Dissertation

By

BISIRIYU, Luqman Adeleke

DEPARTMENT OF DEMOGRAPHY AND SOCIAL OF STATISTICS
OBAFEMI AWOLOYO UNIVERSITY
ILE-IFE NIGERIA

Role of Attitude and Beliefs about STIs/Aids in Sexual Behaviour of Men in Osogbo, Osun State, Nigeria

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1999

ROLE OF ATTITUDE AND BELIEFS ABOUT STIs/AIDS IN SEXUAL BEHAVIOUR OF MEN IN OSOGBO, OSUN STATE, NIGERIA.

BY

BISIRIYU, LUQMAN ADELEKE
B.Sc (HONS) DEMOGRAPHY AND SOCIAL STATISTICS (IFE)

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1999

CERTIFICATION

This is to certify that this Research work was carried out by BISIRIYU, Luqman Adeleke of Department of Social Statistics, Faculty of Social Sciences, Obafemi Awolowo University, Ile-Ife for the award of Master of Science degree in Demography and Social Statistics.

Dr. M.O. Raimi
Head

Prof. J.A. Ebigbola
Supervisor

DEDICATION

This thesis is dedicated to ALMIGHTY ALLAH and my LATE MOTHER (who died when the fruit of her labour is about ripen).

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I want to start this acknowledgement by thanking Almighty Allah for all His unquantifiable support, love and mercy bestowed upon me throughout the period of completion of this programme.

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It is no doubt that, I am to take the blame for all mistakes in this work.

Luqman Adeleke BISIRIYU
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ABSTRACT

This study examines the role of attitude and beliefs about STIs/AIDS in the sexual behaviour of men in Osogbo, Osun State. The study arose from the recognition that there is erosion of various customs which acted to restrict undesirable sexual relationship, especially this era of a deadly disease called HIV/AIDS. And its transmission is predominantly through heterosexual relations made possible by continuous and consistent practices of sexual network especially among men.

The study which is mainly based on a primary source of data as well as in-depth interview had among others the following objectives, namely, to examine the extent to which the attitudes and beliefs about STIs/AIDS can influence the men sexual behaviour; to investigate the socioeconomic and demographic characteristics that favour the risk of contacting STIs/AIDS; and to examine the extent of use of condom in the prevention of STIs/AIDS.

A total of 500 randomly selected men were interviewed, while about 10 men were engaged in in-depth interview. Their responses were subsequently analysed using statistical techniques such as frequency, cross-tabulation and logistic regression after making the dependent variables suitable for such analysis by dichotomising the dependent variables.

It was revealed from the finding that the age at which sexual relationship starts become too low with mean age of 15.26 years. Also, it was found that sexual network is still rampant among the respondents, even though vast majority had knowledge of STIs/AIDS and worrisome of its existence.

It is revealed from multivariate analysis that condoms being the only viable option of preventing STIs/AIDS is not well mentioned or used for STIs/AIDS prevention. However, sexual intercourse is well known as the main route of HIV/AIDS transmission.

Finally, it was found that respondents have not totally desist from keeping multiple partners as revealed by number of sexual partners they had in their life time and in the last four or twelve months before the survey, while in recent times modification has gradually been taken place among the respondents.

Based on the findings, the study recommends among others that sex education should be introduced to all schools (secondary and post secondary). Out-of school should also be reached on the consequences of STIs/AIDS. Campaigns must be on for condoms as the only option for avoiding HIV/AIDS if it is properly used and should be available free of charge to all and sundry. All tiers of government should legislate a law to prohibits the establishment of brothel for commercial sex workers. And also providing necessary equipment for blood screening before transfusion to the needy patients.

CHAPTER ONE

1.1 GENERAL INTRODUCTION

We are now in the age of free-for-all sex. This is attributed to many factors which include the apparent breakdown in the traditional mechanisms of sexual control on the part of the populace. Also the age at which people have sexual intercourse for the first time which is lower in recent time. All these have led to incidence of men pre- and extra-marital sexual relationship. Moreso, the rate of partner change has resulted into high degree of sexual network, with unprecedented rate of Sexually Transmitted Infections (STIs). Most of these, though amenable to treatment, often leave scars such as infertility which affect both sexes (Orubuloye, 1990, 1991; Caldwell *et al.*, 1993).

Furthermore, there is a sexual laxity in the society today because of disrespect for tradition, exposure to Western education, modernisation and living outside traditional environments. These often liberated young men who were out for the first time may engage in sexual behaviours that might not have been tolerated in the rural community. Such behaviours might include unprotected sex with multiple partners, premarital and extramarital and casual relationship, or sexual practices with commercial sex workers (who typically have HIV-seroprevalence levels far in excess of the national averages). High concentration of young males also attracts additional commercial sex workers to the urban centres, particularly if education and employment opportunity for girls and women are scarce (Berezin, 1992).

In fact, it has ceased to be regarded as a sign of purity but an anti-social behaviour if a young woman is found chaste at marriage. This has been attributed to the rapid process of modernisation and westernisation (Orubuloye, 1981). Carael *et al.*, (1991), in their

overview of selected findings of sexual behaviour reported that 'modernity' has erode traditional patterns of sexual behaviour, favours early sexual experience, informal partnership, commercial sex workers and sometimes delays marriage. Nowadays potential husbands want their would-be wife to be pregnant before marriage, as proofs of their fertility. Kulin (1988) also corroborates this stand by saying that the traditional system of young adults receiving guidance mainly from their aunts in the case of girls and uncles in the case of boys has been erode by socioeconomic developments and other 'modernising' influences. Aunts and uncles are now often physically and socially removed from adolescents and are no longer able to guide them. He also noted that modernisation and rapid urbanisation have left young people spatially and psychologically cut-off from their elders, who were traditionally responsible for conveying information.

From the foregoing, therefore, it has been noted that Sexually Transmitted Infections (STIs) and Acquired Immune Deficiency Syndrome (AIDS) which are contacted through unprotected sexual intercourse with multiple partners constituted the greatest threat to the health and well-being of the sexually active population in the world and in sub-Sahara Africa where heterosexual is on the increase. In particular, the rate at which individuals change partners and their choice of partners, that is, the extent of mixing among individuals of different sexual activity levels, determine to a large extent the rate at which infection spreads and the proportion of the population affected (Anderson *et al.*, 1991). Added to the issue of multiplicity of sexual partners is low adoption of appropriate contraceptive methods especially condom.

In many developing countries, STIs are among the five most common health problems for which people seek treatment. HIV has joined the large number of Sexually Transmitted Infections (STIs) that threaten the reproductive health of men. This is central to a number of social and medical problems of the tropical Africa, where unfortunately the facilities are inadequate for the correct diagnosis and treatment of these infections. This presents a number of serious concern to sexual behaviour.

Transmission of venereal infection is mostly regarded as a secular fashion, that is, it knows no frontiers, it reaches anybody, across the border, religion, culture, gender, race, economic level, etc. Also it strikes at rich and poor, at blacks and whites, in both North and South like pollution. For example, STIs are normally taken for granted by a significant proportion of men and women in most developing countries. The recognised venereal infections are confined almost to gonorrhoea and syphilis and rarely chancroid and herpes.

In fact, STIs are everywhere. Gonorrhoea and syphilis are the most widely known. For instance, in Sweden, it was reported by Dunlop (1993) in a study of the sexual behaviour of young people that the most important sexually transmitted infection is infection with Chlamydia. In the early 1980s, when screening methods became available, 20 per cent of youth clinic attenders had Chlamydia. In 1988, Chlamydia infections were included in the law on communicable diseases. The law insists on partner notification and diagnostic procedure. In another study carried out by Lema and Hassan (1994) in Kenya, it was presented that 70.4 per cent of the total respondents mentioned gonorrhoea as a sexually transmitted infection (STI) compared only to 54.3 per cent who mentioned AIDS as a sexually transmitted infection (STI). Kanbargi and Kanbargi (1996) in their study of sexually

transmitted infections in Bangalore City, concluded that Syphilis, Chlamydia, and gonorrhoea were the most commonly seen STIs and more than 30 per cent had been treated at least once before for a STIs. But there are more than twenty other STIs. On average, estimated 685,000 people are infected everyday with STIs. Every year there are about 250 million new cases, nearly as many as malaria (Khanna *et al.*, 1992). The consequences of STIs can be devastating. Infants are infected at birth with blinding eye infections or pneumonia; women suffering chronic abdominal pain, ectopic pregnancy, or infertility. Syphilis can maim or kill infants, and it kills adult as well, sometimes years after the initial infection. Indirectly, STIs also kill through spontaneous abortion, ectopic pregnancy, and cervical cancer.

In most sub-Saharan Africa, people do not see anything special in having venereal infections, hence gonorrhoea which happens to be the most commonly noticeable communicable venereal infection is being referred to as 'arun gbajumo' the infection of the sociable person among the Yorubas of western Nigeria (Orubuloye *et al.*, 1990). They believe that a man who had not contacted venereal infection was not a man in that, he had not had variety of sexual partners. Also, in Calabar, gonorrhoea is metaphorically called 'GCE' (General Certificate of Education). Among the young people and even the old, a person who has not contacted this infection is said not to have earnestly started sexual exploration yet. To sex explorers, therefore, gonorrhoea is said to be a recognised general certificate (Ogbuagu and Charles, 1993). This closely corroborates Sabbatier's (1988) view that 'so common is gonorrhoea among some ethnic groups. African doctors have written that its symptoms are sometimes regarded as a sign of sexual awakening or potency. It was also

emphasized in Nigeria, and elsewhere that, males often regard gonorrhoea as a sign of maturity or of full sexual life, whilst females on the other hand, regard it as just another vaginal infection or discharge. This is, however, not peculiar to any particular ethnic group or nation in sub-Saharan Africa. In Uganda, Arya and Taber (1973) observed that most men had continued their normal routine of sexual activity irrespective of the presence of urethral discharge and dysuria (painful act of urinating).

Sexual activity and behaviour is a dominant factor in STIs epidemiology which causes the rise in the incidence of STIs particularly gonorrhoea. This is prevalent most in the urban centres of African countries. Socio-cultural attitudes towards sex has also been noted to constitute important factor in the epidemiology of STIs and AIDS in many parts of Africa where polygyny is widely practised. Sexual behaviour has, therefore, been described as the most important human activity. As Smith (1991) has rightly observed, this is not only the process by which the human species is reproduced, the central behaviour of which families are formed, and a key component in the emotional lives of individuals but also central to a number of social and medical problems. Among these are the spread of STIs and the new and very lethal infectious agent, the human immuno-deficiency virus (HIV), which is the etiological agent of the acquired immune deficiency syndrome (AIDS). It was also gathered that alcoholism may be a risk factor for STIs/AIDS transmission in that poor nutrition, a secondary problem in alcoholism, may increase susceptibility to HIV. Furthermore, alcohol may impede judgment, and thereby increase the likelihood of unsafe sex practices. For example, a male Nadlech consultant stated that his partners respected him because he, unlike others, 'did not try to just get them drunk to take advantage of them'.

Other male Nadlech consultants also alluded to the use of alcohol to 'pickup' a sexual partner (Parker, 1990).

Wendy (1997) reports that sexual behaviour among young people both in-school and out-of-school, aged between 12 and 25 is vital in influencing the spread of AIDS in Zambia and elsewhere. By 1992, between 9 and 11 million adults and about 1 million children had been infected with the AIDS-causing Human Immuno-deficiency Virus (HIV). According to World Health Organization estimate, two-thirds of these people live in developing countries. By the year 2000, 30 to 40 million people will be infected. By then 10 million people with HIV infection will have developed AIDS, and 90 per cent of them will be living in developing countries (WHO, 1992).

Sexually Transmitted Infections and HIV/AIDS are transmitted through sexual contact. Once contracted, medical attention could be sought in the case of cure. However, what seems to be the most effective prevention is total sexual abstinence.

On the beliefs of the people about the cause of STIs and AIDS, there is a thinking in some circle that STIs are described as punishments not just on individuals but on a group. Small proportion believed that STIs and AIDS can be punishment from God or inflicted by supernatural powers and witchcraft (Orubuloye *et al.*, 1991). Interpreting any catastrophic epidemics as a sign of moral laxity or political decline was as common until the latter part of the 19th century as associating diseases with foreigners or with despised and feared minorities. The persistence of the belief that illness reveals and is a punishment for moral laxity or turpitude can be seen in another way: by noting the persistence of description of disorders or corruption as disease. However, attitude and beliefs of people about STIs and

AIDS vary on the source, cause, treatment and means of transmission. With the recent government campaigns in the media, the level of awareness of the people about AIDS in particular has increased. AIDS is now considered an epidemic in many nations including developing countries. According to World Health Organization (WHO 1992), the rapid spread of AIDS is a matter of much concern, especially in developing countries, Nigeria inclusive. One of the saddest aspect of the African AIDS epidemic is that it has occurred just as Structural Adjustment and Cost-recovery programs are being implemented. These programmes have actually blunted the ability of the medical system to give help with AIDS let alone to extend their services further into the STIs field. Even there are widespread report that transactional sex has increased during the structural adjustment period rather than declined in the face of AIDS (Caldwell *et al.*, 1993).

1.2 JUSTIFICATION OF THE STUDY

Many traditional values and social practices have undergone changes during the course of modernisation, and it is unlikely that traditional pre- or extra-marital behaviour among men in particular would be an exception. Change in norms about pre- and extra-marital sexual behaviour may also be due to a general loosening of family control over the behaviour of young men and women. This erosion of control is likely to be particularly pronounced when young adults are more educated than their parents and other family members, when they live outside family households or compounds, and when they live in less traditional settings, such as urban areas (Feyisetan *et al.*, 1989).

Culture, religion and ethical background did not permit promiscuity and unsatisfying sexual appetite. But as civilization spread, love, romance and sexual practice became depicted as acceptable favourite entertainment. This result in adverse consequences of uncontrollable sexuality among the people.

Sexual intercourse today often marks the start of a relationship rather than the confirmation of an established relationship as it was some decades ago. These attitudes are reflected in the behaviour of young men which is as a result of apparent breakdown on sexual restraints which manifests in the increase of sexually transmitted infections including AIDS.

It is discovered from earlier reports (Feyisetan *et al.*, 1989; Caldwell *et al.*, 1993) that most research focused mainly on the origin and etiology of STIs and AIDS in both the developed and developing countries, few had really devoted to study of attitudes, beliefs and knowledge of people toward these diseases especially among men. There was a clear manifestation of the general belief that men are biologically different from women in their need for sex: while a man has unlimited sex freedom, a woman is expected to have only one partner. Havanon (1996) has this to say when he reported that the status of Thai women in sexual relationship is very low. They are strongly discouraged from practising premarital sex and are forbidden from being involved in extramarital sex, while men are free to practise these behaviours.

The need for man to have sexual variations and the assumed polygamous nature of men were the main reasons that men cannot be satisfied with one woman at a given time or over a life time.

Other reasons while men's sexual appetite is insatiable are lack of self control, they always look out for enjoyment and variation. These are the most popular reasons given by the women (United Nations, 1994). This view seems to be reinforced by the assumptions noted by Orubuloye *et al.*, (1991), that monogamous men and most polygamous men mostly have sexual relations with women other than their wives. The prescribed two or three years female abstinence during the postpartum period has been implicated as a major motivating factor for men's extramarital sexual behaviour. Some also believed that the company a man keeps influences him. Some husbands are believed to have been influenced by their peers to patronize prostitutes. This view confirmed by Orubuloye (1990) that female adultery is negatively sanctioned, while extramarital sexual relations are taken for granted and the society finds justifications for their occurrence. It is not uncommon to find wives who encourage their husbands to go out for mistresses if there are pressures to resume early sexual relation after childbirth or during pregnancy or when a woman considers herself too old for sex or when she has become a grandmother and wanting to commence terminal abstinence. However, the rapid spread of sexually transmitted infections including AIDS in parts of Africa, is predominantly through heterosexual relationship. This makes the provision of accurate information on the disease an urgent and serious endeavour, and also underscores the need for more research on the social peril (Isiugo-Abanihe, 1993).

The rising trend in sexuality and changing behavioural patterns have become crucial with the emergence of the new and very lethal infectious agent, the Human Immuno-deficiency Virus (HIV), which is the etiological agent of the Acquired Immune Deficiency Syndrome (AIDS), especially now with no cure in sight. Since containment of the infection

is likely to rest upon social knowledge that is at present vestigial, it seems probable that the spread of the disease over the next decade is more likely to be decided by changing lifestyles of the people than by medical breakthrough. Although some drugs have been said to reduce the virus load, these are very expensive and unlikely to be available in the developing countries which have the majority of HIV/AIDS cases (New vision, 1996). The lack of a cure for AIDS is usually emphasized as an inducement for people to change behaviour. Also it is widely accepted that, pending the development of an effective vaccine or therapy for HIV/AIDS, behaviour is the only means of averting the continued spread of the disease. The advent of effective biomedical prevention or treatment is unlikely to bring complete solution to the problem, unless accompanied by changes in sexual behaviour.

Despite the fact that much has been heard and said about STIs/AIDS, yet the effects of heterosexuality on the transmission of STIs/AIDS has not been critically examined. There is, therefore, a need for a sort of this study, which attempts to examine the role of attitude and beliefs about STIs/AIDS in the sexual behaviour of sexually active population. Likewise, to zero down on the preventive measures. Also to identify the major route of transmitters of STIs/AIDS, the mode of distribution and how society behaves toward people who are living with AIDS. An in-depth investigation of the sexual behaviour of the potential transmitters of STIs/AIDS may also serve as a good starting point to the preventive approach. The study can also been seen as a torchlight to intervention programmes and a contribution to the behavioural management of STIs/AIDS among high-risk groups. The culture of secrecy, fears, practice of polygamy and the apparent permissive sexual lifestyles of many people especially men had also exacerbated the problem. There is also the problem

of inadequate flow of information in this area of sexual behaviour and STIs/AIDS transmission (Oyekanmi, 1990). Hence, it can be deduced that lifestyle played a dominant role in determining individual chances of infection and the only hope of lessing the epidemic, therefore, lies with prevention of infections and change of behaviour. This is because behavioural change may for long time be our best weapon against the infections.

1.3 OBJECTIVES OF THE STUDY

1. The main objective of the study is to examine the extent to which the attitudes and beliefs about STIs/AIDS can influence men's sexual behaviour.
2. To examine the socioeconomic and demographic characteristics that favours the risk of contacting STIs/AIDS.
3. To examine the extent of use of condom in the prevention of STIs/AIDS.

It must be added that it is hoped that much of the findings of this research will enhance the expansion of Information, Education and Communication (IEC) programmes in Nigeria.

1.4 LITERATURE REVIEW

In the past, the most occurring of the sexually transmitted infections were gonorrhoea and syphilis. The mortality rate of people infected with these diseases made the medical personnel then to concentrate more on how it can be curbed because it was regarded as killer diseases. The extent of the problem today has become so large to have caused not only the medical personnel, both at the national and international level a lot of concern as to curb the spread. This has put social researchers in a position to carry out necessary

research in the area of behaviours of people for preventive approach.

The persistent beliefs that illnesses or disease attacks are a punishment for moral laxity or turpitude has been with us from time immemorial. Thinking of syphilis as a punishment for a person's transgressor was for a long time not really distinct from regarding it as retribution for the licentiousness of a community, until the disease became easily curable (Sontag, 1988). Oni (1992) in his work wrote that several explanations have been proffered for the outbreak of some disease or epidemics which are philosophical, sociological, historical and psychological in nature.

Some christian preachers in Europe had been reported as using syphilis epidemics especially in the sixteenth to eighteenth centuries, to further their aim of confining sexual relationship within marriage. Quetel (1990), in his History of syphilis emphasizes the extent to which religious and community leaders of the seventeenth century condemned syphilis as the product of sexual immorality. Andreski (1989) as well identified syphilis epidemic in Europe as having been the chief cause of the rise in Puritanism. As he pointed out, 'Syphilis ... was ... particularly suited to be viewed as God's wrath'. Indeed, the Holy Roman Emperor and German King, Maximillian, issued an edict as early as 1495 declaring syphilis to be God's punishment for the sexual sin of men.

Davenport-Hines (1990:32-33) wrote of the European Syphilis epidemic that:

> *'With the rise of Puritanism, the idea of a wrathful God taking vengeance on sinners through the working of Providence became ubiquitous ... if some people were singled out [by the syphilis epidemic] it must be, under Puritan reasoning by God's will ... the fearful conscience and retributive superstitions the syphilis provoked in some people, created a sympathetic environment in which Puritanism might spread'.*

Osoba and Path (1984) wrote that in the rural areas of many countries in tropical Africa, STIs are treated along with other communicable diseases in health centre and dispensaries and they essentially have to compete with other conditions for attention, drugs and funds. According to them, there are usually no facilities for individual or private examination. Diagnosis is usually based on rapid clinical examination of available antibiotics and syringes. Those not responding to the treatment may be referred to some miles or kilometres before getting to the district hospitals; usually there is no contact tracing to prevent re-infection and further transmission. However, in old large cities and state capitals there are at least one government hospital and in some cases, a medical school. They discover that the STIs clinical usually formed part of the outpatient department (OPD) either alone or combined with dermatology clinic, and that the clinic are over crowded and under staffed. Diagnosis is usually made by general physician with laboratory facilities usually confined to microscope alone. Most of the clinic can perform reagent tests to diagnose syphilis but *treponema* tests may be available only in the medical school.

The lack of proper facilities for private or individual examination, and adequate treatment have resulted to wide spread of self medication. Consequently many patients resort to chemist and going to unqualified physicians. The result frequently are either lack of treatment or treatment with an inappropriate remedy.

It is a well know fact that in many developing countries the public has access to antibiotics with or without a prescription. Some of the pharmacy laws which suppose to safeguard any product that are injurious to life and health are not enforced; antibiotic are on sale in market stalls and motor parks. In many cases the dosage taken by the patients

depend on his or her wealth, and is frequently taken incorrectly and for wrong conditions. The antibiotic that are most frequently subjected to abuse are the penicillin tetracyclines, ampicillin, and chloramphenicol. For instance many cases of gonorrhoea are being treated with penicillin even at clinics (Ayo *et al.*, 1991). The resultant effect of this self-medication is that initially the risk of unrestricted transmission of the infection (Oni, 1992).

According to Sontag, Gyasuddin and Ahmed (1988), in the study carried out in Botswana, posited that religious norms and values, if properly implemented, can play a vital role in preventing STIs transmission including AIDS in countries where changing sexual partners are becoming the norm of the day.

Studies of sexual behaviour have attracted great attention in recent years not only because there have been departures from tradition norms and practices, but because the present patterns of sexual behaviour associated with tragedies that manifest themselves in terms of STIs and the recent emergence of a new sexually transmitted pathogen, the HIV and its association with the fatal Acquired Immune Deficiency Syndrome (AIDS). While this new virus has presented many unique challenges to health professionals and providers, it has also revealed many of the old issues of inequity, power and stigmatization that have long frustrated attempts to develop an effective public health response to STIs.

Studies in sexual behaviour involve these two concepts: premarital and extramarital behaviour. To this end, Isiugo-Abanihe (1993) wrote in his lecture that though literature reveals that premarital sexuality and sexual behaviour of adolescents will be more better studied than sexual behaviour of married people. First, single people are more likely to engage in risky sexual behaviour, including having casual sex, keeping multiple partners,

some of whom may include commercial sex workers. Though extramarital sexual relations should not be regarded as uncommon. Many married people keep 'sugar daddies', 'sugar mummies', 'sweet sixteens', 'mistresses', concubines, or whatever names or terms by which they are known in places. Presence of a permanent sexual partners through marriages should eliminate or reduce sexual adventures outside the home. It is not surprising that recent studies reveal a very high level of sexual networking in Nigeria (Omu *et al.*, 1981; Oronsaye *et al.*, 1982; Gyepi-Garbrah, 1985; Nichols *et al.*, 1986).

The earlier one starts sexual contact, the more the inclination for sexual desire with multiple partners. For instance, Oloko and Omoboye, (1993), in a Lagos study reported that about half of senior secondary students in Lagos have had sexual intercourse, and most of them had more than two partners. About 4 per cent experienced their first sex at the age of 10, and 36.4 per cent did so between age 15 and 16 years. A study of youths in Calabar found that a quarter of them (males and females) have already experienced their first sexual contact before age 15; at age 17, 62 per cent of men and 54 per cent of women have had sex (Ogbuagu and Charles, 1993). Makinwa-Adebusoye (1992) found in a study of Enugu, Kaduna, Lagos, Onitsha, and Zaria that 50 per cent of sexually active single men and 40 per cent of comparable females had their first sexual encounter by the 17th birthday; 72 per cent of males and 82 per cent of females who have ever had intercourse did so by the end of their teenage years. The study also reported greater sexual activity among urban female youths relative to males, with a larger proportion of females being sexually experienced. However, males are more likely than females to have had sexual relations with more than one partner (58% vs 32%); about a quarter of men had 3 different sexual partners,

compared with only 9% of females. Orubuloye *et al.* (1991) presented data on the reasons for engaging in the first sexual act in Ekitiland. A great majority of their study population have their first sexual relation for fun, enjoyment, curiosity, or because others did it. A few respondents had their first sex 'to show love' and in the hope of marriage. A substantial number of females, more in urban than rural areas, said they engaged in premarital relation primarily for material returns.

Isiugo-Abanihe (1993) observed that premarital sexual relationship has probably more commonplace and perversive over time. As the society undergo social change, premarital sexual relationship become more widespread, start earlier, and tend to involve a larger number of partners with relatively small number of single but sexually active men and women, use contraceptives to prevent pregnancy and childbirth outside marriage, or for protection against STIs (Nichols *et al.*, 1986; Feyisetan and Pebley, 1989).

Though accurate data on sexually transmitted infections are scarce among men especially, but given their high level of sexual activity and the casual nature of their sexual relations, one would expect high incidence.

Orubuloye (1993) has presented evidence of high levels of gonorrhoea in Yorubaland, which reportedly taken for granted among men, or regarded as a sign of manhood. A high incidence of STIs is also documented in Calabar (Ogbuagu and Charles, 1993) as quoted in the work of Isiugo-Abanihe (1993). Incidentally, the common display in our cities and even the countryside, of bill boards or sign posts advertising the services of the apparently large number of doctors' who 'specialize' in treating gonorrhoea, syphilis, and even AIDS, probably testifies to the high incidence of STIs in a society that is

increasingly becoming promiscuous and promiscuity, especially the number of sexual partners is known to be correlated with STIs/AIDS in both the US and Africa (Landesman *et al.*, 1985; Clumeck *et al.*, 1985).

In addition, it was discovered by Mertens and Caraël (1995) that on an epidemical basis, it is possible that circumcised men have different sexual behaviours, or different penile hygiene, from uncircumcised men, which in turn may influence their susceptibility to HIV-infection; reporting patterns to health facilities for genital problems. It is also possible that the same level of wasting or other hygienic measures would ensure a lower level of genital cleanliness among uncircumcised men because of the penile foreskin (Caldwell and Caldwell, 1995). That is, genital cleanliness lies on the causal pathway between circumcision status and HIV or other STIs. Uncircumcised men may be at increased risk of HIV because they may be more susceptible to other STI than circumcised men (Nsanze *et al.*, 1981).

It was documented from the study carried out in Kenya by Moses *et al.*, (1994) that the most important independent predictor of being an STI patient was the number of recent sex partners.

During the 1980s, the acquired immuno-deficiency syndrome (AIDS) emerged as one of the most serious threats to health problems world-wide, with Africa being the most severely affected (Mann, 1987). Several African countries have an extremely high prevalence of HIV infection in their general population (Mann, 1987; De Cock *et al.*, 1989; Rwanda HIV, 1989; Anonymous, 1987).

As HIV emerges as the newest and deadliest of the sexually transmitted infections, it requires the mastery of a new, unique, and complex virology and pathophysiology, as well as a reassessment of our traditional assumptions concerning the prevention and control of STIs. In this way, HIV represents not just 'the latest threat', but also an opportunity to 'expand the discourse' concerning sexually transmitted reproductive health of population in developing countries (Elias, 1991).

Seth (1993), reports on the epidemiology of HIV-1 infection on issues in Management of STIs in Family Planning Settings that the human immuno-deficiency virus entered into human populations in Central Africa. That although it is not known how recently this occurred, it is clear that the emergence of HIV into wider populations was the result of urbanization and modern transportation (e.g. truck drivers). Retrospective analyses of stored sera have documented the presence of HIV infection in Africa as early as 1959. The veracity of a report documenting AIDS in a British sailor in 1959 has been questioned. Several studies have documented seroprevalence rates of approximately 1 per cent in ordinary populations in Zaire by the early to mid-1970s.

AIDS epidemic in US and Europe, first recognised in 1981, has focused on several 'high-risk' groups: homosexual and bisexual males; intravenous drug users and recipients of blood products. More recently, the female sexual partners of these individuals and their children have been the groups with the greatest rate of increase of HIV infection.

The characteristics of the AIDS epidemic in developing nations are considerably different from those in industrialized nations. Heterosexual transmission and much more rapid spread are the norm. High-risk groups including commercial sex workers (male,

female) and intravenous drug users, exist within the general population and have spread HIV infection. Although, HIV infection is focused on urban areas, infection is rising most rapidly in rural areas.

HIV infection spread most rapidly in Africa during the 1980s. By 1990, as much as 20 per cent of the general population and 30 per cent of the urban population was HIV-infected in some countries, including Malawi, Rwanda and Uganda. For instance, in Abidjan, Cote d'Ivorie, between 10 to 15 per cent of the adult population is infected with HIV-1, HIV-2, or both (De Cock, Burn-Vezinet and Soro, 1991). HIV has also continued to spread in North Africa and the Middle East. For example, in Southern Sudan, infection rate as high as 40 per cent have been found in female prostitutes (McCarthy and El Hag, 1990).

During the past decade, HIV infection has exploded in Asian countries. At present, Thailand and India have large populations of HIV-infected individuals, while China and Burma are lagging sexual years behind but showing virtually identical patterns of infection. Figures in Thailand demonstrate the spread of infection: in 1988, there were approximately 12,000 HIV-infected individuals and 18 reported cases of AIDS; by 1993, the figures were 700,000 HIV infections and 8000 AIDS cases. In India, seroprevalence among clients at a STI clinic has risen from less that 5 per cent in 1988 to 40 per cent in 1993. The epidemic have several foci (e.g. commercial sex workers in Bombay and Goa, intravenous drug users in North eastern India).

In Latin and the Caribbean region, Haiti was one of the original foci of the HIV epidemic and seroprevalence is estimated at 10 per cent in urban areas and 4 per cent in

rural areas. Brazil is the most severely affected country in South America (Mati, 1993).

In Nigeria, the first case of AIDS was reported 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. On March 14, 1990, the Federal Ministry of Health (FMOH) announced that 21 deaths had occurred on 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 has been reported to the WHO (WHO, 1992). By April, 1994, 1,148 cumulative AIDS cases were reported to the Federal Ministry of Health and Human Services (FMOHHS) (WHO, 1994).

By 1995, there were 650,000 Nigerians who were HIV-positive, no state is excluded from the scourge. For example, sentinel surveillance was carried out in Edo, 2125 were tested, 97 were HIV sero positive and 21 conformed having AIDS. Edo that had almost zero per cent prevalence has about 0.5 per cent prevalence within 3 years, 82 per cent came from blood donors. In another surveillance, it was found that the commercial sex workers or prostitutes had a prevalence of 5.4 per cent closely followed by STI patients with a prevalence of 5.2 per cent, TB patients had a prevalence of 3.2 per cent, antenatal clinics patients, however, had 1.5 per cent prevalence only. By July, 1992 a total number of 13 AIDS patients had been identified in University of Benin Teaching Hospital (UBTH) and 6 were actually admitted, among which 3 died, 3 still alive. The adults were five while only one was a child. Using WHO's Epi-model, the FMOHHS (1992) project that by 1996, as many as one million adult Nigerians will be infected if the exponential rate of infection

continues unabated.

Ogunjuyigbe (1997) in his paper wrote that Nigeria is demographically acclaimed to house quarter of the population of sub-Saharan African, and with this trend it will have great significant impact on the population of the whole continent of Africa (Orubuloye *et al.*, 1991; Ogunbanjo, 1989; Osoba and Path, 1984).

Cameron *et al.*, (1989) in their study discovered the following factors as having great impact on the chance that men would be infected with HIV. Those with genital ulcers were almost five times more likely to have developed an HIV infection than were those without such ulcers, and those who said they regularly visited prostitutes were three times more likely to be infected with HIV than were men who had been to a prostitute only once. He suggested that besides educating people to avoid having intercourse with those likely to be infected with HIV and promoting the use of barrier methods of contraception, lowering the prevalence of genital ulcers in Africa could help to reduce the rate of HIV infection. McFalls and McFalls (1984) also argued that though, the social upheaval occurring in many of the developing countries, accompanied by frequent population movement; increasing urbanization; family disruption and abandonment of tribal norms, all these favoured the spread of sexually transmitted infections including AIDS. They went further to say that the higher the number of sexual contacts, the greater the risk of infection and that the risk of becoming infected following one act of coitus with an infected partners is substantially greater for women than for men.

Rosenberg and Weiner (1988) report a high incidence of sexually transmitted infections (STIs) in West and Central Africa which contributes to the high-incidence of

AIDS. The long incidence of STIs is largely the result of poor access to medical care and antibiotics (Becker 1990). It is also generally agreed that sexually transmitted infections (STIs) will facilitate the transmission of the Human Immuno-deficiency Virus (HIV) (Caldwell, Caldwell and Quiggin, 1989; Becker *et al.*, 1988).

In both developed and developing countries, many people know little about STIs- how they are transmitted, their symptoms, how they threaten health, how they should be treated, and how to prevent them- and many are misinformed (Adekunle and Ladipo, 1992; Alexander, 1992; Burney, 1976; Nzila *et al.*, 1991). In Nigeria, for instance, some men believe that their semen will cure their partners (Adekunle and Ladipo, 1992). In the US many people say that they do not fear getting AIDS because they are not in any of the groups with a high prevalence of AIDS (Alexander, 1992).

As a result of ignorance or misinformation, some people engage in risky sexual behaviour or delay seeking treatment from a health care clinic as reported in some studies in Nigeria and Uganda, for example, many with symptoms of urethritis waited an average of about 2½ years before seeking treatment at a clinic (Kibukamusoke, 1965; Sogbetun and Osoba, 1974). Also people may be afraid to seek care, some people stay away from public clinics because they do not want to answer questions about their sexual partners, as has been reported in Uganda (Whyte, 1988). Callers to a US STI telephone hotline who were infected or who had been exposed to infection said that they did not seek care because they were worried about confidentiality. The procedures for diagnosis and treatment are humiliated by clinic staff, and the long-term consequences of infection (Knox *et al.*, 1981).

High levels of basic knowledge about HIV/AIDS were found in a study of 160 seafarers passing through the post of Antwerp. Nevertheless, only a quarter of those visiting prostitutes in the last three years (over half the sample) had condoms. More seafarers believed in the benefits of condom use than actually used them; on the other hand, 77 per cent of those who did not use condoms indicated a willingness to adopt their behaviour positively (Goethel, 1989). In another investigation of the availability of information about HIV/AIDS, the crews of 121 ocean-going ships were interviewed. Just under half received no HIV/AIDS information at all on board ship and only 21 per cent reported availability of condoms on board. Seafarers also reported high levels of contact with prostitutes even when the amount of time in port was limited. Cornejo (1973) documents that of 452 Chilean seafarers studied, 66.6 per cent of the sample indicated that they had multiple sexual partners abroad, while 77.2 per cent of these took no steps to pervert infection. Twenty-three per cent of the sample reported past infection with sexually transmitted infections.

It was also reported by Oyeneye and Kawonise (1993) that about 72 per cent of the male respondents and 87 per cent of the females are already well informed about AIDS through the mass media and the campaigns mounted by the government. They also know that the disease is transmitted through sexual relationship, especially with prostitutes and through blood transfusions. Only a small number of the respondents believed that the disease could be contracted through kissing.

Orubuloye (1990) argued that the majority of population are now aware of the dangers of venereal infections and AIDS and their transmission mechanisms. The most serious danger is the widely held belief that AIDS can be cured either by modern or

traditional medicine. There have been several claims by some traditional doctors that they had acquired the expertise and medicine for AIDS. Some of the prostitutes and bar girls found in the urban centre reported that they now have herbal preparations for prevention of AIDS. They, therefore, do not see the need for employing condom in sexual relations.

This position was buttressed by Oyeneye and Kawonise (1993) in their study when they found that majority of their respondents were well informed about venereal infections including AIDS; they were also conversant with the ways in which the disease can be contracted. The problem, however, lies in the fact that many of the respondents believe that the disease is curable through orthodox medicine or traditional medicine. AIDS is, therefore, viewed like any other venereal infection which doctors, herbalists and traditional doctors can cure. Among those who have this belief, the fear of AIDS may not be a constraint on sexual networking.

With the advent of AIDS, condoms have gained increasing importance as one of the few methods of protection against HIV/AIDS transmission. Studies carried out among prostitutes and secondary school boys in Younde, Cameroun show a very low usage of condom, 18 per cent and 10.5 per cent respectively (Louiset 1988). The reason being that men are generally disinclined to use the condom even for medical reasons, it is the only contraceptives option a couple has. Men's perceptions are particularly important since they generally have the final word in most negotiations between couples, for example, it is not uncommon for a family planning client to ask to have her IUD removed because her husband says he feels it and does not like that. In a community where HIV is spread predominantly by heterosexual intercourse, the perceptions of the economically and socially

dominant male towards safe sex and condoms are significant (Wambua, 1993). While Mathews *et al.*, (1990) reported that 80 per cent believed that condoms prevented the spread of AIDS. Lisa *et al.*, (1994) in their study concluded that educational level, number of lifetime sexual partners, and the experience of an STI are significantly and positively associated with the use of condoms to prevent STI/AIDS.

Eka Esu-Williams (1995) in his study of sexually transmitted infections and condom interventions among prostitutes and their clients in Cross River State reports that condom use, preferred related to the respondents' level of AIDS knowledge. While a higher percentage of prostitutes using condoms frequently than those using condoms infrequently were aware that AIDS could be transmitted sexually, there was a much greater relationship between level of condom use and AIDS knowledge with the client population. At baseline only 49 per cent of clients using condoms infrequently knew that sexual intercourse was a primary mode of transmission, while 89 per cent of those using condoms frequently knew of this route of transmission. Similarly, at follow-up 79 per cent of clients using condoms infrequently correctly recognized sexual intercourse as a mode of transmission, while 91 per cent of those using condoms frequently responded correctly. This suggests that if prostitutes and clients were aware of sexual intercourse as a primary mode of transmission, they may have been more likely to use condoms. Conversely, those men who use condoms frequently may have been more likely to learn about the possible role of sexual transmission.

In another study carried out by Corby *et al.*, (1996) it was documented that attitude toward condom use was found to be strongly associated with condom use intentions,

regardless of gender or type of partner. In addition, intention to use condoms with ones's main partner was positively and significantly correlated, for men, with partner norm, and, for women, with partner norm and perceived behavioural control. Intention to use condoms with a casual partner was significantly associated, for men and women, with attitude and perceived behavioural control, but not social or partner norms. Women were significantly more likely than men to perceive themselves as at risk of contracting human immuno-deficiency virus from a non-principal partner. The beliefs that using condoms is a responsible thing to do and can reduce worrying were significantly associated with attitudes toward condom use with both principal and non-principal partners among men, but only for principal partners among women.

Women are supposed to accept this double standard. They are expected not to question their partner about sexual affairs with other women (e.g. commercial sex workers) and not to ask their partner to use condoms. Women have increasingly concluded that their husbands present a major danger to their own health and survival. Ankrah (1991) documented it in his writing that in Uganda, and generally in East Africa, wives had practically no power to negotiate that their husbands should practise safer sex outside the home, or to refuse sex or demand the use of condom within the home. Bassett and Mhloyi (1991) came to a similar conclusion with regard to Zimbabwe in Southern Africa. However, Orubuloye *et al.*, (1991) examined the situation in Southern Nigeria, and West Africa; they found that most wives with STI-infected husbands do not realize the situation (as is also the case with HIV infection), when they do know, most refuse sex until treatment. Relatively few believe that condoms would protect them from the disease.

1.5 CONCEPTUAL FRAMEWORK

Behavioural change, however, is not easy to achieve. Several models have been used to explain change in relation to disease before and since the advent of HIV/AIDS. The development of most of these models has been based on experiences in the developed countries and may not apply in the developing countries with their different cultures and outlooks. However, some of the theories can be extended to HIV/AIDS in sub-Saharan Africans including Nigeria.

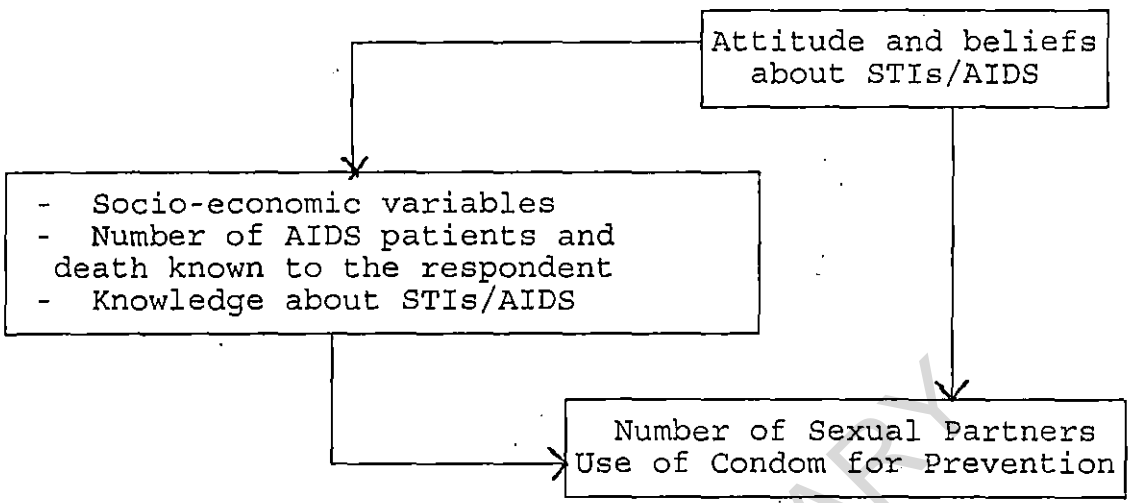
Two of these which seem to be most applicable are the Health Belief Model, and the AIDS Risk Reduction Model (Lindan *et al.*, 1991; Pollak 1992). The Health Belief Model assumes that the individual's attitude plays an important role in the prevention of a disease, especially his or her perception of susceptibility to the disease; seriousness of the disease, benefits of health action, and barriers to health action; and this attitude is modified by demographic and psycho sociological factors (Pollak 1992). According to this model, sufficient knowledge of the disease is essential but not the only prerequisite to behaviour change. The AIDS Risk Reduction Model (ARRM) characterizes people's reports to change sexual behaviours relative to HIV transmission (Catania, Kegeles and Coates, 1990). The model aims to understand why people fail to advance over the change process, in order to gear intervention programmes to a specific stage of the change process. The first stage of the model involves labelling behaviour as high risk for contacting HIV and implies knowledge of the disease and belief that the individual is at risk of the disease. The second stage is a decision-making stage: individuals must evaluate the costs and benefits of

changing their behaviour and whether they are capable of carrying out that change (self-efficacy). The third stage is the enactment stage. This stage often includes intervention-seeking behaviour and requires communication skills with sexual partners. The model is used here to identify the stage of behaviour change of men in order to discuss appropriate interventions for the group. Some other models include some of the above factors like knowledge of disease transmission, belief in the severity of the disease, and perceived risk to becoming infected. They also include peer support for safer behaviour, self efficacy or beliefs in one's ability to avoid disease, and skills in communicating and enacting safer behaviour (Lindan *et al.*, 1991; Livingston, 1992).

Social and behaviour research is needed to develop more effective and culturally acceptable preventative strategies (National Research Council, 1996). This study, therefore, presents a study of the role of attitude and beliefs about STIs and AIDS in the sexual behaviour of men in Osogbo, Nigeria.

The two models will be employed to explain the relationship that exist between the attitude and beliefs about STIs and AIDS and the sexual behaviour of men in terms of number of sex partners, premarital sexual intercourse, unprotected sex and frequent experience of STIs.

1.6 CONCEPTUAL MODEL OF THE SPREAD OF SEXUALLY TRANSMITTED INFECTIONS



Adapted and modified from:

Oyekanmi F.O. (1991): The spread of Sexually Transmitted Infections in Nigeria.

1.7 HYPOTHESES

The major hypotheses to be tested in the study can be stated as follows:

a) That there is a relationship between the attitude and beliefs about sexually transmitted infections and the condoms use.

b) That there is relationship between mode of transmission of AIDS and the number of sexual partners.

c) That a positive attitude about STIs/AIDS reduces the incidence of multiple sexual partners.

d) That positive beliefs about STIs/AIDS will reduce the number of sexual partners.

1.8 CONCEPT DEFINITIONS

Some of the concepts employed in this study are:- Attitude, Belief, Sexually Transmitted Infections (STIs), Human Immuno-deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Sexual Behaviour and Men.

Attitude: This can be defined as the way of feeling; thinking or behaving.

Beliefs: This is the feeling that something is real and true; it has to do with trust and confidence.

Sexually Transmitted Infections (STIs): There are a number of infections that can be contracted through sexual relations, especially when there are multiple sexual interactions.

The word transmitted connotes the situation whereby the infections can only be contacted from one individual to another when they relate together in sexuality.

Human Immuno-deficiency Virus (HIV): is the virus that kill the whole body's immunity which defend the body against any foreign bacteria, leaving the body to be infected by any opportunistic death agent.

Acquired Immune Deficiency Syndrome (AIDS): this can be defined as the end result of HIV, the virus that kills the body's immunity. **Men:** to this study can be defined as those between the ages 15-55 years.

CHAPTER TWO

2. METHODOLOGY

2.1 The Study Area:

The study area is Osogbo. Osogbo is a Yoruba town some 96 km North-East of Ibadan, the Capital of Oyo state of Nigeria. The town is situated on latitude 7° 7' North of the equator and longitude 4° 5' East of the greenwich meridian. The town is bounded on the North by Olorunda Local Government, West by Egbedore Local Government, South-West by Ede South Local Government, South-East by Atakumosa West Local Government, East by Obokun Local Government and North-East by Boripe Local Government.

According to the 1963 National Population Census report, Osogbo has a population of 208,966 people (Oyo Information Division, 1977). The 1991 Provisional Census report put the total population at 108,692 with 53,765 males and 54,927 females. This figure however excluded that of Olorunda Local Government which was carved out of the former Osogbo Local Government.

Osogbo is the administrative headquarters of Osogbo Local Government. The town also became the capital of Osun State on its creation on 27th August, 1991. Due to the establishment of state ministries and government parastatals in the state, the town has been experiencing high population occasioned by mass settlement of government workers in the area.

The town is highly a commercial centre. The commercial activities which are enhanced by the provision of adequate infra-structural facilities, include selling of cloths,

planks, cars, cement etc. Apart from trading in all their undertakings, the people of Osogbo (indigenous and other residents) also engage in traditional cloth weaving - Adire and Batik designs, embroidery designs and a host of other activities. Farming is not left out among the major activities of the people in the area. They plant cash crops such as cocoa, kolanut etc, and food crops like: yam, maize, vegetables and so on.

Osogbo has been made an industrial centre by both the Federal Military Government and Osun State Government. A number of industries has been established in the area. For example, the sanitary pad and Allied Products Factory, Osogbo Steel Rolling Mills and Machine Tools were situated in Osogbo. There are many other private industries in the area.

Besides, there are several banking and financial institutions in Osogbo. The emergence of several new banks and financial houses in the town was not unconnected with the town being the capital of Osun State. Along with a large number of voluntary agencies, the town has general hospital, private hospitals, clinics and dispensaries among which are Okin Hospital, Fagbewesa Hospital, Jaleyemi Catholic Hospital to mention a few where diagnostic of STIs and treatment are taken place.

Inspite of increasing number of mosques and few churches in the study area, the attendance of people at the annual Osun festival still increases. This is a mark of preservation of the cultural and traditional entity on the part of Osogbo people. In fact, the town is very rich in arts and culture, hence its elevation to the level of being given general attention. So far, the Osun shrines have been taken over by the Federal Department of Antiquities for effective management and preservation.

2.2 Sample Size:

The data were generated from a sample size of 500 male respondents, aged 15-55 years old, the sexually active group. With the recognition of the problem of time factor, efficient data management and funds, and the fact that the haphazard building arrangements and the complexity of the structure, coupled with the demographic and socio-economic characteristics of the people residing in the town. The men were selected from varying socio-economic groups: educational, occupational etc. backgrounds.

2.3 Sampling Design

In order to ensure that the sample is representative of the town, Osogbo. Five major residential areas were identified for the purpose of this study. They are traditional area; the migrant area e.g Iwo-Ibadan Rd, Igbona etc; the mixed area i.e the traditional and migrant; the elite area and the outskirts of Osogbo e.g Dagbolu and Ota-Efun.

Each of the areas is represented by more than one streets. All identified streets from each area were given equal chances of being selected through simple random sampling. From each area 100 respondents were selected. The selection followed a multi-stage sampling procedure whereby at first stage, two major streets were selected randomly in each area from a listing of major streets; then within each street selected a second stage selection of 50 households were made from a listing of all households in the street using a systematic random sampling technique. Within each household selected, a male respondent was randomly selected from among those within the ages of 15-55 years and above.

2.4 Questionnaire Design

The household and individual questionnaires were constructed using simple questions to elicit information on the background characteristics of household members and on the attitude and beliefs of male members about Sexually Transmitted Infections (STIs) and Acquired Immuno-Deficiency Syndrome (AIDS).

Issues in which detailed information were sought include: the household composition, socio-demographic background of the respondents, reproductive history, attitude and beliefs about STIs/AIDS.

The questionnaire was pre-tested in Ile-Ife. At the end of pretest, the questionnaire was reframed by adding questions that are essentials for the purpose of the study. This was done before the final print out of the questionnaires to administer.

The questionnaires were administered by trained and carefully selected interviewers who happened to be post-graduate students of the department who were very familiar with the survey location.

2.5 Fieldwork and Supervision

The administration of the questionnaire was by personal interview. This was used to elicit the desired information from the respondents. More hands were employed to assists in data collection. The questions were drawn in English and interviewers can easily interpret what we mean to the respondent in local languages.

The interviewers were given two days training. In the course of the training all the ambiguities were cleared and we made sure that the interviewers were familiar with the

meaning of the terminologies in the questionnaire.

To the illiterate people in the study area, the questions were interpreted to them in their local dialects in order to minimize response error. The interpretations of the meaning of each questions into local dialect was not left out during the course of the training. The fact that the interviewers were very familiar with the study location, this enhance uniformity in the interpretation of the questions to the respondents.

Fieldwork started towards the end of October and lasted for about seven weeks, there were principal research assistants, who acted as supervisor and coordinated the activities of the research assistants ie the field workers. The principal research assistants helped in demarcating and delineating the areas to be covered in the study, and also allocated to each field workers the questionnaires. However, in addition to the supervision of the project, the principal research assistants cross-checked the completed questionnaires done by the field workers to ascertain internal consistency and for editing purposes. At the end of the survey 497 questionnaires were completed by five research assistants. There was one research assistant who covered in-depth interview with some selected respondents to elicit oral responses as a way to buttress the questionnaire responses.

2.6 Field Experience and Problems Encountered

Research of this magnitude is very difficult to carry out given the subject matter of the study. A lot of problems were encountered in the course of the fieldwork. The attitude of majority of the respondents was not encouraging, they were feeling shy and timid in answering most of the questions that were related to sex. Some of the respondents even

frowned at some of the questions because of their personal nature. They atimes showed embarrassing mood even after showing modest approach at the beginning. Some felt reluctant to disclose the number of sexual partners they had before they got married. However, these problems were almost totally welcome by patience and humility on the part of the field workers, to the extent that they can be of a reliable and scientific enterprise.

For the in-depth interview on the other hand, people interviewed were reluctant to answer the field worker as a person, they wanted some or other people to stay with them because they didn't know the identity of the field workers, and this in a way distracted their attention due to the personal nature of the questionnaire during the interview proper.

Misreporting of ages which is retrospective in nature is greatly affected as a result of ignorance and/or due memory lapse about their ages during the survey. Some important events, such as world war, independent day, local important festivals, flood disaster and civil war were referred to estimate the age of the respondents.

The reliability of the data is not in doubt, useful for those who are carrying research on a small scale and the problems encountered do not influence the findings of the study.

2.7 Analysis of Data

Data from the field were edited, coded and subsequently transferred into computer readable data using EPI-INFO version 6.0. Analyses of both qualitative and quantitative data were done using SPSS PC+ and all the in-depth discussions were tape recorded and transcribed and analyzed with Textbase Alpha.

To be able to meet up with the desired objectives of this study, a three-stage method of analysis was employed, namely: the univariate, the bivariate and the multivariate analysis. These methods were used to measure the effects of the variables on the sexual activity (number of partners, and use of condoms as prevention) of men.

The first level of the analysis involves the use of simple descriptive analysis in form of frequency distribution. The second level involves the use of bivariate to explain the relationship between sexual behaviour of multiple partners and attitude and belief about STDS/AIDS. While the third level will involve the use of advanced statistics in term of regression analysis to examine the patterns of association between the various dependent and independent variables. The dependent variables are number of partners and use of condoms as a prevention. This will be dichotomised to make it possible for logistic regression as a measures to test the hypotheses and to discover the kind of the relationship that exist between the variables.

CHAPTER THREE

3.1 DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

This chapter discusses some demographic and socioeconomic characteristics of the respondents at the time of the survey. It gives the composition of the respondents under the following demographic and socioeconomic variables. The variables analysed include age, educational status, occupation, religious affiliation, marital status, type of marriage contracted, age at first marriage, and ethnicity etc of the respondents. One cannot over emphasize the importance of obtaining such basic information about the respondents for better understanding of the analysis. Usually, a knowledge of such characteristics contributes immensely to the explanation of attitudes and belief about sexual behaviour of men in relation to STIs/AIDS. This is done by employing simple univariate analysis procedure.

Table 3.1.1: Distribution of Respondents By Their Age

Variables	Frequency	Percentage
Age-group		
15-19	28	5.7
20-24	37	7.6
25-29	85	17.3
30-34	54	11.0
35-39	75	15.3
40-44	92	18.8
45-49	57	11.6
50-54	22	4.5
55 and above	41	8.4
Total	490*	100.0
Mean 37.15 years		

* excluding non-response category.

3.1.1 Age of Respondents

The percentage distribution of the respondents by age as at the time of survey is shown in table 3.1. Age as a demographic characteristic constitutes a vital parameter in describing population in any study. A 5-year age grouping was applied.

In all, 490 questionnaires were gathered and analysed after excluding non-response category. Of this, 79 per cent are in the age group 25-44 years reflecting that the bulk of the respondents are relatively young. Though, this result might be due to an over-reporting of age in the following age-groups, these are: 25-29, 35-39 and 40-44 years age groups which happen to be the age groups with the highest percentage 17.3%, 15.3% and 18.8%

respectively. This has contributed in no small measure to the mean age of the sampled population which is 37.15 years, while only 8.4 per cent reported 55 and above.

Among those participated in an in-depth interview, majority of them also fall between 25-44 years age group, which indicate that majority of Nigerian population are young, though over-reporting cannot be downplay in this regards.

Table 3.1.2: Distribution of Respondents by literacy level

Variables	Frequency	Percentage
Literacy Level		
Yes	421	84.7
No	76	15.3
Total	497	100.0
Educational Status		
None	76	15.3
koranic	22	4.4
Primary	138	27.8
Secondary	176	35.4
Post Secondary	94	18.9
Total	497*	100.0

* excluding non-response category.

3.1.2 Literacy Level and Educational Attainment

These variables were used to obtain the highest level of education attained as well as literacy level of the respondents. Four classes of educational levels were used, together

with category for no formal education. It can be clearly seen in the table under literacy level that 15.3 per cent of the respondents turned out to have no formal education.

Of those with formal education, the respondents were generally of secondary education and below, with about three-quarters of the respondents, while those with post-secondary are just less than one-quarter of the respondents. The reason that can be proffered for this occurrence is that majority of the respondents did not want to disclose their true level of education for the fear of not associating them with bad sexual behaviour.

On the other hand, almost all the respondents claimed to know how to read and write, that is, 84.7 per cent, while 15.3 per cent claimed to be illiterate, meaning those that cannot read and write. This disparity cannot be unconnected with the effect of adult literacy education of the ouster civilian government of the Second Republic on the total populace in the state.

Table 3.1.3: Distribution of Respondents by Occupation

Variables	Frequency	Percentage
Occupation		
Artisan	123	25.3
Applicant	13	2.7
Farming	56	11.5
Trading	70	14.4
Professionals	76	15.6
Civil Servants	83	17.1
Schooling	65	13.4
Total	486*	100.0

* excluding non-response category.

3.1.3 Respondent's Occupation

Table 3.1.3 shows the percentage distribution of respondents by occupation. Occupation being one of the socio-economic characteristics is important due to its contributions and influence on individual's attitude, beliefs, and perhaps behaviour.

From the table, therefore, it can be seen that a little above one-quarter of the respondents interviewed engaged in artisan works (25.3%). The reasons that could be adduced for this observation are not unconnected partly with their accessibility to the interviewers. Secondly due to the nature of the questions asked which the elites might consider private, can be easily answered with little or no persuasion.

This is followed by those who reported that they engaged in public/civil services (17.1%), professionals (15.5%), trading (14.4%) and schooling (13.4%), while those who

claimed to be farmers and applicants are 11.5% and 2.7% respectively.

Table 3.1.4: Distribution of Respondents by Religious Affiliation

Variables	Frequency	Percentage
Religious Affiliation		
Protestant	172	35.2
Catholic	106	21.7
Muslim	204	41.7
Traditional	5	1.0
No Religion	2	0.4
Total	489*	100.0

* excluding non-response category.

3.1.4 Religious Affiliations of Respondents

About five religious categories were identified as indicated in the above table. It is discernible from this table that, more than half (56.9%) of the respondents reported to be Christians under two categories: Protestant and Catholic which are represented by 35.2% and 21.7% respectively. Those that practice Islam account for 41.7% of the total respondents. Only about 1 out of 20 respondents belong to African traditional religion, while those who reported no particular religion amounted to just 0.4% of the respondents.

It can be deduced from the data that the study area is shared by the two prominent religious beliefs, that is Christianity and Islam.

Table 3.1.5: Distribution of Respondents by Ethnicity

Variables	Frequency	Percentage
Ethnicity		
Hausa	15	03.0
Igbo	30	06.1
Yoruba	450	90.9
Total	495*	100.0

* excluding non-response category.

3.1.5 Distribution of Respondents by Ethnic Group

Looking at Nigeria as an entity, it is ethnically heterogenous in nature, with as many as 374 ethnic groups (Otite, 1990), of which three are most prominent, these are the Hausas, the Igbos and the Yorubas.

Going by the table above, it is clear that the study area is a Yoruba speaking dominated area. In fact, if not for sampling techniques, others would have find it impossible to be represented because majority of the respondents are Yorubas (90.1%), others are only 9.9% which comprises the Hausas and the Igbos.

Table 3.1.6: Distribution of Respondents by Marital Status and Type of Marriage

Variables	Frequency	Percentage
Marital Status		
Single	136	27.4
Married	347	70.0
Others	13	02.6
Total	496*	100.0
Type of Marriage		
Monogamous	263	73.1
Polygyny	97	26.9
Total	360*	100.0

* excluding non-response category.

3.1.6 Marital Status and Type of Marriage

Only three categories of marital status were considered appropriate and used for the analysis. These are single, married, and others. It was observed that while an overwhelming majority of the respondents, about three-quarter were married, only one-quarter belong to unmarried category. The category referred to as 'others' encompasses those who had once married but are not living together due to one reason or the other. They are either separated, legally disengaged from their spouses (divorced) or their spouse died. This class constitutes a relatively small proportion (about 2.6%).

Two types of marriage structure are shown in Table 3.1.6: these are monogamy and polygamy. As shown in the table, more than three-quarter of the respondents reported that they are in monogamous unions while only 22.8 per cent reported polygamy type of

marriage. This means that monogamy is the well acclaimed type of marriage practised in the area of study.

Table 3.1.7: Distribution of Respondents by Age at First Marriage

Variables	Frequency	Percentage
Age at First Marriage		
15-24	61	16.9
25-34	284	78.9
35 and above	15	4.2
Total	360*	100.0
Mean 28.2 years		

* excluding non-response category.

3.1.7 Age at First Marriage

Another demographic parameter used was the age at first marriage of the respondents. This is also shown in Table 3.1.7 above. From the table, the data present 16.9% of the respondents as married between ages 15-24 years, while majority married between ages 25-34 years, this category accounted for almost 80%. Only 4.2% married at the age of 35 years and above.

The category of never married is not shown, though this group is presumed to include singles and those that refused to indicate the year they first married. The mean age at first marriage is 28.2 years indicating late marriage in the study area. This must have been due to the effect of economic situation which has turned majority of young adults to

involuntary singles or postponing marriage to later year. This stance was corroborated by United Nations (1993) and Isiugo-Abanihe *et al*, (1993), when they wrote that Africa is now witnessing a move from a traditional to a modern setting, which is accompanied by nuptiality change, that involves a change from early to late marriage.

Table 3.1.8: **Distribution of Respondents by Current Number of Wives**

Variables	Frequency	Percentage
Current Number of Wives		
1	263	73.1
2	62	17.2
3	28	7.8
4 and above	7	1.9
Total	360*	100.0
Mean (all) 1.4 wives Mean (two and above) 2.4 wives Mean (three and above) 3.2 wives		

* excluding non-response category.

3.1.8 Respondent's number of wives

A comparison of this table with marital status shows a consistency in the number of married respondents 347 (70.0%) and those in 'others' category which encompasses separated/divorced 13 (2.6%), a total of which is 360. While close to three-quarter of the respondents are married to only one wife, others have more than one wife (26.9%).

The mean number of wives for all respondents was 1.4 wives, 2.4 wives for those

with 2 wives and above and 3.2 wives for those with 3 wives and above.

This comparison was corroborated by the type of marriage reported by respondents. Though, there happens to be little disparity in the number of respondents reported monogamy as the type of their marriage and those reported to be married to one wife.

Table 3.1.9: **Distribution of Respondents by Children Ever Born**

Variables	Frequency	Percentage
Children Ever Born		
1-2	73	21.9
3-4	93	27.8
5-6	88	26.3
7 and above	80	24.0
Total	334*	100.0
Mean 4.8 children		

* excluding non-response category.

3.1.9 Children Ever Born

The reproductive behaviour (in terms of children ever born) of the respondents is outlined in Table 3.1.9. Children ever born (CEB) is an important demographic factor that can help to ascertain the fertility level of any given area and this area of study is no exception.

Inference from the table shows the number of children ever born to the respondents as at the time of survey. The estimated mean of CEB is 4.8 children. Included in this class

were those that refused to state the number of children they have ever had. About 21.9% reported to have had 1 or 2 children, while 27.8% of the respondents reported to have had more than 2 but less than 5 children. Those that have had 5 or 6 children accounted for only 26.3%. Others (about 24.0%) reported to have had 7 or more children. The proportion that have had between 1 and 6 children is 76.0%. This is of course assumed to be higher considering the population policy of the Federal Government that has been in existence for over a decade. With this scenario, it can be deduced that the National Population Policy of 4 children per woman has not gone down the throat of the populace. Therefore, to have an effective population policy, efforts must be directed to its implementation.

In summary, this section has been devoted to examining the socioeconomic and demographic characteristics of the respondents. The next section is to examine the patterns of sexual networking of the respondents.

3.2 PATTERNS OF SEXUAL BEHAVIOUR OF THE RESPONDENTS

Among the prominent variables to be examined under this section include: Age at first sexual relation, and that of their partners, various reasons reported for the act, number of sexual partners in the last one year, in their life-time and current numbers etc.

Table 3.2.1: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Age at first sexual relations		
10-14	162	42.4
15-19	191	50.0
20-24	29	7.6
Total	382*	100.0
Mean Age at First Sexual Intercourse 15.26 years		

* excluding non-response category

* Multiple responses are allowed

3.2.1 Age at First Sexual Experience of Respondents

To elicit information about age at which the respondents had their first sexual relation, the question asked is "*Have you ever had sexual relation*?", which was answered by close to three-quarters of the respondents in affirmative; that demands probing with other questions that related to STIs/AIDS. The next question was "*if yes, how old were you when you first had sexual relations*?", only 382 (76.9%) out of 497 respondents responded to this

question, with minimum age of 10 years while the maximum was 24 years, excluding married respondents.

The modal age group is 15-19 years with 191 respondents (50.0%) which is half of the number of respondents that are single at the time of survey. The mean age is 15.26 years (approx. 15 years). This seems to be in harmony with the concepts that age at marriage is about 15 years in most cases. It can be deduced that sexual relations start earlier these days, with close to half of the respondents of age group 10-14 being indulged in sexual relation. This shows the extent by which our traditions have been erode away due in part to western education and civilisation.

The age at which sexual relations starts has serious implication for the spread of this pandemic diseases which have defied cure. This argument underscores the statement given by World Health Organisation's (WHO) representative in the country, Dr. Evarist Njelesani, in the Guardian, Friday, November 13, 1998, that the number of children under 15 years who have lived or are living with HIV since the start of the epidemic in the 1970's has reached 3.8 million, and 2.7 million have already died. It is sad enough to hear these days that children in primary school who suppose to be under their parents' guide are indulging in sexual relation let alone secondary pupils. This reason cannot be unconnected with the prevailing economic depression in the country as a result of Structural Adjustment Programme (SAP).

Table 3.2.2: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Their Partner's Age (Female)		
10-19	246	70.1
20-29	101	28.8
30-39	4	1.1
Total	351*	100.0
Mean Age at First Sexual Intercourse 17.61 years		

* excluding non-response category

* Multiple responses are allowed

3.2.2 Age of the Respondent's Partners (Female)

Table 3.2.2 shows that the age of the majority of respondent's partners is within the age range 10-19 years (70.0%), while only 28.8% fall in the age group 20-29 years, with 1.1% in the third group ie age group 30-39 years (1.1%). The mean age is 17.61 years. However, the age of their male counterparts can be seen to be higher, and this is not in support of the common hypothesis that females are likely to reach the age of puberty earlier than their male counterpart. The reason cannot be far from wrong estimation of their partner's age, or ignorance of age of partners on the part of the respondent.

Table 3.2.3: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Partners at first sexual relations		
Wife	78	18.8
girl/casual friends	315	75.7
Others	23	5.5
Total	416*	100.0

* excluding non-response category

* Multiple responses are allowed

3.2.3 Partners at First Sexual Experience

The question of whom the first sexual act is with is an important one. About 19 percent of the respondents had their first experience with their wives, 75.7 per cent with girl/casual friends, and 5.5 per cent had their first experience with other people including relatives. The high percentage of respondents who had their first experience with girl/casual friends points to the gradual demise of the old tradition of parents' strict supervision of the sexual lives of their sons especially in this recent times of pornographic films and the so-called western civilisation where having girlfriends is no more a taboo. An illustration from an in-depth interview support this position when a 27-year-old, male, single, said thus:

> *'I had my first sexual experience at the age of 18 years while in secondary school with my girlfriend, for reason of curiosity and also because I saw my elders doing same. I indulged in it only thrice.'*

Table 3.2.4: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Reasons for Sexual Relations*		
Starting Marital Life	84	19.9
Enjoyment/Fun	109	25.8
Test of Potency/Pride	29	6.9
Economic Reward	7	1.7
Curiosity	87	20.6
No reason in particular	43	10.2
Others	63	14.9
Total	422*	100.0

* excluding non-response category

* Multiple responses are allowed

3.2.4 Reasons Given for Sexual Relations

From Table 3.2.4, different reasons were proffered by the respondents for engaging in sexual relations. The reasons range from economic reward (1.7%) to mere enjoyment/fun (25.8%). This finding is in line with results of other researchers (e.g Orubuloye, et al., 1991) where it was reported that a great majority had their first sexual relations for fun, enjoyment, curiosity or because others did it. Some said they engaged in it for procreation purpose/starting marital life (19.9%), while to some, it was done subject to curiosity purpose (14.7%). Furthermore, some claim test of potency/pride (6.9%), while some gave different reasons like initiation from girls themselves, civilisation, child play, emulating friends which altogether are put under 'others' (14.9%). To the researcher's surprise, some

cannot even give any particular reason(s) for engaging in the act (10.2%).

Inference that one can draw from this finding is that sex is no more a taboo, due partly to civilisation as claimed by some respondents and partly to various pornographic films and video that are being watched by these younger ones of nowadays which has implication for HIV-transmission and can affect reproductive health in the next millennium.

Even in an in-depth interview conducted, for the above question, one of the participants has this to say:

"*It was just to be social as others*".

Another participant said:

"*It is just for the fun of it*".

Put differently is another participant who said thus:

> *'When I was in form four, we were introduced to biology and we were taught a lesson on sex education and some other things. And we discovered that there is something special in male and female's mating. Most of us do eager to meet with the opposite sex then to actually know the depth of what we've learnt in the school, this is the circumstance that led to my first sexual experience.*

While to some it was done after marriage, with the intention to have children.

Table 3.2.5: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Number of Partners Before Marriage		
1	74	29.6
2	88	35.2
3	30	12.0
4+	58	23.2
Total	250*	100.0
Mean 2.6 partners		

* excluding non-response category

* Multiple responses are allowed

3.2.5 Number of Partners Before Marriage

From table 3.2.5, it can be seen that those who had sexual relations with at least two partners before eventually settled down with one or more wives were more than half of the respondents (64.8%). About 35.2% had more than two partners. The mean number of partners is 2.6. This means that in these days, intending couples normally indulge in premarital sexual relations before settling down. Furthermore, the idea of girlfriends-boyfriends has also give rooms for this act which is now rampart in the society.

Table 3.2.6: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Number of Sexual Partners Had in Life		
None	5	1.2
1	67	15.9
2	96	22.9
3	93	22.1
4+	159	37.9
Total	420*	100.0
Mean 3.6 partners		

* excluding non-response category

* Multiple responses are allowed

3.2.6 Number of sexual partners had in life

Life-time sexual partners as shown on Table 3.2.6, revealed that majority of the respondents have more than one partner, and this is close to 80%, while 15.9% and 1.2% have one partner and none respectively. The mean number of partners, stood at 3.6 (approx. 4 partners). This is not unconnected with the exaggeration of number of partners as given by the respondents. This supports the finding of an earlier study (Pickering, 1988) that young single men exaggerate the number of their sexual partners to gain social prestige.

This can be supported by the response of one participant in an in-depth interview. He said thus:

> *'Sincerely, I couldn't remember the number of partners I had before marriage, the reason being that in the olden days, the order then was that you have as many girl friends you think you can have and the ultimate was*

to have fun with them per chance. And that was the reason why I couldn't say the actual number of sex or sexual partners I've had before.'

Table 3.2.7: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Number of Sexual Partners in the Last One Year		
None	4	1.1
1	214	58.0
2	93	25.2
3	20	5.4
4	16	4.5
5+	22	6.0
Total	369*	100.0
Mean 1.7 partners		
Current Number of Sexual Partners		
None	8	1.9
1	270	64.6
2	84	20.1
3	17	4.1
4	12	2.9
5	27	6.4
Total	418*	100.0
Mean 1.6 partners		
Mean number of Sexual Partners		
Had before marriage	2.6	
Had in life-time	3.6	
Had in the last one year	1.7	
Had Currently	1.6	

* Multiple responses are allowed

3.2.7 Number of sexual partners in the last one year and in recent time

Table 3.2.7 shows a scenario where more respondents claimed to have one partner (58.0%), while others have more than one partner (41.1%). The estimated mean number is 1.7.

From the same table, it is also depicted that majority of respondents have one partner each, which is more than half of the total respondents (64.6%); only 33.5% have more than two partners, including their wives for those that have married. The mean number of current sexual partners for all respondents is 1.6. It can be deduced, therefore, that majority have imbibed the idea of sticking to one partner, this can be as a result of religious belief, especially of the people of the study area.

This is also attested to by participants in an in-depth interview conducted where one of them said the following:

"Due to my religious belief and moral upbringing, that is why I refused to have sex before my marriage".

This summarises the information in Tables 3.2.6 and 3.2.7 under the following main headings: Number of Partners Before Marriage with estimated mean of 2.6, Number of Life-Time Sexual Partners also with 3.6 as the estimated mean number of sexual partners, Number of Sexual Partners in the Last One Year with 1.7 as estimated mean, and Current Number of Sexual Partners with 1.6 estimated mean.

Table 3.2.8: Percentage Distribution of Respondents by Patterns of Sexual Behaviour.

Variables	Frequency	Percentage
Reported Frequency for Sexual Intercourse		
Once a week	18	4.0
Twice a week	75	16.8
Occasionally	268	60.1
Daily	24	5.4
Don't have	61	13.7
Total	446*	100.0

* excluding non-response category

* Multiple responses are allowed

3.2.8 Reported frequency for Sexual Relations

From Table 3.2.8, almost all respondents were sexually active. 60.1 per cent of the respondents claimed to have sex occasionally, 16.8 per cent twice a week. Only 5.4 per cent and 4.0 per cent had sex daily and once a week respectively, while 13.7 per cent claimed not having sex at all.

Table 3.3: Distribution of Respondents by Knowledge of STIs/AIDS.

Variables	NO	Percentage
STIs Knowledge		
Heard of STIs Yes	495	99.6
No	2	0.4
STIs heard about*		
Gonorrhoea	490	98.6
Syphilis	374	75.3
Herpes	126	25.4
Chancroid	96	19.3
Chlamydia	122	24.5
Genital Warts	315	63.4
Others	154	31.0
AIDS Knowledge		
heard of AIDS Yes	487	97.9
No	10	2.1
Source of Information about STIs/AIDS*		
Friends	103	20.7
Schoolmate	53	10.7
Newspaper	117	23.5
Radio	351	70.6
Television	150	30.2
Teacher	28	5.6
Doctor/Nurse/Midwife	93	18.7
Parents	22	4.4

FP Clinic	47	9.5
Others	26	5.2
Knowledge of Friend's with STIs		
Yes	160	32.1
No	337	67.9
Have you Known of anyone who died of AIDS?		
Yes	82	16.4
No	416	83.6

* Multiple responses are allowed

Source: *Authors Field Survey*

3.3.1 Knowledge of Sexually Transmitted Infections

The vast majority of respondents had heard about sexually transmitted infections (99.6%). Information on knowledge was gathered using a general question. The most frequently mentioned STIs were gonorrhoea 98.6 per cent, syphilis 75.3 per cent, genital warts 63.5 per cent, herpes 25.4 per cent, chlamydia 24.5 per cent, chancroid 19.3 per cent, and others such as AIDS and Magun[1] 31.0 per cent.

From this analysis, it can be deduced that, gonorrhoea, the most common infection of all sexually transmitted infections (STIs) is well known to almost everybody in the study area, similar to what was found in studies of Messersmith *et al.* (1994) and Lema *et al.* (1994). To support this position, this is the excerpts from the in-depth interview conducted. One of the participants said thus on the subject matter:

> *'Gonorrhoea, which is the most popular before the advent of AIDS. Those are the two popular ones. I don't know the difference between others, Syphilis or whatever, but I know more of gonorrhoea and AIDS.'*

Also on the table is the knowledge of respondents on their friends who had contacted STIs. 32.1 per cent of respondents reported to have had friends with STIs.

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[1] *Magun was viewed by many respondents as a sexually transmitted infection (STI) and was believed to be an STI for men and a traditional, invisible barrier method of birth control for women (Simpson 1980; Delano 1988).*
The English translation of Magun is 'do not climb' or 'do not mount'. Magun is a charm normally placed on a woman by her husband or partner without her knowledge. If she has sexual intercourse with a man other than her husband or partner, it is believed that the man will convulse three times and either die immediately or become seriously ill (Delano 1988).
Magun is not believed to be curable by biomedical means (Simpson 1980). Examples of the belief in this kind of sexually transmitted illness which a man acquires from a woman through a socially taboo sexual relationship can be found elsewhere in sub-Saharan Africa (Warren 1979; Gelfand et al. 1985; Green et al. 1991; Green 1992 a,b).

3.3.2 Knowledge of AIDS

The knowledge of AIDS can be described as universal with 97.9 per cent of respondents saying they had heard of it. This result confirmed the earlier result found in some studies (Isiugo-Abanihe 1993; Adewuyi 1997), where it was revealed that a large majority of urban Nigerians are aware of HIV/AIDS (i.e 85 per cent of men and 79% women).

Meanwhile, only 16.4 per cent claimed to have known anyone with AIDS virus or who has died of AIDS. However, ethical considerations have been widely embraced - the focus on human rights aspects of the conditions and concerns such as informed consent, non-discrimination against those infected, and confidentiality. This bring to the fore the confidentiality that surround the causes of death in our society, where the causes were not for public consumption.

One of the participants has this to say on whether respondents knew anybody living with AIDS or died of AIDS.

> *'I have seen pictures of some in magazine and they usually cover their faces, they will not even tell us their names. But the most prominent one I've read about although was controversial is that of Fela. The family said he died of AIDS and some said no. In this locality, I've never seen one.'*

Another participant has this to say on the matter:

> *'I heard of people in the General Hospital who contacted AIDS and have died.'*

3.3.3 Source of Information

Table 3.3 reveals that radio was the most accessible source of information to the respondents (70.6 per cent). Followed closely in that order are television 30.2 per cent and newspaper 23.5 per cent. It follows that responses to STIs/AIDS may be influenced easily and effectively by the media's presentation of the disease and the impact on society as identified by Bruce *et al.* (1990) in his study on students' attitude about AIDS, homosexuality, and condoms at Wilmington, North Carolina. Only 20.7 per cent and 10.7 per cent claimed that they heard about STIs/AIDS from their friends and schoolmate respectively, while those that heard from family planning clinic amounted to just 9.5 per cent, parent and other sources were 4.4 per cent and 5.2 per cent respectively.

One participant in the in-depth interview has this to say on the source of information. It goes thus:

> *'I learnt about AIDS through the news media. That is through radio, television and newspaper.'*

Table 3.4: Distribution of Respondents by Attitudes And Beliefs of STIs/AIDS.

Variables	N0	Percentage
AIDS Belief		
Believe that AIDS exist Yes	449	90.3
No	48	9.7
Attitudes to AIDS (worry)		
Yes	382	76.8
No	115	23.2
Any Link Between STIs and AIDS?		
Yes	410	82.5
No	87	17.5
Sources of Contacting AIDS*		
Sexual Intercourse	395	79.5
Shaving/Razor	199	40.0
Injections	254	51.1
Circumcision	123	24.7
Mother to Child	116	23.3
Transfusion of Infected Blood	265	53.3
Sleeping in the same room with AIDS victim	32	6.4
Others	3	0.6
Do you think AIDS can be contacted from*		
Shaking hands with someone who has AIDS?	31	6.2
Kissing someone who has AIDS?	308	62.0
Wearing the clothes of someone who has AIDS?	90	18.1
Sharing eating utensils with someone who has AIDS?	93	18.7

Touching someone who has AIDS?	33	6.6
Mosquito, flea or bedbug bites?	174	35.0
Can healthy looking person be infected with AIDS?		
Yes	414	83.2
No	83	16.8
Can woman with AIDS give birth to a child without AIDS virus?		
Yes	311	62.6
No	186	37.4
Do you think you are at risk of contacting AIDS		
Yes	161	32.4
No	336	67.6
Do you think you can contact AIDS from*		
Wife/partner?	67	13.5
Needles/Injections?	161	32.4
Blood Transfusion?	182	36.6
Prostitutes?	264	53.1
Others	10	1.6

* Multiple responses are allowed

Source: Authors Field Survey

3.4.1 Attitudes and Belief about AIDS

For belief of AIDS, 90.3 per cent of respondents claimed that there exists the devastating disease in the society. With this figure, it indicates that Nigerians have realised the existence of the disease and this can influence their behaviour by reducing the number of partners or play save by using condom.

Attitude of respondents to AIDS in particular can be said to be given some concern. Of all the respondents, 76.8% were worried about the infection while only 23.2% were not worried about it. In the like manner, 82.5% of the respondents considered AIDS to be linked with STIs. With this type of attitude, it means that the vast majority of respondents were aware of the linkage between the two infections. Therefore, AIDS is seen as one of the STIs apart from common one like gonorrhoea, syphilis, Herpes and host of others. One participant in an in-depth interview put his own perception about AIDS in this way:

> *'My perception of AIDS is that it is dreadful and a gradual killer. And once it is contacted the end is death since it is not curable either through orthodox or unorthodox medicine. And whoever is wise will not want to contact what will send him/her to his/her grave untimely.'*

3.4.2 Mode of Transmission

Table 3.4 shows the respondents' knowledge of the mode of transmission of AIDS. Respondents were asked to indicate "true or false" against each of causes specified in the table. However, percentages provided are for only those who indicated "true" for the given cause of transmission. The responses show that the respondents were quite aware of the proper mode of transmission. One of the ways by which AIDS can be contracted was by sexual relations 79.5 per cent. Followed sequentially was blood transfusion 53.3 per cent,

then from prostitutes 53.1 per cent. Others were unsterilised injection, shaving/razor 40.0 per cent, circumcision 24.7 per cent, mother to child 23.3 per cent, while in another similar question, 62.2 per cent of respondents claimed that woman with AIDS virus can give birth to a child without AIDS virus. This discrepancy may have resulted from different interpretation of the question involved. However, some apparently in error, mentioned sleeping in the same room as means through which AIDS could be transmitted.

For verification, we sought information on other means of transmission, the respondents mentioned kissing (62.0 per cent), sharing eating utensils (18.7 per cent), wearing clothes of someone who has AIDS (18.1 per cent), mosquito and bedbug (35.0 per cent), others were touching, and handshaking. This indicates that the mode of transmission has not been recognised properly by the people and there is need for more emphasis on the part of government and other non-governmental agencies on the issue.

On whether it is possible for a healthy looking person to be infected with the AIDS virus, 83.2 per cent answered positively which can be taken as confirming the awareness of the existence of AIDS. Though only 37.4 per cent claimed that woman who has AIDS virus could give birth to a child with AIDS virus, this suggests that knowledge of the transmission of disease from mother to child is uncommon.

The words of one participant in the in-depth interview goes thus:

> *'As far as I am concern I don't know how far it is true but I learnt that one can even contact it in the salon and through dentistry etc, but I have not seen a person who has contacted tone and I don't know whether it is true or not to have sexual intercourse with female partner.'*

While this participant is not sure of sexual intercourse as a means of contacting AIDS, though he mentioned one major mode - through salon, another discussant put it directly thus:

'One can contact AIDS through sex and blood transfusion. Anything that has to do with exchange of blood, the virus can be contacted through such means.'

Table 3.5: Distribution of Respondents by Ways of Preventing STIs/AIDS.

Variables	N0	Percentage
Are STIs Preventable?		
Yes	452	91.0
No	45	9.0
Method of Prevention*		
Condom use	207	41.6
Maintaining one wife/partner	47	9.5
Avoid prostitutes	17	3.4
Avoid casual partners	42	8.5
Seek medical check-up	107	21.5
Avoid Blood transfusion	52	10.5
By saying NO to fornication	50	10.1
Contraceptive as a method of Prevention		
Yes	421	84.7
No	76	15.3
Contraceptive Methods Mentioned*		
Pills/tablets	49	9.9
Injections	109	21.9
Foaming	23	4.7
Durex/Condom	296	59.5
Others	20	4.0
What can people do against AIDS?*		
Protect themselves	462	92.9
Nothing can be done	35	7.1
How to protect oneself against contacting AIDS*		

Do not have sex at all	87	17.5
Limit number of sexual partners	331	66.6
Use condoms during sexual relations	247	49.7
Sterilize syringes/needles	115	23.1
Avoid prostitutes	293	59.0
Others	6	1.2
What Government can do to AIDS victims		
Keep them away from society	327	65.8
Take care of them	139	28.0
Encourage safer sex	76	15.3
Encourage the use of condom	93	18.7

* Multiple responses are allowed

Source: Authors Field Survey

3.5.1 Prevention of STIs

From Table 3.5, it can be seen that almost all the respondents reported that STIs can be prevented (91.0 per cent). To buttress this findings, almost all participants in the in-depth interview conducted answered the same question in affirmative. One of them has this to say:

> *'I think gonorrhoea and syphilis are preventable but AIDS - I have never heard of someone who contacted it and has been cured. But I believe that of gonorrhoea.'*

3.5.2 Methods of Prevention Mentioned

Table 3.5 also shows the respondents' knowledge of method of prevention. Respondents were asked to mention different ways of preventing STIs. However, almost all the respondents mentioned at least one method of preventing STIs. Among the most frequently mentioned were condom (41.6 per cent) and going to the hospital for medical check-up (21.5 per cent). Some respondents linked it with religion tenants by saying that, one should say no to fornication (10.4 per cent), while some mentioned avoidance of blood transfusion. Other methods mentioned were keeping to one wife/partner (9.5 per cent). Avoidance of prostitutes, or avoidance of casual partners though mentioned infrequently, is not unconnected with the fact that the questions were unprompted. In the in-depth interview this is the way one of the participants put it:

> *'By using the most advertised condom and most importantly by adhering to a single sex partner or total abstinence from sex, which I don't believe is possible. The most effective is abstinence from sex though I don't know the extent to which one can abstain from sex, since one is not a "Father" or a "Catholic Bishop".'*

Another participant attested to this by saying that:

> *'Like gonorrhoea, it is contacted from somebody who has it. If you don't sex the person who has it, then that person will not have it.'*

3.5.3 Contraceptive as method of prevention

Knowledge of contraception as a method of STIs prevention was almost universal among the respondents. 84.7% per cent of respondents answered affirmatively the question "Do you think that some of the sexually transmitted infections can be prevented by adopting contraceptive methods?".

Of the contraceptive methods mentioned, durex/condoms was overwhelm mentioned (59.5%). This question served as a check for consistency, whether the respondents could identify the appropriate methods of preventing STIs. However, other methods mentioned were not connected with prevention of STIs. This could be as a result of misconception on the part of respondents.

3.5.4 Methods of Prevention Prompted

Relatively high level of methods of AIDS prevention was observed. Almost 93 per cent of the respondents said that people should protect themselves from getting AIDS by avoiding commercial sex workers (59.0%), using condoms (49.7%), limiting number of sexual partners (66.6%), sterilising syringes/needles before using (23.1%). It can be deduce that sticking to one partner is given prominent role in avoiding AIDS.

Last on the table is what people think government could do to those living with AIDS if identified. The vast majority of respondents (65.5%) were of the opinion that they

should be kept away from society so as not to allow them to infect anybody. Twenty-eight per cent on the other hand said that government should take care of them by providing drugs necessary for their cure, while only 18.7 per cent and 15.3 per cent respectively considered it paramount that government should encourage the use of condoms and safer sex.

Concerning what an individuals, government and NGOs can do, some of those engaged in in-depth interview has this to saying on the matter:

For individual:

Participant A:

> *'what could be done for AIDS carrier is to give them words of encouragement.'*

Participant B:

> *'We need to understand the mechanism of AIDS. For example, I read about a church with AIDS victims in the church and what the people are doing is to help him. Also if people don't know how AIDS is transmitted there is danger of people running away from AIDS victims. But if there is proper understanding as per way it can be contacted, people will not run away from AIDS victim but will instead give helping hands.'*

Participant C:

> *'By praying for him/her so that his/her life can be prolonged. One needs to help them financially. If they have access to medical facilities it will lengthen their life. If one has money, he can establish AIDS Foundation like Late Chief Ogundoyin from Eruwa did for sickle cellers and he spent lavishly on them, so that the disease will allow them to do some good things in life before they eventually die.'*

For government:

Participant A:

> *'They have to mount up enlightenment campaigns that if people have AIDS they don't need to spread it. Let them know that they don't need to hide it either if they have contacted AIDS. The government should take care so that*

they don't spread it. Government should provide job for people so that people will not be "asewo" - prostitutes. For a man who doesn't have any job and the sexual urge is there, he will not marry because he cannot cater for a family. Hence, he will prefer to negotiate with a prostitute at a cheaper price and can through it contact AIDS. For those who have really contacted it, government can settle them somewhere just like the lepers and experiment purely on them so that they will know how they are responding to treatment. If they want to use African Traditional medicine let them use it solely and if it is modern medicine let it be used solely over a period and see what the result will be.'

Participant B:

'It is not only the AIDS victims that government can help but they can help the society at large in terms of educating the people. Another thing government can do is to aid them by making provision for the Hospital in terms of equipment for screening whether an individual is really infected with AIDS virus or not. Also government from time to time should visit schools to educate the school pupils and the society.'

Participant C:

'The government should get a place for them, feed them so that they will not spread it to other places (persons).'

For NGOs like WHO, UNO, UNDP USAIDS etc.:

Participant A:

'They should go ahead with their various researches so that at the end of the day they will come out with what AIDS is all about. And they can still assist by sending their assistance in terms of condom.'

Participant B:

'There was a time WHO was giving out condom and some other preventive measures. All these organisations can still give aids (help) so as to make sure that it is not spread.'

Participant C:

'They can help by rehabilitating and assisting them. They help in public enlightenment. They should spend money on research on it to get curative measure. As they work towards prevention, they should look for curative

measures.'

On the effect on individual and the economy:

Participant A:

'Apart from the financial burden on the person living with HIV/AIDS by attending Hospital, there are also the psychological trauma that he will have to go through. Because once infected with AIDS sooner or later he is going to die and that is the kind of psychological trauma one will carry about until the person die. And this kind of gradual killing is not good for any reasonable person.'

Participant B:

'People don't enjoy themselves again. It creates fear for some people who think that they can contact AIDS.'

Participant C:

'The effect on our economy is so terrible. One, the people who are to work to improve the economy of the country, if they have contacted AIDS, they can no longer work. Those who are to be independent will become dependant. Because of this AIDS people are spending a lot on condom, preventive drugs etc. Some who cannot do without women will prevent themselves by buying costly drugs. If all the money is spent on drugs, there will be no money for investment, since there is no saving. So, economy will continue to be paralysed. Finally, even the economy of the country will be paralysed because we might have used our foreign reserve to import machine to diagnose, drugs and other things only on AIDS which we can prevent. And by this there will be economic problem as we have now.'

Participant D:

'The economy is already bad. Most of the money to be used on economic development will be used on research on how to ameliorate this kind disease in the society. The government will get a place for them, feeding them so that they will not spread it to other places (person). If this money is used in another area of development there will be improvement on our economy.'

In summary, it can be inferred from findings in this chapter that knowledge of STIs/AIDS are almost universal among the respondents, including participants in the in-

depth interview. Most respondents attributed their knowledge to radio and television. The second most important source is the newspaper. The commonly mentioned STIs are gonorrhoea and syphilis. Majority attested to the existence of AIDS which arose their worriness for the deadly disease.

The vast majority of respondents knew about the transmission routes which are sexual intercourse, transfusion of infected blood, needle transmission etc. However, as with STIs, certain misconceptions were still held, including that AIDS was caused by kissing, hands shaking, touching, sleeping in the same room with AIDS patient etc.

On whether there had been any change in their sexual behaviour since hearing of AIDS, it can be deduced from the findings that majority were sticking to one partners in recent times. This might be as a result of their religious believe (especially christians). However, what most of the respondents regarded as changed behaviour include "no sex at all", "reduction in the number of sexual partners", "avoidance of commercial sex workers". and "using condoms during sexual relations".

Condom as a preventive measure appeared related to the respondents' level of AIDS knowledge. As to what government can do to people living with AIDS, the advise ranges from keeping them away to taking care of them. While majority of participants in the in-depth interview mentioned enlightenment campaign. Others mentioned sex education in our secondary schools, enhanced communication between children and parents etc. Lastly, NGOs abroad should endeavour to assist financially in terms of diagnostic equipment for blood screening. Condom should be highly subsidised and probably given the latest vaccine. For those in Nigeria, researches especially, must embark on factors that contribute to the

spread of this deadly disease and then report same to the health authorities for necessary policies formulation. These reports should be made available in our local languages for easy and proper information to the populace who happens to be at receiving end.

CHAPTER FOUR

4.1 SEXUAL BEHAVIOUR AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC VARIABLES

The main thrust of this chapter is to discuss the sexual behaviour of the respondents. This will be done under three sub-headings. The first part presents a cross tabulation of some selected socio-economic and demographic characteristics of the respondents by knowledge, attitudes and beliefs about STIs/AIDS as given in the conceptual framework in chapter one.

Second part will show a cross tabulation of number of sexual partners of the respondents by knowledge of, attitudes and belief about STIs/AIDS. While the third section will be for testing of research hypotheses as shown in chapter two of this study.

Table 4.1.1 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Age

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Age-Group	N0	% Heard of STIs	N0	% Heard of AIDS
15-24	63	13.1	62	13.5
25-34	138	28.7	133	28.9
35-44	166	34.5	159	34.6
45-54	79	16.4	73	15.9
55+	35	7.3	33	7.2

* Excluding non-response category

* Multiple responses are allowed

4.1.1 Respondents who have ever heard about STIs/AIDS by Age

Table 4.1.1 depicts the distribution of respondents who had ever heard of STIs/AIDS by age. It can be observed from the table that 13.1% of those in age-group 15-24 years had ever heard of STIs while a little above that per cent (13.5%) of the same age group claimed to have heard of AIDS. The two age-groups that have greatest Knowledge of the infections are 25-34 and 35-44 years with (28.7% and 34.5%) for STIs and (28.9% and 34.6%) for AIDS respectively. While other age-groups such as 45-54 and 55+ have (16.4% and 7.3%) for STIs and (15.9% and 7.2%) for AIDS. With this observation, one can deduce that STIs including AIDS are well known among the respondents in the middle age groups.

Table 4.1.2 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Sources of Information

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Sources of Information*	N0	% Heard of STIs	N0	% Heard of AIDS
Friends	117	11.8	106	11.4
Schoolmate	54	05.5	54	05.8
Newspaper	103	10.4	93	10.0
Radio	350	35.4	331	35.7
Television	150	15.2	142	15.3
Teacher	28	02.8	27	02.9
Doc/Nurse/ Midwife	93	09.4	80	08.6
Relatives	45	04.5	44	04.7
FP Clinic	47	04.8	47	05.1
Others	2	00.2	2	00.2

* Excluding non-response category

* Multiple responses are allowed

4.1.2 Respondents who have ever heard about STIs/AIDS by Sources of Information

From Table 4.1.2, majority of the respondents identified radio as their source of information on STIs including AIDS; 34.4% and 35.7% respectively. Followed in that order are television (15.2% and 15.3%), friends (11.8% and 11.4%) and newspaper (10.4% and 10.0%). Other sources mentioned with lower percentage are schoolmate, teacher, doctor/nurse/midwife, relatives, FP clinic, workshop etc. It can be deduced that respondents in this area have not exhausted all other sources of information especially Family Planning clinic.

Table 4.1.3 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Religion Affiliation

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Religion Affiliation	N0	% Heard of STIs	N0	% Heard of AIDS
Protestant	169	34.9	161	34.7
Catholic	106	21.9	104	22.4
Muslim	203	41.9	192	41.4
Traditional	5	01.0	5	01.1
None	2	00.4	2	00.4

* Excluding non-response category

* Multiple responses are allowed

4.1.3 Respondents who have ever heard about STIs/AIDS by Religion Affiliation

Table 4.1.3 shows the distribution of respondents by religious affiliation. The table shows christians as the group with widely acclaimed knowledge of STIs including AIDS. When the two related religious groups are pooled together, that is protestants and catholics, they accounted for 56.8% for STIs and 57.1% for AIDS while muslims followed with 41.9% and 41.4% for STIs and AIDS respectively. One is not surprised with this figure owing to the fact that christians are more exposed to reading newspapers than other religious groups.

Table 4.1.4 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Educational Status

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Educational Status	N0	% Heard of STIs	N0	% Heard of AIDS
None	76	17.4	70	16.8
Koranic	2	0.5	2	0.5
Primary	135	30.9	130	31.3
Secondary	164	37.5	155	37.3
Post Secondary	60	13.7	59	14.2

* Excluding non-response category

* Multiple responses are allowed

4.1.4 Respondents who have ever heard about STIs/AIDS by Educational Status

Educational status is shown in table 4.1.4. Respondents with secondary education accounted for 37.5% and 37.3 % for knowledge of STIs and AIDS respectively. Respondents with primary school leaving certificate claimed 30.9% and 31.3% knowledge of STIs and AIDS respectively. Close to 14 per cent knowledge of STIs/AIDS were claimed by respondents with post secondary education. Other categories are respondents with koranic education and those with none with 17.4%, 0.5% and 16.8%, 0.5% for STIs and AIDS respectively. Briefly, it can be deduced that education is an important tools in STIs/AIDS awareness.

Table 4.1.5 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Occupation

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Occupation	N0	% Heard of STIs	N0	% Heard of AIDS
Artisan	120	24.8	111	24.0
Applicant	13	2.7	13	2.8
Farming	56	11.6	54	11.7
Trading	69	14.3	64	13.9
Professionals	75	15.5	74	16.0
Civil Servants	83	17.1	80	17.3
Schooling	68	14.0	66	14.3

* Excluding non-response category

* Multiple responses are allowed

4.1.5 Respondents who have ever heard about STIs/AIDS by Occupation

Table 4.1.5 depicts artisans as having the highest knowledge of STIs/AIDS with 24.8% and 24.0% for STIs and AIDS respectively, while applicants claimed only 2.7% and 2.8% knowledge of STIs and AIDS respectively. Farmers and traders also share almost the same level of knowledge with 11.6%, 14.3% and 11.7%, 13.9% for STIs and AIDS respectively. Professionals and those in school are not left out in the category of those who possess the knowledge. Professionals claimed 15.5% and 16.0% knowledge of STIs and AIDS respectively while those in school claimed 14.0% and 14.3 knowledge of STIS/AIDS as well.

Table 4.1.6 Percentage Distribution of Respondents who have ever heard of STIs/AIDS by Marital Status

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Marital Status	N0	% Heard of STIs	N0	% Heard of AIDS
Single	133	27.0	129	27.3
Married	347	70.4	330	69.9
Widower	3	0.6	3	0.6
Separated	10	2.0	10	2.1
Type of Marriage				
Monogamously Married	278	79.0	265	78.9
Polygamously married	74	21.0	71	21.1

* Excluding non-response category

* Multiple responses are allowed

4.1.6 Respondents who have ever heard about STIs/AIDS by Marital Status and type of Marriage

From table 4.1.6, married respondents who had ever heard of STIs and AIDS are respectively 70.4% and 69.9%. While twenty-seven per cent and 27.3% of those unmarried had ever heard of STIs/AIDS. Other groups are widower and separated with 0.6%, 2.0% and 0.6%, 2.1% knowledge of STIs and AIDS respectively.

Furthermore, the table shows respondents by type of marriage contracted. Respondents with one wife claimed more knowledge (79.0%) of STIs and 78.9% of AIDS; those with more than one wife claimed ignorant of the deadly disease with twenty-one per

cent for STIs and 21.1% of AIDS respectively.

Table 4.1.7 Percentage distribution of respondents who have ever heard of STIs/AIDS by Ethnicity

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Ethnicity	N0	% Heard of STIs	N0	% Heard of AIDS
Yoruba	437	91.0	431	91.5
Hausa	14	02.9	13	02.8
Igbo	29	06.1	27	05.7

* Excluding non-response category

* Multiple responses are allowed

4.1.7 Respondents who have ever heard about STIs/AIDS by Ethnicity

On the table above, it can be seen that Yorubas are in majority in the area of study and this goes a long way to influence the percentage distribution of the respondents by any proximate determinant. Therefore, the table shows the Yorubas as a group with vast knowledge of STIs and AIDS 91.0% and 91.5% respectively. While the other two groups have a little above 10 per cent knowledge of the diseases.

Table 4.2 Percentage Distribution of Respondents who have heard of STIs/AIDS by Sexual Behaviour

Variables	Ever Heard of STIs		Ever Heard of AIDS	
Age at First Sexual Relations	N0	% Heard of STIs	N0	% Heard of AIDS
10-14	29	7.6	29	7.9
15-19	133	34.8	129	35.1
20-24	124	32.5	119	32.3
25-29	67	17.5	64	17.4
30+	29	7.6	27	7.3
Partner at first experience				
Wife	72	18.8	68	17.8
Girl/casual friends	289	75.7	278	72.8
Others	21	5.5	17	4.5
Partner's Age (Female)				
10-14	44	12.6	44	13.1
15-19	200	57.3	193	57.3
20-24	84	24.1	80	23.7
25-29	17	4.9	16	4.7
30+	4	1.1	4	1.2
Reported Frequency for Sexual Relations				
Once a week	18	4.1	16	3.8
Twice a week	75	16.9	71	16.7
Occasionally	266	59.9	257	60.5
Daily	24	5.4	23	5.4
Don't have	61	13.7	58	13.6

* Excluding non-response category
* Multiple responses are allowed

4.2.1 Age at First Sexual Relations

Age at first sexual relations is important as a measure of experience in that the earlier the age one experiences sexual contact, the more one would be prone to the risk of contracting STIs/AIDS, and the higher the knowledge of these infections. From Table 4.2, it is revealed that awareness of STIs is high among age group 15-19 years (34.1%) which influences their knowledge about AIDS (35.1%), followed sequentially are those in age group 20-24 years age group with 32.5% claiming knowledge of STIs and 32.3% claiming knowledge of AIDS, while among their female counterparts similar knowledge of both infections were claimed. Those in age group 15-19 have the highest percentage (57.3%) for STIs/AIDS since respondents' own experiences were similar to what they reported about their friends.

For the question on whom the first sexual experience is with, the analysis reveals that respondents who had their first sexual experience with girl/casual friends had the knowledge of STIs/AIDS. This implies that with the knowledge of STIs/AIDS people still indulge in sexual relations with casual friends without considering the risk involved, although they might claim using condom for prevention. This claim will be discussed later.

4.2.2 Reported Frequency of sexual relations

Table 4.2 depicts those who had occasional sex as having wider knowledge of STIs and AIDS with 59.9% and 60.5% respectively. Followed closely are those who had it twice a week with 16.9% and 16.7% respectively, and those who did not have sexual relations (13.7% and 13.6%).

Table 4.3 Percentage Distribution of Respondents who have heard of STIs/AIDS by Number of Sexual Partners

Variables	Ever Heard of STIs		Ever Heard of AIDS	
	N0	% Heard of STIs	N0	% Heard of AIDS
Number of Sexual Partners Had in Life				
None	5	1.2	4	1.0
1	65	15.7	58	14.8
2	96	23.1	91	23.2
3	93	22.4	91	23.2
4	54	13.0	52	13.2
5+	102	24.6	96	24.5
Number of sexual partners had in the last four or twelve months				
None	4	0.9	3	0.8
1	212	49.6	202	50.6
2	93	21.8	87	21.8
3	49	11.5	47	11.8
4	28	6.6	24	6.0
5+	41	9.5	36	9.0
Current number of sexual partners				
None	6	1.4	4	1.0
1	268	60.4	256	61.2
2	84	18.9	80	19.1
3	47	10.6	42	10.0
4+	39	8.8	36	8.7

* Excluding non-response category

* Multiple responses are allowed

4.3.1 Number of Partners

From table 4.3, number of partners can be seen under three main headings. First, number of partners had in life, followed by number had in the last one year, and lastly number of partners currently having. Generally, it is observed that the knowledge of STIs/AIDS is widely acclaimed among those with more than one partner, especially when considering number of partners had in life time and in the last twelve months. But for current partners, it can be seen that with the knowledge of STIs/AIDS, respondents have indicated relative modification of their sexual behaviour by keeping to one partner with 60.4% and 61.2% for STIs/AIDS respectively.

Table 4.4.1 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by age.

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Age-Group				
15-24	61	15.1	60	15.6
25-34	117	29.0	114	29.7
35-44	148	36.6	142	37.0
45-54	62	15.3	58	15.1
55+	16	04.0	10	02.6

* Excluding non-response category.

4.4.1 Attitudes and beliefs about AIDS by age

Table 4.4.1 presents percentage distribution of respondents' attitudes and beliefs about AIDS by age. It was observed that 36.6% of respondents in age-group 35-44 believed in the existence of AIDS while 37.0% of the same age-group were worried about the deadly disease. Next on the table is the age group 25-34 years with 29.0% for existence of and 29.7% for worriness about AIDS respectively. Of surprise is the lukewarm attitude displayed by those in age group 15-24 years. They claimed 15.1% and 15.6% respectively for the existence and worriness about the deadly disease. This age-group suppose to have the highest worry, because they indulge in indiscriminate sexual relation more often. It can be seen from the table that the belief about the deadly disease is common mostly among the younger respondents meaning that this can influence their sexual behaviour as they move to older ages in the reproductive age.

Table 4.4.2 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by Religion Affiliation

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Religion Affiliation				
Protestant	151	37.2	149	37.1
Catholic	85	20.9	84	20.9
Muslim	163	40.1	162	40.3
Traditional	5	1.2	5	1.2
None	2	0.6	2	0.5

* Excluding non-response category.

4.4.2 Religious Affiliation

Table 4.5 reveals respondents who are christians as the religious group that claims the existence of AIDS with 58.1%. This is when the two categories of christian were pooled together. While the muslims had 40.1% belief in the existence of the deadly disease. Among other groups, the belief stood at 1.8%. Taking their attitudes into consideration, it can be seen that their worrisome is along the same line. This means that christians are more worrisome about the deadly disease than their counterparts in other religious groups owing partly to their exposure to mass media and partly to their level of education.

Table 4.4.3 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by Educational Status

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Educational Status				
None	68	17.8	65	17.5
Koranic	1	00.3	1	00.3
Primary	113	29.5	108	29.0
Secondary	141	36.8	139	37.4
Post Secondary	60	15.7	59	15.9

* Excluding non-response category.

4.4.3 Educational Status

It is shown in table 4.5.3 that for both the existence of AIDS and worriness about its implication. Eight-two percentage of respondents with at least primary education belief in the existence of AIDS while 82.3% of the same group show their concern for the deadly disease. Respondents with no education had 17.8% belief while only 17.5% are worried; those with koranic education had little or no belief in its existence, therefore they were not worry about it. It is crystal clear from the findings above that belief of the existence and worriness of the deadly disease appeared related to the respondents' level of education.

Table 4.4.4 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by Occupation

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Occupation				
Artisans	145	32.4	136	32.0
Applicant	10	02.2	10	02.4
Farming	33	07.4	27	06.4
Trading	54	12.1	52	12.2
Professionals	70	15.7	67	15.8
Civil Servants	75	16.8	74	17.4
Schooling	60	13.4	59	13.9

* Excluding non-response category.

4.4.4 Occupation

Among different categories of occupation mentioned, table 4.4.4 reveals artisans as the group that has the highest percentage of those who belief in the existence of AIDS with 32.4%, and 32.0% worry. Next to this group is the civil servants with 16.8% belief and 17.4% worry. Followed closely are the professionals and those in school with 15.7% and 13.4% belief respectively, while 15.8% and 13.9% of these groups were respectively worried about the deadly disease. Traders and farmers are not left out, though with little or no belief in its existence, as well as their level of worriness about the disease. With this figure, it is observed that respondents who were educated given their occupation claimed

to have belief in the existence of the deadly disease, as well show their worriness about the impact of the disease on their productivity.

Table 4.4.5 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by Marital Status

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Marital Status				
Single	120	29.2	118	29.3
Married	281	68.4	276	68.5
Widower	1	00.2	1	00.2
Separated	9	02.2	8	02.0
Type of Marriage				
Monogamously Married	236	83.4	234	85.1
Polygamously married	47	16.6	41	14.9

* Excluding non-response category.

4.4.5 Marital Status

Table 4.4.5 depicts married as the group that had strong belief in the existence of this disease. They also show the highest concern for the impact of same on their reproductive health. Next on the table are those single with a little above one quarter of them claiming the existence of the disease and worriness respectively.

On the types of marriage, those in monogamy were more worried about the disease with 85.1% owing to their belief in the existence of same. Of those in polygamous marriage, 16.6% believe in its existence while only 14.9% were worried about the deadly disease.

Table 4.5 **Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS according to Selected Characteristics**

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Age at First Sexual Relations				
10-14	20	6.4	18	7.9
15-19	119	37.9	117	35.1
20-24	104	33.1	102	32.3
25-29	53	16.9	51	17.4
30+	18	5.7	17	7.3
Partner at first sexual experience				
Wife	68	18.1	67	18.2
Girl/casual friends	287	76.5	284	79.9
Others	20	5.3	18	4.9
Partner's Age (Female)				
10-14	33	11.2	30	10.8
15-19	174	59.2	168	60.2
20-24	69	23.5	64	22.9
25-29	14	4.8	13	4.7

30+	4	1.4	4	1.4
Reported Frequency for Sexual Relations				
Once a week	15	4.1	14	4.0
Twice a week	59	16.1	56	15.9
Occasionally	232	63.4	228	64.8
Daily	20	5.5	17	4.8
Don't have	40	10.9	37	10.5

* Excluding non-response category

* Multiple responses are allowed

4.5.1 Respondents' Attitudes and Beliefs about AIDS

The table depicts the distribution of respondents' attitudes and beliefs about AIDS by sexual behaviour. First on the table is the age at first sexual intercourse. Majority of respondents who believe in the existence of AIDS are between the age group 15-24 years. The same is true for the concern they show for their worry about the deadly disease. It can then be deduced that with this belief as they move to older age groups they may adjust their sexual behaviour.

Considering the age of their partners as reported by the respondents, majority in the age group 15-19 years believe in the existence of this disease and they were worried as well (59.2% and 60.2% respectively). Next to this group is age group 20-24 years.

On the partners they had sexual experience with, mostly those that had their experience with girl/casual friends believe in the existence of AIDS and accounted for 76.5% while 79.9% of the same group were worried about the consequences of this disease. Given this claim, it is expected that they may modify their behaviour by reducing their contact with casual friends, or better still, use condoms. Other partners include wife while only 18.1% believe in the existence of the disease, 18.2% of same were worried about the disease.

It is observed that respondents who reported occasional sexual intercourse believe in the existence of AIDS and they were also worried about its implication for their health, while those who reported twice a week follow suite.

Table 4.6 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by Number of Sexual Partners

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Number of Sexual Partners Had in Life				
None	5	1.5	5	1.6
1	53	16.3	50	16.3
2	77	23.7	74	24.2
3	80	24.6	78	25.5
4	46	14.2	44	14.4
5+	64	19.6	55	17.9
Number of sexual partners had in the last four or twelve months				
None	4	1.4	4	1.5
1	190	67.6	184	67.4
2	65	23.1	64	23.4
3	13	4.6	12	4.4
4+	9	3.2	9	3.2
Current number of sexual partners				
None	7	2.1	6	1.9
1	240	73.4	237	74.1
2	60	18.3	58	18.1
3+	20	6.1	19	5.9

* Excluding non-response category

* Multiple responses are allowed

4.6.1 Respondents' Attitudes and Beliefs about AIDS by Number of Sexual Partners

Of the respondents who believe in the existence of AIDS, and also show some concern about it, were those who had one partner in their life time, 67.6% and 67.4% respectively, followed sequentially were those who reported having two partners. In the light of this finding, it means that with the belief and concerns about AIDS, respondents tend to adhere to one partner as against having more than one partner.

For number of partners had in the last one year and in recent times. The table shows the respondents with one partner as holding firm belief of existence of AIDS with ominous fear of its implications on the health of individual and economy in general. While quite few respondents with higher number of sexual partners ever show any concern over the implication of the deadly disease. Going by this findings, it can be deduced that in recent times majority would likely modify their sexual appetite, if the belief of the existence of AIDS is anything to go by coupled with its worrisome in the mind of majority.

Table 4.7 Percentage Distribution of Respondents' Attitudes and Beliefs about AIDS by some Preventive Measures

Variables	Believe that AIDS Exist		Worried about AIDS	
	N0	% that AIDS Exist	N0	% Worried about AIDS
Mode of contacting AIDS*				
Sexual Intercourse	360	72.4	358	72.0
Shaving/razor	189	38.0	183	47.8
Injections	241	48.5	237	22.5
Circumcision	117	23.5	112	21.9
Mother to child	110	22.1	109	49.5
Blood transfusion	241	48.5	246	
Sleeping in the same room with the victim	33	6.6	30	6.3
Contraceptive as preventive measure for STIs/AIDS*				
Pill	12	2.4	10	2.0
IUD	2	0.4	2	0.4
Injections	117	23.5	114	22.9
Foaming	23	4.6	21	4.2
Tablets	38	7.6	35	7.0
Durex/condom	332	66.8	328	65.9
Withdrawal	11	2.2	9	1.8
Rhythm	6	1.2	4	0.8
Methods mentioned for prevention of STIs/AIDS*				
Condom use	268	53.9	264	53.1
Maintaining one wife/partner	214	43.1	208	41.8
Avoid prostitutes	186	37.4	183	36.8

Avoid blood transfusion	257	51.7	252	50.7
Seek medical checkup	84	16.9	81	16.3
Use drugs before/after sex	38	7.6	32	6.4
Seek traditional/native solution	34	6.8	27	5.4
Abstinence	198	39.8	194	39.0
Heard of STIs/AIDS				
STIs	369	74.5	298	60.2
AIDS	357	72.1	286	57.8

* Excluding non-response category

* Multiple responses are allowed

4.7.1 Percentage Distribution of Respondents' Attitudes and Beliefs About AIDS by some Preventive Measures

On the mode of contacting AIDS and preventive measures, majority of the respondents who held the belief of AIDS' existence and are appalled by its impact, overwhelmingly claim sexual intercourse as the major source of contacting AIDS (with 72.4% and 72.0% respectively). Next to this are those who mentioned unsterilised injections and blood transfusions, while quite few mentioned shaving/razor and circumcision as other means of contacting AIDS.

On the preventive measures, condom is well mentioned by the respondents who believe in the existence of AIDS (53.9%), while 53.1% of same are worried. Followed closely are those who mentioned avoidance of blood transfusion. Also mentioned is the idea of one maintaining one partner or one's wife. Abstinence from sex and avoidance of prostitutes were not left out in their measures.

Table 4.7 also show the respondents' knowledge of STIs/AIDS as regards their belief and concern for AIDS. About three quarter of respondents who claim knowledge of STIs believe in its existence while 60.2% are worried. For knowledge of AIDS on the other hand, 72.1% and 57.8% respectively believe in AIDS existence and worried about it. It can be seen that people are not that worry about the deadly disease given their level of awareness.

Tables 4.8 Percentage Distribution of Respondents who had a friend that has Experienced STIs, Knowledge of AIDS victim and those who Believe to be at Risk of Contacting AIDS by Socio-Demographic Background

Variables	Do you have a friend(s) who has experienced STIs?		Do you know of anyone who has contacted AIDS or has died of AIDS?		Do you think that you yourself can contact AIDS?	
Age-Group	N0	% that has friend(s)	N0	% that has knowledge	N0	% believe to be at risk
15-24	7	11.3	13	20.6	3	5.4
25-34	50	36.8	33	25.0	50	39.4
35-44	47	29.9	19	12.6	64	43.5
45-54	25	36.2	7	11.3	25	37.9
55+	17	53.1	1	03.6	1	2.9
Religion Affiliation						
Protestant	61	36.3	31	19.4	62	41.1
Catholic	19	19.4	18	19.6	26	25.7
Muslim	60	32.4	21	11.8	52	29.5
Traditional	3	60.0	2	50.0	1	20.0
None	1	50.0	-	-	1	50.0
Educational Status						
None	40	58.8	12	17.6	18	26.5
Koranic	1	50.0	-	-	-	-
Primary	47	37.6	18	14.9	41	35.3
Secondary	45	31.5	29	25.2	48	34.0
Post Secondary	12	20.0	38	58.5	24	42.9
Occupation						
Artisans	58	34.7	23	14.1	53	34.4
Applicant	3	25.0	3	27.3	4	33.3

Farming	20	39.2	4	9.1	13	25.0
Trading	23	29.9	11	15.3	34	44.7
Professionals	10	43.5	9	39.1	8	36.4
Civil Servants	20	27.0	13	18.8	22	31.4
Schooling	18	34.6	32	61.5	6	12.2
Marital Status						
Single	32	24.1	28	21.7	32	25.8
Married	109	34.1	42	13.8	109	35.9
Widower	2	66.7	-	-	-	-
Separated	7	70.0	3	30.0	2	20.0
Type of Marriage						
Monogamously Married	96	36.9	39	16.0	100	41.8
Polygamously married	20	30.3	5	7.7	9	13.0
Ethnicity						
Yoruba	133	31.4	291	16.7	129	32.3
Hausa	5	38.5	8	18.2	4	26.7
Igbo	12	42.9	16	12.0	9	37.5

* Excluding non-response category

4.8 Respondents who had a friend that has experienced STIs, Knowledge of those living with AIDS and those who believe to be at risk of contracting according to Socio-Demographic Background

The following three questions were asked to elicit information from respondents on their past dealings with friends, and also to know whether they have knowledge of AIDS victim and lastly to know their perception on the risk of contacting AIDS. The questions are as follow: "Do you have a friend(s) who has experienced STIs?"; "Do you know of anyone who has contacted AIDS or has died of AIDS?"; "Do you think that you yourself can contact AIDS?".

Table 4.8 shows the distribution of respondents by some selected socio-demographic variables. First on the table is the age of respondents, and the table shows respondents in age group 55+ as having more friends that had experienced STIs in their life time and this suggests that old people are more likely to know more friends that had experienced STIs. Other age groups are not without knowledge of friends who had experienced STIs.

On the question of anyone who has contacted AIDS, those in younger age groups responded a little positive. While for the risk of contacting AIDS, middle age respondents claimed to be more open to the AIDS virus.

Traditionally, Africans are religious and each and everyone belongs to one religious group or the other. Among the religious groups, respondents in traditional category (60.0%) claim to have friends who had experienced STIs in their life. Christians under the auspices of Protestant and Catholic also were with such knowledge 36.3% and 19.4% respectively. Muslims are not left out in this regard.

Knowledge of AIDS victim is not well known to many respondents owing to the

hidden nature of the disease since the victims will be stigmatised in the society. Also people considered the question a curse on them, therefore, unable to take it lightly with the researcher. Fewer respondents claimed to be at risk by religious affiliation.

With education at the background, the table depicts those with no education as being knowledgeable of STIs victims, while others also had knowledge of friends with STIs. On the question of anyone who has contacted AIDS, those with post secondary education had the highest knowledge compared with other categories. For the risk, 42.9% of post secondary respondents affirmed that they are likely to have it, but all efforts will be to resist it by taking necessary caution.

Respondents were different in their opinion on the three questions put to them given their profession. While 43.5% professionals answered that they had friends, others were below 40%. Those still in school (61.5%) reported to know people with AIDS, likewise those in professional category. The knowledge is uncommon in other category.

From the table, respondents in widowhood and separated groups reported to know more friends (66.7% and 70.0% respectively) while those that are married backed the question with 34.1%. The knowledge of AIDS victim is minimal by marital status, while those who married reported to be more susceptible to AIDS virus. This may be due to their extramarital experience.

Among different tribes, STIs were reportedly common as shown in the earlier studies of Orubuloye, et al., 1990 and Ogbuagu and Charles, 1993. From the table, therefore, the result can be taking to follow the same trend. The table also show no knowledge of people living with AIDS.

Table 4.9 Percentage Distribution of Respondents' who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS according to selected Background Variables

Variables	Do you have a friend who has had STIs?		Do you know of anyone who has contacted AIDS or has died of AIDS?		Do you think that you yourself can contact AIDS?	
	N0	% that has friends	N0	% that has knowledge	N0	% believe to be at risk
Age at First Sexual Relations						
10-14	8	28.6	5	17.9	5	19.2
15-19	43	33.6	23	19.5	50	42.7
20-24	44	36.7	15	13.5	44	39.6
25-29	17	29.3	6	10.0	8	13.6
30+	10	38.5	5	20.8	5	17.9
Partner at first sexual experience						
Wife	24	35.3	18	26.5	14	20.6
Girl/casual friends	125	43.6	86	30.1	84	29.3
Others	8	40.0	7	35.0	5	25.0
Partner's Age (Female)						
10-14	9	20.9	6	13.6	8	21.1
15-19	67	34.7	24	13.8	73	41.0
20-24	16	22.5	8	10.7	16	21.3
25-29	4	23.5	4	26.7	5	29.4
30+	8	30.8	7	25.0	8	25.8
Reported Frequency for Sexual Relations						
Once a week	9	56.3	2	14.3	7	43.8
Twice a week	20	29.0	8	15.1	53	14.5
Occasionally	83	32.8	42	17.4	107	44.6

Daily	4	19.0	4	20.0	6	27.3
Don't have	29	49.2	7	12.7	9	15.3

* Excluding non-response category

* Multiple responses are allowed

4.9 Respondents who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS according to selected Background Variables

In the conceptual framework set up in chapter one, it is shown that number of AIDS patients and death known to the respondents would contribute to respondents' modification of sexual behaviour, likewise the other proximate variables such as number of STIs victims known and the risk of contacting AIDS. Therefore, the findings on their relationship is shown in Table 4.9 above. The table shows that about 40% of the respondents who had their first sexual experience above 30-year old claimed to have friends who had experienced STIs. Thus, it could be inferred from the result that, owing to this experience, they might postpone their sexual experience to later age, or better still to the time of marriage. While others who reported younger ages had no friends who had experienced such infection. This trend can be inferred as treading the earlier findings that most newly infected adults are those in the 15-24 years age group, who engage in unprotected heterosexual intercourse (UNAIDS, 1996).

A close look at the table on AIDS victim, the knowledge is generally low across all age-groups, which suggests non-publicity of AIDS victims because of the negative impact on the victim, like isolation of the patient in the community. Those in 15-24 age group claimed to be likely exposed to AIDS virus, and this could be due to their involvement in premarital sexual relations.

From the table, it could be seen that those who indicate having girl/casual friends as their partner still claimed to have friends who had experienced STIs. This finding suggests that this experience has not helped to instill some measure of morality to this group

of respondents. On the AIDS patients, only 30.1% of the same group had knowledge of AIDS patient, while 29.3% of them claimed to be at risk of contacting AIDS. While other groups were not different from the above findings.

Moreso, it is discernible from the table that those who reported not to have done anything with sexual intercourse indicates to have friends who had experienced STIs. This cannot be unconnected with this experience. But for AIDS patient, they hardly knew one patient. While it is only 15.3% of them who claimed to be at risk of contacting AIDS. However, considering reported frequency, 56.3% of the respondents who reported once a week sexual relations claimed having friends who had experienced STIs, 43.8% of those in this category claimed to be at risk.

Table 4.10 Percentage Distribution of Respondents who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS by number of sexual partners

Variables	Do you have a friend who has had STIs?		Do you know of anyone who has contacted AIDS or has died of AIDS?		Do you think that you yourself can contact AIDS?	
	N0	% that has friends	N0	% that has knowledge	N0	% believe to be at risk
Number of Sexual Partners Had in Life						
None	8	28.4	6	15.6	5	26.3
1	24	38.1	10	17.9	18	31.6
2	30	32.6	14	16.3	37	41.1
3	25	29.1	7	8.0	22	26.8
4	10	19.6	6	14.0	21	42.0
5+	10	31.3	4	12.5	7	21.2
Number of sexual partners had in the last four or twelve months						
None	6	24.3	6	14.6	5	24.5
1	71	35.3	38	20.1	62	32.0
2	29	33.3	9	11.7	19	21.3
3	11	64.7	5	29.4	5	27.8
4	6	75.0	5	62.5	1	16.7
5	1	50.0	1	50.0	1	50.0
Current number of sexual partners						
None	7	24.7	5	14.8	5	16.9
1	82	32.4	40	16.7	94	39.0
2	26	33.8	9	12.9	20	25.0
3	10	58.8	5	31.3	3	20.0
4	7	87.5	2	25.0	1	16.7

* Excluding non-response category
* Multiple responses are allowed

4.10 Respondents who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS by number of sexual partners

It could be seen from Table 4.10, on number of partners had in life, last four or twelve months and current number by these proximate variables that there is a gradual knowledge of friends who had experienced STIs as the number of partners had in recent times increases, while there exists fluctuation in the number of friends known as the number had in life and in last four or twelve months increases. But at the higher number of partners, it is observed that higher knowledge is maintained in the three groups. For the AIDS patient, almost the same pattern was observed, likewise for risk of contacting AIDS. It could be inferred from the result that, to be AIDS free, one needs to maintain one wife or partner, because those who claimed to be at risk are mostly the respondents with more that one partners.

4.11 Percentage Distribution of respondents who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS by some preventive measures

Variables	Do you have a friend who has had STIs?		Do you know of anyone who has contacted AIDS or has died of AIDS?		Do you think that you yourself can contact AIDS?	
	N0	% that has friends	N0	% that has knowledge	N0	% believe to be at risk
Mode of contacting AIDS*						
Sexual intercourse	108	48.8	67	18.8	107	29.9
Shaving/razor	62	32.3	46	24.5	83	45.6
Injections	72	29.5	54	23.2	106	46.5
Circumcision	50	41.7	35	29.9	49	45.4
Mother to child	44	38.6	35	31.3	47	45.2
Blood transfusion	74	29.7	53	22.3	99	42.1
Sleeping in the same room with the victim	12	26.7	15	44.1	14	41.1
Contraceptive as preventive measure for STIs/AIDS*						
Pill	5	26.3	2	11.8	3	15.8
IUD	1	20.0	1	33.3	2	40.0
Injections	26	20.6	11	9.5	73	61.9
Foaming	4	14.8	2	8.3	7	25.9
Tablets	8	22.9	4	11.4	14	35.9
Durex/condom	103	28.7	56	16.6	123	36.2
Withdrawal	1	8.3	3	27.3	4	33.3
Rhythm	-	-	-	-	-	-

Methods mentioned for prevention of STIs/AIDS*						
Condom use	56	29.5	29	16.4	78	43.3
Maintaining one wife/partner	26	37.7	7	10.8	19	26.0
Avoid prostitutes	8	24.2	4	12.1	11	42.3
Avoid blood transfusion	7	58.3	2	14.3	3	25.0
Seek medical checkup	11	13.1	8	9.6	28	33.3
Use drugs before/after sex	11	35.5	12	36.4	8	24.2
Seek traditional/native solution	17	51.2	2	6.7	4	11.8
Abstinence	8	26.7	8	27.6	4	14.3
Heard of STIs/AIDS						
STIs	150	30.2	73	14.7	143	28.8
AIDS	145	29.3	69	13.9	134	27.1

* Excluding non-response category

* Multiple responses are allowed

4.11 Respondents who had a friend that has experienced STIs, Knowledge of AIDS victim and those who believe to be at risk of contacting AIDS by sexual behaviour

For internal consistency, respondents were asked to list ways by which STIs/AIDS can be avoided. Of the methods listed by respondents with the knowledge of friends who had experienced STIs known to the respondents, avoidance of blood transfusion is well mentioned (58.3%), followed by seeking traditional/native solution (51.2%), then maintaining one wife or partner and using of drugs before/after having sex. Condom is well mentioned in preventing AIDS, likewise avoidance of commercial sex workers. Thus, the findings suggest that, for one to be secured of HIV virus which leads to AIDS, caution must be taken. This could be enhanced through government owned National AIDS and Sexually Transmitted Diseases (STIs) Control Programme and through other NGOs in the country.

Lastly, for those who has ever heard of STIs/AIDS, 30.2% and 29.3% has friends who had contacted STIs respectively, while only 14.7% knew AIDS victim or anybody who had died of AIDS. Of these who claim to be at risk of contacting AIDS 28.8% of them reported to have heard of STIs. For knowledge of AIDS, on the other hand, only 29.3% knew friends who had contacted STIs. 13.9% and 27.1% knew AIDS victim and as well claim to be at risk of contacting AIDS respectively. It can then be deduced that knowledge of STIs/AIDS has not shown any influence on the respondents in relation to the above three questions.

In summary, the findings suggest that STIs including AIDS are well recognised in middle age groups, and most people learned about these diseases from friends. However, the two most widely trusted medium of communication are "the radio" and "television". The

knowledge of STIs/AIDS can be said to be high among those who started sexual activity earlier, though they are not unaware of the mode of its transmission. Majority indicate relative modification of their sexual behaviour by keeping to one partner.

Of the methods of prevention mentioned, condom is well known followed by avoidance of blood transfusion. For the belief and concern, modal age groups are found to be more concerned as well as those who are deep in religious practice. While those who do not believe in any religion show little or no concern for the existence of AIDS. Education is found to be the motivating factor.

Lastly, as at the time of survey much has not been known about dead AIDS victim. The only well known dead AIDS victim is Fela Anikulapo Kuti owing to the publicity given by his brother Prof. Olikoye Ransom Kuti for majority to know that AIDS kills so as to adjust their life style.

CHAPTER FIVE

5.1 MULTIVARIATE ANALYSIS AND TESTING OF HYPOTHESES

This chapter examines the correlates of the role of attitudes and beliefs about STIs/AIDS in the sexual behaviour of men. However, important inroads have been made in earlier studies (Konde-Lule *et.al.* 1997, Ntozi and Kirunga 1997, Orubuloye *et al.* 1997) that there exist relationship between ever had of STIs/AIDS and variables such as age at first sexual relations, age of respondents, number of partners had in life, in last twelve months and in recent times, and use condom as a preventive measures.

Furthermore, attempts are made in this chapter to test the working hypotheses set for this study in chapter one. These hypotheses are:

a) That there is a relationship between the attitude and beliefs about sexually transmitted infections and the condoms use.

b) That there is relationship between mode of transmission of AIDS the and the number of sexual partners.

c) That a positive attitude about STIs/AIDS reduces the incidence of multiple sexual partners.

d) That a positive beliefs about STIs/AIDS will reduces the number of sexual partners.

The test of the above hypotheses is carried out, with the aid of logistic regression analysis. This approach becomes necessary because of the nature of the dependent variables which has been dichotomised by given respondents who reported having one sexual partner in their lifetime, last four or twelve months and current partner a value of one, and zero, if a respondent reported more than one, similar thing was done for use of condom for

precaution.

The general model of the logistic equation is of the form:

$$Log\frac{p}{1-p} = b_0 + b_1x_1 + b_2x_2 + \ldots + b_nx_n$$

where x_1, x_2, ..., x_n are set of independent variables. P is the probability of having one sexual partner and use of condom for prevention of this deadly disease. A positive coefficient indicates that the higher the value of the covariate, the greater the likelihood of sticking to one partner, similarly, the greater the likelihood of using condom for prevention.

The regression model used in this chapter consists of four tables. Each of these four tables is divided into two. Table 5.1 is the regression of use of condom for prevention on socioeconomic and demographic variables, and on attitude and beliefs about STIs/AIDS. Table 5.2 is for number of partners had in life on socioeconomic and demographic variables and on the attitude and beliefs about STIs/AIDS. Similar thing was done for number of partners had in the last four or twelve months and current number respectively.

TABLE 5.1 LOGISTIC REGRESSION FOR CONDOM AS A PREVENTIVE MEASURES AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Age		
15-24	0.178	1.195
25-34	0.300	1.350
35-44(RC)	0.000	1.000
45-54	0.210	1.233
55+	-2.173	0.114**
Age at First Sexual Experience		
10-14	0.920	2.510***
15-19(RC)	0.000	1.000
20-24	-5.296	0.005
Educational Status		
None	-0.770	0.463*
Primary/koranic	-0.299	0.742
Secondary(RC)	0.000	1.000
Post Secondary	0.398	1.489
Religion		
Protestant	0.304	1.421
Catholic	0.131	1.140
Muslim(RC)	0.000	1.000
Traditional	-6.626	0.001
No Religion	-0.350	0.705
Marital Status		

Single	0.368	1.445
Married(RC)	0.000	1.000
Widowed/separated	a	
Type of Marriage		
Monogamously Married(RC)	0.000	1.000
Polygamously Married	-0.392	0.676**
Ethnicity		
Hausa	0.607	1.836
Igbo	0.424	1.397
Yoruba(RC)	0.000	1.000
Occupation		
Artisan(RC)	0.000	1.000
Farming	0.175	1.192
Trading	0.170	1.185
Professionals/civil servants	0.688	1.989**
Schooling/applicants	0.186	1.218

Notes: [a] dropped automatically from the analysis because of redundant matrices.
*Significance levels are denoted as follows: ***$p \leq 0.01$, **$p \leq 0.05$ and *$p \leq 0.10$. RC denotes Reference Category.*
There are 492 observations for each regression.

5.1.1 CONDOM AND SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Age is an important predictor of the use of condom as prevention of STIs/AIDS partly because as one advances in age, so is the experience about sexual relations, and moreso precautions need to be taken especially this time of free-for-all sex. From Table 5.1, therefore, it is observed that respondents in ages 55 and above were significantly less likely to mention condom as a preventive measure to avoid STIs/AIDS. While those in other age groups were more likely to mention condom. The explanation for this pattern is not unconnected with the accessibility to information on the part of the younger ones.

Similarly, age at first sexual experience is another proximate variable necessary in this type of study. Table 5.1 shows respondents in age-group 15-19 years as less likely to mention condom as a preventive method major relevant in avoiding STIs/AIDS, while those in ages 20-24 years that are supposed to posses information on how to prevent STIs/AIDS were least likely to mention condom. Those in ages 10-14 years were significantly more likely to know condom as a method of prevention.

The level of education is another variable examined. While those with no education were significantly less likely to mention condom, their counterparts with primary were least likely to mention condom as the only viable way of preventing AIDS. Respondents with post secondary were 1.5 times more likely to recognise condom as the main method of STIs/AIDS prevention relative to reference category.

On religion as a variable, muslim is made the reference category. Not surprisingly the findings from the logistic analysis confirm the bivariate-level results that the

traditionalists and those with no particular religion were less likely to mention condoms for prevention, while the Protestants and Catholics were 1.4 and 1.1 times more likely to mention condoms for prevention.

A further variable of condom use as a prevention are marital status and type of marriage. It is surprising that those who were still single were more likely to mention condom than either married counterpart or those in reference category. Similar finding is observed under type of marriage where those who were polygamously married men were less likely to mention condoms even for preventing unwanted pregnancy.

Considering ethnicity, it is observed that almost all tribes were more likely to mention condoms as a way of preventing STIs/AIDS relative to reference category.

Regarding occupation as one of the variables regressed, Table 5.1 shows artisan as the reference category. All other categories of occupation were more likely to mention condom as the only true way of preventing the spread of STIs/AIDS, with professionals/civil servants category as more significant.

In brief, it is found therefore that condom is not well mentioned even among married men and those that were practising polygamy type of marriage among the respondents.

TABLE 5.2 LOGISTIC REGRESSION FOR CONDOM AS A PREVENTIVE MEASURES AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Ever heard of STIs	-5.156	0.006
Ever heard of AIDS	-0.203	0.816
Belief that AIDS exist	-0.180	0.835
Knowledge of Friend's STIs Experience	-0.166	0.847
Knowledge of people living with AIDS/dead	-0.283	0.754
One is at the risk of contacting AIDS	0.250	1.284
Attitude (worry)	-0.170	0.814
Reported frequency for sexual relations		
Once a week	0.056	1.057
Twice a week	0.055	1.056
Occasionally(RC)	0.000	1.000
Daily	0.950	2.585*
Don't have	0.655	1.519*
Mode of transmission		
Sexual intercourse	0.321	1.378
Injections	-0.029	0.271
Blood transfusion	-0.702	0.918**
Commercial sex workers(RC)	0.000	1.000
Circumcision	-0.681	0.587

Notes: Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ and $^{*}p \leq 0.10$.
RC denotes Reference Category.

5.2.1 ATTITUDES AND BELIEFS ABOUT STIs/AIDS AND CONDOM USE

In Table 5.2, the regression results of various independent variables on condom as a preventive measure is shown. It is observed from the table that reported frequency of sexual relations, mode of transmission, knowledge of, attitude to, and beliefs about STIs/AIDS affect the use of condom both positively and negatively, with some significant.

On the knowledge, attitude, beliefs and other related variables condom is least mentioned for prevention of STIs/AIDS. This finding implies that though the awareness about STIs/AIDS is well acclaimed among majority of respondents as shown in bivariate analysis, yet condom is not well mentioned let alone using it.

Table 5.2 further indicates sexual intercourse as a mode of transmission that is favourably associated with condom. Those who claim awareness of sexual intercourse were 1.4 times more likely to mention condom as the only method of preventing STIs/AIDS. While other modes of transmission were least favoured to condom use. The explanation for this is not far-fetched, as condom is only meant for sexual relation.

Summarily, condom as a preventive measure to STIs/AIDS can be said not to have being influenced by the main determinant which are knowledge, attitude and beliefs about STIs/AIDS.

TABLE 5.3 LOGISTIC REGRESSION FOR NUMBER OF LIFETIME PARTNERS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Age		
15-24	0.834	2.302**
25-34	0.682	1.978
35-44(RC)	0.000	1.000
45-54	-0.012	0.988
55+	0.085	1.089
Age at First Sexual Experience		
10-14	-0.309	.0734
15-19(RC)	0.000	1.000
20-24	3.016	20.416**
Educational Status		
None	0.719	2.052
Primary/koranic	0.733	2.082*
Secondary(RC)	0.000	1.000
Post Secondary	1.068	2.901*
Religion		
Protestant	0.263	1.300
Catholic	0.958	2.605**
Muslim(RC)	0.000	1.000
Traditional	-7.034	0.001
No Religion	-6.039	0.002
Marital Status		

Single	1.787	5.950***
Married(RC)	0.000	1.000
Widowed/separated	a	-
Type of Marriage		
Monogamously Married(RC)	0.000	1.000
Polygamously Married	-1.517	0.219***
Ethnicity		
Hausa	-0.503	0.605
Igbo	-0.453	0.636
Yoruba(RC)	0.000	1.000
Occupation		
Artisan(RC)	0.000	1.000
Farming	-0.871	0.917
Trading	-0.610	0.710
Professional/civil servants	0.357	1.293
Schooling/applicants	-0.403	0.630

Notes: [a] dropped automatically from the analysis because of redundant matrices.
Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ and $^{*}p \leq 0.10$. RC denotes Reference Category.
There are 492 observations for each regression.

5.3.1 LIFETIME PARTNERS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Table 5.3 presents the regression result of effects of some selected socioeconomic and demographic variables on respondents' lifetime partners. Age cannot be ignored in determining the number of sexual partners had in ones lifetime. The table shows positive and significant relationship between age of respondents and their lifetime sexual partners when the idea of sticking to one partner is built into the model. The finding reveals that across the ages save to those in reference category were significantly more likely to stick to one partner in this era of HIV/AIDS. Similar trends were observed in age at first sexual relations.

We also found that there is significant positive relationship between level of education and the idea of having only one partner relative to reference category. On religion, it is also observed from Table 5.3 that while Protestants and Catholics were significantly more likely to stick to one partner, the traditionalists and those with no particular religion were less likely to stick to one partner. This implies that they would prefer multiple partners since they believe not in the existence of AIDS.

On marital status and type of marriage, it is not surprising that the polygamously married respondents were significantly less likely to stick to one partner than the monogamously married men. However, the idea of sticking to one partner is also significantly higher among single respondents, which would be considered as a welcome idea if only it can be transformed into reality.

Furthermore, ethnicity is examined and it is found that there is negative relationship between this variable and the idea of sticking to one partner. Similarly, on occupation, the table reveals negative relationship for farmers, traders and applicants/students and positive relationship for professionals/civil servants. This finding suggests that farmers still consider having multiple partners as necessary. Traders and students were not divorced from this idea.

TABLE 5.4 LOGISTIC REGRESSION FOR NUMBER OF LIFETIME PARTNERS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Ever heard of STIs	-2.185	0.062
Ever heard of AIDS	-1.951	0.142***
Belief that AIDS exist	-0.455	0.576
Knowledge of Friend's STIs Experience	-0.350	0.419
Knowledge of people living with AIDS/dead	-0.048	0.049
One is at the risk of contacting AIDS	-0.058	0.060
Attitude (worry)	-0.432	0.465
Reported frequency for sexual relations		
Once a week	-0.078	0.925
Twice a week	0.330	1.391
Occasionally(RC)	0.000	1.000
Daily	-7.559	0.001
Don't have	0.849	2.337*
Mode of transmission		
Sexual intercourse	0.037	1.038
Injections	-0.421	0.657
Blood transfusion	-0.071	0.932
Prostitutes(RC)	0.000	1.000
Circumcision	-0.358	2.917*

Notes: Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ *and* $^{*}p \leq 0.10$.
RC denotes Reference Category.
There are 492 observations for each regression.

5.4.1 NUMBER OF LIFETIME PARTNERS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS

The logistic regression results in Table 5.4 depict that there is negative relationship between knowledge of, attitude to, and beliefs about STIs/AIDS and the probability of sticking to one partner. The odds ratio for all categories were (0.567 or less) times less likely to stick to one partner even with knowledge of AIDS as most significant. It is noteworthy that knowledge of these infections remains a significant determinant of sexual behaviour in terms of sexual networking but this avenue has not been properly adherent to in modifying their sexual behaviour.

Reported frequency for sexual relations is related to having one partner. We found that those who consider having fun daily and once a week were less likely to stick to one partner even at this time of HIV/AIDS that has no cure yet. While those claiming twice a week or abstain from sex were more likely to stick to one partner with those who abstain being significant.

Mode of transmission is also examined, and it is found that while those who reported sexual intercourse as a mode of transmission were more likely to stick to one partner relative to reference category. For other modes of transmission, it is observed that there exist negative relationship. The explanation for this cannot be unconnected with the fact that these modes of transmission were not seen as explaining sexual behaviour in anyway. Thus corroborating hypothesis three of this study.

5.5 LOGISTIC REGRESSION FOR NUMBER OF PARTNERS IN THE LAST FOUR OR TWELVE MONTHS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Age		
15-24	0.194	1.103**
25-34	0.311	1.233
35-44(RC)	0.000	1.000
45-54	-0.566	0.568**
55+	-0.370	0.690
Age at First Sexual Experience		
10-14	0.248	1.282
15-19(RC)	0.000	1.000
20-24	1.219	3.384
Educational Status		
None	-0.243	0.975
Primary/koranic	-0.148	0.862
Secondary(RC)	0.000	1.000
Post Secondary	0.249	1.282
Religion		
Protestant	0.640	1.896*
Catholic	0.294	1.342
Muslim(RC)	0.000	1.000
Traditional	-0.206	1.341
No Religion	-5.182	0.006
Marital Status		

Single	0.828	2.289**
Married(RC)	0.000	1.000
Widowed/separated	a	-
Type of Marriage		
Monogamously Married(RC)	0.000	1.000
Polygamously Married	-0.968	0.380***
Ethnicity		
Hausa	-0.623	0.537
Igbo	-0.182	0.834
Yoruba(RC)	0.000	1.000
Occupation		
Artisan(RC)	0.000	1.000
Farming	-0.145	1.156
Trading	-0.297	0.743
Professional/civil servants	-0.080	0.924
Schooling/applicants	-0.849	2.338**

Notes: [a] dropped automatically from the analysis because of redundant matrices.
*Significance levels are denoted as follows: ***$p \leq 0.01$, **$p \leq 0.05$ and *$p \leq 0.10$. RC denotes Reference Category.*
There are 492 observations for each regression.

5.5.1 NUMBER OF PARTNERS IN THE LAST FOUR OR TWELVE MONTHS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Table 5.5 gives the regression result of the effect of some selected socioeconomic and demographic factors on the number of sexual partners had by the respondents in their last four or twelve months preceding the survey. The table reveals positive and significant relationship between age-groups 15-24 and 25-34, and negative and significant relationship between age-groups 45-54 and 55 and above and number of sexual partners had in the last four or twelve months. This can be interpreted to mean that younger respondents were more likely to stick to one partner while older respondents were less likely because some has found themselves in sexual networking before the coming of HIV/AIDS. Similarly, respondent in ages 10-14 and 20-24 years were more likely to stick to one partner relative to reference category.

Considering education, the regression coefficients show an increase in the probability of sticking to one partner as the level of education increases. There is positive relationship between post secondary level of education and the notion of sticking to one partner, while other categories show negative relationship relative to reference category.

There are mixed relationships between religion and the idea of keeping to one partner. While there is positive and significant relationship between protestants and Catholics on one hand, there exist negative relationship between traditionalists and no religion on the other hand relative to reference category.

On marital status, it is observed that respondents that are single were found to be significantly more likely to have kept to one partner in the last four or twelve months

preceding the survey. For type of marriage, polygamously married category show negative relationship. This finding agreed with the definition of polygamy ie having more than one wife.

Table 5.5 also shows negative relationship between different ethnic groups relative to reference category, meaning that almost all the three major ethnic groups cannot withstand sticking to one partner though not significant.

Looking at the table under occupation, we found that there is an overall decrease in the probability of keeping to one partner among different category of occupation considered relative to reference category.

TABLE 5.6 LOGISTIC REGRESSION FOR NUMBER OF PARTNERS IN THE FOUR OR TWELVE MONTHS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Variable	Logistic Regression	
	Coefficient	Odds Ratio
Ever heard of STIs	-6.034	0.927
Ever heard of AIDS	-0.903	0.406
Belief that AIDS exist	-0.918	0.503***
Knowledge of Friend's STIs Experience	-0.021	0.022
Knowledge of people living with AIDS/dead	-0.174	0.190
One is at the risk of contacting AIDS	-0.692	0.500***
Attitude (worry)	-0.781	0.642
Reported frequency for sexual relations		
Once a week	1.569	4.804***
Twice a week	0.799	2.225***
Occasionally(RC)	0.000	1.000
Daily	-0.328	0.720
Don't have	0.043	1.044
Mode of transmission		
Sexual intercourse	1.165	3.204***
Injections	-0.232	0.262
Blood transfusion	-0.742	0.476***
Prostitutes(RC)	0.000	1.000
Circumcision	-0.732	0.453**

Notes: Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ and $^{*}p \leq 0.10$.
RC denotes Reference Category.
There are 492 observations for each regression.

5.6.1 NUMBER OF PARTNERS IN THE FOUR OR TWELVE MONTHS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Table 5.6 shows the results of effects of knowledge of, attitude to, belief about STIs/AIDS, knowledge of respondents' friend's experience of STIs, knowledge of people living with or died of AIDS on number of sexual partners had in the last four or twelve months. The regression coefficients show a decrease in the probability of keeping to one partner given the knowledge of, attitude to, belief of STIs/AIDS, knowledge of friend's STIs experience and knowledge of people living with or died of AIDS. While significant relationship is found for belief and risk of contacting AIDS, others are not significant.

Followed closely on Table 5.6 is the reported frequency of sexual relations. The probability of keeping to one partner is higher among those who indulge in sexual relations once and twice a week, while those who abstain have weaker but positive probability. Among those who reported daily sexual activity, there exist negative relationship between their activity and keeping to one partner. This means that the more one indulge in the act daily, the higher the idea of keeping multiple partners.

From the findings on mode of transmission, it could be seen that sexual intercourse as the most relevant factor for sexual behaviour is positively and significantly related to the number of sexual partners one keeps. This implies that the more sexual intercourse is recognised as a route for HIV/AIDS transmission the better for keeping to one partner. Other modes of transmission were less likely to affect the number of partners since they are not related to sexual behaviour..

TABLE 5.7 LOGISTIC REGRESSION FOR NUMBER OF CURRENT PARTNERS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Variables	Logistic Regression	
	Coefficient	Odds Ratio
Age		
15-24	-0.745	0.475
25-34	-0.145	0.865
35-44(RC)	0.000	1.000
45-54	-0.678	1.508**
55+	-0.665	0.515
Age at First Sexual Experience		
10-14	0.907	2.477***
15-19(RC)	0.000	1.000
20-24	1.084	2.955
Educational Status		
None	0.333	1.395
Primary/koranic	-0.084	0.920
Secondary(RC)	0.000	1.000
Post Secondary	-0.174	0.841
Religion		
Protestant	0.550	1.734**
Catholic	0.333	1.395
Muslim(RC)	0.000	1.000
Traditional	-0.777	0.460
No Religion	-6.199	0.002
Marital Status		

Single	1.541	4.668***
Married(RC)	0.000	1.000
Widowed/separated	a	-
Type of Marriage		
Monogamously Married(RC)	0.000	1.000
Polygamously Married	-1.091	0.336***
Ethnicity		
Hausa	0.362	0.696
Igbo	-0.384	0.681
Yoruba(RC)	0.000	1.000
Occupation		
Artisan(RC)	0.000	1.000
Farming	0.008	1.008
Trading	0.335	1.397
Professional/civil servants	0.850	2.339***
Schooling/applicants	1.057	2.878***

Notes: [a] dropped automatically from the analysis because of redundant matrices.
Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ and $^{*}p \leq 0.10$. RC denotes Reference Category.
There are 492 observations for each regression.

5.7.1 NUMBER OF CURRENT PARTNERS AND SOME SELECTED SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS.

Table 5.7 presents the logistic regression result of effects of some selected socioeconomic variables on the current number of respondents' sexual partners. It is observed from the table that age of respondents shows negative effect of the likelihood of keeping to one partner. A possible explanation for this finding may be that people of all ages consider keeping more sexual partners as a measure of ones popularity. While age at first sexual experience on the other hand were positively associated with the likelihood of keeping to one partner in recent times. The odds ratio shows for ages 10-14 and 20-24 are respectively 2.5 and 3.0 times more likely to keeping to one partner in recent times, which if true is an encouraging finding.

From Table 5.7 education shows negative effect on the likelihood of keeping to one partner, meaning that nobody is left out in keeping multiple partner, except those without education.

Table 5.7 further indicates protestants and Catholics as 1.7 and 1.4 times more likely to keep to one partner relative to reference category. While traditionalists and those who has no particular religion had less likelihood of keeping to one partner.

On marital status, there is positive and significant relationship between those who are single and keeping to one partner when compared to reference category. Also according to the table, the polygamously married people still hold the belief of having more than one partner with odds ratio of 0.34.

Ethnicity is another variable examined, and the table shows the two tribes as having

negative effect on the likelihood of keeping to one partner relative to the reference category.

Regarding occupation, Table 5.7 indicates that there is high probability of sticking to one partner among all categories of occupation with professionals/civil servants and schooling/applicants been significant. They are 1.0 and above more likely to keep to one partner, which if true is an encouraging finding.

TABLE 5.8 LOGISTIC REGRESSION FOR NUMBER OF CURRENT PARTNERS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Variables	Logistic Regression	
	Coefficient	Odds Ratio
Ever heard of STIs	6.594	731.005
Ever heard of AIDS	0.820	0.441
Belief that AIDS exist	1.019	2.771***
Knowledge of Friend's STIs Experience	-0.117	0.889
Knowledge of people living with AIDS/dead	-0.209	0.812
One is at the risk of contacting AIDS	-0.118	0.887
Attitude (worry)	1.217	2.672
Reported frequency for sexual relations		
Once a week	0.148	1.159
Twice a week	0.561	1.752
Occasionally(RC)	0.000	1.000
Daily	-0.479	0.619
Don't have	0.237	1.378**
Mode of transmission		
Sexual intercourse	0.391	1.479*
Injections	-0.024	1.024
Blood transfusion	-0.199	0.819
Prostitutes(RC)	0.000	1.000
Circumcision	-0.178	1.008

Notes: Significance levels are denoted as follows: $^{***}p \leq 0.01$, $^{**}p \leq 0.05$ *and* $^{*}p \leq 0.10$.
RC denotes Reference Category.
There are 492 observations for each regression.

5.8.1 NUMBER OF CURRENT PARTNERS AND ATTITUDE AND BELIEFS ABOUT STIs/AIDS.

Table 5.8 gives the logistic regression result of various independent variables such as knowledge of, attitude to, belief about STIs/AIDS etc and current number of sexual partners. The table reveals that, ever heard of STIs/AIDS, belief of AIDS and worriness had positive effect on the likelihood of keeping to one partner, while others like knowledge of friend's STIs experience, knowledge of people living or died of AIDS and risk of contacting AIDS have negative effect on the likelihood of keeping to one partner. A possible explanation for this may be that people are yet to consider risk of contacting AIDS and the effect of full-blown AIDS as important.

Those who indulge in sex once or twice a week were more likely to keep to one partner as reveals by Table 5.8. Similar finding is for those who abstain from the act. While those who claim daily sexual activity were less likely to keep to one partner. Thus corroborating the fact that for one to indulge in sexual activity everyday there is every possibility that such a person will have to keep multiple partners.

Mode of transmission is the last variable depicted on Table 5.8 and sexual intercourse as a major mode of transmission in heterosexual situation is seen to be significantly more likely of act as a modifier of people sexual behaviour by keeping or sticking to one partner. Thus corroborating number two hypothesis for this study.

CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 SUMMARY AND CONCLUSION

The sexual networking of sexually active population and the changing sex behaviour patterns of the society has caused an increased rate of STIs and the spread of AIDS especially in sub-Saharan African and it tends to affect majority of population in reproductive age. Thus, the thrust of this study is, therefore, to ascertain the role of attitude and beliefs about STIs/AIDS in the sexual behaviour of men in the study area.

The data used for the study were collected through interview with the aid of structured questionnaire for quantitative data, and an in-depth interview was carried out to elicit qualitative data to support what is obtained with questionnaires. In all 497 respondents were selected through systematic random sampling techniques. Four hypotheses were subsequently tested using logistic regression model after dichotomising the necessary dependent variables, while other statistical techniques were also applied.

The results of the analyses of the study start from univariate to multivariate indicate important findings. The first finding is that the age at which sexual relations started has become too low with mean age of 15 years or less, even in face of the acclaimed knowledge of STIs/AIDS. Love and enjoyment, accentuated by media portrayal of Western lifestyles, has led to early initiation of sex and high coital frequency as noted by Isiugo-Abanihe (1993). One of discussants even supported this subject matter by saying that "*it is just for the fun of it*".

It is also found that people living with AIDS must be taken care of, by individual relations, NGOs and government by providing the necessary medical equipment for hospitals to enable them screen available blood before transfusion.

The multivariate analysis indicates that socio-economic and demographic factors have effect on condoms as a method of curbing STIs/AIDS. The findings show that those who are young especially those in (15-34) age group, the elites mainly of post secondary education, Protestants and Catholics, those who are still single at the time of the study, monogamously married, and all categories of occupation exert positive and significant influence on recognition of condoms as the only viable option for preventing STIs/AIDS. There is negative relationship between traditionalists, those who has no particular religion, those in age 55 and above, those with no or are of primary education, and polygamy marriages and use of condoms for prevention of STIs/AIDS.

As stated in one of the hypotheses that there is a relationship between attitude and beliefs about STIs/AIDS and condom use, the findings show negative relationship suggesting that condoms has not been well acknowledged as the main option for preventing the spread of STIs/AIDS.

Another very important finding is that modification of sexual behaviour among men is much likely to be influenced positively by knowledge of, attitude to, and beliefs about STIs/AIDS and the likelihood of respondents sticking to one partner in recent times, which is an encouraging finding. Not less significant is the role played by religion especially Protestants and Catholics, types of marriage practised mainly monogamous marriage and occupation. The result corroborates the third and fourth hypotheses.

Finally, it is found that sexual intercourse as a route of HIV/AIDS transmission is well known in the study area partly because the main mode of HIV transmission in Sub-Saharan Africa is through heterosexual contact, with sexual intercourse as the backbone. It is positively and significantly related to the notion of sticking to one partner as the only way of curbing the spread of the deadly disease called HIV/AIDS.

6.2 RECOMMENDATIONS

Attempt will be made here to suggest some recommendations based on the findings of the study.

As discussed earlier that condoms has not been given its prominent role in the people's sexual behaviour, it is therefore suggested here that campaign should be gear up for promotion of condoms as the only option to curb STIs/AIDS infections. Likewise, evils of multiple unfaithful partners should be shown to the public for them to desist from keeping more than one partner.

Efforts should be placed on religion and moral ethics to discourage adolescents from engaging in sexual activity indiscriminately. With advent of AIDS there is need to return to the norms of premarital chastity for all sexes as noted by Isiugo-Abanihe (1993). Also there is need for sex education being introduced in our secondary school curriculum as well as in the first year of undergraduates programme on sexual behaviour.

On the side of government, all tiers of government should endorse adolescent cum adult health policies and legislation through their respective legislative council especially on HIV/AIDS and sexually transmitted disease preventions. Nigeria government should emulate

their Brazilian counterpart that made a special law in 1996 to ensure that right of all HIV carriers to universal and cost-free access to all anti retroviral drugs. There should be legislations that will make all intending couples to go for blood screen before eventually got married.

With the formation of Nigerian Network of People Living with HIV/AIDS (NNPLWA) and other related groups, these groups should be consulted to share their experiences on the travails and psychological effects they undergo since being diagnosed of the virus with the public in order to reduce the rate of the infection.

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APPENDIX

DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS
OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE.

ROLE OF ATTITUDE AND BELIEFS ABOUT STIs/AIDS IN THE SEXUAL BEHAVIOUR OF MEN IN OSOGBO, OSUN STATE

Thus survey is intended to collect information for analyzing the Attitude and Beliefs of males about Sexually Transmitted Infections (STIs) and Acquired Immune Deficiency Syndrome (AIDS) in Osogbo.

Your kind assistance and cooperation is highly needed.

Thanks.

QUESTIONNAIRE NUMBER: [_____]
STREET ADDRESS:_____
PHC:_____
INTERVIEWER VISITS: 1 2 3 FINAL VISIT
DATE OF INTERVIEW:_____
INTERVIEWER'S NAME:_____

RESULT* [_____]
*RESULT CODES

1. COMPLETED 3. POSTPONED 5. PARTLY COMPLETED
2. NOT AT HOME 4. REFUSED 6. OTHER (Specify)_____

SECTION 1: RESPONDENT'S BACKGROUND

101. In What month and year were you born?
Month ____ _____
Month Unknown 98
Year _____
Year unknown 98

102. How old were you at your last birthday? (Compared 101 and 102, if inconsistent probe to correct either 101 or 102).
Age in completed Year _____
Age Unknown 98
Age Estimated _____

103. What is your occupation?_____

104. What is your religion?
Protestant 1

Catholic 2
Muslim 3
Traditional 4
No religion 5
Other (specify)_____

105. What ethnic group do you belong to?
Yoruba 1
Hausa 2
Igbo 3
Other (specify)_____

106. Have you ever attending a school? Yes 1 No 2 Go to 111
107. Are you currently attending school? Yes 1 No 2 Go to 110
108. At what level of school are you currently enrolled?
Koranic 1
Primary 2
Secondary 3
Teacher Training 4
Tertiary inst. 5
Others (specify) 6

109. In what class or form are you at this level?
IF SECONDARY AND ABOVE GO TO 115 Class or Form _____

110. At what level of school are you currently enrolled?
Koranic 1
Primary 2
Secondary 3
Teacher Training 4
Tertiary inst. 5
Others (specify) 6

111. What is the highest class or form you completed at that level?
IF SECONDARY AND ABOVE GO TO 115 Class or Form _____

112. Have you ever attended adult literacy classes? Yes 1 No 2

113. Can you read say a letter or newspaper easily, with difficulty or no at all?
Easily 1
With difficulty 2
Not at all 3

114. In what language can you read?
Arabic 1
Hausa 2
Yoruba 3

	Igbo	4
	English	5
	Others specify	6

115. How often do you listen to radio?

Everyday	1
A few times a week	2
Once a week	3
Every other week	4
Infrequent	5
Never	6

116. What is your present marital status?

Single	1
Married	2
Widow	3
Separated	4
Other specify	5

117. How old were you when you were first married? ____
118. How many sexual partners have you had before marriage? ____
119. Is (Was) your marriage monogamous or polygamous?

Monogamous	1
Polygamous	2

120. How many wives do you have at present? ______
121. Number of wives separated or divorced from you? ______

SECTION 2: REPRODUCTIVE HISTORY

201. Have you ever had children? Yes 1
No 2 Go to 210

202. How many children of your own are living with you at home?
\..... (Number)

203. How many children of your own are living far from the family?
\..... (Number)

204. Have you ever had any other children who were born alive to you but are not living now? Yes 1 No 2
If yes, how many are males? \.....(Number).
If yes, how many are females? \..... (Number).

205. Can you please tell me the number of live births you have ever had to data?
\..... (Number).

206. Do you want more children? Yes 1 No 2
If yes, how many? \.....(Number).

207. Does your wife(ves) want to have a (another) child or would she prefer not to have any (more) children?
Have a (another) child 1
No more/none 2
Wife(s) undecided 3
Does not know wife's desire 4

208. Have you and your wife(ves) ever discussed the number of children you would like to have? Yes 1 No 2

209. Do you think your wife(ves) want the same number of children that you want or dies she want more or fewer children than you want?
Same Number 1
More children than I want 2
Fewer than I want 3
Don't know 4

210. How many children do you think is enough for any couple?
\.....(Number)

211. Do you prefer any sex pair? Boy 1 Girl 2
If boy, why?.....
If girl, why?.....

212. Can you allow your wife(s) to have a say in the number of children you want to have? Yes 1 No 2
If yes, why?.....
If no, why?.....

213. What do you think is the best number of months or years between the birth of one child and the birth of the next child? Month(s) \..... Year(s) \.....

SECTION 3: ATTITUDE AND BELIEFS ABOUT STD/AIDS

301. If single, have you ever had sexual intercourse? Yes 1 No 2 Go to 310

302. How old were you when you first had sex relations? \.....
(IF DON'T KNOW, PROBE ON HOW MANY TEARS AGO THEN SUBTRACT FROM HIS CURRENT AGE)

303. How old was your partner? \.....

304. What were your reasons for having such experience?

.....

305. How often do you have sexual intercourse?
Once a week 1
Twice a week 2
Occasionally 3
Daily 4
Don't have 5

306. How many sexual partners have you had in your life time including your first sexual partner? \.....

307. How many sexual partners have you had in last four or twelve months?

308. How many do you have now? \.....

309. Have you ever heard that there are Sexually Transmitted Diseases? Yes 1
No 2 Go to 317

310. Which sexually transmitted diseases have you heard about?

DISEASES	YES	NO
GONORRHOEA		
SYPHILIS		
HERPES		
CHANCROID		
CHLAMYDIA		
GENITAL WARTS		
OTHER (SPECIFY)		

311. Are the STDs preventable? YES 1 NO 2

312 How?.....

313 Do you think that some of the sexually transmitted diseases can be prevented by adopting contraceptive methods? Yes 1 No DK 9

314. Which contraceptive method(s) do you think can be used to prevent some of these diseases? (CIRCLE ALL THAT RESPONDENT MENTIONED)

PILL	1	IUD	1
INJECTIONS	1	FOAMING	1
TABLETS	1	DUREX\CONDOM	1
WITHDRAWAL	1	RHYTHM	1
OTHER (specify)	1		

315. What is your source of information? (CIRCLE ALL THAT RESPONDENT MENTIONED)

Friend	1	Schoolmate	1
Newspaper	1	Radio	1
TV	1	Teacher	1
Doc/Nurse/Midwife	1	Parents	1
Brother/Uncle	1	Sister/Aunt	1
Youth Adviser	1	FP Clinic	1
Other specify	1		

316. Have you ever heard of AIDS?
YES 1 NO 2 DK 9

317. Do you believe there's AIDS at all?
YES 1 NO 2 DK 9

318. How do you think AIDS is contracted? (CIRCLE ALL THAT RESPONDENT MENTIONED)

Sexual intercourse	1	Shaving /Razor	1
Injections	1	Circumcision	1
Mother to child	1	Transfusion of Infected blood	1
Other (specify)	1	Sleeping in the same room	1
Don't know	9		

319. Do you think that AIDS can be contracted from

Shaking hands with someone who has AIDS?	1
Kissing someone who has AIDS?	1
Wearing the clothes of someone who has AIDS?	1
Sharing eating utensils with someone who has AIDS?	1
Touching someone who has AIDS?	1
Mosquito, flea or bedbug bites?	1

320. Is it possible for a healthy looking person to be infected with the AIDS Virus?
Yes 1 No 2 DK 9

321. Is it possible for a woman who has the AIDS Virus to give birth to a child without the AIDS Virus? YES 1 NO 2 DK 9

322. Can people protect themselves from getting AIDS or is there nothing that people can do?

Can protect themselves	1
Nothing they can do	2
DK	3

323. How can people protect themselves from getting AIDS?
(CIRCLE ALL THAT RESPONDENT MENTIONS)

Do not have sex at all	1
Limit number of sexual partners	1
Use condoms during sex	1
Sterilize syringes/needles	1
Avoid commercial sex workers	1
Other specify	1

324. Do you have a friend who has had a sexually transmitted diseases?
Yes 1 No 2 DK 9

325. Do you know of anyone who has contracted AIDS or who has died of AIDS?
Yes 1 No 2 DK 9

326. Do you think that you yourself can contract AIDS?
Yes 1 NO 2 DK 9

327. How do you think you might contract AIDS?
(CIRCLE ALL THAT RESPONDENT MENTIONED)

From wife/partner	1
From needle/injections	1
From Blood Transfusion	1
From Commercial Sex Workers	1
Other (Specify)	1

328. What do you think Government can do to people who has been infected with AIDS?

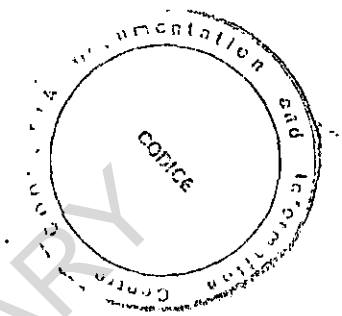
To keep them away from society	1
Take care of them	2
Encourage safer sex	3
Encourage the use of condom	4

Yes 1 No 2 DK 9

321. Is it possible for a woman who has the AIDS Virus to give birth to a child without the AIDS Virus? YES 1 NO 2 DK 9

322. Can people protect themselves from getting AIDS or is there nothing that people can do?

Can protect themselves	1
Nothing they can do	2
DK	3



323. How can people protect themselves from getting AIDS? (CIRCLE ALL THAT RESPONDENT MENTIONS)

Do not have sex at all	1
Limit number of sexual partners	1
Use condoms during sex	1
Sterilize syringes/needles	1
Avoid commercial sex workers	1
Other specify	1

324. Do you have a friend who has had a sexually transmitted diseases?
Yes 1 No 2 DK 9

325. Do you know of anyone who has contracted AIDS or who has died of AIDS?
Yes 1 No 2 DK 9

326. Do you think that you yourself can contract AIDS?
Yes 1 NO 2 DK 9

327. How do you think you might contract AIDS? (CIRCLE ALL THAT RESPONDENT MENTIONED)

From wife/partner	1
From needle/injections	1
From Blood Transfusion	1
From Commercial Sex Workers	1
Other (Specify)	1

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To keep them away from society	1
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