

**SEXUAL BEHAVIORAL PATTERNS AND SEXUALLY TRANSMITTED
INFECTIONS AMONG YOUNG ADULTS IN OREDO LOCAL
GOVERNMENT AREA, EDO STATE, NIGERIA**

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BENIN CITY**

OCTOBER, 2023

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**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF
SOCIAL WORK, FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF
BENIN, BENIN CITY, IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF THE BACHELOR OF
SCIENCE (B.Sc.) DEGREE SOCIAL WORK**

OCTOBER, 2023

CERTIFICATION

We, the undersigned persons certify that this project was carried out by Vanessa Eloghosa OSAYANDE in partial fulfillment of the award of B.Sc. Degree in Department of Social Work, Faculty of Social Sciences, and University of Benin, Benin City.

Mr. Charles Mfon
Project Supervisor

Dr. S.O. Ibibor, Ph.D.
Head of Department

Date

Date

DEDICATION

This project is dedicated to the *ALMIGHTY GOD*, the source of all knowledge and strength for the inspiration during the work, and to my father, mother and siblings' for their prayerful support.

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Vanessa Eloghosa OSAYANDE
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ABSTRACT

This study examined sexual behavioural patterns and sexually transmitted infections among young adults in Edo South senatorial district of Nigeria. The objectives of the study were to ascertain the age at first sexual intercourse of the young population ages 10-24 years, ascertain if any association exists between young population age at first sexual intercourse and religious belief, ascertain incidence of contract of sexually transmitted infections by the young adult population, observe the “health seeking” behavior of young adult population when infected with these sexually transmitted infections, and ascertain the extent of young adult population knowledge of HIV/AIDS’ transmission.

A sample size of 800 was used for this study. The sample size were chosen bearing in mind the time, finance and feasibility of the study. Out of the 800 questionnaires that were sent out for the study, about 783 were fully completed. Information gathered from the questionnaire was coded and recorded on the spreadsheets. From here they were fielded into the computer for statistical analysis using the SPSS computer software. In all percentages and proportions, pie and bar charts were used for data interpretation. The chi-square test of significance and F-ratio were used to test the hypotheses. Findings from the study reveals that a greater number of youth of ages (10-24) years of both sexes are engaged in schooling activities. The population of the youth increases with age. The youth comprises slightly more males than females. That they are more engaged at school indicates rising age at marriage. Thus there is reduced likelihood of early marriages and associated consequences. The full embrace of education by youth is of benefit to the individuals as well as to the Nation in thence of skilled man power development.

The study then recommended that preventive programs should focus on developing positive attitude toward infected persons in a way that they are not discriminated against, reproductive health information, including STDs should be included in university curriculum in order to enhance student knowledge and attitude regarding STDs prevention, free HIV testing should be inculcated into the undergraduate students my management in order to be able to receive HIV testing without financial burden. This action may increase the rate of HIV testing among the student population and in turn reduce rates of transmission. It was also recommended that students’ sources of information should be increased in terms of mass media and health education regarding the spread of STDs on campus, and STDs prevention programme should be developed and implemented by the university to promote changes in attitude in order to prevent the spread of STDs.

Keywords: Incidence, Measures, Prevention, Sexually Transmitted Diseases, Transmission

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Sex is a basic physiological need of every human being, male and females are created with different class, to serve as a compliment for each other, this complementary role includes sex (Muyiwa, 2019). Therefore, a man and a woman are expected to engage in sexual relationship. This sexual relationship has over the years been affected by various infections known as the sexual transmitted diseases (STDs) (Mongkuo, Lucas & Taylor, 2021).

Sexual behavioural patterns and reproductive health of young adults is an issue of immense concern for the Nigerian people. It is known that at 5.6 HIV/AIDS prevalence in Nigeria, rates are highest for young people between the ages of 20-24 compared with other age groups (Nkya, Gillespie & Howlet, 2020). It is also known that over 60% of new HIV infections are in the 15-25 year old age group (United States Agency for International Development, USAID, 2003). By the end of 2000, there were estimated 3,600,000 people living with HIV/AIDS with 170,000 recorded deaths. At the end of 2007, an estimated 310,000 death were attributed to AIDS, leading to 1.3 million orphans between 0-17 years of age (Nkya et al. 2020). The long-term outcome of increasing adult deaths is an increase in the number of child-headed households. This is the largest

number in the world after South Africa and India (Joint United National Program on UNAIDS, 2004).

These STDs are in various forms and their effects are also different. One among such Sexual Transmitted Diseases STDs is Human Immune Virus and Acquired Immune Deficiency Syndrome (HIV/ AIDS). These two Sexual Transmitted Diseases are the most dangerous and ravaging of the STDs. HIV/AIDS are the most serious Health problem in the world, the number of people infected with the Human Immune deficiency virus (HIV) and acquired Immune deficiency virus Syndrome (AIDS) has been increasing all over the world (Obuekwe, Osaiyuwu, Onyeaso & Ugbodaga, 2017). In more than three decades since the beginning of the HIV/AIDS epidemic, over 60 million people worldwide have become infected, including more than 20 million who have already died, and more than ten persons get infected with the virus every minute. The majority of new infections occur in young adults (Koksal, Namal, Vehid, & Yurtsever, 2015).

Today's young people are the first generations who have never known a world without sexually transmitted diseases. In the world, one in four new STDs is among young adults that is why adolescents and young adults need information in order to make such responsible choices in terms of sexual Behavior/relationship and sharing needles (Odu & Akanle, 2018). Nigeria is geographically vulnerable to STDs and has various degrees of this epidemic even some research findings on STDs, but they are not efficient to gather information for awareness of the undergraduate students. There is evidence of increased

sexual activity and high risk behaviours among young adults in Nigeria with high prevalence rate of sexually transmitted infections (STDs), 16.3% and 23%, in the North and South respectively (Akinyemi, Adesina & Kuti, 2022).

Particularly in Nigeria, studies have documented that young adults have very high sexual behavioral pattern and sexually transmitted diseases, and it is importance for them to find preventive measures and care (Odu & Akanle, 2018; UNAIDS, 2008, Oyediran, Feyisetan & Akpan, 2019). Comparing the linkages between sexual behavioral pattern and STDs and its implications for responsive sexual-related behavior among young adults in Nigeria remain a major gap.

Therefore, what is the extent of young adult knowledge of HIV/AIDS' transmission and other STIS? Is the age at first sex increasing or decreasing among young population? How is the young population behavior or interaction on STIs' contract? These and other issues will be examined in this study.

1.2 Statement of the Problem

This study is on young adult sexuality and sexually transmitted infections (STIs) in Oredo Local Government Area of Edo State. Half of the World's population are under the age of 25 and the number of young adults is expected to grow to more than 1.2 billion in 2010 (Boyd Haub and Cornelius, 2000). In Nigeria, the median age is 17.5 years (National Population Commission, 1998).The median age is the age at which half of the

population is older and half is younger. This implies that half of the Country's population is less than 17.5 years. Therefore, the country's population is very young and highly youthful.

While it is known that youth make up preteens (ages 10-12 years), teenagers (ages 13-19 years) and young adults (ages 20-24 years), it is important to understand the segment that is more knowledgeable of HIV/AIDS and other STIs. In other words, what is the effect or influence of age, sex, education, and religion? What percentage of the young population is sexually active? When do they start having sex? How many? What is the trend? Policy makers, health planners, medical practitioners, and demographers need to understand these issues. Lack of knowledge of these matters may retard helping the young population.

Nigeria is Africa's largest country with an estimated 198,000,000 inhabitants (1/4th of Africans live in Nigeria) with almost half of the population under 15. According to globalhealthreporting.org through the percentage of Nigerians with HIV/AIDS is relatively low for Africa at 3.9%, its large population gives it the largest number of people suffering from AIDS in Africa after South Africa-2.9 million and India. According to PEPFFAR, only 92,000 Nigerians are presently receiving anti-retroviral therapy (AVR). UNICEF says that out of almost 7 million orphans in Nigeria, 1.8 million are orphaned by HIV/AIDS. With the spread of HIV/AIDS, the number of

orphans is expected to increase rapidly in the coming years to 8.2 million by 2010. The reports call for concern, hence the rationale for this study.

1.3 Objective of the Study

The following are the objective of the study:

- (i) To ascertain if any association exists between young population age at first sexual intercourse and religious belief
- (ii) To ascertain incidence of contract of sexually transmitted infections by the young adult population.
- (iii) To observe the “ health seeking” behavior of young adult population when infected with these sexually transmitted infections.
- (iv) To ascertain the extent of young adult population knowledge of HIV/AIDS’ transmission.

1.4 Research Questions

The following are the objective of the study:

- (i) Does any association exists between young population age at first sexual intercourse and religious belief?
- (ii) What is the incidence of contract of sexually transmitted infections by the young adult population?

- (iii) What is the “health seeking” behavior of young adult population when infected with these sexually transmitted infections.
- (iv) What is the level of young adult population knowledge on HIV/AIDS’ transmission.

1.5 Hypotheses

The following hypotheses are formulated for this study:

1. There is no significant relationship between sex and age at first sexual intercourse
2. The religious belief of young adults has no significant relationship with age at first sexual intercourse
3. That young adult awareness of HIV/AIDS infection does not differ by age

1.6 Significance of the Study

The issue of sexual behavioral pattern and sexually transmitted infections among young adults in Nigeria has continue to be the major concern not only to Edo State government but the Federal government and the entire world. When this study is concluded, it findings will serve as a pioneer effort towards the understanding of sexual behavioural pattern and STDs among young adults in Oredo local government area, Edo State. The result of this study will help policy makers, particularly educational planners in Edo state to design more appropriate instructional programme on sexual behavioural pattern and sexually transmitted infections among young adults in Edo State and Nigeria in general.

The result of this study will be helpful to create prevention strategies which translate to an increase in the knowledge and positive sexual behavioural patterns and preventive measures for STDs among young adults and the general populace.

The study will also form a basis for further research for future researchers who intends to carry out a study on the issue of sexual behaviour and sexually transmitted infections among young adults.

1.7 Scope of Study

Study is intended to cover the young adults (ages 10-24 years), male and female. That is the population that are of primary, secondary, and tertiary school age. It also covers the young population in the early reproductive ages irrespective of their marital status, in Oredo local government area, Edo State.

1.8 Area of the Study

The area of study is Oredo local government area, Edo State. Oredo Local Government Area is one of the 18 local government areas in Edo State, Nigeria. It is situated in the southern part of the state and is the local government area that encompasses the capital city, Benin City. Oredo LGA is centrally located within Edo State, and its administrative headquarters is in Benin City. It is a historic city known for its cultural heritage, including the famous Benin Bronzes and historical landmarks. Oredo LGA serves as the economic and commercial hub in Edo State. The LGA host various businesses, markets,

and government institutions, contributing significantly to the state's economy. Oredo LGA plays a crucial role in Edo State's political landscape, as it houses the state's government institutions, including the Governor's Office and the State House of Assembly. The local government area has witnessed significant development in terms of infrastructure, including roads, healthcare facilities, and public services, due to its importance as the state capital.

1.9 Definition of Terms

Sexual Behavioural Pattern: This refers to the various ways in which individuals express their sexuality and engage in sexual activities. It encompasses the range of behaviors and actions that people engage in when it comes to their sexual desires and preferences. These patterns can vary widely from person to person and may include choices related to sexual orientation, frequency of sexual activity, types of sexual activities, and the dynamics of their sexual relationships.

Sexually Transmitted Infections: Sexually transmitted infections (STI) or sexually transmitted disease (STDs) are infections that are transmitted from one person to another through sexual contact. They are usually spread, during oral or anal sex.

Attitude: is acquired features of the individual, learned through social interaction and defined as a relatively enduring organization of beliefs around an issue which predisposes one to respond in some preferential manner. An attitude includes three components:

knowledge, feeling, and tendency for action, once formed, attitudes are difficult to change.

Awareness: Is the state or condition of being aware having knowledge, consciousness, the object of the information is to awareness of what spreads STDs.

Knowledge: the fact of knowing something general understanding of familiarity with a subject placed situation.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter comprises of review of theoretical and empirical literature. The literature reviews are previous related works which was done on sexual behavioural patterns and sexually transmitted infections among young adults in Edo South senatorial district of Nigeria. The rationale behind this is that a review will help in determining what contribution this study can make in terms of adding new knowledge and value to the existing ones.

2.1 Review of Relevant Concepts

The period of adolescence is a very significant period of development because it encompasses that stage termed “puberty”, when the adolescent faces the strong impetus with lowest resistance to risky sexual behaviors. The period of adolescence is characterized by belief in one’s immortality (Moon, Meyer and Grau, 1999). A desire to experiment, the seeking of peer approval , relatively short-termed relationships (Overby and Kegeless, 1994) and unrealistic expectations about the likelihood and consequences of pregnancy (Condon, Donovan and Corkindale, 2000). Adolescents’ delay seeking prescription contraception for an average of one year after initiating sexual activity (Alan Guttmaker institute, 1994). In addition, younger ages are strong risk factor for sexually

transmitted infections like Chlamydia trachomatis (Hilger 2001; Han, Coles and Hipps, 1997); and Burstein, Gaydos and Diener – West, 1998). Hence effective prevention strategies must include young adolescent ideally; before they become sexually active.

The health, social and economic consequences of most of these sexually transmitted infections (STIs) such as Chlamydia trachomatis infections, syphilis, etc and particularly repeated infections are considerable (Opaneye and Ashton, 2000); Opaneye and surtees, 1998). Ascending infection is the main cause of pelvic inflammatory disease (PID). Adolescent are at greater risk of this complication with attendant legal implications where they are sexually abused (Hammerschlag, 1998). This pelvic inflammatory disease may lead to tubal blockage, chronic pelvic pain, and ectopic pregnancy. This causes substantial drains on private funds during adult years and a potentially strong cause of marital disharmony and marriage failures.

Young adults are also faced with the problems of teenage pregnancy. Teenage pregnancies are more likely to have uncertain dates and fewer antenatal visits. Teenage births are prone to carry a higher risk of medical complications including prematurity, low birth weight, the need for neonatal intensive care and neonatal death (Moon, Meyer and Grau, 1999). Adolescents on debut sexual encounter experience psychological distress, illicit and licit substance use (Izugbara, 2001).

The Human Immunodeficiency Virus (HIV) is noted in the science community as a serious medical condition that could lead to a spectrum of disease state called the

Acquired Immune Deficiency Syndrome (AIDS). Which has besieged mankind claiming so many lives since the early 70s and 80s? Fostered by many propounded theories as to its origin such as the Hunter theory, Oral Polio Vaccine theory, contaminated needles theory, colonialism theory and the conspiracy theory, it has become widely speculated that the Human Immunodeficiency Virus infects a number of different cells of the Human Immune System. It is believed to have mutated from the Simian Immunodeficiency Virus (SIV) that affects monkeys. The most susceptible of the cells is a type of white blood cell until the body is left defenseless against all types of diseases and infections. By the time the count of CD₄ cells goes below about 200 cells per cubic millimeter of blood, infected person is said to have progressed to the Acquired immune Deficiency syndrome (AIDS) stage, which is the final stage of the spectrum of disease that ultimately precedes death.

HIV/AIDS is the current dreaded human pandemic, ravaging the World over; depriving nations of most of their productive and skilled labor force. The effect is even more devastating in sub-Saharan African due to the over-whelming level of poverty, which acts as a precipitant in facilitating the spread of this disease through sexual contact mainly in form of prostitution for money making, as well as constituting a serious hindrance to obtaining appropriate treatment and control due to the cost effective nature of the drugs. More still, skilled health personnel and adequate health facilities poses a major problem in the developing world as there are no enough well equipped hospitals and skilled health personnel to cope with the rising population.

Schofield et al, (2011) also used a microsimulation method to determine the economic impacts of diseases on older workers, aged 45 to 65 years. Their paper describes an application of Health and WealthMOD to project labour force participation up to 2020 given the ageing population and long-term trend in chronic conditions. They demonstrated that health is a major driver of labour market participation and without health interventions to treat or prevent chronic illness, will only have a limited impact on labour force participation. Consequently, Leclerc et al, (2007) developed a two-sex microsimulation model of HIV transmission in the population of Zambia, where women tend to marry early and where divorces are not frequent. The authors focus on age-specific estimates of exposure to risk through the modelling of the formation and dissolution of relationships, marriage, casual partnership and commercial sex. They observed that the basic parameters could not explain the dynamic of the HIV epidemic in Zambia.

In terms of the impact of HIV/AIDS on education, Hargreaves et al, (2007) for instance, used a systematic review method of all published peer-reviewed articles on educational attainment and risk of HIV Infection in Sub-Saharan Africa and they observed that information collected prior to 1996 generally found either no association or the highest risk of HIV infection among the most educated, while information collected from 1996 onwards were more likely to find a lower risk on HIV infection among the most educated. Where information overtime were available, HIV prevalence fell more consistently

among highly educated groups than among less educated groups, in whom HIV prevalence sometimes rose while overall population prevalence was falling. Similar study conducted by Cutler and Alsan (2013) examined girls education and HIV risk in Uganda and observed that girls enrollment in secondary education significantly increased the likelihood of abstaining from sex and not infected with the virus using a triple-difference estimator.

Hontelez et al, (2011) used an established model of the transmission and control of HIV in specified sexual networks and health care settings to look at the impact of the New WHO antiretroviral treatment guidelines on HIV epidemic dynamics and cost in South Africa. They predicted the HIV epidemic dynamics, number of ART and program costs under the new guidelines relative to treating patients for 30 years. They find that during the first five years, the new WHO treatment guidelines require about 7 percent extra annual investments, whereas 28 percent more patients received treatment. Apata (2013) used Descriptive Statistics and Overlapping Generation (OLG) Model to examine long run economic cost of HIV/AIDS on agriculture for twenty-two African countries. The author looked at the causes of high prevalence rate of HIV/AIDS and issues related to poverty, fertility, myth and migration. He observed that factors responsible for high HIV/AIDS prevalence rates are issues closely associated with patterns of human mobility, while procreation and high values placed on morals lower HIV/AIDS prevalence rate. A positive correlation between HIV prevalence and GDP per capita was also found.

Evidence from these cited studies looked at the direction of the impact of HIV/AIDS and labour market force but, none of these studies captured the distributional impact of this epidemic and the impact of remittances income on HIV/AIDS infected household member. This study therefore, addresses this gap in literature by examining the distributional impact of HIV/AIDS on household income in Nigeria.

Control measures for most negative effects from sexual transmitted infections, and teenage pregnancies/complications require health and sex education which adolescent hardly take serious either due to ignorance or high propensity to adventurism. For instance, (Mirza, Kovacs and Mc Donald, 1998) reported that teenagers are the most frequent users of emergency contraception at Australian high-school students do not use condoms consistently (Lindsay, Smith and Rosenthal, 1999).

Sexual contact is the most common form of HIV/AIDS transmission compared to other routes such as use of unscreened blood, use of unsterilized needles/syringes or through transplacental route, etc. This is why it poses such a threat to Africa's youth. Some African studies (Izugbara, 2001 and Ejikeme, 2003) have found that very early age, most boys and girls have become sexually active. Sexual behavior is also difficult for policy makers to deal with because it is so intensely personal. Everyone should be free to develop his/her own sexual personality on his or her own terms. Be that as it may, one is forced to recommend in this era of state and for policy makers. The problem is that when it comes to young people, much of the policy is muddle headed and wrong. People are

engaging in sex at an increasingly young age but many of these encounters are coercive viewed from sub-Saharan Africa experience. Millions of children and young people are trafficked into prostitution. Tens of thousands are drafted to war. Millions more work in oppressive working conditions. All of these environments in different ways are conducive to sexual exploitation. Deprivation and poverty are also coercive. Throughout the world, 100 million children under the age of 18 are walking the streets, many of them male and female sell their bodies just to stay alive. To many, the long term-risk from HIV/AIDS will seem much less important than the struggle against starvation. Deprivation can be a factor even when free choice appears to be exercised; hence, prostitution is easily, one of the main transmitters of HIV/AIDS in Africa.

Even the family can be coercive and help to spread HIV/AIDS. Within marriage, many young wives are not free to exercise their sexual choice, if their husbands take mistresses or determine when and if sex occurs. This is however not a generalized situation. Some adults believe that young people are by nature sexually promiscuous and that giving them information about sex will make young people more sexually active. As a result sex education in schools either does not take place or promote only certain risk reduction measures; most usually abstinence. Within sub-Saharan Africa, young people have been common stereotyped as uniformly hedonistic and irresponsible; they are in fact a remarkably heterogeneous group. Their experiences vary widely according to cultural background, gender, sexuality, and socio-economic status among other variables. Some

young people risk their lives through their sexual behaviors but many others are even more responsible than their parents. In many societies, family and immediate community traditionally provide young people with information and guidance about sex and sexuality. In some societies, the provision and guidance about sex used to be formalized as part of initiation into adult roles. However, the onset of rapid urbanization with the migration of western culture and attribute is fast making these indigenous African cultures less welcomed by the youth. It is not just for young people's vulnerability but also for efforts to address the issues. According to Ejikeme (2003),” some young virgin (males and females) in Nigeria have been forced into ritual sexual abuse by older persons seeking quick wealth, power, long life, protection or cure from diseases”. This was because of the cultural belief in some parts of Eastern and Northern Nigeria that sex with virgins, in conjunction with certain ritual activities could generate quick wealth, power, long life and cure from mysterious disease. This according to Ejikeme (2003) has a lot of psychological implications on the young who are traumatized and destabilized by such experiences thus creating a casual relationship between sexual abuse and adolescent suicide, loss of self-worth and poor mental health.

Izugbara (2001) reported an analysis of pre-marital sexual behavior in Lagos, Nigeria. It was found that the median age at first sexual encounter differed on the basis of ethnicity, religion and parental social class. It was also observed that the first sexual encounter took place at an early age with most of such experiences occurring in the context of mutual

consent that were nevertheless regarded as often unsafe. Furthermore, Izugbara (2001) reported similar studies in the Senegal and Ghana in the same article where amongst urban people in Senegal, prostitutes were the most likely first partners for males and older men for girls. This poses a high risk of sexually transmitted infections or unwanted pregnancies. In Ghana about two third of debut sexual encounter were found to be voluntary and one third was third was through coercion. The argument continues that a variety of partners at initial sexual encounters ranged from prostitutions, sugar dads, relatives, caretakers, teachers, sugar moms, house maids and cousins. Circumstances of first sexual encounter ranged from being drugged, raped, coercion, enticements, and mutual consent. There was also poor utilization of safer sex skills as debut sexual encounters. The outcomes of initial sexual encounters produced identifiable consequences ranging from penile vaginal lacerations, wounds, sexually transmitted infections, and unwanted pregnancies to induced abortions. Today however, more young women are enrolled in school. Increasing urbanization means that families have less need for large number of children. Traditional values have given way to more modern life styles. Social conditions in urban areas promote education and delayed marriage. However, because safe, legal abortion is generally not available in Africa, an adolescent's decision to terminate a pregnancy poses great health risks. With regards to reproductive health matters, most women in Africa have had sexual intercourse and marry before the age of 20 especially in rural areas (DHS 1994-1998). High rate of early marriage occurs in Mali, Mozambique, and Uganda amongst several others, and early marriage is least

common in Kenya (DHS 1994-1998). In most of these African Countries, a higher proportion of young women had sex before the age of 18. The incidence for adolescent premarital birth varies widely across Africa. In Ghana and Nigeria, about 10% of the women aged 20-24 reported having had a premarital birth .

Female genital mutilation (FGM) also known as female circumcision is practiced as a cultural value in Cameroon, Mauritania, Chad, Niger, Burkina Faso, and Nigeria. According to report on female genital mutilation is a cultural practice where all or part of female genitalia is removed. It is reported that 60% of all Nigerian women have experienced female genital mutilation. It is most common in the South where up to 85% of women have undergone it at some point in their lives. FGM puts women and girls at risk of contracting HIV from unsterilized instruments such as knives, broken glass, etc that are used in the procedure. The most extreme form, infibulations involving removal of entire clitoris as well as the Labiae minora and majora is practiced in Northern Nigeria as well. This procedure can lead to hemorrhage, shock, acute infection, and death. It can also complicate childbirth, prolong labor, and cause birth of still born or brain damaged children.

2.2 Review of Empirical Studies

Ngalinda, (2001) reported that literate adolescent women and urban adolescent women have a higher likelihood of premarital sexual intercourse than illiterate and rural adolescent women. Protestant unmarried adolescents were also reported to be less likely

to experience sexual intercourse compared to Moslem. Moslem adolescents were said to have first birth earlier than Christians.

According to a demographic survey on adolescent women and health obtained from National Statistics Office, Malawi (1994), the following countries in sub-Saharan region showed marriage and sexual experience among female adolescents as follows: percentage of women unmarried in Niger was 39%, Nigeria 59%, Senegal 44%, Sudan 16%, Togo 27%, Burkina Faso 45%, Cameroon 24% and Ghana 26%. Percentage single but sexually experienced in Niger was 16%, Nigeria 12%, Togo 37%, Burkina Faso 9%, Cameroon 24%, and Ghana 26%. Percentage of women on current use of modern methods of family planning among female adolescents by marital status showed: Burkina Faso 2, Cameroon 2, Ghana 2, Niger 1, Nigeria 1, Senegal 1, Sudan 2 and Togo 2. Brief by Population Council (2004) on Nigeria claimed that girls get married between the ages of husband and wife. Young girls are said to marry at risk of contracting HIV from their husbands. Men are to have sexual partners outside marriage; polygamy is common and young married girls cannot negotiate condom use to protect themselves. Professor Eghafona of Microbiology department, University of Benin, Benin-City, at his 80th inaugural lecture titled “The Dangerous and Miraculous Particle” delivered on the 16th March 2006 at the Akin Deko auditorium, Ugbowo Campus; University of Benin implicated polygamy as the major factor encouraging the transmission of HIV from persons to persons in Nigeria.

He decried the rate of infection among the youth, especially those from age 20-29 who recorded the highest 3.3% compared with males 0.65% in his study on HIV in Nigeria.

World Health Organization (WHO) report 2005, ascribed following values on health indicators to Nigeria: Contraceptive prevalence rate (modern methods) in 1999 was 9%; pregnant women who had one antenatal visit and 4 ante natal visit in 2003 was 61% and 47% respectively. Births attended by skilled health personnel in 2003 was 33%, births in health facilities in same year was 2%. Number of midwives available in 1992 was 4787, annual number of live births in 2000 was 4645 with maternal mortality ratio/100, 00 live births same year (2000) was 800. A stillbirth rate/1000 live birth in 2000 was 40; a neonatal mortality rate/1000 live birth in 2000 was 53. Although with annual growth rate from 1993-2003 of 2.8% according to WHO report 2005, the total expenditure on health as percentage of gross domestic product of 5.5 in 1998 and 4.7 in 2002 is grossly inadequate for a country with a high dependency ratio/100 in 1993 as 96 in 2003 as 90. The long-term effect is a situation whereby the level of maternal and reproductive healthcare is poor and these tend to affect mortality rates greatly. No wonder life expectancy at birth in both sexes was reported to be 45 years. In a country where health facilities are still inadequate, with even very poor database where hospital statistics is faced with problems of maintaining reporting system; sexual and reproductive health seeking behavior can scarcely be assessed. The importance of this cannot be overemphasized; hence, research efforts along these lines targeting the

adolescents/youths will help enlighten the populace about sexual and reproductive health needs and necessities in order to reduce the associated health risks for the future.

HIV/AIDS, devastating human pandemic is on the rise in the continent with Nigeria experiencing a rising profile. However, Nigeria stands to benefit by adopting the level of seriousness with which Senegal- an impoverished nation of ten million on Africa's West Coast has lived up to control the problem of HIV/AIDS (John Donnelly in Boston Globe,2003) on "Senegal's Aggressive Aids Strategy saves thousands from infection". The country was said to have HIV/AIDS rate that has never risen above 2% but marked out well preventive efforts, which involved government officials, Islamic leaders, and international Organizations. Both the government officials and Islamic leaders permitted more open discussion about sexual behavior that can lead to HIV infection. Scientists in the country made research break through that sparked national pride, and health officials initiated programs that targeted marginal groups likely to spread the disease. Prostitutes were allowed to work as long as they registered with a health clinic and saw doctors for monthly checkups and free condoms. The government provided health provided health benefits to children of prostitutes and the religious leaders did not object to the government's promotion of condom use.

Several efforts have been made by individuals, corporate organizations, regional organizations and international organization to curb HIV/AIDS, When AIDS first surfaced in the United States, there were no drugs to combat it and few treatments existed

for the opportunist diseases that resulted. Researchers have however developed drugs to fight both the HIV infection and its associated infections and cancers.

Tommy G. Thompson, Secretary, Department of Health and Human Services (HHS), in May 2003 testified to the effort made by HHS in combating the global spread of HIV/AIDS. According to him, the United States has a long history of assisting countries in need. The Department of Health and Human Services, in conjunction with the United States Agency for International Development, the Department of State and other partners is continuing the humanitarian tradition in a variety of ways, but most especially in helping countries in need address the devastation caused by AIDS and other diseases.

The National Institute for National (NIH) Works with the Centre for Disease Control (CDC) and the Ministries of Health to strengthen or create the research infrastructure of developing countries as well as the capacity of in-country investigators to conduct clinical trials of therapeutic and preventive strategies. These strategies include treatment for opportunistic infection such as TB, AIDS vaccines and intervention to prevent mother to child transmission. Nigeria is one of the beneficiaries from these activities. It is hoped that efforts along these lines will curb the rising trend of HIV/AIDS; and thus save our youths the needed future.

2.3 Theoretical Framework

The focus on sexual activity and HIV/AIDS has since assumed a dominant scene with the implication of heterosexual intercourse as notable route (N'Glay & Ryder, 1995; WHO, 1994) as well as the rapidly increasing population amidst fast declining economies of most African States.

Anthropological Perspective:

This recognizes the influence of social structure in shaping reproductive health and sexual behaviors. To this end, variations in sexual behavior are primarily associated with socio-cultural factors specific to each society (Braude, 1981). These factors include norms, beliefs, (religious, superstitious, traditional, etc). Okolocha and Chiwuzie (1999) in their study on 'approach to reducing maternal mortality in Africa' noted that several traditional beliefs hamper the use of modern medical care. Also, Goody (1971) revealed that the key factor explaining moral restraint in sex in the old world was religious belief.

Social Disorganization Perspective:

Varied patterns of behavior have arisen due to hindered previous dominance of traditional ties/beliefs or controls that prevented women from being self-assertive in a frequently understood male dominant world. Education, Urbanization, and the mass media are the main agents implicated for this disorganization.

Social Exchange Perspective:

This stipulates that there is a price for everything and everything has its price. “All contact among men rest on the scheme of giving and returning the equivalence” (Simmel, 1950). People choose what they get involved in after proper consideration of the costs and benefits of alternative courses of action. Human beings are rational in their interactions with each other. Colman, (1972). Succinctly put, this theory asserts that people would utilize medical services if they understand it to be the best and most cost effective alternative.

Conflict Approach:

Conflict approach sees medicine not just as healing profession, but as a regulatory mechanism of social control (Conrad and Schneider, 1972; Zola 1972). Conflict theorists therefore seek to determine the workings of health care institutions-that is who benefits, who suffers, and who dominate at the expense of others. It is also important to recognize the age-long conflict between the optimist of population increase and its beneficial effects for humanity. Before then, were optimists of the relationship between population and sustenance of human life (Godwin and Condorcet). It was against this that Thomas Robert Malthus (1766-1834) predicted doom for humanity on account of the geometric increase in population size unless the former was controlled. In Malthus view, population was increasing geometrically while the means of subsistence was at arithmetic

progression rate. Several proponents have emerged over the centuries to address issues concerning population and its effects on human life.

The criticisms or part of the limitation of the Malthusian theories were that he failed to foresee the Important role that science and technology could play in offsetting the inhibiting forces of rapid population growth. However, this does not at all mean that over-population does not have negative influences on development one of which is poor health system. Nigeria is a country with rapid population growth. How far she can survive the ills associated with over-population depend on the level of embrace of science and technology. This would reflect on how health related issues are being treated. Since the future of any country rests on the youth, this study seeks to confirm how far disease condition such as HIV/AIDS and other STIs are being effectively managed in order to reduce the incidence of morbidity and mortality.

Socialist/Marxist Theory:

This theory separately draws attention on the class differentiation and the misery of the working class that was attendant upon the growth of capitalism. Criticizing Malthus principles of population, Marx posited that there could not be a natural and universal of population. To him, the population laws peculiar to capitalism bothered on relative surplus population (over-population), which was a consequence of the accumulation of capital as well as a condition for the perpetuation of the system. To Marx and Engels,

social re-organization, production, reproduction of life itself and careful planning of both human and material resources were the anti-dote to population problem (UN, 1973).

Sociological Theory:

Viewed from the other perspective, sociological theory depicted by Dumont's "social capillarity" is a classic example of sociological theory applied to demographic phenomena. He claimed that the weakening of the desire to procreate was caused by the progress of civilization and attributed the reduction in family size to individual's ambition to improve his position in the society. The development of individualism and the desire of personal improvement and that of children in advanced societies created a state of mind conducive to declining fertility (UN 1973).

Demographic Transition/Middle Range Theories:

Beginning with Landry's description of demographic stages in 1909, this theory states that societies that experienced modernization progress from pre-modern regime of high fertility and high mortality to a postmodern one in which both are low (kirk, 1996). These post-modern ones would become developed societies.

From the middle range theories, it is useful to link interpreting present scenario with the "Chicago Model" which contextualized fertility from the rational decision and cost-benefits analysis point of view. Also is the "Pennsylvania Model" that analyzed the forces that constrained fertility. These include budget constraints, birth production

function, that is family planning or contraception. The “Wealth flow Model” of Caldwell (1982) Justified the rationality of fertility behavior in Africa and Third World Countries as to include all present and anticipated economic benefits over a life time. The same is with the “Forcing Model” of demographic transition theory of Loschkey and Wilscox (1974), which sees various stages of birth and death rate in a society as dependent on “The diffusion of technical knowledge and the acquisition of mechanical or chemical equipment”.

Nigeria falls within stage 11 of transition theory that is with high fertility and declining mortality. Judging from the above analysis, this study is intended to critically evaluate sexuality and sexually transmitted infections amongst the respondents. The framework is expected to adopt the propounded theories over the years. This is to rationalize the current sexual behavior of young adult population and the attendants’ consequences of negligent approach to these realistic issues among them. How much has the institutional efforts to recognize and prevents pandemic effects of HIV/AIDS and other STIs been supportive or reflective of the perspectives? That is, how far has the strategic measures to tame the vices been associated with the framework or perspectives? To what extent are the attitude to behavior and knowledge of youth on sexuality and STIs largely influenced by their socio-cultural background and level of education in the context of these perspectives? These are issues addressed in this study with these perspectives at the background.

The Yanyi K. Djamba (1997) Model takes into consideration the influence of family background, individual characteristics, socio-cultural factors, and exposure related factors etc.; on behavior and services utilization. This is being modified and adopted for this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers the description and discussion on the various techniques and procedures used in the study to collect and analyze the data as it is deemed appropriate.

3.2 Research Design

According to Asika (2009), research designs are often referred to as the structuring of investigation aimed at identifying variables and their relationships to one another. This study was designed to make a survey of sexual behavioural patterns and sexually transmitted infection among young adults in Oredo L.G.A, Edo State, to this end, the field survey research design was employed for the purpose of this study.

3.3 Population and Sampling

Population of study is the young adults. This comprises young adults of 10 to 24 years of age. This population is chosen because it is the segment of the population that is sexually active. It includes the males and females resident in Oredo local government area, Edo State. Young adult population was chosen irrespective of their marital status, religious, ethnic background, occupation and length of residence in their locality.

3.4 Sample Size and Sampling Techniques

The purposive sampling technique was adopted for this study. The sample of this study was drawn from the respondent within the research location. However, a sample size of 800 was used for this study. The sample size were chosen bearing in mind the time, finance and feasibility of the study. Out of the 800 questionnaires that were sent out for the study, 783 were fully completed. This was done to gather detailed data from the respondents.

3.5 Research Instrumentation

The main research instrument to be used for this study is the ‘questionnaire’. The research questionnaire was therefore be constructed in line with the research questions in chapter one. The questions was presented in a simple language to elicit responses from the respondents and for those respondents who cannot fill the questionnaire. The questionnaire was draft in two sections, ‘A’ and ‘B’. Section A covers the demographic data of the respondents. Section B contained items and response on the research topic.

3.6 Validity and Reliability of Instrument

Reliability means the accuracy of precision of a measuring instrument while validity means the extent to which the research instrument measures what it is supposed to measure. In order to determine the reliability and validity of the study, the test-retest method will be used. To have a valid instrument, the questions in the questionnaire will

be free from ambiguity (i.e. the questions will not be too complex). To have reliable instrument, the questionnaire will be followed with interview of sample of respondents to know their view on the subject.

3.7 Data Collection

Questionnaire is the main research instrument that will be used for the study to gather necessary data from the sample respondents. The questionnaire is structured type and provides answers to the research questions and hypotheses therein. The Questionnaire comprised two parts: Part 1 contained the socio-economic background of respondents. These include the sex, age, marital status, education, religion and residence. Part 11 comprised young adults' sexual behavioural patterns and sexually transmitted infections (STIs) such as gonorrhoea, herpes simplex, Chlamydia trachomatis, genital warts, syphilis, staph aureus and HIV/AIDS.

3.8 Method of Data Analysis

Information gathered from the questionnaire was coded and recorded on the spreadsheets. From here they were fielded into the computer for statistical analysis using the SPSS computer software. In all percentages and proportions, pie and bar charts were used for data interpretation. The chi-square test of significance and F-ratio were used to test the hypotheses.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

4.1 Introduction

This chapter contains data presentation, data analysis and hypotheses testing. It presents the age, sex, marital status, education and religion of the respondents. It also presents youth sexuality, knowledge and contract of the sexually transmitted infections.

4.2 Presentation and Analysis of Demographic Data

Table 4.1: Age Distribution of the Respondents

Age (years)	Frequency	Percentage
Preteens (10-12)	80	10.2
Teenagers (13-19)	315	40.2
Young adults (20-24)	388	49.6
Total	783	100

Source: field survey (2023)

Data in 4.1 show the age distribution of the respondents. Age is categorized into preteens (10-12 years), teenagers (ages 13-19 years) and young adults (ages 20-24 years).data reveal that the young adults (49.6%) form the majority of the youth in this population. This is followed by the teenagers (40.2%); the preteens (10.2%). This tends to suggest that the population of youth increases with age this can be explained by the age-sex

selectivity in migration, as the area of study is an attraction to youth due to the presence of university of Benin and other economic institutions.

Table 4.2: Sex Distribution of the Respondents

Sex	Frequency	Percentage
Male	399	51
Female	384	49
Total	783	100

Source: field survey (2023)

Data in Table 4.2 show the sex distribution of the respondents. It reveal that the males (51%) are slightly higher than the females (49%). This is consistent with the findings of 2006 and 2016 estimated census that there are more males than the females in the country.

Table 4.3: A Distribution of the Marital Status of the Respondents

Marital Status	Frequency	Percentage
Single	662	84.6
Married	109	13.9
Divorced	4	0.5
Widowed	8	1.0
Total	783	100

Source: field survey (2023)

Table 4.3 indicates the marital distribution of the respondents. The bulk of the respondents is never married (84.6%). Only 13.9% is married. The number that is widowed is very negligible. Therefore this is an indication of rising age at first marriage due to attendance at school and training embraced by the youth.

Table 4.4: Educational Distribution of the Respondents

Schooling Status	Frequency	Percentage
Attended before	39	5
Attending primary	144	18.4
Attending secondary	313	40
Attending post secondary	287	36.7
Total	783	100

Source: field survey (2023)

Level of education of youth is categorized into schooling status as attended before, attending primary, attending secondary and attending post secondary. Majority of the youth (76.7%) in the survey area are attending secondary and post secondary. 18.4% is attending primary while only 5% belong to the category of those who attended before. This tends to suggest that majority of the youth are engaged in educational activities as students.

Table 4.5: Religious Affiliation of the Respondents

Religion	Frequency	Percentage
Christianity	605	77.2
Moslem	150	19.2
African traditional	28	3.6
Total	783	100

Source: field survey (2023)

Table 5.5 show that about (7.7%) of respondents are Christians (19.2%) are Moslems while (3.6%) of the respondents practice the African traditional religion.

4.3 Presentation and Analysis of items in the Research Questions and Hypotheses Tested

This section presents the analysis of the research objectives as stated in the chapter one of this study.

RESEARCH OBJECTIVE ONE: To ascertain the age at first sexual intercourse of the young population ages 10-24 years.

Table 4.6: Youth That Have and That Have Not Had Sex

Had Sex	Frequency	Percentage
Yes	363	46.4
No	420	53.6
Statistics on age at first sexual experience		
Number	363	
Mean age	17.58 years	
Median age	18 years	
Modal age	20 years	

Source: field survey (2023)

As on table 4.6, 53.6% of the youth reported already having sexual intercourse. This number is in excess of the number of youth (46.4%) that have not had first sex

Table 4.7: Age at First Sexual Intercourse

Age	Frequency	Percentage
10	1	.3
11	2	.6
12	7	1.9
13	13	3.6
14	27	7.4
15	28	7.7
16	33	9.1
17	49	13.5
18	62	17.1
19	42	11.6
20	74	20.4
21	13	3.6
22	7	1.9
23	4	1.1
24	1	.3
Total	363	100

Source: field survey (2023)

From data in Table 4.6 and 4.7, it is revealed that the mean age at first sexual experience for the youth is 17.58 years. The median age, that is the age at which half of the population of young adults have had first sexual intercourse is 18 years. Interestingly, it is revealed first, that at age 20 years, 93.1% of the youth have had sex. Secondly, at that age (20years), the largest number, 20.4% indulges in first sex.

Table 4.8: Sex and Age at First Sexual Intercourse of the Respondents

Ages (years)	Males	Percentage	Females	Percentage
10-12	21	42	29	58
13-19	101	47.2	113	52.8
20-24	52	52.5	47	47.5
Total	174	47.9	189	52.1

Source: field survey (2023)

Regarding sex and age at first sexual intercourse of youth, data on table 4.8 tend to suggest that more females had first sexual intercourse at younger ages than their male counterparts. Specifically, it is observed that the percentage of males indulging in first sex increases with age up to 20 years. Inversely, their female counterpart decrease in number with age up to 20 years. Also it is observed that teenagers are more vulnerable. This is in line with findings from DHS (2016, Ejikeme, 2003).

In order to find out if any association exists between age at first sex and religious belief of the young population, the response on their religious affiliation was related with the age at first sex.

Table 4.9: Religion and Age at First Sexual Intercourse of the Respondents

Age (years)	Religion				
	Catholic	Protestant	Pentecostal	Moslem	Total
10-14	15	10	13	12	50
15-19	55	72	57	30	214
20-24	21	30	32	16	99
Total	91	112	102	58	363

Source: field survey (2023)

Data in table 4.9 show the relationship between age at first sexual experience and the religious affiliation of the respondents. Data revealed the dominance of teenage age-groups followed by the young adults to have had first sexual experience. Secondly, the number of youth who have had first sex seem is most amongst the Protestants; and least amongst the Muslims.

RESEARCH OBJECTIVE TWO: To ascertain incidence of contract of sexually transmitted infections by the young adult population.

Table 4.10: Multiple Sex Partners

Age (years)		Yes	No	Total
Preteens (10-12)	Count	59	76	135
	% within age categorized	43.7%	56.3%	100%
Teenagers (13-19)	Count	167	91	258
	% within age categorized	64.7%	35.3%	100%
Young Adults (20-24)	Count	271	103	374
	% within age categorized	72.5%	27.5%	100%
Total	Count	497	270	767
	% within age categorized	64.8%	35.2%	100%

Source: field survey (2023)

Data on table 4.10 show relationship between age and knowledge of multiple sex partners as a risk factor for HIV/AIDS. The degree of knowledge of multiple sex partners as a risk factor for preteens, teenagers and young adults was 43.7%, 64.7% and 72.5% respectively, while 56.3%, 35.3% and 27.5% are unaware of this means as risk factor of spread of the disease. Generally, 64.8% of respondents acknowledge this means of spread as opposed to 3.2% that do not.

Table 4.11: Homosexuality

Age (years)		Yes	No	Total
Preteens (10-12)	Count	20	115	135
	% within age categorized	14.8%	85.2%	100%
Teenagers (13-19)	Count	87	171	258
	% within age categorized	33.7%	66.3%	100%
Young Adults (20-24)	Count	130	244	374
	% within age categorized	34.8%	65.2%	100%
Total	Count	237	530	767
	% within age categorized	30.9%	91.1%	100%

Source: field survey (2023)

The age categorized level of homosexuality, as a predisposing factor to contract of HIV/AIDS amongst the preteens, teenagers and young adults was 14.8%, 33.7% and 34.8%, while 85.2%, 63.3% and 65.2% respectively are unaware of this mode of spread of the disease. 30.9% on the average of the general population knows of this means of spread while 69.1% do not.

Table 4.12: Unscreened Blood Transfusion

Age (years)		Yes	No	Total
Preteens (10-12)	Count	69	66	135
	% within age categorized	51.1%	48.9%	100%
Teenagers (13-19)	Count	165	93	258
	% within age categorized	64.0%	36.0%	100%
Young Adults (20-24)	Count	243	131	374
	% within age categorized	65.0%	35.0%	100%
Total	Count	477	290	767
	% within age categorized	62.2%	37.8%	100%

Source: field survey (2023)

Table 4.12 shows that the preteens, teenagers and young adults amongst the respondents know of unscreened blood transfusion as a route of contract of HIV/AIDS in the order of 51.1%, 64.0% and 65.0% respectively, while 48.9%, 36.0% and 35.1% of preteens, teenagers and young adults respectively; expressed lack of awareness. Generally, 62.2% of the respondents know this route and 37.8% do not.

Table 4.13: Unsterilized Needles, Cuts and Abrasions

Age (years)		Yes	No	Total
Preteens (10-12)	Count	71	64	135
	% within age categorized	52.6%	47.4%	100%
Teenagers (13-19)	Count	175	83	258
	% within age categorized	67.8%	32.2%	100%
Young Adults (20-24)	Count	239	135	374
	% within age categorized	63.9%	36.1%	100%
Total	Count	488	282	767
	% within age categorized	63.2%	36.8%	100%

Source: field survey (2023)

The percentage of preteens who recognize this route of contract of HIV/AIDS was 52.6%, teenagers 67.8% and young adults 63.9%, while invariably 47.4% of preteens, 32.2% of teenagers and 36.1% of young adults are ignorant of it. On the average of 63.2% of the respondents are aware of this route while 36.8% are not.

Table 4.14: Mother to child spread at birth and during breastfeeding

Age (years)		Yes	No	Total
Preteens (10-12)	Count	71	64	135
	% within age categorized	52.6%	47.4%	100%
Teenagers (13-19)	Count	175	83	258
	% within age categorized	67.8%	32.2%	100%
Young Adults (20-24)	Count	239	135	374
	% within age categorized	63.9%	36.1%	100%
Total	Count	488	282	767
	% within age categorized	63.2%	36.8%	100%

Source: field survey (2023)

Data on table 4.14 show that the preteens, teenagers and young adults with 35.6%, 54.7% and 59.6% respectively, acknowledge awareness of HIV/AIDS spread through this route while 64.4% of the preteens, 45.3% of teenagers and 40.4% of young adults are ignorant. Generally, 53.7% of total respondents are aware while 46.3% are not aware of this route.

Table 4.15: Female circumcision

Age (years)		Yes	No	Total
Preteens (10-12)	Count	14	121	135
	% within age categorized	10.4%	89.6%	100%
Teenagers (13-19)	Count	84	174	258
	% within age categorized	32.6%	67.4%	100%
Young Adults (20-24)	Count	127	247	374
	% within age categorized	34.0%	66.0%	100%
Total	Count	225	542	767
	% within age categorized	29.3%	70.7%	100%

Source: field survey (2023)

The above data on table 4.15 show knowledge of female circumcision as a possible route through which HIV/AIDS could be contracted amongst the respondents. Only about 10.4% of the preteens acknowledge awareness of this route, 32.6% of teenagers and 34.0% of young adults know that HIV/AIDS can be contracted thus via this means. Conversely, 89.6% of preteens, 67.4% of teenagers and 66.0% of young adults expressed lack of awareness.

Generally, amongst the respondents, only about 29.3% of the respondents emphatically is knowledgeable of this means as a risk factor of HIV/AIDS. The rest 70.7% of the respondents are ignorant. The result generally indicates that while multiple sex partners, unscreened blood transfusion, unsterilized needles, cuts and abrasion, mother to child spread by birth and during breastfeeding are fairly known routes for contract of HIV/AIDS, homosexuality and female genital cutting are still very poorly acknowledge to be risk factors amongst the young adults. Also awareness of these risk factors generally increases with age.

RESEARCH OBJECTIVE THREE: To observe the ‘‘ health seeking’’ behavior of young adult population when infected with these sexually transmitted infections.

Table 4.16: Health-Seeking Behavior of the Youths

Gone for treatment of STIs in hospital?	Frequency	Percentage
Yes	65	57.5
No	48	42.5
Total	113	100

Source: field survey (2023)

Data in table 4.16 show those treated of the infections in the hospital/clinic. Only 57.5% of the infected youths claim to have sought medical attention in the hospitals or clinics while 42.5% did not, but resorted to alternative health care providers such as chemist shops, traditional herbalists and midwives etc. this is not quite encouraging because 42.5% is proportionately significant and could perpetuate prevalence of sexually transmitted infections due to poor management.

Table 4.17: Health-Seeking Behavior of Sex Partners

Gone for treatment of STIs in hospital?	Frequency	Percentage
Yes	51	45.13
No	62	54.87
Total	113	100

Source: field survey (2023)

Similarly, table 4.17 illustrate that 45.1% of the infected persons had their partners treated while 54.9% did not treat their partners as well. The implication here is that

54.9% is proportionately significant; hence emphasis should be placed on need for partners treatment in order to reduce the spread of sexually transmitted infections.

RESEARCH OBJECTIVE FOUR: To ascertain the extent of young adult population knowledge of HIV/AIDS’ transmission.

Table 4.18: Youth Knowledge of HIV/AIDS Risk Factors

Risk Factors of HIV/AIDS	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Multiple Sex Partners	510	65.13	273	34.87
Homosexuality	244	31.16	539	68.84
Unscreened blood transfusion	489	62.45	294	37.55
Unsterilized needles cut and abrasions	496	63.35	287	36.65
Mother to child spread at birth and during breastfeeding	423	54.02	360	45.98
Female Circumcision	232	29.63	551	70.37

Source: field survey (2023)

Data on table 4.18 reveal that 65.1% of the respondents are knowledgeable of multiple sex partners as a causative risk factor, 34.9% are not. 3.2% know homosexuality as a risk factor 68.8% don't. 62.5% are aware of unscreened blood transfusion as a risk factor, 37.5% are not, 63.4% know about unsterilized needles, cuts and abrasions as risk factors but 36.6% do not. 54% know of mother to child spread at birth and during breastfeeding as a risk factor, but 46% do not and finally only about 29.6% of the respondents identified female circumcision or female genital mutilation as a possible risk factor for

HIV/AIDS, while 70.4% do not. The results generally indicate that the youth have appreciable level of awareness of these routes of spread of HIV/AIDS- multiple sex partners, unscreened blood transfusion, unsterilized needles, cuts and abrasions and mother to child spread. However, the awareness of homosexuality and female circumcision as possible risk factors of HIV/AIDS is relatively poor.

Table 4.19: Youth Awareness of STIs

Heard of STIs?	Frequency	Percentage
Yes	699	89.3
No	84	10.7
Total	783	100

Source: field survey (2023)

The response indicated that the bulk of the youth 89.3% have known or heard of STIs. Only 10.7% of them claimed ignorance.

Table 4.20: Youth Knowledge of types of STIs

Sexually Transmitted Infections (STIs)	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Gonorrhoea	552	70.50	231	29.50
Herpes Simplex	112	14.30	671	85.70
Chlamydia	99	12.64	684	87.36
Trachomatis				
Genital Warts	116	21.20	617	78.80
Syphilis	369	47.13	414	52.87
Staph aureus	140	17.88	643	82.12
HIV/AIDS	682	87.10	101	12.90

Source: field survey (2023)

Table 4.20 illustrate the percentage of respondents that have knowledge of gonorrhoea as a type of sexually transmitted infection as 70% while 30% feigned ignorance; 14.3% are aware of Herpes simplex as sexually transmitted, 85.7% are unaware. Only 12.6% are aware of Chlamydia trachomatis, 87.4% are ignorant, 21.2% are aware of genital warts while about 79% are ignorant of it, 47.1% knows about syphilis as sexually transmitted about 52.9% are unaware while only 17.9% know of staph aureus as sexually transmissible, 82.1% are ignorant of it. For HIV/AIDS 87.1% knows it is sexually transmissible while only about 12.9% claimed ignorance. The results generally show very poor level of awareness of Herpes simplex, Chlamydia trachomatis, genital warts and staph aureus as sexually transmissible infections. Level of awareness of syphilis as sexually transmissible is moderate while level of awareness of gonorrhoea and HIV/AIDS as sexually transmissible infections is relatively high.

Table 4.21: Youth Knowledge of types of STIs

Sexually Transmitted Infections (STIs)	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Gonorrhoea	51	6.51	732	93.49
Herps Simplex	3	0.38	780	99.62
Chlamydia Trachomatis	6	0.77	777	99.23
Genital Warts	20	2.55	763	97.45
Syphilis	15	1.92	768	98.08
Staph aureus	8	1.02	775	98.98
HIV/AIDS	10	1.28	773	98.72

Source: field survey (2023)

Data in table 4.21 show that only about 6.5% of the respondents have contracted gonorrhoea infection previously while about 93.5% had not. 0.4% has had Herpes simplex infection while 99.6% have not. 08% have had Chlamydia infection and 99.2% have not. 2.6% have had genital warts while 97.4 have not, 1.9% has had syphilis and 98.1% have not. About 1% has contracted staph aureus and 99% have not. 1.3% claimed to have contracted HIV/AIDS while 98.7% have not. The results generally show low level of incidence of contract of any of these sexually transmissible infections amongst the respondents.

4.3.1 Hypotheses Testing

The following hypotheses were formulated from this study and tested for significance using the appropriate statistical tool as shown below:

Hypothesis 1: That there is no association between sex and age at first sexual intercourse.

In order to test for significance of this hypothesis, data in table 4.22 were analyzed using the chi-square test. On analysis of table 4.22 at $P \geq 0.05$, df 2, X^2_c was 1.58 and X^2_t , 5.992.

Since $X^2_c < X^2_t$ Null hypothesis is accepted. That is there is no significant relationship between sex and age at first intercourse.

The finding reveals that the age at which males and females have their first sexual experience does not statistically differ.

Hypothesis 2: That the religion of the youth has no association with his/her age at first sex.

In order to test for significance of this hypothesis, table 4.23 was analyzed using the chi-square test. The results of the categorized age groups were related with the religion of the respondents. -Catholic, Protestant, Pentecostals and Islam to ascertain if any association. On analysis of the table $P \geq 0.05$, $df = 6$; $X^2_c = 6.962$ and $X^2_t = 12.5916$. Since $X^2_c < X^2_t$ Null hypothesis is accepted. Thus, there is no significant relationship between the religion of the youth and his/her age at first sex.

Hypothesis 3: That youth knowledge or awareness of HIV/AIDS transmission does not differ by age.

In order to find out if variation in the knowledge of risk factors of HIV/AIDS differs significantly with the age of the youths, tables 4.16 to 4.21 shows the variation in the knowledge amongst the different age groups as summarized in table 4.22 below, was subjected to analysis using the F-ratio (Analysis of variance, (ANOVA). The result on separation of the means is shown in table 4.23.

Table 4.22: Knowledge of Risk factors of HIV/AIDS: Age of Respondents

Risk factors	Preteens	Teenagers	Young adults
Multiple sex partners	59	167	271

Homosexuality	20	87	130
Unscreened blood transfusion	69	165	243
Unsterilized needles, cuts and abrasions	71	175	239
Mother to child spread	48	141	223
Female Genital cutting	14	84	127
Total	281	819	1233
Means	46.8 ^a	136.5 ^b	205.5 ^c

Source: field survey (2023)

Table 4.23: Means

Variate: Awareness				
Grand mean	129.61			
Risk factor	FGM	HOMOSEXUALITY	MSP	MTCS
	75.00	79.00	165.67	137.33
Risk factor	UNCAA	USBT		
	161.67	159.00		
AGE	Preteens	Teenagers	Young adults	
	46.83	136.50	205.50	
Risk factor	Preteens	Teenagers	Young adults	
FGM	14.00	84.00	127.00	75 ^a
HOMOSEXUALITY	20.00	87.00	130.00	79 ^a
MSP	59.00	167.00	271.00	165.7 ^b
MTCS	48.00	141.00	223.00	137.3 ^b
UNCAA	71.00	175.00	239.00	161.7 ^b
USBT	69.00	165.00	243.00	159.0 ^b
X	46.8 ^a	136.5 ^b	205.5 ^c	

NB: Means with some alphabetic remark are significantly different at 5% probability

only

- Horizontal comparison only

- Vertical comparison only

From table 4.22, the F-test (Analysis of variance ANOVA) at $P \geq 0.05$, $F_{cal} = 12.94$ while $F_{tab} = 3.86$. since $F_{cal} > F_{tab}$, the test is significant which means significant difference exists between the different age groups on level of awareness of the risk factors of HIV/AIDS amongst. Hence, the Null Hypothesis is rejected

Applying Duncan's multiple range tests for least significant difference in separation of the means, at t. 05/2 tail distribution, mean = 55.42. Thus the degree of significance is found to increase in the age of the youth.

4.4 Discussion of Findings

This study examined sexual behavioral patterns and sexually transmitted infections among young adults in Edo South senatorial district of Nigeria. Findings from the study reveals that a greater number of youth of ages (10-24) years of both sexes are engaged in schooling activities. The population of the youth increases with age. The youth comprises slightly more males than females. That they are more engaged at school indicates rising age at marriage. Thus there is reduced likelihood of early marriages and associated consequences. The full embrace of education by youth is of benefit to the individuals as well as to the Nation in thence of skilled man power development.

There is also no doubt that sexually transmitted infections are still prevalent. This has a tendency to worsening the HIV/AIDS incidence rate since such compromised genital

tract system by sexually transmitted infections is known to be more susceptible to HIV/AIDS. Study revealed that the age at first sexual experience by the youth does not differ by sex. The mean age at first sexual intercourse amongst the youth was 17.58 years. The median age at first sex was 18 years. With the findings of National Population Commission, 1998, where median age for the country's population was 17.5 years in mind, there is no doubt that the population is youthful. A median age at first sex of 18 years in this survey truly implies that the youth are very sexually active. In other words, a significant proportion of the country's population is implied to be sexually active. Furthermore, the modal age at first sex of 20 years revealed in this study, indicates that at age 20 years, 93.1% of the youth have had sex.

Also more females than males had first sexual intercourse at younger ages. This is consistent with findings of (DHS 2015/2016) where in most of African countries, higher proportion of young women had sex before the age of 18 years. The percentage of males indulging in first sex increases with age up to 20 years, the reverse is the case for the females up to age 20 years. At teenage age, the youth are highly vulnerable as revealed in this study with greater number of the teenagers indulging in first sexual encounter. Peer group influence, coercion and youth adventurism amongst others as revealed by previous studies (Izugbara, 2001; Ejikeme, 2003 and Overby and Kegeless, 1994) may have role to play here. This is more so when one observes that as the youth becomes more matured and more educated, the number indulging in first sexual encounter decreases especially

amongst the females. This finding can be explained from the assertion of social disorganization perspective on the role factors like education plays in making women more assertive in a previously male dominated world.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This chapter entails the summary of findings, conclusion and recommendations.

5.2 Summary of Findings

The study reveals that a greater number of youth of ages (10-24) years of both sexes are engaged in schooling activities. The population of the youth increases with age. The youth comprises slightly more males than females. That they are more engaged at school indicates rising age at marriage. Thus there is reduced likelihood of early marriages and associated consequences. The full embrace of education by youth is of benefit to the individuals as well as to the Nation in thence of skilled man power development.

There is also no doubt that sexually transmitted infections are still prevalent. This has a tendency to worsening the HIV/AIDS incidence rate since such compromised genital tract system by sexually transmitted infections is known to be more susceptible to HIV/AIDS. Study revealed that the age at first sexual experience by the youth does not differ by sex. The mean age at first sexual intercourse amongst the youth was 17.58 years. The median age at first sex was 18 years. With the findings of National Population Commission, 1998, where median age for the country's population was 17.5 years in

mind, there is no doubt that the population is youthful. A median age at first sex of 18 years in this survey truly implies that the youth are very sexually active. In other words, a significant proportion of the country's population is implied to be sexually active. Furthermore, the modal age at first sex of 20 years revealed in this study, indicates that at age 20 years, 93.1% of the youth have had sex.

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Study revealed further that a proportionate number of the population still resort to non-orthodox means or assistance from quacks to treat themselves of sexually transmitted

infections, with infected partners being scarcely treated by skilled hands. This is at risk of infertility to the young people's reproductive health. The level of sexual activities amongst the youth if unguided also could imply increased risk of sexually transmitted infections including HIV/AIDS, teenage pregnancy and its associated consequences. This finding exposes the poor health system still prevalent in the country. Apart from poor statistical record of those who report in clinics and hospitals for screening and treatment of these infections, non orthodox, inefficient as well as medically uncertified sources of seeking treatment such as herbal home, quack personnel or roadside chemist shops are still being patronized by the youth. The Nigerian State therefore, is hereby confirmed as a truly developing one, far from a post-modern state with developed health system; in line with the position of 'demographic transition theory.'

That there is no association between age at first sexual experience and religion implies that religious belief alone might not be enough to control risky sexual indulgence. It could therefore be inferred from this, that the influence of beliefs such as religion on attitude or behavior compared to pre-historic times is fast on the decline. This can be explained from the positions of both anthropological and social disorganization perspectives. Therefore, sex education should be more emphatically embraced both in schools and at home.

The association between age of the youth and knowledge of HIV/AIDS was significant in this study. This reveals the role literacy plays in helping to mould the mind and thus

behavior. Such youth will be more conscious of their rights and are more assertive. Study however detected that youth scarcely know of the risks associated with female genital mutilation such as HIV/AIDS. Knowledge of homosexuality as a risk factor of HIV/AIDS is also poor amongst the youth. More public enlightenment is needed to address these issues.

Six development agencies, African Development Bank (AFDB), United Kingdom Development for International Development (DFID), Japan Bank for International Cooperation (JBIC), KFW Entwicklungsbank (KFW Development Bank), Asian Development Bank (ADB), and the World Bank have recognized the urgency for action in the infrastructure sectors to tackle the global HIV/AIDS crisis. There have also been strong expressions of endorsement from further bilateral and multilateral funding agencies, which will be welcomed to join the initiative. According to them, in view of the success in their respective organizations of funding in sectors which include transport, energy, water, urban and rural development, the Development Agencies propose to coordinate their activities in order to mainstream HIV/AIDS prevention and treatment programs in infrastructure sectors, to reduce the impacts of the diseases as a result of infrastructure interventions, to take opportunities for implementing further countermeasures and to contribute to strengthening the HIV/AIDS strategies of partner countries.

Robust health systems play a fundamental role in channeling globally recognized prevention and treatment of HIV/AIDS. However, certain social and biological complexities profoundly affect the transmission, progression and mortality of the disease. These lie beyond the scope of health services. Intrinsically difficult to control, these elements constitute significant obstacles to the prevention and management of the HIV/AIDS epidemic. Biological factors, such as exposure to infected individuals (through sex, contamination blood production, or perinatally), infectivity (determined by the viral load) and concomitant sexually transmitted infections (STIs) greatly increase susceptibility to infection. Social and environmental determinants, which include socio-economic status (for example, unemployment, poverty, degree of urbanization and migration) may increase the propensity to risky behavior (such as unprotected sex or drug abuse) and heighten the possibility of infection. Another important factor here is gender and age. Women lower status and adolescents relative youth renders both groups more vulnerable to infection due in part to consequent lack of power in relationships (Tallis, Cavanagh, and Ewing 2004; Narayaman, Narang, Dhar, Muthur and Mittal, 2004, Naseem, 2004). The international effort to control spread of HIV/AIDS need to be complemented by local support. How successful this has been in Nigeria deserve evaluation.

5.3 Conclusions

Globalization which can be said to represent the emerging world-wide interdependence of individuals and countries which is characterized by various economic, political, cultural and social relative (Anyakoha, 2006) has a role to play in the HIV/AIDS pandemic. As the removal of barriers to free trade and the closer integration of national economics (Stiglitz, 2003), the principle underlying globalization becomes advantageous in curbing the spread and control (management) of HIV/AIDS. It is a known fact that though huge sums of money have been sunk into this project by many international agencies and non-governmental organizations such as the President's Emergency Plan for AIDS, tuberculosis and malaria, the global alliance for Vaccines and Immunization, the Global Health Council, Medicines sans frontiers, the Bill and Melinda Gates Foundation, the World Bank, Multi-country HIV/AIDS program (MAP), the Acceleration Access initiative and William J Clinton Presidential Foundation etc..., developing nations of the world including Nigeria experience far-reaching impact from the disease due to poverty, disease, famine, political and economic instability and weak health infrastructure and planning (Travis, Bennett, Haines, Pang, Bhutta, Hyder, Pielemcier, Mills and Evans, 2001).

Globalization brought with it many benefits in addressing the spread of HIV/AIDS, but that benefit can only be harnessed or realized if the targeted population, who needs it, would receive the dedicated resources. Also, appropriate programs such as building

capacity in recipient countries have to be put in place and genuinely pursued with empirical focus. This is a major challenge in Nigeria and all stakeholders should indeed support the efforts to address HIV/AIDS and other related matters with uncompromised transparency. Indeed; the future of our youths will depend on this.

5.4 Recommendations

Based on the findings of the study, it is recommended that;

- i. The preventive programs should focus on developing positive attitude toward infected persons in a way that they are not discriminated against.
- ii. Reproductive health information, including STDs should be included in university curriculum in order to enhance student knowledge and attitude regarding STDs prevention.
- iii. Free HIV testing should be inculcated into the undergraduate students my management in order to be able to receive HIV testing without financial burden. This action may increase the rate of HIV testing among the student population and in turn reduce rates of transmission.
- iv. It was also recommended that students' sources of information should be increased in terms of mass media and health education regarding the spread of STDs on campus.
- v. STDs prevention programme should be developed and implemented by the university to promote changes in attitude in order to prevent the spread of STDs.

- vi. It was further recommended based on the findings of this study that a comprehensive knowledge and attitude of transmission and skills of preventing STDs as a priority on campus, should be introduced to the student population.
- vii. Finally, to reduce the misconception about sex education and STDs and intervention programs are needed to be embarked upon by management in order to increase the level of knowledge and awareness of STDs as this will reduce its spread among the student population.

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APPENDIX

**DEPARTMENT OF SOCIAL WORK
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QUESTIONNAIRE

**SEXUAL BEHAVIOURAL PATTERNS AND SEXUALLY TRANSMITTED
INFECTIONS AMONG YOUNG ADULTS IN EDO SOUTH SENATORIAL
DISTRICT OF NIGERIA**

(Strictly Confidential)

The questionnaire is designed to provide information on Sexual behavioural patterns and Sexually Transmitted Infections among young Adults in Edo South Senatorial District of Nigeria Thank you

PART 1: SOCIO-ECONOMIC BACKGROUND OF RESPONDENTS

1. What is your age (in completed years as at last birthday) please?Years
2. Sex: Male () Female ()
3. Marital status: Single () Married () Divorced () Widowed () Separated ()
4. What was your age at first marriage, please?Years
5. What is your current schooling status? Never attended () Attended in the past but not now () Attending Primary () Attending JSS () Attending Tertiary ()

6. What is your highest level of formal education completed? None () Primary ()
Secondary () Tertiary ()
7. What is your religion? Christianity () Moslem () African Traditional Religion ()
Others Specify ()
8. If Christianity, state your denomination: Catholic () Protestant () Pentecostal ()
others (Specify)
9. What work do you normally do?
10. To which ethnic group do you belong? Bini () Esan () Etsako () Urhobo () Itsekiri
() Ijaw () Isoko () Igbo () Yoruba () Hausa/Fulani ()
11. What is your state and LGA of origin: State.....
12. For how long have you resided in this locality? Since birth () Less than () 1 year to
less than 5 years () 5 years to less than 10 years () 10 years and above ()

PART 11: SEXUALITY AND REPRODUCTIVE BEHAVIOUR OF RESPONDENTS

13. Have you heard about sexually transmitted infections? (1) Yes () (2) No ()
14. Have you contracted any of these? (1) Yes () (2) No ()
15. If Yes to Question 14, which of the following types of sexually transmitted diseases do you know of and/or have contracted previously?

S/No.	Types	Known		Contracted	
		Yes	No	Yes	No
1	Gonorrhea				
2	Herpes aimplex				
3	Chlamydia trachomatis				
4	Genitals warts				
5	Syphilis				
6	Staph aureus				
7	HIV/AIDS				
8	Others specify				

16. If Yes to Question 14, did you/have you gone for any treatment? (1) Yes () (2) No ()
17. Did your sexual partner also go for screening and treatment? (1) Yes () (2) No ()
18. Tick possible risk factors of HIV/AIDS that you know of: (1) Multiple sex partners () (2) Homosexuality () (3) Unscreened blood transfusion () (4) Use of unsterilized needles, cuts, abrasions etc () (5) Spread from mother to child at birth and during breast feeding () (6) Female circumcision () (7) Others (specify please).....
19. Have you been screened for HIV/AIDS (1) Yes () (2) No ()
20. If Yes in Question 19, where were you screened? Hospital / Clinic () Herbal Home () Churc () Nursing Home () Chemist (Pharmacy) Shop () Others (specify):.....
21. If No in Question 19, why haven't you been screened? Afraid of consequences if positive e.g. social stigma and death () Don't believe there is HIV/AIDS () Believes in being HIV positive by faith () I have never heard of HIV/AIDS () Others (specify, please).....
22. How old were you when you had your first sexual intercourse?Years. No sexual intercourse yet ()
23. How old were you when you had your first menstruation?..... Years. Not menstruating yet ()

24. Were you circumcised when you were younger? Yes () No ()
25. Would you recommend the continuous practice of female circumcision? Yes () No ()
26. Please give reason(s) for your answer to Question 25 above
27. Are you pregnant now? Yes () No ()
28. How many pregnancies have you ever had or how many times have you impregnated someone?(Number)
29. Which of the following complications have you had during pregnancy and or child delivery? Bleeding () Fever () Retained placenta () Convulsion () Foul smelling discharge () Incontinence of urine () High blood pressure () Diabetes () Others (specify):.....
30. In your last pregnancy, did you attend antenatal/postnatal care in the hospital? Yes () No ()
31. Some people get pregnant and lost the baby either during pregnancy or after birth. Have you ever given birth to any child who later died? Yes () No ()
32. Please do not feel that I am counting your children, but this information will be helpful. God bless and protect you and your children. How many children do you have alive?.....
33. Family planning is the ways and methods that women or men use to delay or avoid pregnancy. Do you know of any of these methods? Yes () No ()
34. Which of the following methods of family planning have you known or used?

S/no	Types	Known		Used	
		Yes	No	Yes	No
1	Pills				
2	Injections				
3	Condom				
4	IUD				
5	Douche				

6	Norplant				
7	Female sterilization				
8	Vasectomy				
9	Rhythm/Safe period				
10	Withdrawal				
11	Abstinence				
12	Herbs				
13	Arm bands				
14	Charms				

35. How many children do you wish to have?

Male Children.....

Female Children.....

Total

36. Have you ever had any complications with the use/practice of your choice method of contraception/family planning? Yes () No ()

37. If Yes to Question 36, what complication(s) have you had? Bleeding excessively ()

Discomfort/Pain () Infection () Fatness or obesity () Others (specify).....

Thank you so much.