3.4 Sample and sampling procedure.**

The sample size of this study was determined by using a prevalence of 18.1% for use of modern contraception among all male and female aged 15-24 worked out from the NDHS 2008 report (NPC & ICF Macro, 2009) and confidence interval of 93% with an estimated 3.5% precision level. A sample size of 481 respondents was computed. This will be rounded up to 500 respondents and allowed the detection of difference within 3.5% point of the true difference.

As a result, a sample size of 500 respondents were used for the questionnaire, 200 respondents from Tertiary Institution and 200 respondents from secondary institutions, while 50 respondents each was allocated to traders and artisans respectively. Non-probability sampling was used to select 10 in-depth interview (IDI) sessions, thereby making the total sample size for the study to be  $500 + 10 = 510$ .

Therefore, using simple random sampling or balloting, one higher institution as well as one secondary school were selected and used for the study. Simple random sampling will be used to select the students, traders and artisans because of its fairness and objectivity, since everyone in the population has the same chance of being selected. However, four departments as well as four classes (i.e SS1 ó SS 3) will be randomly selected while the traders and artisans were located in market places and shops. Senior classes were used for the study because they are considered to fall between the age ranges of 15-24 years. Thus, there will be 50 respondents each from the four departments and four senior classes including 50 traders and 50 artisans purposively selected for the

study. Ten key informants like traders, artisans, students, union executives, religious groups and social club leaders will be purposively selected, 1 from each of the 8 classes, while 1 session IDI each will be conducted for traders and artisans, and used for the IDI session. Respondents to the questionnaire will not be used for the IDI session to avoid duplication of ideas.

### **3.5 Instruments for Data Collection**

There are two instruments used in this study. They are questionnaire and in-depth interview schedule. The questionnaire contains two sections. The first section sought to identify the socio-demographic characteristics of the respondents in the study, while the second part sought information on knowledge and use of contraceptive methods among the youth in Abuja metropolis. The questionnaire was the major instrument of data collection; it is the kind of instrument that can cover wide range of most of the issues raised in this study. The interest is to use the questionnaire to obtain the background characteristics of the respondents, their knowledge, opinion and behavioral patterns in relation to knowledge and use of contraceptive methods proper

The in-depth interview was used to investigate salient issues that may not have been covered in the questionnaire. It seeks information on the respondent's knowledge and attitude to the use of contraceptives. The above two instruments were used, because they will facilitate this research more than any other techniques in gathering the desired data among the youth.

### **3.6 Methods of data collection**

The questionnaire was administered with the help of six research assistants, four for the schools and two for traders and artisans. They were recruited and trained by the principal investigator to collect data. This was expected to be accomplished in two weeks. When the research assistants arrive in the school, they introduce themselves to the school authority and after a briefing, they seek consent to undertake the administration. The questionnaire was other administered. The reason for the other ó administered questionnaire is in taking into consideration of the non-literate respondents especially among the traders and artisans who cannot read and write well. Where there are difficulties in understanding, the respondents were assisted by the research assistants.

For the In-depth Interview (IDI), only subjects who had at least secondary school education were purposively selected. This was applicable to traders and artisans, to ensure that they can express their views. The researcher personally conducted the interviews among the traders and artisans since he is conversant with Abuja metropolis while the research assistants conducted interviews among the students. Key informants selected who later decline were substituted during the data collection exercise.

### **3.7 Method of data analysis**

The data from the questionnaire were analyzed with the help of Statistical Package for the Social Sciences (SPSS). Frequency distribution tables and

descriptive statistics like percentages: mode, mean and rates were used to describe the characteristics in the study subjects. This statistical package helped for clarity and easy understanding of raw data. The chi-square ( $X^2$ ) was used to test the hypotheses in which the conclusion was drawn on the result of the test. This is to clarify nature strength of the relationship between the dependent and independent variables of the hypotheses.

Analysis of qualitative data focused on interpretation, and description of what was actually said by the interviewees. In going through the transcriptions, phrases with special connotation were noted and pulled out as illustrative quotes to complement the quantitative data, describing the responses of the respondents.



## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSIS

This chapter presents and analyzes the data collected for this study. The entire five hundred (500) questionnaires administered to the respondents in Abuja metropolis, which constituted the representative samples of youth in Abuja metropolis were returned. Therefore, the analyses were based on five hundred (500) returned questionnaires. The analyses were divided into five major sections to include: personal data of respondents: knowledge of contraception, sexual history, barrier to contraceptive use. The hypotheses that guided the execution of this study were tested in the last section of this chapter.

Also included in the present analysis are qualitative data collected through in-depth interviews with the school functionaries including religious group leaders as well as traders and artisans in the study area. During the interview sessions, the researcher observed that there two categories of adolescent/youth on were they spend their leisure time. The first group was referred to as "homely group" that comprises of youth who spend their time reading books, watching television, listening to the radio, playing games with their friends or helping their parents in different kinds of activities.

The second was the group labeled as "modern" who spend most of their leisure time in illegal video houses, dancing halls, in bars, and where prepared beverages are being sold.

#### 4.1 Personal Data of the Respondents

This section deals with the socio-demographic characteristics of the respondents in this study. This includes Sex, Age, Religion, Education Qualification etc.

##### 4.1.1: Distribution of Respondents by Sex

The sex of the respondents includes male and female youth in Abuja metropolis. (See table 1 below)

**Table I: Distribution of Respondents by Sex**

<b>Sex</b>	<b>Frequency</b>	<b>Percentage</b>
Female	266	53.2
Male	234	46.8
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011)

Table 1 shows that majority of the respondents were female youth (53.2%). While the male respondents were (46.8%) of the sample. This shows that the female respondents were majority and showed more interest to the study at the time of the administration of the questionnaires.

##### 4.1.2: Age Distribution

The ages of the respondents ranging from 15-25 years were categorized into intervals of 5 years given a total of three intervals. This was presented in table 2 below

**Table 2: Distribution of Respondents by Age**

<b>Age</b>	<b>Frequency</b>	<b>Percentage</b>
15-19	272	54.4
20-24	191	38.2
25+	37	7.4
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011)

Table 2 showed that the highest proportion of respondents was aged between 15 and 19 years (54.4%). Followed by those aged 20-24 (38.2%) and then those aged 25 years (7.4%). Since the highest respondents is between 15-19 years, it means that contraceptive information should be made available to this age bracket because it was presumed that this is the age youth engages in sex whether contraceptive are available or not. And most of the people interviewed agreed that this the age of critical point of starting sexual relationships for some of them if they are not properly guided.

#### **4.1.3 Level of Education**

The concern here was to show how level of education attained influences the knowledge and use of contraceptives among youth. This was presented in table 3 below.

**Table 3: Distribution of Respondents by Educational Qualification**

<b>Education Qualification</b>	<b>Frequency</b>	<b>Percentage</b>
Secondary school	200	40.0
Higher institution	200	40.0
Not in school	100	20.0
<b>Total</b>	<b>500</b>	<b>100</b>

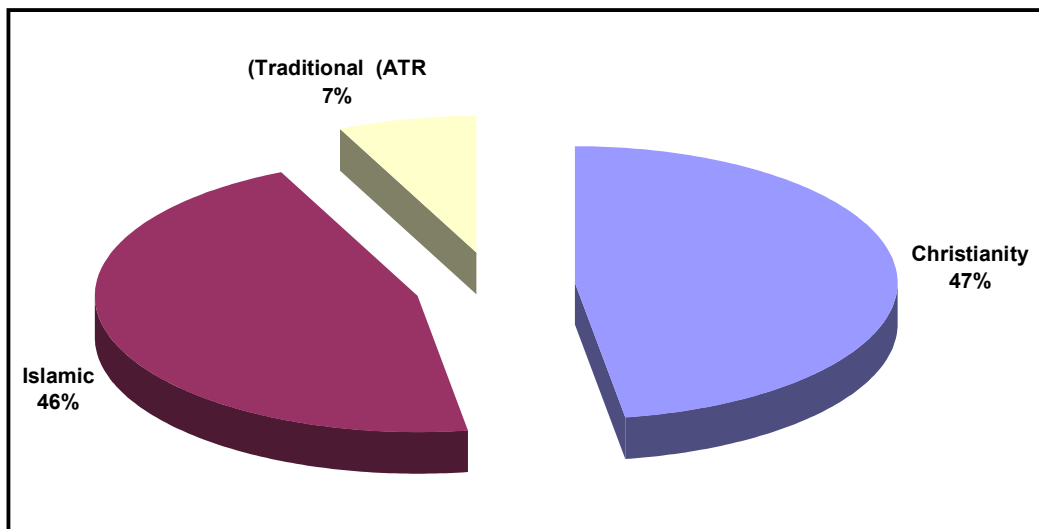
**Source:** Field work (2011)

The table shows that majority of the respondents are currently in secondary schools (40.0%) and Higher institution 40.0 percent respectively. Those respondents who are not privilege to be in school at time of this study were 20.0 percent of the samples. During this study, a higher percentage of the respondents were located in their school hostels which made it easier for the distribution and collection of the questionnaires by the researcher, while majority of the respondents outside school either lived their brothers or sisters who have little or no time for them.

#### 4.1.4 Religious Affiliation

The respondents were grouped into three namely Christians, Moslems and African Traditional Religion (ATR) worshippers. (See figure 1 below)

**Figure 1: Distribution of Respondents by Religion**



The distribution of respondents by religious affiliation showed that Christianity (47.4%) was the dominant religion in the study location. This was followed by those who practiced Islamic Religion (45.6%). The remaining small proportions 7.0 percent are practicing African Traditional Religion. In view of the above, it is evident that Christians are slightly predominant in the area of study and more available at the time of the administration of the questionnaires.

#### 4.1.5 The Educational Attainment by Parents.

The highest level of education attained by parents respondents was the concern here, since it was presumed that the higher the educational attainments by parents the more their children are exposed to sexuality education.

**Table 4: Distribution of respondents by Parents level of Education**

Parents level of Education	Sex of Respondents	
	Father	Mother
No formal education	50(10.0%)	256(51.2%)
Completed elementary	50(10.0%)	70(14.0%)
Completed secondary	141(28.2%)	66(13.2%)
First degree and above	224(44.8%)	58(11.6%)
Don't know	34(7.0%)	50(10.0%)
<b>Total</b>	<b>500 (100%)</b>	<b>500(100%)</b>

**Source:** Field work (2011)

Table 4 shows that sizable number of the respondents indicates that their mother has no formal education (51.2%). This was followed by those who indicate their father has first degree and above (44.8%). Respondents who indicate that their fathers completed secondary education were (28.2%) of the samples. The lowest number of respondents shows that they don't know the level of their parent's education 7.0 percent.

#### 4.1.6 Youth Relationship with their Parents

The concern here was to know the level of relationship between the respondents and their parents. This was in relation with a report by Advocate for Youth (2011) which indicates that when parents affirm the value of their children, they more often develop positive, healthy attitudes about themselves, especially in unprotected sex and its effects to their future life. The result was presented below.

**Table 5: Distribution of Respondents by Relationship with their Parents**

<b>Level of relationship</b>	<b>Frequency</b>	<b>Percentage</b>
No response	3	0.6
Very Easy	112	22.4
Easy	175	35.0
Difficult	84	16.8
Very Difficult	84	16.8
Not at all	42	8.4
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 5 shows that 35 percent of the respondents find it easy to talk to their parents about things that are important to them. This was followed by 22.4 percent of respondents who find it very easy. The table also revealed that (16.8%) each of the respondents find it difficult and very difficult to talk to their parents. Besides, the table shows that (8.4%) of the respondents indicated that they don't discuss with their parents at all about things that are important to them. Meanwhile, smaller proportion (0.6%) of the respondents did not indicate whether they relate with their parents or not. The observation here was that since a good number of the respondents indicate that they don't talk to their parents about

things that are important to them, the effect is that majority of them will not be exposed to various issues that will be significant to their life, especially the issue of sex education..

#### 4.1.7 Discussion of Sex related matters with Parents

The main interest here was to show how parents discuss sex related matters with their children. (See table 6 below)

**Table 6: Distribution of Respondents by how often they discuss Sex-Related matters with parents**

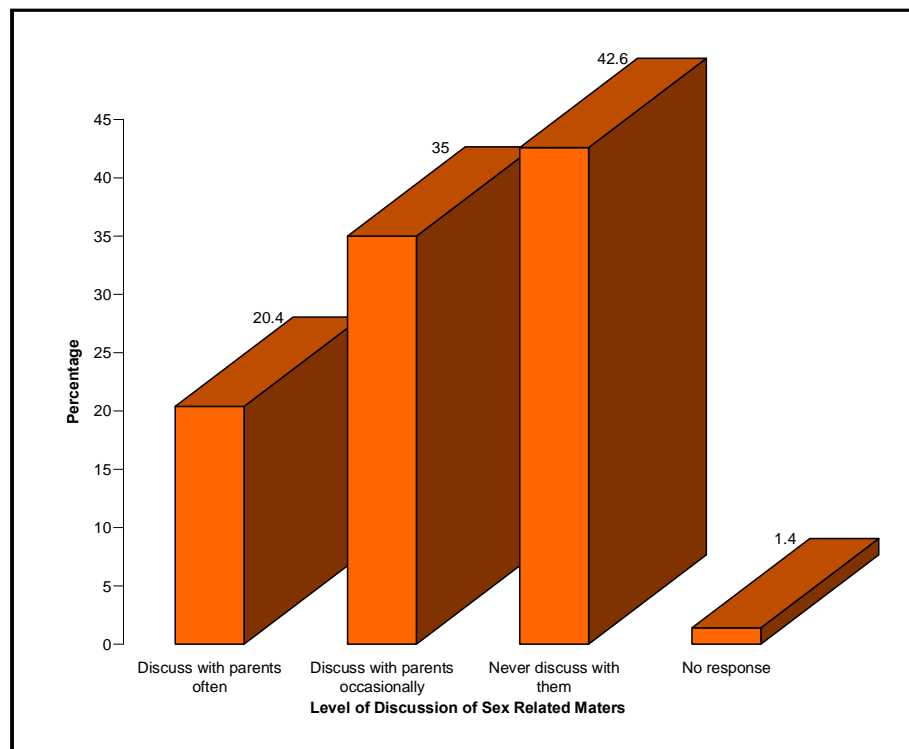
<b>Level of Discussion of sex related Matters</b>	<b>Frequency</b>	<b>Percentage</b>
Discuss with parents often	102	20.4
Discuss with parents occasionally	178	35
Never discuss with them	213	42.6
No response	7	1.4
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011)

Table 6 shows that (42.6%) of the respondents indicates that they never discuss sex-related matter with their parents. This was followed by (35.6%) of those respondents who indicate they occasionally discuss with their parents about sex-related issues. Meanwhile, 20.0 percent samples indicate that they often to their parents about sex-related issues. The smaller proportion (1.4%) of the respondents gave no response. However, from the analyses of table 6 above, it shows that since a good number of the respondents never discuss sex-related issues with their parents, it means that majority of the parents still imbibe the culture that access to sex related issues should be prohibited to children.

Figure 2 below further illustrates the relationships on how parents discuss sex-related matters with their parents. From the three options identified, those who admitted that they never discuss sex-related matters with their parent are at the high side. This could be as a result of social taboos and misery associated with sex in different societies. Secondly, some parents treated sex as if it is downright dirty. And finally, some parents will want their children to be timid and innocents when it comes to sex matters or issues.

**Figure 2: Distribution of Respondent how often they discuss sex related matters with parents.**





From the different IDI sessions the fact came up that there are wide gaps between parents and their children regarding the issue of sex-related matters as indicated by the respondents?

*A 16 year old school girl stated “No one taught us about sex, I only know about sex because we live in a single room through my parents”.*

*Another student, an 18 year old undergraduate said “The only time I talk about sex-related matters with my mother is when she wants to warn me not to start to have sex until I get married”.*

*In a similar vein, a 20 year old student said “my parents always drive us away whenever they are doing programmes on sex and contraceptive related programmes on televisions and radio”.*

#### **4.1.8 Parents Job Status**

The respondent's parent's job status was categorized into four groups which include: Both of my parent works, my father only work, my mother only work and both don't work.

**Table 7: Distribution of Respondents by Parents' Job Status**

<b>Parents Job Status</b>	<b>Frequency</b>	<b>Percentage</b>
Both of my parent work	210	42.0
My father only work	136	27.2
My mother only work	63	12.6
Both don't work	91	18.2
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011)

Table 7 above revealed that greater proportion (42.0%) respondents indicate that both their parents work either in public or private sectors. On the other hand, (27.2%) of

the respondents indicate that only their father work. Meanwhile (18.2%) of the respondents indicate that both of their parents don't work. Only a small proportion (12.2%) indicates that only their mother work. The table shows that the researcher had more of the respondents whose parents work either in private or public sectors of the economy at the time of the administration of the questionnaires.

## 4.2 Knowledge of Contraception

This section presents the results of the frequency distributions and percentages of the variables that we used in our analysis.

### 4.2.1 Knowledge of contraception

With the increasing rate of sex related diseases like HIV/AIDS, STDs and STIs in our society today, the researcher seeks to know whether the youth have knowledge of contraceptives in the study area.

**Table 8: Distribution of Respondents by Knowledge of Contraception**

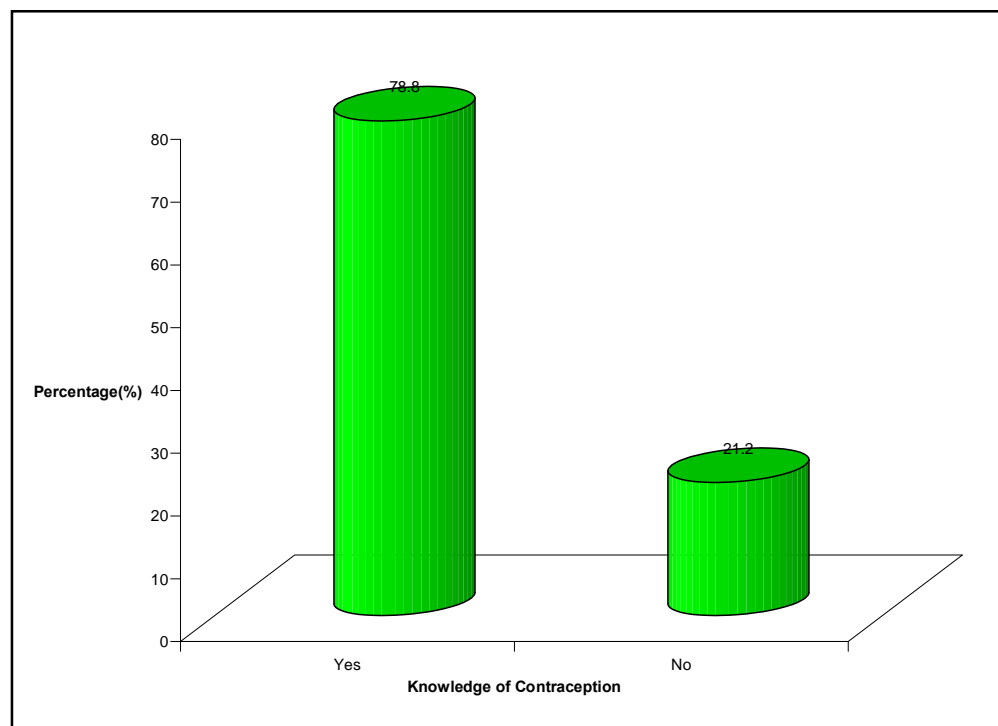
<b>Knowledge of Contraception</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	398	78.8
No	106	21.2
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011)

Table 8 shows that a higher proportion of respondents (78.8%) have heard of any contraceptives while 21.2% of the respondents have not heard of any method of contraception. The result shows that majority of the youth in Abuja metropolis have knowledge of contraceptive method during the period of administration of the questionnaires.

Figure 3 illustrates the level of contraceptive knowledge by the respondents. The figure shows that those who admitted that they have knowledge of contraceptives are higher than those who identified that they don't have the knowledge. This could be as a result of numerous advertisements of contraceptives on radio and television stations including bill boards to prevent HIV/AIDS and other sexual related diseases.

**Figure 3: Distribution of respondents on knowledge of contraceptives**



The qualitative data also exposed that most of the youth interviewed from the two groups labeled 'homely and modern' thought that almost all the youth between the ages of 15-25 years living in Abuja metropolis have knowledge about contraceptives and where to get them if they desired. But the problems they encounter are how to use it properly and embarrassment involved in buying it.

*A 23 year old undergraduate had an example to give. “My friend told me that girls always take a drug before they have a date with their boyfriends especially to protect themselves from unwanted pregnancy”.*

*A 20 year old trader also indicated that his friends encouraged him to use condom whenever he wants to have sex with her girl friend who is in secondary school to avoid impregnating her.*

*A 17 year old SSII student said “me and my boyfriend have knowledge about contraceptive methods and how to use them through watching blue films”.*

#### **4.2.2 Types of Contraceptive method**

Since, majority of the respondents indicates that they have knowledge of contraception, it is important here to know the type (s) of contraceptive method they know

**Table 9: Distribution of Respondents by type of Contraceptive**

**Methods they know**

<b>Contraceptive methods</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
Pills	267(53.4%)	233(46.6%)	500(100%)
Condom	267(53.4%)	233(46.6%)	500(100%)
Safe period	202(40.4%)	298(59.6%)	500(100%)
Withdrawal methods	115(23.0%)	385(77.0%)	500(100%)
IUD	47(9.4%)	453(90.6%)	500(100%)

**Source:** Field work (2011).

The above result shows that the three most frequently spontaneously named contraceptive methods the respondents indicate they know were condom, pills and safe periods (46.6%, 46.6% and 40.4% respectively). This was followed by withdrawal

methods and Intra Uterine Device method that youth in Abuja metropolis have more knowledge of condoms, pills and safe periods as a contraceptive method than any other methods in this study at the period of administration of the questionnaires.

#### 4.2.3 Means of Contraceptive method

From table 9, where respondents were asked to indicate different methods of contraceptives they know, it is now necessary to know the means through which they know about contraceptive. Another question was asked on whether they know where to get contraceptive. This was presented in table 10 and 11 respectively.

**Table 10: Distribution of Respondents on how they know about Contraceptives.**

Means of contraceptive knowledge	Yes	No	Total
School Teacher	243(48.6%)	357(51.4%)	500(100%)
Mother	59 (11.8%)	441(88.2%)	500(100%)
Father	6(1.2%)	494(98.8%)	500(100%)
Brother	54(10.8%)	446(89.2%)	500(100%)
Sister	73(14.6%)	427(85.4%)	500(100%)
Friends	274(54.8%)	226(45.2%)	500(100%)
Health Professionals	90(18.0%)	410(82.0%)	500(100%)
Books/Magazines	269(53.8%)	231(46.2%)	500(100%)
Others/Internet/Tv/Radio	133(26.6%)	367(73.4%)	500(100%)

**Source:** Field work (2011).

Table 10 shows that friends, books/magazines, and school teachers were three most reported source of information about contraceptives (54.8%, 53.0% and 48.6%). While only (1.2%) of the total respondents know about contraceptives through their father.

**Table 11: Distribution of respondents on whether they know where to get contraceptives**

<b>Level of knowledge on where to get contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	359	71.8
No	115	23.0
No Response	26	5.2%
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 11 indicate that three hundred and fifty nine (309) respondents know where to get contraceptives if they wanted. One hundred and fifteen (115) respondents identified that they don't know where to get it even if they wanted.

The qualitative data generated from **in-depth interviews** indicated that most of the people interviewed have different sources of information about sex and use of contraceptive. They indicated friends, media and biology class as most important means to know where to get contraceptives. The majority of the youth agreed that neither parents nor their teachers were open to talk about sex and contraceptive use which makes the youth to have conflicting information/knowledge about sex and contraceptives through friends, media and religious services. They further stressed that it is relevant that youth were given basic knowledge of sexuality and contraception from appropriate sources in order to avoid confusion.

#### **4.2.4: Sources of contraceptive Methods**

The focus here was to find out the respondents best sources of contraceptives, since majority of them admitted that they have knowledge of contraceptives. This was presented in the table below.

**Table 12: Distribution of respondents by sources of contraceptives  
Methods they know?**

Sources of contraceptive	Yes	No	Total
Govt Health Centre	214(42.8%)	286(57.2%)	500(100%)
Any office	27 (5.4%)	473(94.6%)	500(100%)
Private hospital/clinic	165(33.0%)	335(67.0%)	500(100%)
Govt Hospital	96(19.2%)	404(80.8%)	500(100%)
NGO Clinic	54(10.8%)	446(89.2%)	500(100%)
Youth centre	74(54.8%)	426(85.2%)	500(100%)
Any open market	131(26.2%)	369(73.8%)	500(100%)
Shops	296(59.2%)	204(40.8%)	500(100%)
Others (Pharmacy/Chemist shops)	51(10.2%)	449(89.8%)	500(100%)

**Source:** Field work (2011).

Table 12, shows that majority of the respondents who said they know where to get contraceptives identified at least one source of contraceptives. Government health centre, private hospitals/clinic and shops (42.8%, 33.0% and 59.2%) were three most frequently named sources of contraceptives. Youth centre, pharmacy/chemist shops, NGO clinic (14.8%, 10.8% and 10.8%) were second most named sources of contraceptives. The result further shows that other sources of contraceptives are at any open market.

This was also confirmed in many other in-depth interviews with the youth as to where do youth prefers to get contraceptive services, most of them agreed that youth feel comfortable to be entertained with their peers at the recreational/youth centre. However, this will reduce afraid of being identified as sexually active by every one if they are seen in the variety of the youth centre. While using government health institutions necessitates showing identification card and registration that might create problem in confidentiality among youth. Pharmacy/chemist shops are good but most of them might not have money

to buy contraceptive every time. There were no general agreements as to which centre were the best for the youth.

**Table 13: Distribution of Respondents on if they will like to know more about contraceptives**

<b>Will you like to know more about contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	57	11.4
Yes	339	67.8
No	104	20.8
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 13 above indicates that three hundred and thirty nine (339) respondents want to know more about contraceptives. This was followed by one hundred and four (104) respondents who indicated that they don't want to know more about contraceptives with their reasons below at table 16, while fifty seven (57) respondents did not give any response.

#### **4.2.5: Reasons for more Knowledge of Contraceptives**

First, the interest here was to find out the reasons why respondents seek to have more knowledge and information about contraceptives methods. And secondly, why some of the respondents do not want to know more about contraceptives. This was presented in table 14 and 15 below.



**Table 14: Distribution of Respondents by reasons for more Knowledge of contraceptive**

<b>Reasons for more knowledge</b>	<b>Frequency</b>	<b>Percentage</b>
No Responses/Not Applicable	225	45.0
Have little knowledge	48	9.6
I need to be enlightened about the usage	126	26.2
The rate of unwanted pregnancy and abortion among youth is high	31	6.2
Because I will get married to somebody one day	21	4.2
Prevention is better than cure	31	6.2
For future use and to guide me	10	2.0
To know the side effects of contraceptive	8	1.6
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 14 shows that those respondents who out rightly said that they need to be enlightened about the use of contraceptives were in the majority (25.2%). Followed by respondents who said they have little knowledge about contraceptives (9.6%) that is why they want to know more about contraceptives while those respondents who said that the rate of sex, unwanted pregnancy and abortion among the youth is high is (6.2%). The lowest respondents (8%) said they want to know the side effect of contraceptives.

**Table 15: Distribution of Respondents by reasons why they don't want to know more about contraceptives**

<b>Reasons why I don't want to know more</b>	<b>Frequency</b>	<b>Percentage</b>
No Responses/Not Applicable	430	86.0
Because I know them	42	8.4
It is against my faith	11	2.2
I restrict myself from sex	14	2.8
I enjoy feeling the natural body while sexing	3	.6
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 15 shows that the majority of the respondents did not give any reason (86.0%). This was followed by those who respondent that they know about contraceptives (8.4%) that was the reasons why they don't want to know more about contraceptives. Meanwhile, (2.8%) said because they restrict themselves from sex. The respondents that said using contraceptives is against their faith are 2.2 percent. The lowest respondents were those who said they enjoy feeling the natural body while sexing 0.6 percent of the sample.

#### 4.2.6: Options taken on if the Respondents approve use of contraceptives

The interest here was to know if the youth in Abuja metropolis approve use of contraceptives since majority of them know about contraceptives and where to get them. And again to know whether is male or female youth should take responsibility to practice contraceptives. This was presented in table 16 and 17 below.

**Table 16: Distribution of Respondents on if they approve use of contraceptive methods by youth**

<b>Approve use of contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	57	11.4
Yes	339	67.8
No	104	20.8
<b>Total</b>	<b>500</b>	<b>100</b>

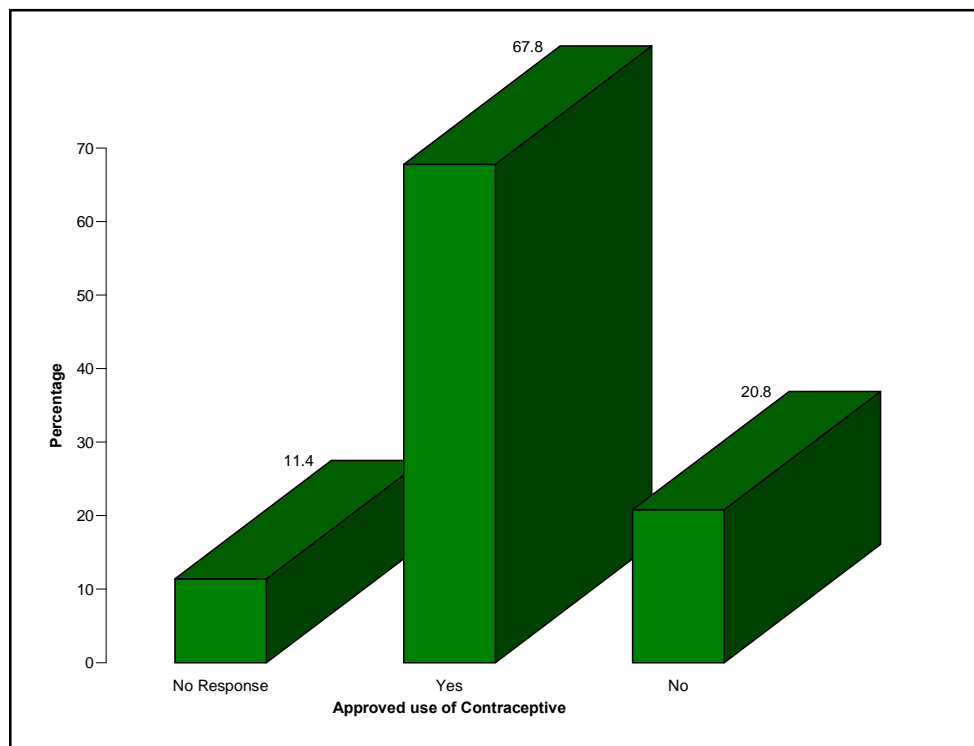
**Source:** Field work (2011).

Table 16 indicates that three hundred and nineteen (319) respondents approved use of contraceptives by youths, followed by one hundred and fifty seven (157) respondents. Twenty four (24) respondents did not respond approve or approve use of contraceptives

by youth. From the in-depth interviews most of the youth identified that their parents disapprove use of contraceptives, they also stated that their societies disapprove involvement of youth in sexual activity and sees it as evil and dangers for success.

Figure 4 illustrates how the respondents approve the use of contraceptives by youth in Abuja metropolis. The table clearly shows that youth who approved the use of contraceptives are higher than those that indicated that they don't approve use of contraceptives by youth. And this could be as a result of restrictions imposed by tradition and other religious institutions on sex as taboo.

**Figure 4: Distributions of respondent on if they approve use of contraceptive by youth**



Field work (2011)

*This was confirmed in many other in-depth interviews with the youth, which includes: A 17 year old secondary school girl said my parents always warned me how dangerous*

*and shameful to see a young girl buying and using contraceptives and also engaging in pre-marital sexual activity”*

*A 24 year carpenter said, “We know that our parents and elders do not oppose our involvement in sexual activity because they do not advice us not to have sex but they always advice us not to use any condoms because of bad side effects and again is not in our culture”.*

*An 18 year old secondary school girl also said, “My elder brother always warned me not to allow any boy to use condoms on her because it can seize inside her vagina”.*

**Table 17: Distribution of Respondents by who they think should take responsibility to practice contraceptives.**

<b>Who should practice contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	68	13.6
Female	59	11.8
Male Partner	63	12.6
Both partners	310	62.0
<b>Total</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 17 shows that 62.0 percent think both partners should practice contraceptives. Similarly, 12.6 percent think male partner should be responsible to practice contraceptives while the lowest respondents (11.8%) think it should be female partner. However, 13.6 percent of the respondents did not give any response.

### 4.3 Sexual History

This section examines the issues related to sexual activity and other sex related matters among youth in Abuja Metropolis. Questions were asked to know if the respondents have ever had sexual partner, and if they have ever had sexual intercourse and at what age they are the first time they had sex. This was presented in table 18, 19, and 20 below respectively

**Table 18: Percentage distribution of Respondents on if they have sexual partner**

<b>Do you have sexual partner</b>	<b>Frequency</b>	<b>Percentage</b>
Don't know	10	2.0
Yes	291	58.2
No	199	39.8
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 18, shows that (58.2%) of the total population have sexual partner. While (39.8%) indicate that they don't have sexual partner. With the high percentage of respondents who have sexual partner, it shows that sexual activities are quite high among youth in Abuja metropolis.

The qualitative data generated from **in-depth interviews** with the youth confirmed the fact that why youth engaged in pre-marital sexual activity majority of them agreed to be the effect that majority of the parents do not teach and guide their children the way they should handle the natural feelings. This lack of guidance about sexuality made youth ill-prepared to face challenges of peer pressure. Behavioral

changes like drinking alcohol, and watching pornographic films have also blocked the perceptions of youth to see the consequences of engaging in pre-marital sex.

Similarly, some of the youth interviewed who are not in school also identified youths' joblessness and shortage of money as what made them to have sexual partner and see sex as a cheap alternative of having leisure time especially the boys and an easier way of getting an income for girls (some of the girls claimed that their friends regularly rush into Abuja central area by weekends to make quick money from senators and well to do men). The following were some of the expression taken from them,

*A motor mechanic, aged 18 years claimed that "sex is a means of relieving stress after along day of struggle to get money, which is why I have sexual partner".*

*More so, an undergraduate of one of the tertiary institutions indicate that "boys after watching pornographic films are like bombs ready to explode any minute. At this moment they cannot pass any opportunity to have sex in order to relieve their internal tension activated by the film". According to him, that is why most of them patronize sex hawkers.*

*Similarly, a 17 year old undergraduate said that these days' girls have sexual partner for material gains and to dress fancy/well, since Abuja is a world class modern city in order for them to attract men.*

**Table 19: Distribution of Respondents by if they have ever had sexual intercourse**

<b>Have you ever have sexual intercourse</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	11	2.2
Yes	300	60.0
No	189	37.8
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 19, shows that the majority of the respondents 60.0 percent have had sex, followed by 37.8 percent respondents who reported they have never had sex, while 2.2 percent declined to respond to the question. From the in-depth interviews youth who identified that they have had sex stated that they were not properly guided about sexuality before the age they are likely to begin to have sexual activities. They also stated that they had sex because of influence of different substances like alcohol.

**Table 20: Distribution of Respondents by how old they were the first time they had sex**

<b>Age Group</b>	<b>Frequency</b>	<b>Percentage</b>
0 ó 09	67	13.4
10 ó 14	57	11.4
15 ó 19	339	67.8
20 ó 24	104	20.8
25 <sup>+</sup>	11	2.2
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 20 shows that the majority of the respondents had sex for the first time between the ages of 15-19 years. This was followed by those respondents between the ages of 20-24 years. From the table it was obvious that respondents between the ages of

10-14 years had sexual intercourse for the first time compared with respondents who admitted they had sex for the first time from 25 years and above. From the study, it was observed that as age increases, sexual activities also increase among youth.

**Table 21: Distribution of Female Respondents by if they have ever been pregnant**

<b>Have you ever been pregnant</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	25	10.2
Yes	23	9.4
No	186	80.3
<b>TOTAL</b>	<b>234</b>	<b>100</b>

**Source:** Field work (2011).

Table 21 indicates that out of the two hundred and forty four (234) sexually active female respondents who responded to question that asked whether they had been pregnant, (9.8%) of the total population admitted they had been pregnant while (79.4%) admitted they never been pregnant. However, 10.6 percent declined to respond to the question. Also, from the **in-depth interviews** girls who have been pregnant identified fear of side effect, partners' disapproval as well as their partner don't approve use of contraceptives as reasons why they got impregnated.

**Table 22: Distribution of male respondents by if they have impregnated a girl**

<b>Have ever impregnated a girl</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	33	12.4
Yes	24	9.0
No	209	78.6
<b>TOTAL</b>	<b>266</b>	<b>100</b>

**Source:** Field work (2011).



Table 22 shows that out of the two hundred and sixty six (266) sexually active male respondents, twenty four (24) admitted they have impregnated a girl while two hundred and nine (209) identified that they have not. Two hundred and sixty seven (33) respondents declined to respond to the question. From the **in-depth interviews** some one the youth stated that they impregnated a girl because they don't know how to use contraceptives properly, some also identified afraid of being seen by their parents and elders, embarrassment to buy condoms as well as religious opposition as the reasons why they impregnated a girl.

#### 4.3.1: Outcome of pregnancy

The important issue here was that since about 9.4 percent of the female respondents admitted that they have been pregnant and 9.0 percent male respondents admitted they have impregnated a girl, it is now necessary to know the outcome of the pregnancies. (See figure 5 below)

**Figure 5: Distribution of Respondents on the outcome of the Pregnancy**

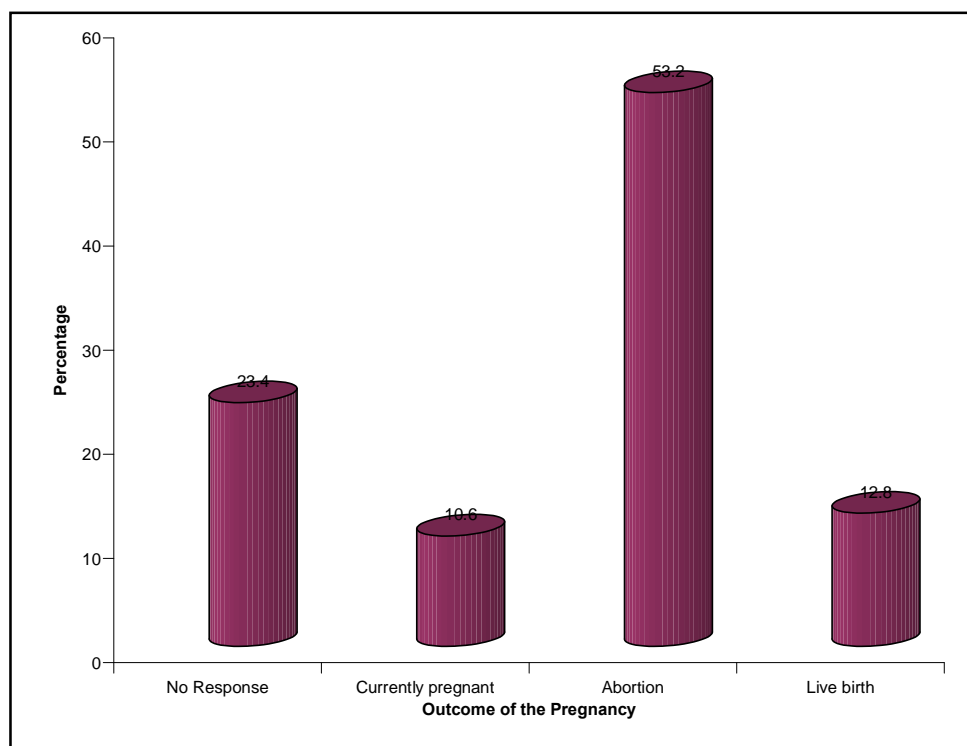


Figure 5 shows that out of 23 sexually active female who have been pregnant and 24 sexually active male who have impregnated a girl, (53.2%) ended up in abortion while (10.6%) respondents are currently pregnant. However, 12.8 percent have given birth. Eleven (11) respondents did not indicate any outcome.

**Table 23: Distribution of Respondents on if they have ever used any Contraceptives**

<b>Have you ever use any contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	52	10.4
Yes	171	34.2
No	277	55.4
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 23 shows that one hundred and seventy one (171) respondents reported that they have used contraceptives while two hundred and seventy (277) reports that they have never used any contraceptives. Fifty two (52) respondents did not indicate whether they have used or not. With the highest proportion of respondents who reported that they have never used any contraceptive methods at the period of this study, it shows that youth in Abuja metropolis don't usually use contraceptive when having sexual intercourse.

**Table 24: Distribution of Respondents on if they discuss Contraceptive methods with their partner the first time they had sex.**

<b>Did you discuss contraceptive method with your partner</b>	<b>Frequency</b>	<b>Percentage</b>
No response	161	32.2
Yes	239	47.8
No	100	20.0
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 24 shows that the majority of the respondents 47.8 percent identified that they discuss contraceptives the first time they had sex while 20.0 percent of the respondents identified that they did not discuss any contraceptives with their partner the first they had sex.

**Table 25: Percentage distribution of respondents by if they use contraceptives the first time they had sex**

<b>Did you use contraceptive method the first time you had sex</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	180	36.0
Yes	173	34.6
No	147	29.4
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 25 shows that high majority of the respondent (36.0%) did respond if they have used contraceptive or not. Meanwhile, 34.6 percent of the respondent reported they have used a contraceptive method. On the other hand, 29.4 percent indicated that they did not use any contraceptives method.

In view of the above result based on the number of respondents that identified that they did not use any contraceptives the first time they had sex, there is need to empower youth in order to expose them to the opportunity for improved access to information on contraceptive use. Given them the basic information will equally help in addressing their fear of side effects of contraceptives.

The qualitative data also exposes some of the youths' reasons why they did not used contraceptives the first time they had sex with their partner. Their reasons is that they did not have adequate knowledge on how to use contraceptive properly, that

contraceptives use is not culturally acceptable, that their religion opposes the use of contraceptives by the youth and fear of side effects. Below are some of their expressions:

*A 19 year old undergraduate said, “Using contraceptives is not good and our church forbid using of contraceptives by the youth”.*

*It is not good at all, we feel comfortable with our natural body instead of contraceptive that is why we did not use any contraceptives the first time we had sex (IDI respondents).*

*I have never been aware of contraceptive, the first time I had sex (IDI respondents).*

In line with the above, it becomes necessary that youth, should be guided and taught on the importance of contraceptives be aware they reach the age they are likely to have sex.

**Table 26: Distribution of Respondents on the types of Contraceptive method(s) they have used.**

<b>What contraceptive method did you used</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	289	57.8
Condom	133	26.6
Pills	8	1.6
Injectable	6	1.2
Withdrawal	32	6.4
Safe period	29	5.8
IUD	03	0.6
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 26 shows that condom (26.6%) was most frequently used method. Withdrawal (6.4%) was second most frequently used methods, followed by safe periods (5.8%), pills (1.6%) and IUD (0.6%) respectively at the period of administration of the questionnaires. The results from **in-depth interviews** also confirmed that majority of the

youth use contraceptives especially condoms, though not all the time they have sex. They raised the issue of negligence, engaging in unplanned sex, having sex when the state of mind is not clear due to influence of alcohol and substances and imposition from partner as reasons for inconsistency use of contraceptives.

**Table 27: Distribution of Respondents on why they used a particular Method of contraceptive during their last sexual intercourse**

<b>Why did you use a particular contraceptive method</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	85	17.0
Easy for secret use	115	23.0
Easy to get it	70	14.0
Cheap to buy	108	21.6
I get it free	30	0.6
Have better knowledge about it	92	18.4
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 27 shows that easy for secret use 23.0 percent, cheap to buy 21.6 percent and have better knowledge about it 18.4 percent were the most frequent reasons why they used a particular method during their last sexual intercourse. This was followed by easy to get 14.0 percent and I get it free 0.6 percent respectively.

**Table 28: Distribution of Respondents for what purpose did they use a particular method**

<b>What purpose did you used a particular method</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	136	27.2
Prevent unwanted pregnancy	164	32.8
Prevent STDs	130	26.0
For medication	20	4.0
Child spacing	35	7.0
Others	15	3.0
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 28 shows that the majority of the respondents 32.8 percent stated that the purpose why they used a particular method was to prevent unwanted pregnancy, followed by 26.0 percent of those who said they used a particular method to prevent sexual transmitted diseases. Similarly, child spacing and for medication were other reasons.

**Table 29: Distribution of Respondents on what method(s) they will prefer to use in the future**

<b>What method will you lie to use in future</b>	<b>Frequency</b>	<b>Percentage</b>
No Response	100	20
Natural methods	89	17.2
Modern methods	186	37.2
Both methods	125	25.0
<b>TOTAL</b>	<b>500</b>	<b>100</b>

**Source:** Field work (2011).

Table 29 reveals that 37.2 percent of the sample will want to use modern methods. This was followed by 25.0 percent that would want to use both methods; again 17.2 percent would want to use natural methods. About 20.0 percent did not respond to the question.

#### **4.4 Barrier to Contraceptive Use**

This section seeks to find out the barriers youth encounter in accessing and using contraceptives. Questions were asked on problems they encounter for those who used contraceptives and reasons why some of them did not use any contraceptives. This was presented in table 32 and 33 below

**Table 30: Distribution of Respondents by Problems they encounter to use contraceptives**

<b>Barrier to Contraceptive Use</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
Lack of Knowledge of Contraceptive	149(29.8%)	351(70.2%)	500(100%)
Short of Money	40 (8.0%)	460(92.0%)	500(100%)
Long waiting at health institute	58(11.6%)	442(88.4%)	500(100%)
Disapproval by parents	114(19.%)	386(77.2%)	500(100%)
Disapproval by partner	60(12.0%)	440(88.0%)	500(100%)
Lack of information where to get Contraceptive	59(11.8%)	441(88.2%)	500(100%)
Bad health worker's attitude	26(5.2%)	474(94.8%)	500(100%)
Fear of side effect	121(24.2%)	379(75.8%)	500(100%)
Embarrassment to buy	168(33.6%)	332(66.4%)	500(100%)
Others	32(6.4%)	468(93.6%)	500(100%)

**Source:** Field work (2011).

Table 30 shows that majority (33.6%) of the respondents identified embarrassment to buy contraceptives as a major problem while the lowest percentage (5.2%) of the respondent associated bad attitude of health workers as their problem to contraceptive use.

Among the respondents (29.8%) associated lack of proper knowledge of contraceptives as the problems they encounter to use contraceptives. This was followed by respondent (24.2%) who identified side effect of contraceptives as a barrier to contraceptive used. This shows that this group prefers having sex with natural body than using any contraceptives. Other problems identified by the respondents (22.8%) and (12.0%) were disapproval by parents and also disapproval by partner. From this statistics it shows that parents don't encourage their children to use contraceptives whenever they want to engage in sex. However, (11.6%) and (8%) of the respondents identified long waiting at

health institute and short of money as problems they encounter to use contraceptives. Among the respondents (11.8%) also identified lack of information where to get contraceptive as a problem they encounter. This shows that media houses and other broadcasting organization/agencies need to create more awareness on proper use of contraceptives.

The qualitative data also exposed a number of problems youth face in trying to use contraceptives, almost all the people interviewed agreed that youth encounters problems in trying to use contraceptives both at acquisition and usage. They further explained that embarrassment to buy is one of the major problems they face. This according to them is because asking for contraceptives shows that the person is wayward and not disciplined, and he/she is not from a good Christian/Moslem home. However, those that managed to buy do not ask properly on how to use them to avoid being seen by their relative or friends. Others raised the issues of being humiliated by providers while asking for contraceptive to be an important barrier. Others indicated the religious opposition to contraceptives as their own barriers to use contraceptives. This was also confirmed by some of their expression.

*A 20 year old undergraduate said “one day I went to buy a condom in a chemist shop and one of our fellowship leaders saw me. She reported me to our fellowship and after a lot of questions. I was suspended for a month”.*

*A 19 year old hair dresser claimed “youth faced a lot of problems while buying condoms, their problems are fear and shame to buy, humiliating by the sellers and refusal by partners and again where to keep the remaining after use.*



**Table 31: Distribution of Respondents by the Reasons why they did not use any contraceptives**

<b>Barrier to Contraceptive Use</b>	<b>Yes</b>	<b>No</b>	<b>Total</b>
Lack of Knowledge	144(28.8%)	356(71.2%)	500(100%)
Religious Opposition	188 (37.6%)	312(62.4%)	500(100%)
Fear of side effect	134(26.8%)	366(73.6%)	500(100%)
Afraid to be seen by parents	159(31.8%)	341(68.2%)	500(100%)
Partners disapproval	73(14.6%)	427(85.4%)	500(100%)
Do not know where to get Contraceptive	39(7.8%)	461(92.2%)	500(100%)
I can't afford to buy	33(6.6%)	467(93.4%)	500(100%)
Embarrassment to buy	169(33.8%)	331(66.2%)	500(100%)
Don't approve use of Contraceptive by youth	39(7.8%)	461(42.2%)	500(100%)
Fear of bad health worker	23(4.6%)	477(95.4%)	500(100%)
Preferred method not available	19(3.8%)	481(96.2%)	500(100%)
Preferred source is far	32(6.4%)	468(93.6%)	500(100%)
Do not have sexual partner	78(15.6)	422(84.4%)	500(100%)
I have not yet started sex	55(11.0%)	445(89.0%)	500(100%)
Others	55(11.0%)	445(89/0%)	500(100%)
Others	32(6.4%)	468(93.6%)	500(100%)

**Source:** Field work (2011).

Table 31 indicates that assessments of reasons why respondents don't use any contraceptives show that embarrassment to buy (33.8%) religious oppositions (37.6%), lack of knowledge how to use it properly (28.8%) and afraid to be seen parents (31.8%) were the first four frequently reported reasons faced by sexually active youth. From the same table , a little higher proportion of the respondents identified fear of side effect (26.8%), disapproved by partner (14.6%) and parents disapproval (14.6%) respectively as the reasons why don't use contraceptives at their last sex intercourse.

The lowest respondents identified fear of bad health worker (4.6%), preferred source not available (3.8%), preferred source is far (6.4%), I do not have sexual partner (15.6%) and others (11.0%) as the reasons why they had sex without contraceptives.

#### 4.5 Test of Hypotheses

Three hypotheses were formulated and tested as shown below :

##### 4.5.1 HYPOTHESIS ONE.

Hypothesis one states that female youth approve use of contraceptives more than there male counterparts. To test this hypotheses, knowledge and use of contraceptive methods was cross-tabulated with the sex of the respondents as shown in the table below.

**Table 32: Knowledge of Contraceptive Method \* Sex of the Respondents**

Approve use of Contraceptives	Sex		Total
	Male	Female	
Approved	139(27.8%)	200(40.0%)	339(67.8%)
Not approved	64(12.8%)	40(8.0%)	104(20.8%)
No Response	20(4.0%)	37(7.4%)	57(11.4%)
<b>Total</b>	<b>228(44.6%)</b>	<b>227(55.4%)</b>	<b>500(100%)</b>

$$X^2 = 187.741, df = 49, P = .000$$

Table 32 shows that the higher the knowledge of contraception, the higher the use of contraceptive methods among youth. The table reveals that 40 percent of female respondents approve use of contraceptives compared to 27.8 percent of their male counter-parts. On the other hand, 12.8 percent of male respondents did not approve use of contraceptives by youth as well as 8.0 percent of female respondents. Therefore, from the analysis of table 34, it shows that female youth approve use of contraceptives more than their male counter parts

The chi-square value shows that female youth approve use of contraceptive methods more than their male counterpart. Therefore, hypothesis 1 is upheld, since the

knowledge and use of contraceptive will reduce unwanted pregnancy and HIV/AIDS infections among the female youth.

#### 4.5.2: HYPOTHESIS TWO

Hypothesis two states that youth in tertiary institutions are more aware of contraceptive methods than those in secondary and not in school. To test this hypothesis, knowledge and use of contraceptive method was cross-tabulated with current level of education of the respondents.

**Table 33.: Knowledge of Contraceptive \* Current level of Education**

Knowledge of contraceptive methods	Current level of Education			Total
	Secondary	Tertiary	Not in school	
Aware of Contraceptive	90(18.0%)	179(35.8%)	55(11.0%)	324(64.8%)
Not Aware of Contraceptive	85(17.0%)	14(2.8%)	23(4.6%)	122(24.4%)
No Response	25(5.0%)	7(1.4%)	22(4.4%)	54(16.8%)
<b>Total</b>	<b>200(40.0%)</b>	<b>200(40.0%)</b>	<b>100(20.0%)</b>	<b>500(100%)</b>

$$X^2 = 346.525, df = 98, P=.007$$

Table 33 above clearly revealed that youth in tertiary institutions (35.8%) are more aware of contraceptive methods than youth in secondary schools and those that are not in schools (18.0% and 11.0% respectively) at time of this study. Again, from the table, we also observed that 17.0 percent of youth in secondary schools are not aware of contraceptives compared to only 2.8 percent of youth in tertiary institutions who are not aware of contraceptives.

Therefore, since chi-square value 346.525 was significant at 0.007 levels, this clearly shows that youth in tertiary institutions are more aware of contraceptive method than youth in secondary schools in Abuja Metropolis.

#### 4.5.3: HYPOTHESIS THREE

Hypothesis three states that the higher the knowledge of contraceptives, the more the use of contraceptive among youth. To test this hypothesis, knowledge and use of contraceptive methods was cross-tabulated with knowledge contraceptive.

**Table 34: Knowledge and use of contraceptive \* Knowledge of contraceptive.**

Use of contraceptive methods	Knowledge of Contraceptive			Total
	High	Low	Don't know	
Approve	180(36.0%)	106(21.2%)	46(9.2%)	332(66.4%)
Not approve	112(22.4%)	-	10(1.2%)	122(24.4%)
No Response	-	-	46(9.2%)	46(9.2%)
<b>Total</b>	<b>292(58.4%)</b>	<b>106(21.2%)</b>	<b>102(19.6%)</b>	<b>500(100%)</b>

$$X^2 = 4494.56, df = 1029, P=.000$$

Since knowledge was important factor in safety measures. Table 34 clearly show that the higher the knowledge of contraceptive methods the more the use of contraceptives. For instance, 36.0 percent of those who have knowledge of contraceptive methods approved the use of contraceptives while 1.2 percent of those who don't have knowledge of contraceptive methods did not approve use of contraceptive by youth in Abuja metropolis.

Therefore, the chi-square of 4494.56 was significant at 0.000 levels. This shows that the higher the knowledge of contraceptive methods, the more the use of contraceptives among youth. The table clearly indicates that high knowledge of contraceptive among youth can help in reducing HIV/AIDS and other sexually related disease among youth in Abuja metropolis.



## **CHAPTER FIVE**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Summary of Findings**

This study was conducted in Abuja metropolis, among youth between 15 ó 25 years old. It covered youth in higher institutions, Secondary schools, and others who are not in school like traders and artisans.

A total sample of five hundred (500) was chosen for this study. The questionnaires were other-administered and were duly completed. In-depth Interview (IDI) was also conducted to revalidate and complement the findings of the survey instruments.

##### **5.1.1 Socio-Demographic Characteristics of Respondents**

The respondents for the survey comprised, fifty three percent (53%) males and forty six percent (46%) females. The age range of most of the respondents clustered between 15-19 years. The current level of education of most of the respondents are higher institutions and secondary schools (40%) each respectively and (20%) of traders and artisans who are not privileged to be in school. However, majority of the respondents were Christians (47.4%) and Moslems (45.6%). This shows that populations of those who practices Christianity and Moslem are quite high in Abuja metropolis.

#### **5.2 Knowledge and Use of Contraceptives**

Since knowledge is an important prerequisite in gaining access to contraceptives, it means that knowledge of contraceptives level could be promising for better future use.

With above 50% of total population of those who have knowledge of contraceptives from this study, it shows that knowledge of contraceptives among youth in Abuja metropolis is quite high. And with 78.8% of youth who have heard about contraceptives, it shows that knowledge of contraceptives is also quite high in Abuja metropolis. And with 62% means of those who lack knowledge of contraception, It shows that youth/adolescent have limited knowledge and access to contraceptive methods in Abuja metropolis.

### **5.3 Sexual History**

The study revealed that 58.2% of respondents were sexually active or have sexual partner. It shows that sexual activity is quite high among youth in Abuja metropolis. The mean age at the sexual debut was 0.83% for males and 0.88% for females. This indicates that females are at higher risk facing consequences of youth sexuality than their male counterparts. Differences in engagements in sexual activity between male and female could be due to various societies in Nigeria's norms that prohibits youth's involvements in sexual activity. (Whereby some society considers premarital sexual activity of male as normal but strictly disapprove female involvements in pre-marital sexual activities to avoid unwanted pregnancies). Engagements in sexual activity in this study are quite lower among youth between the ages of 20 years and above.

#### **5.4 Contraceptive Use**

Majority of the respondents (55.4%) identified that they have not used any contraceptives during their last sexual exercise/intercourse. While the lowest proportion (34.2%) identified that they used contraceptive methods at their last sexual intercourse. Condoms were used by 26.6% of all the respondents at their last intercourse. Shops were identified as the sources of contraception for higher proportion of the respondents at 59.2% while Government Health Centres (42.8%) and private hospital/clinic (33.0%) were the second and third sources of contraceptives used by the respondents at their last sexual intercourse. I know where to get contraceptives, I can afford to buy and I approve use of contraceptives, were the major reasons to get contraceptives from the selected sources for high proportion of the respondents. The main purpose of using contraceptive by the respondents at their last sexual intercourse was to prevent unwanted pregnancy, followed by prevention of sexually transmitted diseases (STDs).

However, for the fact that the rate of use of contraceptive by the respondents at their last sexual intercourse was to prevent unwanted pregnancy, followed by prevention of sexually transmitted diseases (STDs), it shows that youth were more exposed to the risk of unprotected sex. This could also be an indication to give information about unprotected sex before they start to engage in sexual activity is lacking among them.

#### **5.5 Barriers to Contraceptive Use**

The study found that majority of the respondents who have ever used contraceptives and inconsistent users might reflect the presence of problems that youth face when trying to use contraceptives. Considering the fact that (4.6%) of the female respondents have been pregnant and (4.8%) of male respondents have impregnated a girl,



therefore the level of contraceptive use could be even lower and unsatisfactory. In this study most of the respondents identified, embarrassment to buy (60.57%), Religious opposition (59.45%) fear of side effect (63.55%), Afraid of being seen by parents (60.55%) and lack of knowledge (61.30%) means was commonly reported barriers by the respondents.

This is in agreement with qualitative finding that indicted that youth face various barriers both at the level of accessing and using contraceptives considering the reasons for non use especially embarrassment to buy, lack of knowledge, fear of side effect and religious opposition could imply that even youth who have the knowledge and want to use contraceptives, factors like fear of sharing sensitive personal matters and fear of facing side effect could also be a challenge to youth decision to use contraceptives.

The study shows that youth aged 14 ó 19 years were less likely to use contraceptives than those aged 20 years and above. And again youth who discuss contraceptives with their friends and those that approve use of contraceptives by youth were more likely to use contraceptives without considering the barriers they may face. This explains why youth at their early stages should need to provide information and guidance. It could also indicate the importance of teachers/parents in providing information about contraceptive use and clearing the negative rumors about contraceptives.

## **5.6 Conclusion**

Firstly, the level of knowledge of contraceptives methods was quite high among the youth, but the majority of the respondents ever used any method was quite low. This implies that majority of sexually active youth are highly exposed to consequences of unprotected sex and sexually transmitted diseases.

Secondly, the study found that majority of the youth have who plans to use contraceptives in the future, choose to use modern methods mostly preferred condom and lesser proportion of the respondents identified pills and withdrawals, injectables as their preferred choice.

Thirdly, greater majority of the youth had positive views towards contraceptives and were interested to know more about it especially before the age they are likely to start sexual activity. Some of them identified they were not properly thought and guided on how to lead their sexual life neither from their parents nor from their teachers.

Fourthly, the study found that sizeable proportion of youth prefers to use chemists/pharmacy shops to avoid identifying them sexually active and to avoid embarrassment by health workers at government and private hospitals, who will request for registration before attention could be given to them.

Finally, the study found that youth faced a wide range of barriers to the use of contraceptives both at accessing it and level of use.

## **5.7 Recommendations**

Based on the findings, the following recommendations were proffered:

- Programs promoting safe sexual behaviour should be encouraged among youth and it should be integrated with other behavioural change intervention.
- Provision of information about contraceptive should also include the possible sources of contraceptives, especially where it could be accessed without embarrassment by the providers.
- Youth should be provided with basic knowledge of sexuality and contraception before the age they are likely to engage in sexual activities and effective channels of communication should be used to inform and educate youth using health professionals including, the author, trained teachers, and trained peer promoters and media.
- Creating public awareness (especially on parents, teachers and service providers to create supportive environment to inform youth about sexuality, encourage abstinence and reduce barriers to use of contraceptive by sexually active youth.
- Since Abuja is a modern and developing world class city, youth friendly centers should be encouraged through sensitization of the providers to enhance the function of youth centre which should include recreational, education, income generating activities to reduce fear of youth to utilize the centres.

#### **Areas of Future Research**

- It will be interesting to conduct further research among youth on the use of contraceptives in various rural communities in the federal capital territory to identify whether they are facing similar barriers to use contraceptives, parents and teachers on their knowledge about and attitude towards youth contraceptive use and provides of different delivery points on their knowledge about and attitude

towards youth sexuality and contraceptive needs and how they feel about youth contraceptive use.

- Researchers should also be committed to using the findings of research to improve the reproductive health of the youth by embarking in field works in order to find out those factors which affect youth's reproductive health; as youth's reproductive health matters a lot being one of the major contributors of death of youth in their youthful ages, (15-20 years ) through incessant abortions and HIV/AIDS infections.

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## **QUESTIONNAIRE**

### **LETTER OF RESPONDENTS**

Department of Sociology/Anthropology

University of Nigeria, Nsukka.

Date: / /

Dear respondent,

I am a post graduate student of the above department. I am carrying out a research on the ðknowledge and use of contraceptive methods among youthð. The research is purely for academic purpose as a research requirement for the award of a master's degree in Sociology/Anthropology.

You have been chosen as one of the respondents in this study through a random sampling process. The information you provide will be treated with strict confidentiality. Your response to the following questions will be highly appreciated.

Thanks for your cooperation.

Yours sincerely

Ugwu, N. Henry

PG/M.Sc/08/48493

### **SECTION A: RESPONDENTS' PERSONAL INFORMATION**

**INSTRUCTION:** Please kindly tick [ç] as your response inside the boxes and you are also required to write in some questions as may be required by the question(s). Note: if your response in question 12 is No, move to question 15.

1. Sex (a) male [ ] (b) female [ ]
2. How old were you at your last birthday?.....years.
3. What is your current level of education?
  - (a) Secondary [ ]
  - (b) Higher institution [ ] (c) Not in school [ ]
4. Religious affiliation.
  - (a) Christian [ ]
  - (b) Moslem [ ]
  - (c) ATR [ ] (d) others.....
5. How often do you discuss sex-related matters with your parents?
  - (a) Often [ ]
  - (b) Occasionally [ ]
  - (c) Never [ ]
6. What is the level of your mother's education?
  - (d) No formal education [ ]
  - (e) Completed elementary [ ]
  - (f) Completed secondary [ ]
  - (g) First degree and above [ ]
  - (h) Do not know [ ]
7. What is the level of your father's education?
  - (a) No formal education [ ]



- (b) Completed elementary [ ]
  - (c) Completed secondary [ ]
  - (d) First degree and above [ ]
  - (e) Do not know [ ]
8. Do you find it easy to talk to your parents about things that are important to you?
- (a) very easy [ ]
  - (b) Easy [ ]
  - (c) Difficult [ ]
  - (d) Very difficult [ ]
  - (e) Not at all [ ]
9. How often do you discuss sex-related matters with your parents?
- (a) Often [ ]
  - (b) Occasionally [ ]
  - (c) Never [ ]
10. What is your parents' job status?
- (a) Both of my parent work [ ]
  - (b) My father only work [ ]
  - (c) My mother only work [ ]
  - (d) Both don't work [ ]

**SECTION B: KNOWLEDGE OF CONTRACEPTIVES**

11. Have you heard of any contraceptives?

(a) Yes [ ]

(b) No [ ]

12. If yes, Please name all the contraceptive methods you know?

(a) í í í í .

(b) í í í í ..

(c) í í í í í

(d) í í í í í

(e) í í í í í .

13. How do you know about contraceptives? More than one answer is possible.

(a) School teacher [ ]

(b) Mother [ ]

(c) Father [ ]

(d) Brother [ ]

(e) Sister [ ]

(f) Friends [ ]

(g) Health professional [ ]

(h) Books/Magazine [ ]

(i) Others specify í í í í í ..

14. Do you know where to get contraceptives?

(a) Yes [ ]

(b) No [ ]

15. If yes, please tick all the sources of contraceptives you know? More than one answer is possible.

(a) Govt. health centre [ ]

(b) Any office [ ]

(c) Private hospital/ Clinic [ ]

(d) Govt. Hospital [ ]

(e) NGO clinic [ ]

(g) Youth centre [ ]

(h) Any open market [ ]

(i) Shops [ ]

(j) Others specify í í í í .

16. Would you like to know more about contraceptive methods?

(a) Yes [ ]

(b) No [ ]

17. If yes, please give reason(s) í í í í í í í í í í .

18. If no please give reason(s) í í í í í í í í í í í í .

19. Do you approve use of contraceptive methods by youth?

(a) Yes [ ]

(b) No [ ]

(c) Others please specify í í í

20. Who do you think should take responsibility to practice contraceptives?

(a) Female partner [ ]

(b) Male partner [ ]

(c) Both partners [ ]

### **SEXUAL HISTORY**

21. Do you have sexual partner?

(a) Yes [ ]

(b) No [ ]

22. Have you ever have sexual intercourse?

(a) Yes [ ]

(b) No [ ]

23. How old were you the first time you had sex? í í í í years

24. (A) Have you been pregnant? (Girls only)

(a) Yes [ ]

(b) No [ ]

(B) Have you impregnated a girl? (Boys Only)

(a) Yes [ ]

(b) No [ ]

25. What was the outcome of the pregnancy?

(a) Currently pregnant [ ]

(b) Abortion [ ]

(c) Live birth [ ]

(d) Live birth and abortion [ ]

#### **CONTRACEPTIVE USE**

26. Have you ever use any contraceptives?

(a) Yes [ ]

(b) No [ ]

27. Did you and your partner discuss contraceptive methods the first time you had sex?

(a) Yes [ ]

(b) No [ ]

(c) Don't remember [ ]

28. Did you or your partner use contraceptive the first time you have sex?

(a) Yes [ ]

(b) No [ ]

(c) Don't remember [ ]

29. What method did you or your partner use?

(a) Condom [ ]

(b) Pills [ ]

(c) Injectables [ ]

(d) Withdrawal [ ]

(e) Safe period [ ]

(f) Others specify í í í í í í í í í í í í í í í í .

30. Why did you use the method you used during the last intercourse?

(a) Easy for secret use [ ]

(b) Easy to get it [ ]

(c) Cheap to buy [ ]

(d) I get it free [ ]

(e) Have better knowledge about it [ ]

31. For what purpose did you use contraceptive methods the last time you had sexual intercourse?

(a) Prevent unwanted pregnancy [ ]

(b) Prevent sexually transmitted diseases [ ]

(c) For medication [ ]

(d) child spacing [ ]

(e) Others specify í í í í í í í í í í í í í í í í .

### **CHOICE OF CONTRACEPTIVE METHODS**

32. What methods of contraceptive do you prefer to use in the future?

(a) Natural methods [ ]

(b) Modern methods [ ]

(c) Both [ ]

33. If you are given a choice, what method(s) would you like to use?

(a) Condom [ ]

(b) Pills [ ]

(c) Injectables [ ]

(d) Spermicidal [ ]

(e) IUD [ ]

(f) Others please specify í í í í í í í í í í í í í í ..

### **BARRIER TO CONTRACEPTIVE USE**

34. Tick all the problems you encounter to use contraceptives?

(a) Lack of knowledge on how to use properly [ ]

(b) Short of money [ ]

- (c) Long waiting at the health institute [ ]
- (d) Disapproval by parents [ ]
- (e) Disapproval by partners [ ]
- (f) Lack of information where to get contraceptive [ ]
- (g) Bad health workers attitude [ ]
- (h) Fear of side effect [ ]
- (i) Embrace to buy [ ]
- (j) Others please specify í í .

35. Tick all reasons why you did not use modern or traditional methods of contraceptives?

- (a) Lack of knowledge [ ]
- (b) Religious opposition [ ]
- (c) Fear of side effects [ ]
- (d) Afraid of being seen by parents [ ]
- (e) Partner's disapproval [ ]
- (f) Do not know where to get contraceptives [ ]
- (g) I cannot afford to buy [ ]
- (h) Embrace to buy [ ]
- (i) Don't approve use of contraceptives by youths [ ]
- (j) Fear of bad health workers [ ]
- (k) Preferred method not available [ ]
- (l) Preferred source is far [ ]



(m) Do not have sexual partner [ ]

(n) I have not yet started sexual intercourse [ ]

(o) Others please specify í í í í í í í í í í í í í ..

**INDEPTH INTERVIEW GUIDE (for key informant)**

**Part 1:** (a) Where do adolescents/youth spend their leisure time and what do they do?

(b) Why do they engage in sexual activity before marriage?

(c) At what age do they start having sex and why?

(d) How do youth of your age perceive youth engagement in sexual activity?

(e) What about your immediate elders?

(f) What about parents and old people?

**Part 11 :** (a) How do you perceive the level of knowledge and use of contraceptive among youth?

(b) From where or whom do youth/adolescents get information about sex?

(c) From where or whom do youth get information about contraceptive and where to get them?

**Part 111:** (a) Do youth/adolescents face problems in trying to use contraceptives? probe for knowledge, access, and availability as possible sources of the constraints.

(b) From where or whom do the problem emanate? probe for teachers, parents, peers and siblings as possible sources.

(c) Where do youth/adolescents prefer to get contraceptives? probe for youth friendly centre, hospitals, patent medicine stores as possible sources