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Factors motivating extramarital sexuality and their implications for stds, HIV transmission in Ile-Ife

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FACTORS MOTIVATING EXTRAMARITAL SEXUALITY AND THEIR IMPLICATIONS FOR STDs/HIV TRANSMISSION IN ILE-IFE

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DEDICATION

This dissertation is dedicated to the AUTHOR & FINISHER OF MY FAITH, LORD JESUS Who Has brought me from my utter darkness into HIS marvelous LIGHT and Who Has made His Grace available for me at all times to do all things in HIS own time. To the woman after my heart HER ROYAL HIGHNESS OLUBUNMI AYOMITOLA, and to Tolulope and Temilolu - our precious GIFTS.

CERTIFICATION

I certify that this Research Project was carried out by Mr Bamiwuye, Samson Olusina and has been approved for the Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife.

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ABSTRACT

Correlates of extramarital sexuality which place individuals and their spouses and other sex partners at high risk of becoming infected with STDs/HIV were investigated among 308 men and women in Ile-Ife.

Results show that reported levels of extramarital sex is high and surprisingly higher among females than males. The mean age at first intercourse for males is 17.3 years and for females is 15.1 years. The mean number of sexual partner in the last year for males is 3.1 and for females is 1.2. The bulk of women who had extramarital relations had it because of economic considerations.

Added to the issue of multiplicity of sexual partners is the low adoption of condoms even among parties involved in extramarital sexual behaviour. The age-long cultural belief that semen can pollute breastmilk does not help matter. Men generally do not approve of the use of condom when wife is breastfeeding. The bulk of these men expressed the fear that condoms can burst during intercourse and semen can then escape and contaminate the breastmilk.

Favourable attitude to money and or material compensation for sex correlates significantly with high level of extramarital sex. Women economic status is also found to predict significantly level of extramarital relations. Increasing economic hardships in the country have forced many people young or old to resort to promiscuous sexual behaviour to make a living. Unfortunately most of these illicit sexual relationships go unprotected. The fear of AIDS let alone other STDs, is of less concern than the immediate lack of basic necessity such as food, clothes and shelter. Incidence of sexually transmitted diseases correlates significantly with level of extramarital sex.

Survey results though show a high level of awareness of AIDS among men and women, the proportion of respondents reporting incorrect mode of transmission e.g. by evil spirits is also high. This clearly shows that more detailed information about HIV modes of transmission and prevention means are needed.

Since marital infidelity is widespread and seems to be morally acceptable in Ile-Ife, an effort should be made to target married adults for education on AIDS.

The study suggests more in-depth analysis on the extramarital sexual behaviour using more comprehensive assessment of variables measuring extramarital sexuality. Future endeavours using qualitative research methods could also allow for an improved understanding of factors motivating extramarital sex in Ile-Ife.

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CHAPTER ONE

1.0 INTRODUCTION

Acquired Immune Deficiency Syndrommes (AIDS) is a disease that has aroused international concern more than any other diseases. The World Health Organisation has estimated that by December 1993 more than 14 million adolescents and adults would have been infected with HIV since the start of the pandemic (WHO, 1994). The most unfortunate thing is that the largest number of infections is still in Sub-Saharan Africa - more than nine million cases have been identified. The basic transmission pattern of this global disease is through unprotected sexual intercourse.

The first case of AIDS was reported in Nigeria in 1986 in a sexually active 13 year - old girl. In the same year, several cases of sero-positivity were reported among commercial sex workers. In 1990, the Federal Ministry of Health (FMOH) announced that 21 deaths had occurred as a result of AIDS and that blood taken from 68,355 persons yielded 308 seropositive cases (Orubuloye,1990).

The FMOH gave the number of patients reported to be infected with AIDS as 530 between 1986 and 1993. As at January 1992, fewer than 100 cases have been reported to the World Health Organisation (WHO, 1992). By April 1994, 1,148 cumulative AIDS cases were reported to the Federal Ministry of Health and Human Services (FMOHHS 1994). As at 1995, there were 650,000 Nigerians who were HIV - positive. No state is excluded from the scourge. Using WHO's Epi-model, the FMOHHS (1992) projected that by 1996, as many as one million adult Nigerians will be infected if the exponential rate of infection continues unabated. Estimate of WHO shows that 10-12 million people would have been infected with HIV, a number that will be more than triple by the year 2,000.

An individual that engages in unprotected sexual intercourse is not the individual that has it with one person but with several partners over a number of years. According to Messersmith et al, 1994, in a population of approximately 100 million people, if the HIV prevalence rate is one percent, the number of AIDS cases will be one million.

Because of the high risk of AIDS, it has become necessary to be explicit about sexual practices that are known to carry a high risk of HIV transmission. Against this background, Nigeria has been identified with the rest of the world in preventing HIV infection. The Nigerian Government has carried out some activities under the National AIDS and STD control programme (NASCP).

The objectives of the second medium term plan of NASCP include:

(i) Preventing HIV infection

(ii) Reducing personal and social impacts of HIV/AIDS on patients and their families

(iii) Impact of HIV/AIDS epidemic on the society and

(iv) Unifying and mobilising of national and international efforts and resources in the fight against AIDS.

This effort may not have much success without a comprehensive information on the prevalence and especially factors behind sexual lifestyle of her citizens within known socio-cultural settings.

This study shall be concerned with sexual behaviour that may carry some risk of HIV infection and factors sustaining such practice. The emphasis here is on extramarital sexual behaviour.

1.1 PROBLEM STATEMENT

Apparent breakdown in sexual restraints which manifested in the increase of sexual partners has been documented by researchers (Feyisetan and Pebley, 1989).

Cultural norms and practices which affect the transmission of HIV/AIDS is critical to understanding local thinking if one attempts to develop programmes that change behaviour. Traditionally, men before marriage are usually not expected to remain chaste in many parts of Africa. The Nupes in Nigeria for instance, generally assumed that boys need sexual adventures and therefore place little or no restraint on them (Nadel, 1942).

In many parts of the continent, studies have shown that there has been a traditional pattern of long female sexual abstinence after a birth (Page and Lesthege, 1981, Caldwell, 1977). It is therefore assumed that among men, husbands will continue to have sex during post partum and this period may last for 3 years (Caldwell, 1977).

In many societies there persists cultural beliefs and biases that value male children over girls, as a result many surveys of sexual behaviour document a larger rate of partner change among married and single men than women. Also societal customs such as wife inheritance, frequent informal divorce and polygamy encourage multiple partnership. In preparation for marriage men could also engage in premarital and extramarital relations with unmarried women. Women who challenged their husbands' infidelity places their relationship, economic security and physical safety at risk.

Another factor that has contributed to this global disease is social beliefs.

Studies have shown that most people fail to protect themselves lulled by the belief that those to whom they gravitate sexually will not have acquired the Virus. According to Etienne (1990) men claim to choose their partners carefully but caution can be limited to the avoidance of "Slim women". This confirms the public perception that healthy looking sexual partner cannot transmit the disease.

These societal attitudes coupled with breakdown in sexual restraints has made heterosexual transmission of AIDS to become a dominant mode of transmission. Consequently, it has become necessary to be explicit about factors that encourage incidence of extramarital sexual contacts.

A review of some AIDS literature revealed that the incidence of extramarital sexual relationship cuts across societies and has even become institutionalised in some societies. For instance, in Guinea Bissau, 'cassa dois' means second home, in Ghana, 'mpena' means sexual partner and in Lesotho 'bonyatsi' means marital infidelity. In Ile-Ife, the study area; personal experience has shown that extramarital sexual practices are common. Literature focusing on the extent of this practice and especially factors motivating extramarital relations appears to be scarce.

With the worsening economic conditions in Nigeria, sexual strategies that maximize material returns can become increasingly important, thus exacerbating the risk of STDs/HIV infection.

1.2 OBJECTIVES OF THE STUDY:

a) To identify the correlates of extramarital sexual relationship which

put individuals and their spouses and other sex partners at high risk of becoming infected with STD/HIV. This will be necessary in order to examine the mechanism by which users of condoms can increase especially parties involved in extramarital sexual practices as well as how and in what ways, through appropriate advice, government and Non-Governmental Organisations can benefit from private efforts in its future intention to establish national action programmes

b) To explore the socio-economic factors affecting sexual behaviour of respondents.

c) To investigate how the fear of HIV has affected extramarital relationship in Ile-Ife.

LITERATURE REVIEW

1.3.1 THE EPIDEMIOLOGY OF HIV AND AIDS IN SUB-SAHARAN AFRICA

AIDS is primarily transmitted heterosexually rather than homosexually and via intravenous (iv) drug use as in the case of the US and Europe. In 1992, the UN Human Development Report estimated that one adult out of 40 in Sub-Saharan Africa is HIV infected. WHO (1994) reported that the largest number of infections is in Sub-Saharan Africa - more than 9 million.

The concentration of infected people according to Caldwell and Caldwell (1994) was found only in ten countries, eight in East Africa, one in Southern Africa, and one in West Africa. Over 1.9 million of the global cases are estimated for the adult population while children account for the remaining 550,000 cases

(WHO, 1993).

Chin (1992) reported that extensive spread of HIV in Sub-Saharan Africa started during the late 1970s and early 1980s. According to WHO (1993) 1 million persons were newly infected globally, the majority of whom were in Sub-Saharan Africa. Anarfi (1993) remarked that AIDS is not by who you are but by what you do. Therefore, people are not at risk due to identification with a high risk group but due to participation in high risk behaviour.

People are now forced to re-examine their sexual values and behaviour. For instance, WHO (1993), noted that behavioural change is dependent on a range of economic, political, cultural and gender related issues. In the less developed countries, especially Nigeria, people continually experience most

severely the effects of poverty and consequently the spread of AIDS (AIDS LINK, 1993). Prices of essential consumer items and services have skyrocketed. In consequence women many of whom make substantial monetary contributions to the budgets of poor and middle class families may find it increasingly difficult to make ends meet. Nor are they able to call upon extended families as virtually all but the wealthiest are feeling the pressure of the economic crisis. Many women whose regular partners are unable to provide adequate support and who lack skills, capital and connections are forced into sexual relations. In a study conducted by Ulin (1992), women in Africa often form relatively stable union with several sexual partners each of whom contribute in some way to the maintenance of their families. Women clerical workers, school girls and female traders are examples of larger proportion of urban women who often survive by occasional trading sex for resources and upward mobility (Ulin, 1992).

1.3.2 STDs/HIV IN NIGERIA

Sexually transmitted diseases (STDs) are groups of infections/communicable diseases that are primarily transmitted via sexual contact. STDs can cause pain, and some can cause infertility and death if not treated. Some common curable STDs are gonorrhoea, chlamydial infection and syphilis. Each year there 333 million new cases of curable STDs and millions of other viral STDs such as herpes and hepatitis B (Hatcher et al, 1997).

Sexually transmitted diseases may enhance HIV because they increase the number of white blood cells which are targets for HIV in the genital tract. STDs such as chancroid, gonorrhoea and trichomoniasis may increase the risk of HIV

transmission by two to nine (Population Reports, 1993).

The data on the incidence and prevalence of STDs in Nigeria are limited, especially a national data. Common STDs in Nigeria include gonorrhoea, syphilis, genital warts trichomoniasis, chlamydia and candidiasis (Ogunbanjo 1989). Clinic-based studies in different communities have shown difference prevalence rates in common STDs in the country. For instance the prevalence rate for gonorrhoea ranges between 5-15 percent , 11-15 percent for chlamydia and 6 percent for syphilis (Sogbetun, Alausa and Osoba 1977; Ogunbanjo 1989; Aladesanmi, Mumtaz and Mabey 1989).

Human Immunodeficiency Virus (HIV) attacks and destroys a certain type of white blood cells in the human immune system called a T4 or T-helper cell. HIV targets these cells because it is able to attach itself to a particular molecule called CD4 on the cell surface. The impact of the immune system can be measured by recording the level of these cells using a blood test called a CD$ cell or T Cell count. A low count can indicate that a person has symptomatic HIV infections or AIDS.

In Nigeria, the first AIDS case was reported in 1986 (Messersmith et al, 1994). This was in a sexually active 13 year old girl. Between 1984 and 1989 few cases were reported to the Federal Ministry of Health and Human services (FMOHHS). In the month of April 1994, it was reported that 1,148 cumulative AIDS cases had been found in Nigeria (WHO, 1994).

In a 1993 sentinel survey on increase in HIV sero prevalence among certain groups was reported. Rates recorded were 1.4% of antenatal patient, 2.2% of Tuberculosis patients, 4.6% of patients attending STD clinics and 22.9%

of commercial sex workers (AIDS monitor, 1993). Another sentinel study in 1994 testifies to an escalation. Surveillance shows HIV infection is present in 52% of commercial sex workers, 22% of STD patients, 14% of TB patients and 6% of ANC attenders (AIDS monitor, 1994). Using WHO's computer programme EPI-model, FMOHHS (1992) projected that by 1996 as many as 1,000,000 adult Nigerians will be infected if the rate of infection is not curbed.

HIV infection and full blown AIDS have been reported in virtually all the states in Nigeria. Demographically, the reported AIDS cases in Nigeria indicate that about two-thirds of them are males and that the disease affect mostly people aged between 20 and 39 among both sexes (Isiugo-Abanihe, 1994).

Surveillance report by WHO shows that Lagos has the highest reported AIDS cases closely followed by Enugu. As at September 1993, 137 cases of AIDS were reported in Lagos, and 133 in Enugu. In Osun State, the number of AIDS cases reported was 23 (National AIDS committee, 1993).

Feyisetan (1993) reported that among the 90 cases found in Lagos between 1989 and 1991, 85% (77) were involved in multiple unprotected sexual contacts and 15% (14) had a history of other STDs. Hary et al (1993) reported an overall prevalence rate of 1.67% in a clinic based serosurvey of 1259 subjects in Borno State (Maiduguri, Potiskum and Biu) during 1989-90.

Orubuloye et al (1990) in a study in Ekiti, South West of Nigeria found 308 seropositive cases from blood samples taken from 68,355 persons.

In response to the grave, social and economic consequences of AIDS pandemic, the Nigerian government has undertaken some effort to ensure that people become aware of AIDS, it's mode of transmission and ways of preventing

the spread. Nigerian Educational Research and Development Council (NERDC) is making efforts in integrating AIDS education into school curriculum to take care of adolescents. Various messages have been developed targeted at specific audience. For pupils in primary 5 and 6, their message is "Saying no to sex". While secondary school message is "What you should know before you say yes to sex". Tertiary institutions were not left out "Condom use for casual sex" is part of the messages to be integrated into the General Studies programme. These efforts are to make youths adopt positive attitudes towards practice of safe sex.

Government has also recognised the role the mass media can play in imparting information to raise public awareness. To this end, there has been a total of 15 TV jingles as well as 5 radio jingles. There have also been 103 personnel appearances on television and 10 radio phone-in sessions (FMOH AND SS, 1993). In ensuring accurate presentation of HIV/AIDS and STD reports, seminars were conducted to update journalist from various parts of the country on AIDS. Radio drama were also sponsored by NASCP while there is a gradual inclusion of AIDS related issues in existing soap-operas. A documentary video titled "Dawn of Reality: AIDS in Nigeria" was produced in English, Pidgin and three major Nigerian Languages by NASCP. This is aired on TV networks.

Non-governmental organisations have played vital roles in controlling the spread of AIDS. For instance STOPAIDS employs the use of poster with a rolled up condom to reinforce messages like "STOP AIDS tonight use a condom". STOPAIDS organisation as part of its project activity with long distance drivers conducted a knowledge, attitude and practice study among the drivers in Ido, Ojota and Ojo motor parks on AIDS, modes of transmission and prevention.

A Task force on blood transfusion was inaugurated in 1991. This Task force has since formulated a national blood transfusion policy. There are 23 screening centres and additional 28 are on the way. Nine sentinel surveillance sites and twelve STD clinics have been established throughout the country (Messersmith et al, 1994).

1.3.3 DEMOGRAPHIC & SOCIO-ECONOMIC CONSEQUENCES OF THE AIDS EPIDEMIC

It is difficult to predict the future level of HIV and its associated mortality rates. This is because of lack of data in measuring precisely the prevalence of HIV. Consequently, scholars have resulted to use of models to estimate mortality due to AIDS. The scope and intensity of the impact of AIDS on mortality will depend on the long-term evolution of the epidemic. This will be governed by transmission process and probabilities, incubation period, variability of infections, sexual practices and other behaviour affecting exposure to the virus. Stover (1994) argued that under five mortality rates are likely to rise in many countries inspite of the tremendous advances in preventing and treating other childhood diseases.

Deaths associated among adults will occur between ages 25 and 40. This means loss of productive adults which no doubt has repercussions for economic growth and social structure.

Researchers have studied the question of impact of AIDS on population growth and the consensus is that AIDS is not going to cause negative population growth in any country in Africa. Firstly, the major factor determining the future rates of population growth will continue to be changing fertility rates (Stover

1994). Secondly both the mortality of children and the adult will be increased. What will happen is that the number of orphans will be increased as a result of those born to HIV-infected mothers but who are not infected themselves and those born before their mothers were infected. According to Lamboray and Elmendorf (1992) more than ten million children under the age of ten are expected to become AIDS-bereaved orphans in Africa during the 1990s.

Lamboray and Elmendorf, (1992) argued that it is possible that young adults might get married earlier to avoid high risk sexual behaviour, thereby increasing their fertility. Because of the long incubation period of AIDS, it is also possible that women infected with HIV but unaware of their status to conceive several children before they developed AIDS and die. Women who know they have contracted HIV might decide to stop childbearing to avoid transmitting the infections to newborns. Women who are childless on the other hand might be more inclined to conceive. To them, it might be worth taking the risk of giving birth to an HIV-infected baby. AIDS epidemics have the potential to derail development in the most seriously affected third world countries and to slow down progress in many others. For instance at the household level, additional pressures are expected. The allocation of household resources, for instance, will be altered as medical expenditures and funeral costs assume increased importance. Some families may not be able to afford basic necessities.

At the societal level, the epidemic also have important consequences. One of the most immediate and direct impacts of the epidemic is in the health sector. The size and quality of the labour forces of vital industries will be impacted. The rural agricultural sector may also be affected, further limiting food supplies.

Other changes are likely to occur within the extended family. Household incomes are likely to fall when a member of the household becomes infected with HIV. The extended family suffers not only the loss of income that had been provided by the economically productive AIDS patient, but also experiences increases in household expenditures for medical treatments and ultimately funerals.

1.3.4 CONDOM USE IN NIGERIA

A condom is a sheath, or covering, made to fit over a man's erect penis. Most condoms are made of this latex rubber. Some condoms are coated with a dry lubricant or with a dry lubricant or with spermicide. Female condoms that are inserted into a woman's vagina are available in the US and many other European countries. The method is being introduced in many developing countries.

During sex, condoms are the best protection against catching STDs or giving STDs to a partner. Condoms can stop sexual transmission of many diseases including HIV/AIDS. Studies have shown that condom users have about two-thirds as much risk of getting gonorrhoea, trichomoniasis or chlamydia infections as people that have never used condoms (Hatcher et al , 1997).

In many countries, condoms are an important part of family planning programmes. Because condom is associated primarily with illicit sex and with disease prevention, married couples are often reluctant to use it for family planning purposes. With the advent of AIDS epidemic, there has been a greater emphasis on the role of condoms in the prevention of sexually transmitted

infection.

Studies have shown that prevalence of current condom use as a family planning method is low in sub-saharan Africa ranging from less than one percent in at least 10 African countries during the 1985-1992 period to as high as 13 percent in Mauritius in 1991 (Messersmith et al, 1994).

Data from 1990 Demographic and Health survey (NDHS) showed that 2.5 percent of all women had ever used condoms to delay or prevent a pregnancy. In a study conducted by Orubuloye, Caldwell and Caldwell (1993), condom use for family planning was approximately 16% in Ekiti, South West of Nigeria.

Recent evidence from end of year project knowledge, attitude, practices and behaviour survey of AIDSCAP'S intervention programme among students in tertiary institutions in Nigeria showed that students in tertiary institutions have begun to initiate the use of condoms during sexual intercourse. They have also increased the use of condoms for both regular and casual partners (Adewuyi, 1997)

With respect to availability of condoms, they are readily available in pharmacies and hospitals as well as store. Family planning clinics established by government provide free condoms, and costs as much as ₦10.00 for a pack of 4 condoms in stores.

1.3.5 SEXUALITY IN TRADITIONAL NIGERIAN SOCIETY

Hogan (1995) described sexuality as the totality of sexual behaviour of human being. It includes all the biologic, as well as the socio-cultural , psychologic and ethical components of sexual behaviour. Sexual behaviour

includes all the individual considers as a necessary part of their masculine or feminine role. The way sexuality is expressed in any society is learned through culture.

There were variations in the traditional requirement of female premarital chastity among ethnic groups in Nigeria just as in other parts of Africa. While some societies promote female virginity, no value is placed upon chastity in other societies (Orubuloye et al, 199O).

The traditional Igbo and Yoruba societies placed a high premium on virginity of bride (Fadipe 1970, Orubuloye 1981, Bolaji 1984, Uchendu 1965, Ellis 1970). The practice in traditional Fulani society is that an evidence of white cloth with marks of blood must be shown for a proof of female virginity. This according to de st Crux, (1972) usually attracted feast and words of praises for the betrothed girl.

Virginity was so important in traditional Yoruba society that two women often waited outside the couple's room on the wedding night to take the good news to her parents that the bride was intact (Fadipe, 1970).

With respect to extramarital sexual relation in traditional Nigerian society, married women often fear their husbands by desisting from adultery. For instance in a study conducted by Mair 1969, there was widespread belief that an adulterous woman is likely to die during delivery unless the woman confesses. Studies have also shown that some kinds of traditional medicines are placed on promiscuous women to restrain them from extramarital relation.

According to Talbot (1969), adultery in a wife is punishable by death or divorce, but as a rule the injured husband beats his erring wife, and recover

damages from the adulterer.

1.3.6 THE NEW SEXUAL ORDER

Sexual behaviour in Nigeria has started to take different dimension from what it used to be. Attitude of people toward sex has become increasingly liberal (Feyisetan and Pebley, 1989). Nowadays potential husbands want their future wives to be pregnant before marriage as proofs of their fertility. Studies have shown that free marriages are on the increase (Southwold, 1973) making divorce and separation to be on the increase. The divorcees and the separated often enter into another relationships in a bid to remarry for various reasons, primarily for emotional and financial assistance from men. It is not news to find young school girls and those out of school (drop-outs) soliciting for sexual partners in the premises of hotels and bars in our society or towns and cities. The global economic problem and particularly the hardship brought by structural Adjustment programme have worsen the situation. Married men and women are not left behind in the exchange of sex for money or material recompense.

1.3.7 EXTRAMARITAL SEXUALITY IN SUB-SAHARAN AFRICA

Several studies have confirmed that the breakdown in the mechanism of sexual behaviour has increased (Feyisetan and Pebley, 1989, Orubuloye 1991, Makinwa-Adebusoye 1991, Oguntimehin 1992, Oyekanmi 1992, Messersmith et al, 1994). Cultural and social sanctions about extramarital sexual activity have

become weaker, and in some societies, the practice has become institutionalised.

Extramarital sexuality has been found to be more common among males than females. The reason was because women could be punished by the husband (Southwold 1973, Obbo 1987). In Kenya study, 25% of married men and 4.7% married women reported casual partners. Carael, Cleland and Ingham (1994) findings in 14 surveys on sexual behaviour and other topics related to HIV/AIDS also showed that levels of extramarital sex were higher among males than females in all survey sites. The researchers found that the prevalence of sexual activity outside regular partnerships ranges from less than 10 to nearly 50 percent among males but from zero to less than 20 percent among females.

With regards to incidence of extramarital affairs among tribes of Uganda, the Baganda men frown upon a man who is faithful to his wife and adultery seems to be a common practice among their women (Southwold, 1973) . Kisekka (1973) noted that among the same tribe in Uganda, many undesired children resulted from extramarital and concubinage relationships. The Langi society though prohibits her women from engaging in extramarital sexual practice, it encourages the men to engage in such practice (Curley, 1973).

Among the Banyakole, Middleton (1975) reported that extramarital sexual relations were allowed between a wife and her in-laws when the husband is on labour migration. Hogsborg and Aaby (1990) found in a study in Guinea Bissau, that a man with a lactating partner could take a lover and if the lover got pregnant as well, she was likely to become a secondary wife to be set up in a different home . This second home is known as 'cassa dois'.

Extramarital relations appeared widespread throughout Lesotho, 'Bonyatsi'

individuals could easily be identified. The 'Bonyatsi' (marital infidelity) practice was recognised as a usual state of affairs only in private rather than in public forum. Folk songs made reference to it. Bonyatsi is a relationship which may be maintained on a long term basis between already married persons and it is different from prostitution. The origin of Bonyatsi were claimed to be part of the creation and a feature of all human social life (Spiegel, 1991).

In a rural area of Senegal, Enel and Pison (1990) noted that extramarital sexual relationships though was a rare occurrence; married men seize the opportunity of seasonal migration for indulging in extramarital relationships.

In Ghana, the Akan tradition welcomed marriage between cross- cousins. According to Anarfi (1993), majority of men reported they have sexual relationships with girl friends when their wives are lactating and such relationships can develop into marriage since polyandry is acceptable to the society. Ghanaian women often limit the extramarital sexual activities of their husbands by cutting down the overall period of abstinence in marriage. To many Ghanaians the idea of sexual partner implies the 'mpena' relationship or concubinage. 'Mpena' is a regular or permanent relationship which carries with it some financial and other rewards for the females (Anarfi, 1993).

The result of a study of sexual networking among women in Benin City, Nigeria showed that 26% of the women surveyed were having intercourse with strangers and 70% of the women have had extramarital sexual relationship. (Omorodion, 1993).

In a study of sexual networking among Nigerian police officers Akinnawo (1995) found that most of their extramarital sexual partners were single girls

particularly students.

Orubuloye et al (1994) found that extramarital sexual activities were rampart in Ondo State. They found that most males extramarital relationships are with younger women whom they describe as friends or singles. For most female extramarital relationships, married men are often their partners. These men might have been known to them before they married. The researchers also found one third of such relationships to be with relatives by marriage, for example brothers-in-law and sons of co-wives. They suggested that a programme aimed at increasing the practice of safe sex, especially the use of condoms by everyone participating in sexual networking should be encouraged.

In Brazil, and other Latin American countries there is a practice which insists on sexual monogamy for women while tolerating extramarital sex for men. Women who suggest condom use risk accusations of marital infidelity and possible abandonment (Diniz, 1995). In Argentina, 37% of men and 12% of women who reported being in a stable relationship engaged in extra-marital relationship

in the six months before the survey.

It is evident from the limited review that while reasonable evidence emerged on nature and prevalence of extramarital sex, the studies scarcely addressed the factors behind such practice.

Extramarital sexual relations can be affected by socioeconomic statuses, attitude to money or material recompense, duration of post-partum sexual abstinence and form of unions among others. In the face of the present economic predicament of the country, it becomes essential to investigate how much sexual

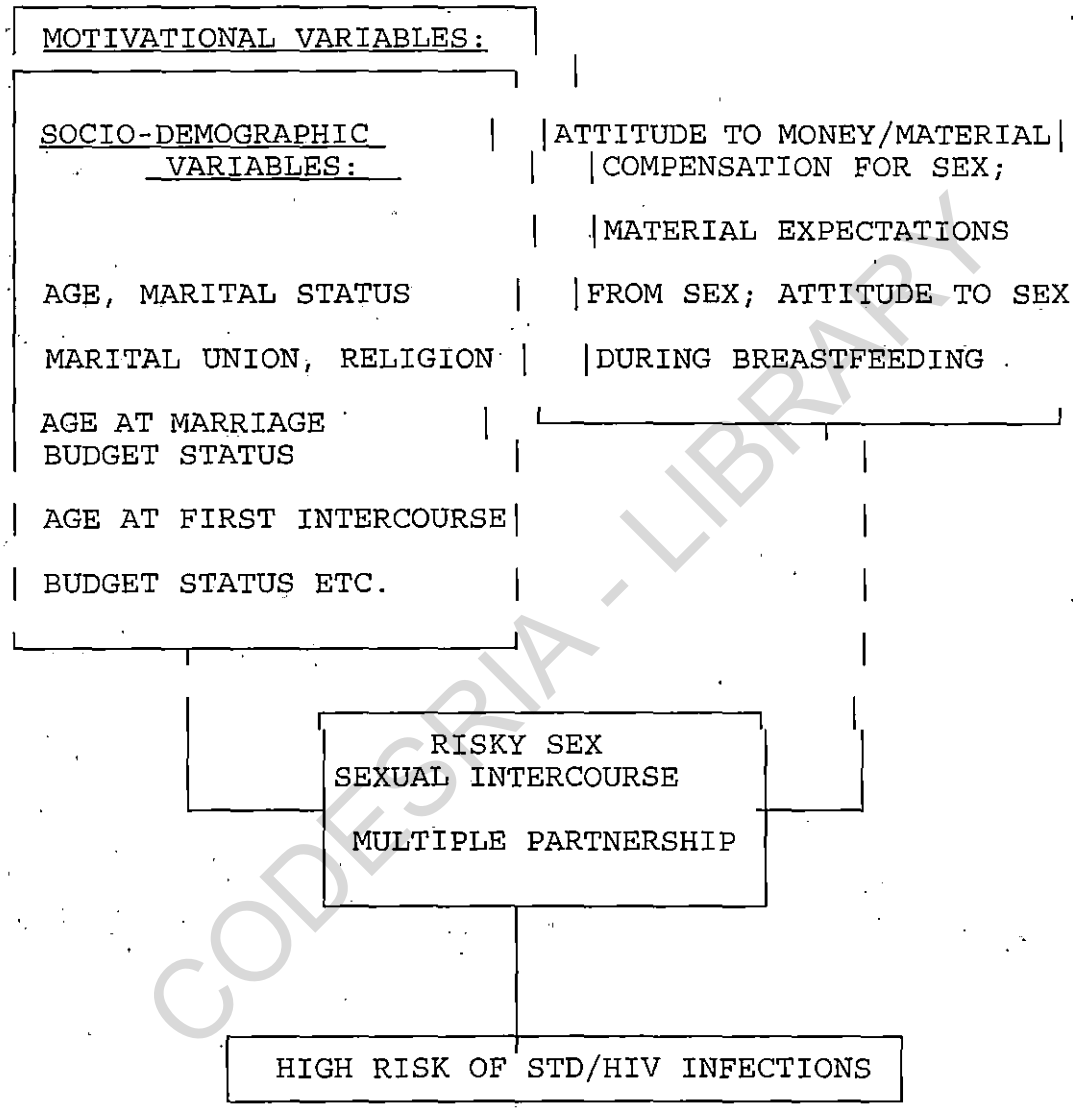
contacts outside union take place in exchange for money and other material compensations.

1.4 CONCEPTUAL FRAMEWORK

The main focus of the study is to explain factors determining sexual relations outside marriage within known socio-cultural settings. There exists many motivating factors that cause men and women to engage in extramarital sex within the normative pattern of the society and there are also expected gains. To engage in sex outside marriage is to be involved in an unprotected sex relationship which enhances the risk of contracting STD/HIV.

A conceptual model adapted from Sexual Exchange Risk Model is employed to explain the nature of extramarital sexual relationship and the risks involved. This is because before one can fully comprehend sexual behaviour in present day Nigeria, it is helpful to view sexual behaviour (both premarital and extramarital) as basically transactional. A powerful theoretical explanatory construct that fits in here is the theory of social exchange. A possible argument from this approach is that people enter into sexual relations just because they find such relationship rewarding. Sexual relationships are therefore contracted for pecuniary gains (different from formal prostitution) and sexual life generally is woven round the notion of material recompense for sex. Ankoma and Ford (1993) adopted this approach in explaining premarital sexual relations. They concluded that most sexual relationships are consumerist with women exchanging sex for material compensations.

FIG 1. SCHEMATIC DIAGRAM ADAPTED FROM SEXUAL EXCHANGE MODEL



SOURCE: Framework adapted from Sexual Exchange Risk Model

The operational definitions of some of the variables involved in the Sexual Exchange Risk Model are as follows:

Material Expectations From Sex:

These include specific items and services or monetary rewards.

Multiple Partnership:

Practice of having multiple sexual partners at a time.

Unprotected Sexual Intercourse:

Penetrative Sex outside marriage without condom use.

1.5 HYPOTHESES:

1. Men and women who have a favourable attitude to money/material recompense for sex are likely to engage in extramarital sex.
2. Economic status of women may determine the extent of extramarital sexual involvement. In other words higher economic status will be associated with lower number of sexual partners.

1.6 ORGANIZATION OF THE STUDY

This study is presented in five chapters. The first chapter begins with introduction and the statement of the problem. The objectives of the study, statement of the problem and the hypotheses. The chapter also features the review of relevant literature and the conceptual framework.

Chapter Two deals with Methodology of the study . Under this are background information of the study area, sample design, sample size, techniques of data collection, data management and analyses and some practical measures adopted to enhance validity of the data collected.

Chapter three starts with the univariate analysis of data using some

selected background variables by gender. The chapter also examines health and sexual behaviour characteristics of the sample. Some selected variables were examined in relation to extramarital sexual practices among males and females.

The fourth chapter presents the Bivariate and Multivariate analysis of extramarital sexuality, respondents' awareness of HIV/AIDS and their perceived vulnerability to infections, utilization of condom in extramarital sexual contacts. In the concluding chapter, highlights of major findings are discussed while conclusions and implications of findings followed.

In the appendix section, the only instrument of data collection used - the questionnaires was presented.

CHAPTER TWO

2.0 METHODOLOGY

2.1 BACKGROUND INFORMATION ON THE SAMPLED AREA

Ile - Ife is one of the ancient cities in Yorubaland and one of the three largest in Osun State, South West of Nigeria. It is situated in the tropical zone with longitude 4:6°E and latitude 7.5°N. Ile - Ife is about 2.75 metres above the sea level. Ile - Ife is about 80km North East of Ibadan. It is the headquarter of Ife central Local Government.

According to oral traditional history, Ile - Ife was the first created living place and the original home of all beings. 'Obatala' otherwise known as 'Orisa Nla', the chief artist was regarded highly by the ancient Ife people as the greatest of all Yoruba deities. It was generally believed in the past that "Olodumare" (God) created solid and shapeless figures, but later commissioned 'Obatala' in Ife to give shape to the figure. Thus, the nose, mouth, eyes, limbs e.t.c were the making of the great artist Obatala - the patron of all sculptors (Eluyemi, 1978).

Traditionally, the City of Ile - Ife was divided into five quarters - Iremo, Okerewe, More, Ilode, and Ilare. Within each quarter there are compounds, within each compounds, there are many family lineages. Another quarter named Modakeke quarter was later created to absorb the Oyo people. In the centre of the town is the 'Aafin' (palace) of the "Ooni" the title of the traditional head of the town. Surrounding the palace are houses grouped into compounds in the traditional pattern.

In the past, the town administration was entirely carried on by the Ooni supported by sixteen high chiefs representing major royal lineages. "Obatala" is the next in rank to the "Ooni" Chief Obalufe and other chiefs advise the King and help in the running of the affairs of the town.

The Ife people are predominantly farmers. Cocoa is the most important cash crop, the next is oil palm produce. There are also Kolanut and Rubber. The major food crops include Yam, Maize, Cassava, Beans e.t.c. Apart from farming, Ife people also engage in Blacksmithing, saw-milling, Bricklaying e.t.c, Dyeing, Wearing, Pottery and Oil Extraction are popular among women. A large proportion of the people are traders while some are engaged in government services.

Ile - Ife has two large hospitals (one teaching hospital which includes an STD clinic and a family planning clinic and one mission hospital), one comprehensive health centre and five satellite health centres, several private hospitals and a private diagnostic laboratory.

Ile -Ife is blessed with a University - Obafemi Awolowo University, a technical college, a school of nursing and many primary and secondary schools.

The town enjoys pipe-borne water, telephone and telegraphic services. There are many Commercial banks.

Ile-Ife is linked by roads to other parts of the country through the four major road which link the town with Osogbo, Ibadan, Ondo and Ilesha.

The choice of Ile - Ife as a study area for this research is motivated by the following factors:

(1) The proximity of the study area to the researcher will be an asset in terms of cost, time and efficient supervision.

(2) As a University town, Ile - Ife has attracted all categories of workers of all socio-economic grades and with the heterogeneous nature of the residents, one would expect different patterns of sexual behaviour.

2.2 SAMPLE SIZE AND SAMPLING DESIGN

Covering the total population of Ile -Ife was impossible because of the constraints of cost and time. It was then decided to have a sample of at least 300 respondents. The unit of analysis comprised married men between ages 18 and 60 and married women in the age range 15 to 49. In all, a total of 308 (181 males and 127 females) were covered.

In arriving at this total, three residential areas were first distinguished by socio-economic status - low, middle and upper middle. Each area was then divided up into small roughly equal blocks out of which 5% of all the blocks listed were selected. The houses in each of the blocks selected were listed and a systematic random sampling was adopted.

2.3 METHOD OF DATA COLLECTION

The only instrument of data collection was a carefully designed structured scheduled questionnaire. The fieldwork started with only two interviewers, the researcher and another experienced female graduate colleague. The female colleague interviewed women while the researcher solicited information from men only. Efforts were not made to recruit additional interviewers to speed up the process of data collection because of the sensitive nature of the study. Most of the questionnaire were self administered with the researcher and his assistant recording the responses

as given by the subjects. Only very few questionnaires were given out (on the insistence of the respondents) to be filled by themselves.

The interview technique adopted made it possible to collect quality data. There were proper assessment of the adequacy of responses. In all, three hundred and eighteen questionnaires were returned, but three hundred and eight were fully completed.

2.4 TYPES OF DATA COLLECTED

The questionnaire was divided into five main sections. Section 1 was devoted to Background characteristics of the respondents. Questions on sexual behaviour featured prominently in the second section. The section also asked questions on opinion on virginity and attitudes to

money/ material compensation for sex.

The third section examined the knowledge and experience of our subjects about sexually transmitted infection. Knowledge of AIDS was treated separately on section five while section 4 examines respondent's knowledge attitude and use of condoms especially for the prevention of sexually transmitted diseases.

2.5 CONSTRAINTS TO DATA COLLECTION

The interviewers did not experience much difficulties during the data collection period. Most people gave their fullest cooperation especially when they had been assured of the confidentiality of whatever information they gave. However, some of them still complained of having no time to attend to us and insisted that they would fill in their responses themselves. On the average, each interview lasted about 35

minutes and six questionnaires were collected per day. Most of the respondents felt more relaxed on Sunday evenings.

We had a little problem on the aspects of sexual behaviour of the respondents. While some discussed their behaviour frankly and freely, we took pain to assure others of the secrecy of whatever information they gave before we could gain their support for the interview. Using a female interviewer for the females and a male interviewer for the males helped to enhance the validity of the data collected.

Generally, the illiterates were found to be more ready and willing to attend to us. From the respondents who insisted to fill the questionnaires themselves, six questionnaires were misplaced. They did not consider it necessary to apologize for the loss of the questionnaires. However, some respondents who were probably familiar with social research and who recognized the importance of such study gave their fullest cooperation.

It is pertinent to note that inspite of all these problems, the reliability of the data was not affected. Where inconsistencies in responses were discovered, the questionnaires were cancelled. The fieldwork lasted for about six weeks.

2.6 VARIABLE DEFINITION AND MEASUREMENT

The Dependent Variable

The dependent variable is "whether respondents have had extramarital sex in the past year". Respondents were to respond "Yes" if they have ever had extramarital relations twelve months preceding survey and "No" if otherwise.

The Independent Variables:

The independent variables are grouped into 4 categories; socio-demographic

variables; health variables and sexuality variables and some indices of spousal closeness. The socio-demographic variables include age, education, marital status, marital union, age at first marriage, age at first intercourse, occupation, budget status and religion. Health variables include ever had STDs, treatment of STDs, perceived vulnerability to infection, use of condoms to prevent infections etc. Sexuality variables are extramarital sexual relations in the past yea, reasons for extramarital relations, number of sexual partners, ever paid or been paid for sex, attitude to money/material compensation for sex, age at first intercourse, attitude to extramarital sexual behaviour and opinion about virginity.

Indices of spousal closeness are : sleeping in the same room, eating together and keeping the same account.

2.7 DATA MANAGEMENT AND ANALYSES

The data collected were properly screened and edited to check for consistency and or omission especially in those questionnaires given out to be filled by the respondents.

The data entry was handled personally by the researcher.

There were two levels of analyses each with different analytic procedure. In the first level, an examination of the gender distribution of the respondents according to some selected characteristics were performed. Univariate and bivariate forms of analyses were first performed using SPSSPc+ package.

The multivariate analysis adopted was the logistic regression. The multivariate logistic regression procedure helped in controlling for simultaneous effects of independent variables like age, education, occupation, religion, form of marital union,

indices of marital conjugality on dichotomous dependent variable which in this study is extramarital sex twelve months preceding survey.

The general model of equation is of the form

$$\log p/(1-p) = b_o + b_1x_1 + b_2x_2 + x_2 + b_3x_3 + \ldots + b_nX_n$$

$$Where X_1, X_2, X_3 \ldots X_n$$

are the set of independent variables P is the probability of having extramarital relation in the past year.

This technique of analysis has been used successfully on studies on sexual behaviour by Messersmith et al 1994, Isiugo-Abanihe, 1993; Carael et al 1994 and in other studies (Feyisetan et al, 1997;) for a dichotomous dependent variable.

2.8 DESCRIPTION OF EXPLANATORY VARIABLES

AGE

Less than 25 = 1 if respondent reported age is less than 25 years; 0 otherwise

25-29 = 1 if respondent reported age is between this age bracket; 0 otherwise.

30-34 = 1 if respondent reported age is between this age bracket; 0 otherwise.

35-39 = 1 if respondent reported age is between this age bracket; 0 otherwise.

40-44 = 1 if respondent reported age is between this age bracket; 0 otherwise.

45-49 = 1 if respondent reported age is between this age bracket; 0 otherwise.

50 and above = 1 if respondent reported age is between this age bracket; 0 otherwise.

EDUCATION:

None = 1 if respondent has never attended school; 0 otherwise.

Primary = 1 if respondent highest level of education is primary; 0 otherwise.

Secondary = 1 if respondent highest level of education is secondary; 0 otherwise.

Post Secondary = 1 if respondent has education higher than secondary level;

0 otherwise.

MARITAL UNION

Monogamous = 1 if a female respondent is the only wife or a male respondent has only one wife; 0 otherwise.

Polygynous = 1 if a female respondent is not the only wife or the male respondent has more than one wife; 0 otherwise.

RELIGION

Christians = 1 if respondent religious affiliation is christianity; 0 otherwise.

Muslims = 1 if respondent's religious affiliation is Islam; 0 otherwise.

Traditional Religion = 1 if respondent is an adherent of traditional religion; 0 otherwise.

OCCUPATION

Farming = 1 if respondent engages primarily in farming activities; 0 otherwise.

Trading = 1 if respondent's primary occupation is trading; 0 otherwise.

Artisans = 1 if respondent's is an artisan; 0 otherwise.

White Collar = 1 if respondent primarily engages in white collar job; 0 otherwise.

Others = 1 if respondent engages in other occupation different from above; 0 otherwise.

EVER HAD STDs

Yes = 1 if respondent reported ever contracting sexually transmitted diseases;

0 otherwise

EVER PAID/BEEN PAID FOR SEX

Yes = 1 if respondent reported ever had sex for money; else "Ever Paid/Been Paid for Sex" = 0.

BUDGET STATUS:

Low = 1 if respondent rated his/her budget status low; 0 otherwise.

Medium = 1 if respondent rated his/her budget status as medium; 0 otherwise.

High = 1 if respondent rated his/her budget status high; 0 otherwise.

ATTITUDE TO MONEY/MATERIAL COMPENSATION FOR SEX

Approve = 1 if respondent okays money/material compensation for sex; 0 otherwise.

CHAPTER THREE

3.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The first part of this chapter discusses the socio-demographic characteristics of the respondents. The variables analysed include age, place of birth, education, occupation, age at marriage, and marital status. Others are ethnic background and religious affiliation. The second part examines the Health and Sexual Behaviour Characteristics of our subjects.

TABLE 3.1 DISTRIBUTIONS OF RESPONDENTS BY SOCIO-DEMOGRAPHIC VARIABLES

AGE	MALE (181)	FEMALE (127)	BOTH SEXES (308)
Less than 25	23.3 (42)	35.4 (45)	28.2 (87)
25 - 34	40.3 (73)	21.3 (27)	32.5 (100)
35 - 44	27.6 (50)	34.6 (44)	30.5 (94)
45 - 49	7.7 (14)	8.7 (11)	8.1 (25)
50 & Above	1.1 (2)	N.A.	0.6 (2)
TOTAL	100.00	100.00	100.00
MEAN	32.33 (MALE)	31.58 (FEMALE)	
RELIGION	**MEN (181)**	**FEMALE (127)**	**BOTH (308)**
Protestants	79.6 (144)	71.7 (91)	76.5 (235)
Catholic	3.3 (6)	3.1 (4)	3.3 (10)
Islamic	14.4 (26)	20.5 (26)	16.9 (52)

Traditional	2.8 (5)	4.7 (6)	3.6 (11)
TOTAL	100.00	100.00	100.00
MARITAL STATUS	**MALE (181)**	**FEMALE (127)**	**BOTH (308)**
Married living with spouse	96.7 (175)	97.6 (124)	97.1 (299)
Living Separately	2.8 (5)	0.8 (1)	1.9 (6)
divorced/widowed or separated	0.6 (1)	1.6 (2)	1.0 (3)
TOTAL	100.00	100.00	100.00
AGE AT MARRIAGE	**MALE (181)**	**FEMALE (127)**	**BOTH SEXES (308)**
Less than 25 yrs	49.2 (89)	66.1 (84)	173 (56.2)
25 - 34	47.5 (86)	33.1 (42)	128 (41.6)
35 and more	3.3 (6)	0.8 (1)	7 (2.2)
TOTAL	100.00	100.00	100.00
TYPE OF MARRIAGE UNION	**MALE (181)**	**FEMALE (127)**	**TOTAL (308)**
Monogamous	72.9 (132)	78.7 (100)	75.3 (232)
Polygynous	27.1 (49)	21.3 (27)	24.7 (76)
TOTAL	100.00	100.00	100.00
EDUCATION	**MALE (181)**	**FEMALE (127)**	**BOTH SEXES (308)**
None	5.0 (9)	11.8 (15)	7.8 (24)
Primary	37.0 (67)	32.3 (41)	35.1 (108)
Secondary	44.8 (81)	47.2 (60)	45.8 (141)
Post Secondary	13.3 (24)	8.7 (11)	11.4 (35)
TOTAL	100.00	100.00	100.00

OCCUPATION	MALE (181)	FEMALE (127)	BOTH SEXES (308)
Farming	29.3 (53)	13.4 (17)	22.7 (70)
Trading	16.6 (30)	56.7 (72)	33.1 (102)
Artisan	33.1 (60)	15.0 (19)	25.6 (79)
White Collar	13.8 (25)	11.0 (14)	12.7 (39)
Other	7.2 (13)	3.9 (5)	5.8 (18)
TOTAL	100.00	100.00	100.00
PLACE OF BIRTH	**MALE (181)**	**FEMALE (127)**	**BOTH SEXES (308)**
Indigene	76.2 (138)	77.2 (98)	76.6 (236)
Non Indigene	23.8 (43)	22.8 (29)	23.4 (72)
TOTAL	100.00	100.00	100.00

3.1.1 AGE DISTRIBUTION

The analysis in this study comprises of males aged between 18 and 60 years and females in the age range 15 and 49. Information about age was recorded for 308 persons comprising 181 males and 127 females. Analysis of the age distribution in Table 3.1 reveals that the females are very much more concentrated among respondents below age 25 while there are more males in age group

25 - 34 than in any other age group in the table.

The mean age of 32.3 years for married men and 31.6 years for married females shows that a large proportion of the sampled population are in their prime ages.

3.1.2 RELIGIOUS AFFILIATION

Table 3.1 also presents the distribution of respondents according to their religious affiliation. The table reveals that the sample population is predominantly Christian. For instance, close to 4 in every 5 respondents are Christian with Catholicism claiming slightly more than 3%. Muslims were less than 20% and there are few adherents of traditional religion (3.6%). One would expect a high proportion of traditional worshippers in Ile - Ife because it is the home of many ancient gods (Eluyemi, 1978). The marked deviation of this can be attributed to the impact of Christianity in the area. This trend is likely to continue, because churches and fellowship centres are springing up at an exponential rate in the study area.

3.1.3 MARITAL STATUS

An examination of the marital status of the sample reveals that almost all the respondents are currently living with their spouses (97.1%). More males than females are living separately from their spouses (2.8%). Males as the head of the household may need to search for economic fortunes to be able to fulfil their marital expectation. This is presented in table 3.1 above.

3.1.4 TYPE OF MARRIAGE UNION

With respect to type of marriage union, the proportion in monogamous union surpasses those in polygamous union (72.9% of males vs 78.7% of females). Family sociologists have once noted that polygynous marriage is giving

way to monogamous union especially among the younger generation (Azu, 1974). Although in the traditional Yoruba setting, polygyny was encouraged because of the need for labour farm, but the findings on occupational distribution confirmed that farming does not enjoy much popularity any longer. Hence there seems to be no need for many wives. Another probable explanation is the downtrend in the economy which does not favour marrying many wives.

3.1.5 AGE AT MARRIAGE

Analysis of age at marriage according to table 3.1 reveals a marked differential pattern by gender. For instance more females than males have married before reaching age 25. Male respondents reportedly married at later ages than the females. The mean age at first marriage for males and females were 25.9 years and 23.3 years respectively.

3.1.6 EDUCATION

Analysis of the distribution of respondents level of education by sex shows that the level of education among the sample is quite high. Over 3 in every 5 respondents have attained at least secondary level of education. More females than males have completed secondary schooling (47.2% vs 44.8%). The proportion of married men that have attained post-secondary education is more than 1.5 times than that of their female counterparts. The high literacy level could be attributed to the impact of relocation of a Federal University (Obafemi Awolowo University) to the town in January 1967. Secondly there is widespread continuing education centres in the past 6 years in the study area.

3.1.7 OCCUPATION

A consideration of the economic activities of the sampled population reveals that more men than women engaged in farming, artisan and white collar jobs. Women are more prominent in trading activities (56.7%). Traditionally, farming is the major occupation in Ile - Ife, but this has given way to trading and artisan. Slightly more than 1 in 5 respondents are in farming while over one third are traders. Men who are artisans are more than double their women counterparts.

Traditionally a non-working wife in Yorubaland is considered to be lazy. A typical Yoruba woman works to cater for herself, her children and other members of her extended family. Perhaps this might explain why none of the women reported themselves as not working.

3.1.8 ETHNIC BACKGROUND & PLACE OF BIRTH

Reported data on characteristics of respondents by their ethnic background reveals that almost all the respondents are Yoruba (96%). This is not a surprise because the study area is basically a Yoruba society. Respondents from other ethnic groups were mainly Igbo and the Hausa.

Place of birth variable shows that over three quarter of our sample are indigenes. (See table 3.1).

3.2 HEALTH AND SEXUAL BEHAVIOUR CHARACTERISTICS

In order to be able to grasp well the determinants of extramarital sexuality , further investigation into the health and sexual behaviour characteristics of the respondents were conducted. Among variables examined are extramarital sexual practices, knowledge and experience with STDs, condoms knowledge, attitude and utilisation, opinion about virginity and knowledge of AIDS and perceived vulnerability to AIDS.

TABLE 3.2: Distribution of respondents by selected health and sexual behaviour variables

VARIABLES	MALE (181)	FEMALE (127)	BOTH (308)
Mean age at first intercourse	17.3 (181	15.1 (127)	16.2 (308)
% who approved extramarital sex	37.6 (181)	24.4 (127)	32.1 (308)
Percentage Ever had extramarital sex	35.9 (181)	37.8 (127)	36.7 (308)
Reasons for Extramarital sex	**MALE (N=65)**	**FEMALE (N=48)**	**BOTH (N=113)**
Fun	41.5 (65)	12.5 (48)	29.2 (113)
Sexual variation	29.3 (65)	4.2 (48)	18.6 (113)
Money/Material needs	7.7 (65)	66.7 (48)	32.7 (113)
Sexual Deprivation by spouse	16.9 (65)	2.1 (48)	10.6 (113)
Companionship	4.6 (65)	14.6 (48)	8.9 (113)
TOTAL	100.00	100.00	100.00
% Ever heard of STD *	**MALE (181)**	**FEMALE (127)**	**BOTH (308)**
Gonorrhoea	100 (181)	100 (127)	100 (308)
Syphilis	72.9 (181)	90.6 (127)	80.2 (308)
Herpes	65.2 (181)	77.2 (127)	70.1 (308)
Magun	97.2 (181)	95.3 (127)	96.4 (308)
Chlamydia	47.0 (181)	35.4 (127)	42.2 (308)
Candidiasis	48.6 (181)	46.4 (127)	47.7 (308)
Genital Warts	55.8 (181)	76.4 (127)	64.3 (308)

% Ever had STD	29.1 (45)	24.9 (37)	26.6 (82)
Source of Sexually Transmitted Infections	**MALE (N=45)**	**FEMALE (N=37)**	**BOTH (N=82)**
spouse			
extramarital partner	20.0 (45)	51.4 (37)	(34.1)(82)
prostitutes	64.4 (45)	40.5 (37)	(53.7)(82)
Not sure	-	NA	-
	15.6 (45)	6.7 (37)	(12.2)(82)
TOTAL			
	100.00	100.00	100.00
% who told spouse they had infections	24.4 (45)	48.6 (37)	35.4 (82)
Treatment of STI	**MALE (N=45)**	**FEMALE (N=37)**	**BOTH (N=82)**
Gov.Hospital/Clinic	21.6 (45)	8.9 (37)	14.6 (82)
Private hospital	43.2 (45)	43.2 (37)	41.5 (82)
Traditional Medicine	2.7 (45)	2.7 (37)	8.5 (82)
Chemist/Pharmacy	32.4 (45)	32.4 (37)	35.4 (82)
% Ever paid/been paid for sex	27.1 (49)	25.2 (32)	26.3 (81)
Mean number of sexual partner (last 12 months)	3.1 **(MALE)** 1.2 **(FEMALE)**		
Mean number of sexual partner (lifetime)	6.8 **(MALE)** & 1.7 **(FEMALE)**		
	MALE (181)	**FEMALE (127)**	**BOTH (308)**
% Ever heard of condom to prevent disease	40.9 (74)	39.4 (50)	40.3 (124)
% Ever used condoms to prevent disease	29.3 (53)	23.6 (30)	26.9 (83)
% who approves condom use when wife is breastfeeding	39.2 (71)	39.4 (50)	39.3 (121)

* multiple responses allowed.

3.2.1 EXTRAMARITAL SEXUAL RELATIONS

The mean ages at first intercourse as presented in table 3.2 are 17.3 years for males and 15.1 years for females. With respect to the attitudes of our sample

to men and women engaging in extramarital sexual behaviour in the sample, more males than females reported they approved of such behaviour (37.2% vs 24.3%). Although more people did not respond favourably to extramarital relations, yet the proportion of women who reported extramarital sex was greater than those who approved of the practice (37.8 vs 24.8). Findings also reveal that the level of extramarital sexual relations is quite high in Ile-Ife. More than 2 in 5 respondents reported they have engaged in extramarital sex in the past 12 months. Surprisingly this level is higher among married women than men (37.8% vs 35.9%).

The mean number of sexual partner in the last year is 3.1 for males and 1.2 for female while the mean number over their life time is 6.8 for males and 1.7 for females. These figures are comparable to some extent with mean number of lifetime sexual partner of 7.1 and 1.5 found by Messersmith et al in a similar study 4 years ago in the same area.

The reasons for engaging in sexual practice outside marriage was also investigated. About 7.7% of the male respondents and 66.7% of the female respondents who reported ever having extramarital sex in the past year had it because of money/material compensation. About 29.3% of males and 4.2% of females had it for sexual variation. Among those who had such relationship, 16.9% of males and 2.1% of female had it because of sexual deprivation by spouse. 41.5% of men and 4.5% of women had it because of fun.

3.2.2 Knowledge and Experience with Sexually Transmitted Diseases

The study also examines respondents' knowledge and experience with Sexually Transmitted Infections. Findings reveal that knowledge of STDs is widespread. For instance almost all the respondents have heard of at least one STD. The most frequently mentioned of all the diseases were gonorrhoea (all respondents), 'Magun' (97.2% men vs 95.3% women) and syphilis (72.9% men vs 90.6% women). Other STDs that are not as much reported were Chlamydia (47.0% vs 35.4%), Genital Warts (55.8% vs 76.4%) and Herpes (65.2% vs 77.2%). More men than women reported ever contracted an STD (29.1% of men vs 24.9% of women). Among the people who reported infections, 64.4 % of men and 40.5% of women contracted it from extramarital sexual partner, Over half of the women who reported ever had STD said they contracted it from their husband while 20% of men who reported such incidence traced the source of infection to their wives. None of the men reported contracting the disease from commercial sex workers. Among those who reportedly had an STD, 24.4% of males and 48.6% females told their spouse they have contracted STDs. With regards to how the disease was treated, most respondents reported visiting private clinics (40.0% of males vs % 43.2% of females).

3.2.3 Condoms: Knowledge, Attitude and Utilisation

Studies have shown that condoms play an important role in family planning programmes in many countries including Nigeria. The AIDS epidemic has put an even greater emphasis on the roles of condoms in the prevention of sexually transmitted infections including HIV. Since there is no cure yet for this deadly disease, most countries have mounted campaigns that condoms are the best

protection for sexually active people who cannot hold on faithfully to one partner.

An examination of knowledge of condom as a means of preventing infections was carried out. Result shows that 40.3% have heard about condoms as a means of protecting infections. There is slight variation in knowledge by gender (40.9% of males vs 39.4% of females). This shows that knowledge is not widespread enough that condom can play a dual role both in preventing unwanted pregnancies and preventing infections. There are still more to be done in creating condom awareness especially to parties involved in risky sexual behaviour. A little above one quarter of the respondents have ever used condoms to prevent infection. More men than women have ever used condoms in their sexual adventures (29.3% against 23.6%).

An important aspect of this study is whether condom use is acceptable to couple during breastfeeding. Studies have pointed to the fact that the traditional society believes that semen can pollute breastmilk and so endanger the life of a suckling baby and so, it is a taboo in some societies to have sex when the wife is breastfeeding. One implication that such society faces is that men may want to seek for other means of satisfying their sexual urge especially in a monogamous union. This has a grave consequence for the spread of STDs/HIV. Respondents were asked whether condom use is acceptable when wife is breastfeeding. Less than 2 in 5 respondents approved of such practice. With respect to gender variations, there exists no marked difference in opinion (39.2% vs 39.4%). It is important therefore, to educate women especially during the prenatal period that it is safe to have sex during lactation and as such they should not deny the moves

of their husbands.

The study also collects information on knowledge, attitude and use of condoms from the respondents who reported extramarital sexual relations in the past year.

Knowledge of condoms was widespread among this risk group as almost all of them were able to identify condoms when the interviewers showed condoms to them. With respect to where condoms can be obtained, over half of the total population mentioned pharmacy/chemist while others mentioned hospital/health centre. None of them mentioned market as a place where condoms can be bought. Although our sample can readily identify condoms, but a significant proportion don't know that condoms can prevent infections from sexual intercourse.

3.2.4 Opinion About Virginity

The traditional Yoruba society places a high premium on female virginity at the time of marriage. (Fadipe 1970, Orubuloye 1991, Feyisetan and Pebley, 1989). Research findings however have shown that there had been an apparent departure from the traditional sexual norms (Feyisetan and Pebley 1989; Orubuloye 1991; Makinwa- Adebusoye 1991; Oguntimehin 1992, Oni 1992; Messersmith et al 1994). In 1990, 44 school girls whose ages range between 11 and 13 years were reported to have been arrested by the police in brothels in Kano City. The girls were found to be offering sex to elderly men in exchange for money.

The opinions of the respondents were sought about whether a spouse should be a virgin at marriage. Table 3.3 below shows that 61% of the

respondents support the fact that a spouse should be a virgin at marriage. With respect to gender variation, there is little difference in opinion (61.3% vs 60.6%). About 1 out of 5 men relative to over 4 out of 5 of women value virginity at marriage. Respondents were asked further whether virginity matters till marriage, more than 3 out of every five respondents do not think so.

Table 3.3 Distribution of Respondents by their Opinions about Virginity

OPINION ABOUT VIRGINITY			
	MALE	FEMALE	BOTH
Believe spouse should be virgin	61.3 (181)	60.6 (127)	61.0 (308)
Virginity matters till marriage	40.3 (181)	39.4 (127)	39.9 (308)

3.2.5 Acquired Immune Deficiency Syndrome: Knowledge and Awareness of Health Risk

In assessing the knowledge of the respondents about AIDS, each respondent was first asked whether they have heard about AIDS, and how they learned about it. All the respondents claimed to have heard about AIDS. They traced their sources of information mostly to media, hospital and friends. The respondents were then probed further on what they have heard about AIDS. To be sure that the respondents have an accurate knowledge of AIDS, several methods of transmission were proposed. To each method, the respondents had to say either Yes if they thought it is a likely way to contract the disease or NO if they thought otherwise or don't know if they were not sure. The results of answers to these questions are displayed in Table 3.4 below.

Table 3.4 Responses to Various Proposed Methods of Contracting AIDS

Method	MALE 181	FEMALE 127	BOTH 308
Sexual intercourse	76.2	74.6	75.4
Use of unsterilised needles/reused blades	56.3	48.9	52.6
Blood transfusion	73.5	64.6	69.1
Breastfeeding from an infected mother to child	75.8	79.6	77.7
Evil spirits/charms	44.5	64.5	54.5
Shaking hands	18.2	27.3	45.5
Pregnancy	20.3	32.3	26.3
Mosquito bites	11.2	3.3	7.3

Table 3.5 Responses to various proposed methods of preventing AIDS

VARIABLES	MEN (N=181)	WOMEN (N=127)	BOTH (N=308)
Maintaining one sexual partner	81.2 (181)	82.7 (127)	81.8 (308)
Regular Use of Condom	49.2 (181)	45.7 (127)	47.7 (308)
Not seeking sex from Commercial Sex Workers	99.4 (181)	97.6 (127)	98.7 (308)
Not using unsterilised instrument	50.0 (181)	71.6 (127)	54.2 (308)

Most people were able to identify the correct sources of AIDS. There are however variations by gender. More males than females correctly reported sexual intercourse (72.6% vs 74.6%), blood transfusion (73.5% vs 64.6%) and unsterilised instruments (56.3% vs 48.9%) as the known modes of transmission. More women than men reported pregnancy (32.3% vs 20.3%) and breastfeeding (79.6% vs 75.8%) as the mode of transmission. Some however believed that the disease can be transmitted by insects (11.2% of men, 3.3% of women) and hand shaking (18.2% men, 27.3% women) There is no evidence to support that insects can transmit the disease yet. It is too bad that as many as 44.5% men and 64.5% women still believed that the disease can be transmitted by spiritual means (witchcraft).

Knowledge about prevention of AIDS was also investigated and the two most popular responses were not seeking sex from commercial sex workers and maintaining one sexual partner.

CHAPTER FOUR

4.0 Bivariate and Multivariate Analyses of Extramarital Sexuality

This chapter is presented in three sections: The first section presents a descriptive display of variations in the overall prevalence of sexual encounters since marriage in the last year by gender. Further examinations in the variations in the reported level of extramarital sex are carried out firstly when education is controlled for and secondly when age has been taken care of.

As a measure of extramarital sexuality, respondents were asked whether they have had sex outside marriage in the past twelve months . Secondly they were asked to report on their number of sexual partners (outside regular union) in the twelve months preceding the survey and in their lifetime. In the second section, the use of logistic regression model was employed. This is necessary to control for simultaneous effects of the selected variables on extramarital sexual behaviour which is dichotomously measured. The hypotheses of the study were also tested.

Table 4.0 summarises the percentage distribution of married adults who have ever had extramarital sex by selected variables.

Table 4.0. Table Showing Differentials in Extramarital Sexual Practices by Selected Variables

AGE	**MALE 35.9 (181)**	**FEMALE 37.8 (127)**
Less than 25	42.8 (42)	55.5 (45)
25 - 34	38.4 (73)	37.0 (27)
35 - 44	32.0 (50)	25.0 (44)
45 - 49	21.4 (14)	18.2 (11)
50 and above	0.0 (2)	N.A.
MARITAL STATUS		
Married living with spouse	35.4 (175)	37.9 (124)
Others	50.0 (6)	50.0 (2) *
EDUCATION		
Low Education	26.3 (76)	41.1 (56)
High Education	42.8 (105)	35.2 (71)
OCCUPATION		
Farming	22.6 (53)	11.8 (17)
Trading	26.7 (30)	51.4 (72)
Artisan	58.3 (60)	21.0 (19)
White collar	36.0 (25)	28.6 (14)
Other	7.7 (13)	20.0 (5)
AGE AT MARRIAGE		
Less than 25	26.3 (76)	41.1 (56)
25 and above	42.8 (105)	35.2 (71)
KEEPING SAME ACCOUNT		
Yes	30.0	22.2
No	36.6	41.4

EATING TOGETHER		
Yes	36.0	31.6
No	35.9	47.1
GOING OUT TOGETHER		
Yes	33.7	46.3
No	37.8	31.6

* sample too small.

4.0.1 Age and Extramarital Sex

Table 4.0 presents a description of incidence of variations in extramarital relations in the past year. With respect to age, 42.8% of male and 55.5% of female in the age group less than 25 years, reported extramarital sexual practices in the past year. As the age increases, level of extramarital relations tends to decrease. Apart from the age group less than 25 years, men consistently reported a higher level of extramarital relations than women.

4.0.2 Marital Status and Extramarital Sex

Reported married adults living with their spouses are less likely to be involved in extramarital sexual contacts than those living separately from their spouses and those widowed. Table 4.0 revealed that more females than males living with their spouses reported ever had extramarital relations in the past year (37.9% vs 35.4%).

4.0.3 Occupation and Extramarital Sex

An examination of occupational variations of parties in extramarital relations revealed that over half of male respondents who reported extramarital relations are artisan. The proportion of men in white collar job who reported incidence of extramarital relations is greater than men who are farmers (36.0% vs 22.6%) and men in trading (36.0% vs 26.7%). The bulk of the women who reported extramarital sex in the past year were traders (51.4%). Among women in white collar job, 28.6% were involved in extramarital sex.

4.0.4 Education and Extramarital Sex

The education variable was dichotomised. Respondents who have less than secondary education including those with no education was categorised as having low education. Respondents who have completed at least secondary school level of education was categorised as having high education. The result reveals that men who have attained secondary school level and above are much more prominent in extramarital sex than those with lower education (42.8% vs 26.3%). Among women, lower education is associated with extramarital sexual behaviour. The proportion of women with low education who engaged in extramarital relations is greater than those with higher education (41.1% vs 35.2%).

4.0.5 Age at Marriage and Extramarital Sex

A consideration of age at marriage by level of extramarital sexual relations by gender shows a disparity in the incidence of extramarital relations. For instance, among men who married earlier than age 25, 26.3% practised marital infidelity in the last twelve months preceding survey compared with 41.1% of women in the same age group. Women who married before age 25 are associated with more extramarital sexual involvement than those who married at a later age while men who married at the age of 25 years and above are more likely to report high extramarital relations.

4.0.6 Spousal Closeness and Extramarital Sex

Some measures of spousal closeness were adopted in the study. These measures were: whether respondents keep the same account with their spouses; whether they sleep together in the same room; and whether they eat together. Analysis from Table 4.0 revealed that the proportion of men who keep the same account with their wives are less involved in extramarital sexual relations (30.0% vs 36.6%). Similarly, women who keep same account with spouse are less involved in extramarital sexual behaviour (22.2% vs 41.4%). Surprisingly, there is hardly any difference between proportion of men who always eat together with their wives and those who do not in relation to extramarital sexual behaviour (36.0% vs 35.9%). Women who always eat with their husbands also reported that they had extramarital sex than those who do not in the past 12 months preceding the survey (31.6% vs 47.1%). Men who go out together with their wives are more faithful in marriage than those who do not (33.7% vs 37.8%). In contrast women who go out with their husbands still engage in extramarital practice more than those who do not (46.3% vs 31.6%). Marital closeness may not necessarily be a good index of faithfulness.

4.1 Extramarital Sex by Selected Variables by Education

Further attempt in table 4.1 is to examine extramarital sex by selected variables when controlled for education. The selected variables were most of those already examined in table 4.0. They are age, education, occupation, age at marriage, ever had STDs, ever used condoms to prevent infections and attitude to paid sex.

Education has generally been regarded as major determinant of demographic behaviour. This variable can also shape pattern at which people engage in illicit sexual behaviour. Education may indirectly affect sexual behaviour in various ways. For instance, education may increase people's knowledge and their perceived vulnerability to infections when they engage in unprotected sexual intercourse with multiple partners.

Education variable is dichotomised into low education and high education. Low education group are those who were below secondary school level of education including never attended school. High education group consists of those who have attained at least secondary school level of education.

Table 4.1 Number and percent of men and women who had extramarital sex by selected variables and education

EXTRAMARITAL SEX (12 months preceding survey)				
SELECTED VARIABLES	LOW EDUCATION		HIGH EDUCATION	
	MALES	FEMALE	MALES	FEMALES
AGE				
Less than 30	32.1 (53)	36.8 (14)	45.0 (40)	21.7 (23)
30 and above	13.0 (23)	50.0 (18)	41.5 (65)	41.7 (48)
OCCUPATION				
White collar	31.0 (58)	17.6 (17)	52.7 (55)	57.9 (19)
Non White collar	11.1 (18)	51.3 (39)	68.0 (50)	26.9 (52
AGE AT MARRIAGE				
Less than 25	29.3 (58)	38.3 (47)	15.5 (58)	25.0 (28)
25 and above	16.7 (18)	55.6 (9)	76.6 (47)	41.9 (43)
EVER HAD STD				
Yes	83.3 (12)	85.7 (14)	84.8 (33)	65.2 (23)
No	15.6 (64)	26.2 (42)	23.6 (72)	79.2 (48)

EVER USED CONDOMS TO PREVENT INFECTION				
Yes	25.0 (24)	25.0 (12)	51.7 (25)	22.2 (18)
No	26.9 (52)	45.5 (44)	40.0 (75)	40.4 (52)
ATTITUDE TO PAID SEX				
Favourable	39.0 (16)	44.0 (11)	45.5 (20)	58.1 (18)
Unfavourable	11.4 (4)	38.7 (12)	41.0 (25)	70.0 (28)

Age of the respondents is subdivided into less than 30 years and 30 years and above. The panel under age showed that young males with high education engaged more in extramarital relations than their female counterpart and those of them that have low education. The tendency for highly educated men to be involved in extramarital relations is confirmed even for the elderly; however among females, the less educated are more active in extramarital relations than their counterparts with higher education.

Respondents with high education who are in white collar occupations irrespective of sex engaged more in extramarital relations than those with low education. This pattern is different for respondents in non-white collar occupations. In this latter occupation, while women with low occupation again experience more extramarital sex than their counterparts with high education; the males with high education who are in non-white collar job had more extramarital sex than their counterparts with low education.

Both males and females whose age at first marriage is twenty five years and above tend to engage more in extramarital sex except for the males with low education. There is a clear evidence also that both male and female irrespective of level of education who have ever had STD engage more in extramarital relations than those who had no STD infection. The exception is found among the highly educated women with no previous STD history. These women tend to be more promiscuous than any group with no history of STD.

More males with high level of education and who also have ever used condom to prevent infection experience higher extramarital relations than their male counterparts and as well as male and female with low education. Among the

sampled population who had not used condoms to prevent infection, those of them with high education and women with low education tend to be involved more in extramarital relations.

Over two-fifths of the respondents with favourable attitude to paid sex irrespective of education tend to engage in extramarital sex. However, women whose attitude are unfavourable to paid sex but with high education indulge more in sexual practices outside marriage than their male counterparts as well as male and female with low education.

With further control for education, it appears that high education tends to promote more involvement in extramarital relations for males in particular. It is also noted that women with low education engaged more significantly in extramarital sex than their male counterparts. This is suggestive of the fact that such women engaged in extramarital sex purposely for material recompense

Table 4.2. Extramarital Sex by Selected Variables by Age

EXTRAMARITAL SEX (12 months preceding survey)								
SELECTED VARIABLES	AGE (BELOW 30 YEARS)				AGE (30 YEARS & ABOVE)			
	MALES		FEMALE		MALES		FEMALES	
AGE AT MARRIAGE	%	N	%	N	%	N	%	N
Less than 25	36.1	61	32.1	53	20.0	10	36.4	22
25 and above	40.6	32	25.0	8	35.9	78	47.7	44
OCCUPATION								
White collar	41.9	62	33.3	18	41.2	51	44.4	18
Non White collar	29.0	31	30.2	43	24.3	37	43.8	48
BELIEVE IN VIRGINITY								
Yes	14.5	55	7.5	40	12.6	56	13.5	37
No	71.1	38	76.2	21	71.9	32	82.8	29
EVER HAD STD								
Yes	87.5	24	80.0	10	81.0	21	70.4	27
No	20.3	69	21.6	51	19.4	67	25.6	39
ATTITUDE TO PAID SEX								
Favourable	50.0	46	39.0	41	33.3	39	45.5	44
Unfavourable	25.5	47	11.4	35	34.7	49	41.0	61

Extramarital sex by selected variables is also further examined when controlled for age - the young and the elderly. For women who married before age 25, irrespective of their current age, over 3 respondents in every 10 engaged in extramarital sex except for males aged 30 years and above. For those who married at age 25 years and above, over two-fifths of the young males and close to a half of the eldely women engaged in extramarital sex.

The respondents in white collar occupation tend to engage more in extramarital relations than those in non-white collar jobs with the exception of the elderly women in non-white collar jobs. As expected, women who believed in virginity irrespective of age, engaged less in in extramarital relations than those who do not have the belief. Indee, among the respondents that do not believe in virginity, 7 in every 10 engaged in extramarital sex whether young or old. Similarly respondents who have ever had STD irrespective of age, are more promiscuous than those who had no history of STD.

Although there appears to be more practice of extramarital relations among the respondents with favourable attitude to paid sex; the difference is not significant particularly between the elderly males with favourable and unfavourable attitude to paid sex.

4.3 Multivariate Analysis of Extramarital Sexuality

This section presents multivariate analysis of extramarital sexuality. Some selected variables especially those relevant to our hypotheses were examined.

Table 4.3 Logistic regression of engaging in Extramarital Sex in the past year

AGE	COEFF MALE	ODD RATIO MALE	COEFF FEMALE	ODD RATIO FEMALE
LESS THAN 25	**0.304**	1.355 **	0.3967	1.49 *
25-34	0.279	1.322*	0.2912	1.34*
35-44	0.108	1.111	0.2465	1.28
45-49	0.095	1.099*	-	1.00
50 AND ABOVE	_	1.00	n.a	n.a.
EDUCATION				
NONE (RC)	-	1.00	-	1.00
PRIMARY	0.7318	2.079	0.393	1.48
SECONDARY	0.9061	2.475*	1.081	2.94**
POST SECONDARY	0.6956	2.005**	1.034	2.81*
MARITAL UNION				
MONOGAMOUS	-0.3916	0.676	-0.178	0.838
POLYGAMOUS (RC)	-	1.00	-	1.00.
RELIGION				
CHRISTIANS	0.1579	1.171	0.0639	1.066
MUSLIM	-0.0555	0.946	0.6051	0.546
TRADITIONAL WORSHIPPER (RC)	-	1.00	-	1.00
OCCUPATION				
FARMING	0.109	1.115	-0.032	0.97
TRADING	-0.106	0.899 *	1.413	4.11*
ARTISANS	0.770	2.175**	0.186	1.20**
WHITE COLLAR	1.170	3.222	0.575	1.77
OTHER (RC)	-	1.00	-	1.00
EVER PAY/BEEN PAID FOR SEX				
YES	**0.2429**	**1.275****	**2.068**	7.91***
NO (RC)	-	**1.00**	-	1.00
EVER HAD STDs				
YES	0.555	1.742**	0.268	1.31**
NO (RC)	-	1.00	-	1.00

BUDGET STATUS				
LOW	-	1.00	-	1.00
MEDIUM	0.27	1.30 *	-0.61	0.54**
HIGH	0.36	1.70 *	-0.67	1.51*
ATTITUDE TO MONEY/MATERIAL COMPENSATION FOR SEX				
FAVOURABLE	0.26	1.3 *	0.84	2.7 **
UNFAVOURABLE	-	1.00	-	1.00

Note: RC means reference category and its odd ratio = 1.00 * ($p<0.05$) ** ($p<0.01$) *** ($p<0.001$)
n.a. Not applicable.

The multivariate analysis approach adopted in this section is that of logistic regression model. The logistic procedure is particularly useful because of its capacity to control simultaneous effects of our independent variables on the dependent variable. The logistic regression model was used to calculate odds ratios for the correlates of extramarital sex by gender. The dependent variable for the logistic regression model is a measure of whether respondent engaged in extramarital relations in the last twelve months before survey. The dependent variable is coded 1 if respondent has had extramarital sex in the past year and 0 if the respondent is faithful within marriage. The covariates examined included age, religion, education, type of marital union, occupation, ever pay/been paid for sex etc. The covariates are entered as dummy variables. A positive coefficient indicates that the higher the value of the covariate, the greater the likelihood of having extramarital sexual relations in the last one year.

As contained in Table 4.3, the odds of engaging in extramarital sexuality by married men decreases as the age increases. Younger men and women are more likely to engage in extramarital sex than other age categories. Women in these younger age groups are also more likely to report extramarital sex than their men counterparts (1.355, p=.003 for men; 1.487, p=.008 for women). Age group 45-49 was made the reference category for the females while age group 50-54 was made as the reference category for the males. As the age increases, the likelihood of extramarital relations decreases among men and women.

Men and women with secondary level of education appear to be more prominent in extramarital sexual behaviour than other levels of education. Men with Secondary level of education were 2.5 times more likely to be unfaithful in

marriage than those uneducated (p=.031). Women with secondary level of education were about 3 times more likely to engage in sex outside union than the those with no education (p=0.004). Men in post secondary level of education were twice as likely to engage in extramarital sex than those without education (p=.009). Similarly women with post secondary level of education were more likely to engage in extramarital sex than those without education but less likely than those with secondary education (p=0.042).

A consideration of occupation of respondents reveals that women traders are more likely to engage in sex outside unions than their counterparts in other occupational categories (p=.039). Men in white collar jobs are more likely to have practised extramarital relations in the past year than their counterparts in other occupational classifications.

Men and women in monogamous union are less likely to engage in extramarital sex in the last year than their counterparts in polygynous setting. This result is however not statistically significant.

Incidence of sexually transmitted diseases is found to be positively related to likelihood of engaging in extramarital sexual relations. Men who reported ever had at least an STD are 1.7 times as likely to be unfaithful in marriage than those with no history of disease (p=.008). Women who have had experience with an STD are 1.31 times more likely to practice extramarital relations (p=.004).

An examination of the budget status using logistic regression in table 4.3 shows that low budget status is associated with higher incidence of extramarital relation among women. This highlights one of our hypotheses to be tested namely "Men and women who have unfavourable attitude to money/material compensation

for sex are likely to engage in extramarital relations". This result confirms the suspicion that women may often want to make up especially in the face of economic hardship to trade sex for money or other material compensation. High budget status correlates significantly with extramarital sex among married men (p=.013). Married men with high budget status are 1.7 times more likely to engage in extramarital sex relative to their counterpart with low budget status (p=.011). Among women on the other hand, there is a significant inverse relationship between budget status and marital infidelity. Women with medium budget status are less likely engage in extramarital relations than those who have low budget status (p=.003). Similarly women who rated their budget status as high are also less likely to be involved in marital infidelity (p=.014). This is the second hypothesis proposed to be tested in this study. It is demonstrated here that the second hypothesis is confirmed.

Information on attitude towards money and material consideration for sex show that men and women who have a favourable attitude are 1.3 and 2.7 times more likely to engage in marital infidelity than those whose attitude are unfavourable (p=.031 for men) and (p=.000 for women). Multivariate analysis of ever pay or been paid for sex revealed that men and women who reported transactional sex are more likely to have had extramarital relations in the past year than those who have never had sex for money or material considerations. Women who reported ever had sex because of money are 7.9 times more likely than those who never had sex for money and this is statistically significant (p=.000).

CHAPTER FIVE

5.0 Discussions and Recommendations

The study identified socio-demographic and motivational factors that were statistically associated with level of extramarital sexuality in Ile-Ife, Osun State, South West Nigeria.

A systematic sampling technique was used to select 308 married men and women. The eligible women (age between 15 and 49) and men (18 - 60) selected represented different socioeconomic backgrounds. The mean age of men and women were 32.3 years and 31.6 years respectively. These averages compare favourably with what was found four years ago in a similar study in the same area study by Messersmith et al (1994).

Data on self-reported intimate sexual behaviour presented here show some consistent patterns that are helpful in having a better understanding of levels of extramarital sex, the demographic correlates of sexual behaviour and their relationships to the HIV pandemic.

Extramarital sexuality in Ife is high. More than 2 in every 5 respondents reported they have had extramarital sex in the past 12 months. Interestingly women were more likely to engage in extramarital sex than men in Ile-Ife (37.8% vs 35.9%). Past studies have shown that men generally exaggerate their sexual activities and women generally underreport their sexual adventures, if these findings are correct then the rate of extramarital sexual practices among married women need to be investigated. Men consistently reported larger number of sexual partners than women. The mean number of sexual partner in the past year among men was 3.1 and the mean number in lifetime was 6.8. For women, the mean

number of sexual partners in the past year was 1.2 and in lifetime was 1.7 . One can infer here that the women do not often change their sexual partners like men.

The bulk of women who have had extramarital sex had it either because of money or material rewards (66.7%). Among men who had such relationships, over two-fifth had it because of fun while about a third had it for sexual variations.

Young adults are more likely to engage in extramarital relations than the older adults. This finding confirmed the general breakdown in traditional sexual norms which Feyisetan and Pebley (1989) and Oyekanmi (1993) attributed to increase in modernization. The result is also consistent with those obtained by Isiugo-Abanihe, 1993 and previous studies by Orubuloye, 1990. As Isiugo-Abanihe rightly observed, younger wives tend to maintain sexual links with premarital sexual mates or friends and hold on to this for sometime before cutting such links.

Men and women who have favourable attitude to material compensation for sex were found to be more likely to have multiple sexual partners. Increasing economic hardships have forced many people young or old, especially women to resort to promiscuous sexual behaviour to make a living. Like O'Connor et al (1992) put it, the fear of AIDS, let alone other STDs, is of less concern than the immediate lack of basic necessity such as food, clothes and shelter. Persons exchanging sex for money and or material compensations constitute a high risk group.

Added to the issue of multiplicity of sexual partners is the low adoption of condoms as a means of preventing infections. For instance among male

respondents the proportion of those who have ever used condoms for preventing infections was 29.3% (53/181). Unprotected sex among married men and women have two major undesirable outcomes. First is the problem of illegitimate birth which society disapproves. Secondly, is the risk of infections with sexually transmitted disease including AIDS. In a study of reproductive health problems among youth in Tanzania, Leshabari and Kaaya (1997) found that STDs including HIV infection were common among the subgroup who practised unprotected sex.

Because of the age-long cultural belief that semen can pollute breastmilk, the attitude of men towards the use of condom when wife is lactating was investigated. Finding revealed that men generally do not approve of the use of condom when their wives are breastfeeding. It is not unlikely that men especially in a monogamous union will want other means of satisfying their sexual pleasure under this circumstance. The fear that condom can burst during intercourse may be a probable reason for those disapproving the use of condom during breastfeeding and not necessarily because of the reduction of sexual pleasure from such encounter. This area can be further investigated.

More men than women have ever contracted at least an STD (29.1% of men vs 24.9% of women). With respect to knowledge and transmission of AIDS, most respondents though knew that indiscriminate sexual relations were the main mode of transmission. Knowledge is not widespread on how to prevent AIDS. There was a tendency to believe that they could avoid contracting AIDS if they did not have sexual intercourse with prostitutes. Incidence of sexually transmitted diseases among men and women relates positively with marital infidelity ($p=.008$ for men and $p=.004$ for women).

It is surprising to find that men and women in monogamous marriage did not seem to have experienced a higher incidence of extramarital relations than their counterparts in polygamous union. Given that men in monogamy probably have more need to satisfy their sexual desires outside the home than polygamous men, one would have expected a higher rate of extramarital incidence.

Two hypotheses were tested in the study and results indicated that favourable attitude to money/material consideration for sex correlates significantly with high level of extramarital sexuality among men ($p < .05$) and females ($p < .01$). Men with higher economic status were found to be more engaged in sex outside marriage than those with low budget status ($p = 0.01$). Economic status of women was found to predict significantly level of extramarital sexuality. For instance the higher the economic status of women the less the likelihood of engaging in extramarital relations ($p = 0.01$). In the face of present economic hardship, one wonders how much of this risky sexual practices go on unprotected. This has a great implication for the spread of STDs and particularly AIDS.

5.1 Policy Recommendations

The discussion and interpretation above have generated the following recommendations:

There are ways extramarital sex can be managed. First is to change or modify societal practices that support money and/or material compensations for sex. Massive community mobilisation will be to achieve a societal consensus that can weaken transactional sex and lay emphasis on sticking to one sexual partner. Second is to highlight the risk of HIV infection the need for men and women alike to negotiate sex that will involve condom use in extramarital sex relations.

Another issue emerging form this study is the connections between AIDS and poverty and other barriers to AIDS prevention. These connections must be acknowledged and explored. The underlying poverty issue which put women at risk of contracting sexually transmitted infections including HIV must be addressed.

The findings in this study point to the lack of comprehension about seriousness of AIDS and STDs. There is an urgent need for the implementation of a well designed national AIDS campaign aimed at promoting healthy sexual behaviour. Such campaign must be sensitive to the socio-cultural framework, contexts, and specific scenarios within which extramarital sexual contact occurs. Also life experiences of Nigerians who are actually HIV/AIDS patients could be shown in the mass media. This is to educate those who think that AIDS is not real.

Extramarital sex is high in Ile-Ife, consequently there is need for more intensive mass education to convince the population of the health implications of

condom use especially parties involved in extramarital sexual behaviours.

There is also the need to educate the populace that partner selection based on trust is not reliable. One can be HIV positive and still look very healthy. We should also seek to disabuse the faith of the populace about 'watchful period'. Studies have shown that men and women who engage in unprotected extramarital sex often wait for two to three weeks before they have sex with their spouses in the belief that if they have no problem in the meantime they are free from infections (Ankrah and Henry, 1994 ; Aina, 1994).

The impact of HIV goes far beyond HIV-positive individuals. It has great implications for their sexual partners and family members including future children.

The rapid spread of AIDS suggests that counselling services are becoming increasingly needed. Counselling according to Population Reports (1987) is a face to face communication in which one person helps another to make decisions and act on them. Counselling allows people to assess their situations, decide upon changing sexual behaviour or maintaining a safe behaviour. It also entails managing infections or illness and coping with psychosocial consequences (FMOH &SS, 1992). Issues such as risk of infection, sexuality and sexual partners, HIV transmission, clients understanding and feeling about diagnosis and importance of preventing STDs are important aspect of counselling.

More in-depth studies on the extramarital sexual behaviour in Ile-Ife, using more comprehensive assessments of variables measuring extramarital sexuality are necessary. Research methods such as focus groups and indepth interviews can be incorporated to assess sexual behaviour of married men and women outside union.

Future endeavours using qualitative research methods which cover rural and urban setting of the town on a larger scale would allow for an improved understanding of correlates of sexual behaviour in Ile-Ife. Such research effort will be helpful in developing interventions that promote reduction in risky sexual behaviour.

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APPENDIX

QUESTIONNAIRE ON FACTORS MOTIVATING EXTRAMARITAL SEXUALITY IN ILE-IFE AND THEIR IMPLICATIONS FOR STDs/HIV INFECTIONS

Introduction:
My name is (Interviewer's Name), and I am a researcher from Obafemi Awolowo University, Ile-Ife. We are conducting a study on sexual behaviour of married men and women in Ile-Ife. Although some of the questions are somewhat personal in nature, all information you provide will be kept strictly confidential. Your cooperation would be very much appreciated. Would you be willing to answer a few questions?

SECTION 1 : BACKGROUND INFORMATION: (All Respondents):

101. Are you currently married, divorced, widowed, separated or have you never been married (Thank and terminate the interview if never been married)

1. Married (currently living together)
2. Married (Living Separately)
3. Separated (4) Divorced (5) Widowed

102. In what year were you born 19----- (age in years) If the respondents do not know his/her age, try to estimate it if they were between 15 and 60 (males) and 15 to 49 (females) based on the age of their children if any. If age cannot be estimated thank and terminate the interview)

103. What is your current occupation_____

104. What is your religion? [ ]

1) Protestant
2) Catholic
3) Muslim
4) Traditional
5) No religion

6) Other: Specify ----------

105. How many years of schooling have you completed?

1) none

2) Primary (1-6)

3) Secondary or high school

4) University

5) Koranic

6) Other: (Specify: ----------)

106. What ethnic group do you belong to?

1) Yoruba

2) Hausa

3) Ibo

4) Other: Specify:----------

107. SEX OF RESPONDENT (Do not ask, simply record) (1) Male

2) Female

108. Do you have a separate income/budget from those of your spouse(s)?

1) Yes

2) No

109. Do your spouse have separate budget?

1) Yes

2) No

110. Do you normally eat together?

1) Yes

2) No

111. Do you normally sleep in the same room?

1) Yes

2) No

112. Do you normally sleep on the same bed?

1) Yes 2) No

113. Do you normally go out together (e.g to parties)?

1) Yes

2) No

114. How old were you when you were first married?

115. Is(Was) your marriage monogamous or polygynous?

1) Monogamous (SKIP TO QUESTION 22)

2) Polygynous

116. How many co-wives do you have?

117. What position do you occupy?

1) First wife

2) Second wife

3) Third wife

4) Fourth wife

SECTION 2: SEXUAL BEHAVIOUR

INTERVIEWER TO READ THE FOLLOWING: The next few questions are sensitive in nature, but are very important for our study. The information you provide will be kept strictly confidential)

201. Have you had sexual intercourse in the last four weeks?

1) Yes

2) No (SKIP TO QUESTION 203)

202. How many times have you had sexual intercourse in the last four weeks?

203. How old were you when you first had sex relations?

(IF DON'T KNOW AGE AT FIRST INTERCOURSE, ASK HOW MANY YEARS AGO AND SUBTRACT RESPONSE FROM CURRENT AGE. IF STILL DON'T KNOW, CODE 99).

204. With whom did you have this first experience?

_____

205. What were your reasons for having such experience then?

_____

206. In what circumstances did you have the experience?

_____

207. Some women lose their virginity before marriage:

a) Do you believe that a spouse should be a virgin at marriage?

1) Yes

2) No

b) Does it really matter that you keep the virginity till marriage?

1) Yes

2) No

208. How many sexual partners have you had in the last four weeks?

209. How many sexual partners have you had in the last twelve months?

210. How many sexual partners have you had in your life time plus your first sexual partner ?

211. How many sexual partners do you have now?

212. What kind of help/benefit do you give/receive from your partner(s)

213. Does your spouse know that you have extramarital partner(s)

214. Do any of your relatives know?

1) Yes

2) No

215. Does the spouse of your partner know that you are his/her partner.

1) Yes

2) No

216 Do you know the partner/partners of your partner/partners?

1) Yes

2) No

217. How many of them do you know?

218. How many sexual partners have you had before marriage?

219. What were your reasons for having sexual partner(s) before marriage?

1) For money

2) For gifts

3) For fun

4) Because others were doing so

5) Other; specify:----------

220. Who is your last sexual partner apart outside union?

1) boy/man friend

2) girl/woman friend

3) Prostitutes

4) Other: Specify ----------

221. Please state your reasons for having sexual partners?

1) For money

2) For gifts

3) For longer term material relations

4) Because spouse is away

5) Separated/Divorced/Widowed

6) For fun

7) Wife is in a period of post-partum abstinence/breastfeeding

8) Wife is pregnant

222. What do you think about male/female who never had sex before marriage?

223. Some men/women have concubine or outside wives/husband. Do you think they can do without this?

1) Yes 2) No

224. a) If yes, why? _____

225. b) If no, why? _____

226. Do you think married women/men should have extra sexual partners?

1) Yes 2) No

227A. a) If yes, why _____

227B. b) If no, why _____

228. Would you approve of men/women giving/receiving money/materials in exchange for sex ?

1) approve

2) disapprove

SECTION 3: KNOWLEDGE AND EXPERIENCE WITH SEXUALLY TRANSMITTED DISEASES

301 Do you know or have you ever had that a person can contract diseases or illnesses through sexual contact? 1) Yes 2) No

302 Which sexually transmitted diseases have you heard of?

(CODE 1 (YES) 2 (NO) FOR EACH METHOD HEARD OF)

a) a) Gonorrhoea 1 2

b) Syphilis 1 2

c) AIDS 1 2

d) Genital Warts 1 2

e) Magun 1 2

f) Herpes 1 2

g) Columbitis 1 2

h) Candidiasis 1 2

i) Chlamydia 1 2

j) Other STDs: Specify exact Yoruba wording

303 Just to be sure, have you ever heard about----------?

(FOR EACH METHOD NOT MENTIONED ABOVE)

a) Gonorrhoea 1 2

b) Syphilis 1 2

c) AIDS 1 2

d) Genital Warts 1 2

e) Magun 1 2

f) Herpes 1 2

g) Columbitis 1 2

h) Candidiasis 1 2

i) Chlamydia 1 2

j) Other STDs: Specify exact Yoruba wording

304 Whom would you MOST likely talk to in order to get information about how to prevent Sexually Transmitted Diseases?

_____

305 Have you ever been treated for venereal diseases?

1) Yes 2) No (SKIP TO QUESTION 311).

305A If Yes what type? (tick all applicable)

A. Gonorrhoea

B. Syphilis

C. Herpes

D. Magun

E. Others: (specify)

306. How did you know that you had venereal disease_____

307. From whom do you think you got it?

1) spouse

2) extramarital sexual partner

3) prostitutes

4) Others: Specify----------

308. Did you do anything to treat the disease?

1) Yes 2) No (SKIP TO QUESTION 309)

309. What did you do to treat the disease ?

311. Did you tell the person who infected you?

1) Yes 2) No

312. Did you have sex with the person during the period?

1) Yes 2) No

313 Did you tell your spouse that you had venereal disease?

1) Yes 2) No

314 Do you think wives have the right to refuse sex to a husband who has a venereal disease? 1) Yes 2) No

SECTION 4: CONDOM USE FOR STD PREVENTION?

401 Have you ever heard of using condoms to prevent sexually transmitted diseases.

1) Yes 2) No (SKIP TO QUESTION 403)

402 Have you ever used condom during sexual intercourse with anyone to prevent sexually transmitted diseases?

1) Yes 2) No

403 (FOR MEN ONLY) Have you ever paid a prostitute or commercial sex worker for sex? 1) Yes 2) No (SKIP TO QUESTION 501)

404 (FOR MEN ONLY) How many times have you visited a prostitute or commercial sex worker during the past year?

SECTION 5: KNOWLEDGE OF AIDS

501 Have you ever heard of AIDS? 1) Yes 2) No (THANK AND END INTERVIEW)

502 What have you heard about AIDS?

503 Where did you hear about AIDS (TICK ALL SOURCES MENTIONED)

a) friend [ ]

b) radio [ ]

c) T.V. [ ]

d) Print media [ ]

e) doctor [ ]

f) Nurse [ ]

g) Health care worker [ ]

h) co-worker [ ]

i) school [ ]

j) other _____

504 Please tell me whether you think any of the following ways a person can contract AIDS: (1=yes 2=no 9=don't know)

504A Can you get AIDS from sexual intercourse?

504B Can you get AIDS from shaking hands with somebody?

504C Can you get AIDS from a mosquito bite?

504D Can you get AIDS from reused unsterilised needles?

504E Can a mother transmit AIDS to her infant?

04F Can someone get AIDS from evil spirits or charms?

504G Can you get AIDS from blood transfusion?

504H Can you get AIDS from razor blades/knives used in circumcision?

505 Do you know of any ways to prevent getting AIDS?

1) Yes 2) No (THANK AND END INTERVIEW)

506 How can you prevent getting AIDS?

1) Using condoms during intercourse

2) Maintaining one sexual partners/reducing number of partners

3) Using sterilised or new needles

4) not seeking sex from commercial sex workers

5) total abstinence

6) Other ways _____