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GYNAECOLOGY

Sexual behaviour and negotiation of the male condom by female students of the University of Ibadan, Nigeria

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Summary

This study explored the sexual behaviour of unmarried female students of the University of Ibadan, Nigeria, and assessed the extent to which those who were sexually active negotiated and used the male condom. Four focus group discussions were conducted followed by a survey of 354 students. The results show that the mean age of the students was 22·5 years 55·1% had had sexual intercourse; the mean age at first intercourse was 16·5 years. The number of lifetime sexual partners ranged from 1 to 20 with a mean of 3·4; 75% of those who had had sex reported ever using condom; 16·9% and 39% used it during their first and last sexual episodes respectively; only 34·3% used it consistently. Seventy-three per cent had ever negotiated condom use with a partner, but only 41% did so during their last sexual encounter. A significant association was found between condom negotiation and number of sexual partners: Students with fewer life time partners (3·2) had less frequently negotiated condom use than those with more partners (4·3) ($P<0·05$). Condom negotiators also scored significantly higher (4·6) on a 6-point AIDS Knowledge Score than those who had never done so (4·0) ($P<0·05$). About a quarter (26·7%) had ever bought a condom, while 38·5% had ever carried it. We conclude that although many female students had sometimes used a condom only a few used it consistently and are therefore at risk of the unintended outcomes of unprotected sex. We propose appropriate interventions to address the problem.

Introduction

Young people are increasingly recognised as an important but neglected group in many developing countries. In Nigeria, for example, although about 32% of the population are between the ages of 10 and 24 years (National Population Commission, 1991; Makinwa-Adebusoye, 1997) the reproductive health information and service needs of this population is neglected by most social services and institutions in the country. Existing government and privately supported reproductive health service programmes target mainly married couples (Okonofua, 1996). Although some non-governmental Youth Serving Organisations (YSO) had responded to the reproductive health needs of young people, the services provided and the population reached are limited by financial constraint.

Schools which ought to be a primary source of reproductive health information for young Nigerians have not lived up to this expectation because reproductive health education is not yet introduced into the curriculum. This is because policy makers, teachers and parents believe that such an initiative would encourage young people to experiment with sex and become promiscuous (National Guidelines Task Force 1996). However, this contention is unfounded because a recent literature review of the impact of sexual health education on the sexual behaviour of young persons commissioned by the United Nations Programme on HIV/AIDS (1997) showed that education does not promote promiscuity. On the contrary, education has helped adolescents to delay the onset of sexual activity (Howard and McCable, 1992), it had helped youths to reduce their number of sexual partners and it had reduced the rates of unplanned pregnancy and sexually transmitted diseases (STD) (United Nations Programme on HIV/AIDS, 1997) in this population.

One consequence of the current neglect is that many young Nigerians know little about reproduction (Makinwa-Adebusoye, 1992; Oladapo, 1996; Amazigo *et al.*, 1997). For example, 60% of the young people surveyed by Makinwa-Adebusoye (1992) in urban areas did not know that pregnancy was possible during the first intercourse. Oladapo (1996) reported that secondary school students averaged 11 points on a 33-points scale of reproductive health knowledge.

Yet, sexual debut for most young people in the country occurs during the teenage years (Nichols *et al.*, 1986; Mudefem, 1994; Dada *et al.*, 1998). In Nigeria, the mean age at first intercourse is 16 years for boys and 18 years for girls (Oyediran *et al.*, 1996). Therefore, many young Nigerians commence sexual activity when they have inadequate information about the consequences of their actions. The result is that a high proportion engage in risky sexual activities including unprotected sex with multiple partners (Jinadu and Odesanmi, 1993; Oladepo and Brieger, 1994; Makinwa-Adebusoye, 1997; Dada *et al.*, 1998). For example, Jinadu and Odesanmi (1993) studied male adolescents aged 15 to 19 years and found that 76% of the secondary school youths had been sexually active within the past 12 months, 5% with prostitutes and 56% with more than one partner, but that only 8% had

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used a condom during that year. Another survey of secondary school students, showed that only 36% of sexually active males and 21% of females were condom users (Araoye and Adegoke, 1996). These behaviours increase the vulnerability of youth to STD including HIV.

While intervention that addresses the reproductive health needs of all young Nigerians is justified, females deserve a high priority because they are disproportionately affected by reproductive morbidity associated with unprotected sex (Berer, 1993; Oladepo and Brieger, 1994; Advocates for Youth, 1995; Dada *et al.*, 1998). In Nigeria, teenagers account for 80% of unsafe abortion complications seen in hospitals (Federal Ministry of Health and Human Services, 1994). A study in one teaching hospital found that 72% of the patients hospitalised for abortion complications were under 20 years (Archibong, 1991). About 40% of women with septic abortion in another teaching hospital between 1981 and 1985 were aged between 12 and 20 years (Adekunle and Ladipo, 1992). In addition, sexually active young girls are at an increased risk of STD because organisms causing STD more easily penetrate the cervical mucus of girls than that of older women (McCauley *et al.*, 1995). One study in rural Nigeria revealed that 40% of girls younger than 19 years had had at least one reproductive tract infection (Brabin *et al.*, 1995).

Prevention is one of most realistic public health strategies for controlling reproductive morbidity in young females. Abstinence is traditionally recommended but this is often unrealistic because most young girls in Nigeria prefer sex to chastity (Olaseha and Alao, 1993; Makinwa-Adebusoye, 1997). Therefore, the consistent use of condoms are now being promoted as a second is line of action. Unfortunately, consistent use of the male condom remains poor among sexually active young women (Ajuwon *et al.*, 1998; Dada *et al.*, 1998). The female condom is available only in the urban areas and the price is exorbitant, therefore it is not affordable to the average Nigerian women who needs it (World Health Organisation, 1997). The male condom is a viable alternative in that it is cheap and readily available in most parts of the country. However, a girl who wants to protect herself from STD must negotiate its use with her partner. This is not easy in a setting like Nigeria where women are expected to play a passive role to men in sexual relationships (Adekunle and Ladipo, 1992). This task is even more difficult for young women who are in their formative ages when they have limited communication and assertiveness skills.

In Nigeria, the few studies that had assessed women's ability to negotiate condom use with their partners were limited to commercial sex workers (Esu-Williams, 1995). Little attention has so far been paid to the assessment of condom negotiation among other young females. In this article, we describe the sexual activity of female students of University of Ibadan, Nigeria and the extent to which those who were sexually active had negotiated and used the male condom. This information is essential for planning an effective campus-based programme on the prevention of risky sexual behaviour among the female students.

The setting

Founded in 1948, the university of Ibadan is Nigeria's premier tertiary institution. With a campus covering over 1032 hectares of land and a student population of approximately 19 000, the University of Ibadan is one of the largest universities in the country. There are 11 faculties and 57 departments in the university. With the exception of Law, Pharmacy and Veterinary Medicine, each faculty runs a variety of undergraduate and postgraduate courses leading to the award of diploma and degrees.

Some of the features of the university favour a risky sexual lifestyle. For example, admission into the university provides the students the first opportunity of freedom from direct parental supervision and guidance. Many may take advantage of this situation to express their sexuality by initiating sexual activity. There is a popular practice in the university called 'October rush' (Oladepo and Brieger, 1994) a time when the older male students take advantage of the naiveté of the new female students to pressurise them sexually. Some female students, particularly, those from poor economic background, yield to the pressure by acquiescing to sexual activity. Others resort to befriending older men 'sugar daddies' from outside the campus, who provide money and other material support for the students in exchange for sex (Adekunle and Ladipo, 1992). The study population was limited to the unmarried female students because condom negotiation and use are important in the context of non-marital sexual relationship where the risk of unwanted pregnancy and STD are high.

Methods

Both qualitative and quantitative methods were used to collect data. The qualitative aspect consisted of focus group discussion while the quantitative component was a survey. The two methods were combined to obtain reliable information because of the sensitive nature of sexual behaviour, the main focus of the study. The focus group discussion was conducted first to explore the sexual behaviour of the students and their attitude towards condom use. The participants were recruited from the departments that were randomly selected for the survey. In order to facilitate a free flow of discussion (Kruger, 1988), the students were divided into four homogeneous groups based on the their current level, i.e. the number of years they had spent in the university. Between six and eight students participated in each session. A discussion guide was developed and used by the female member of the investigating team to moderate each session which was recorded on audiotape and transcribed later. The issues covered during the discussion were the reproductive health concerns of female students, their sexual activities including the consequences, condom negotiation and use and the difficulties encountered in convincing their partners to use it. The focus group discussion provided useful data regarding the sexual behaviour of the students and their attitude towards use of a condom which helped in planning the larger survey that followed.

Stratified sampling method was used to recruit the survey respondents. The faculties were stratified into 11 and one department was randomly selected by balloting from each faculty. A list was compiled of all courses being taught in each selected department. One of these courses was then selected randomly by balloting from the department and all the female unmarried students who were studying the course were

invited to participate in the survey. Informed consent were obtained from the students by explaining the purpose of the study and informing them that participation in it was voluntary.

A questionnaire was developed and used for the survey. It elicited information regarding personal characteristics of the students, their sexual activities, knowledge about HIV/AIDS, use of the condom including buying and carrying it. In order to ensure its validity and reliability, a draft of the questionnaire was pre-tested among 20 students from the polytechnic, a tertiary institution in Ibadan with comparable features with those of the university. Feedback from the polytechnic students led to some modifications of the questionnaire. The questionnaires were administered after the end of each of the courses selected. They were distributed to the respondents who filled and returned them immediately. Although all the 400 students invited to participate in the study agreed to do so, giving a response rate of 100%, only 354 of the questionnaires were properly completed and used for the analysis. The data were entered into the computer and analysed using the EPI-INFO package.

Results

Demographic information

The ages of the students ranged from 15 to 39 years with a mean of 16·5 years. More than half (55·5%) belonged to the 20–24-year-old age group followed by those aged 15–19 years (23·9%), and 25–39 years (13%). Christianity and Islam were the dominant religions (85·6% and 11·3%, respectively). The main ethnic groups were Yoruba (65·5%) and Ibo (20·9%). Parents were the main source of income for majority of the students (89·3%) followed by fiancé/boyfriend 10 (2·8%) and relatives 8 (2·3%).

Sexual practices

Focus group discussion participants said the main reproductive health concerns of female students were, how to deal with the sexual pressures from male students, men from outside the university and the risk of sexual coercion including rape. One discussant described the nature of the sexual pressure in this way 'with the October rush on this campus every guy wants to go out with the most pretty girl, there is always go slow of cars at Idia (one of the female halls of residence) in the evenings. Cars are jam-packed, all kinds of guys from within and outside campus come to pick girls to "sleep with" in exchange for money'. Rape was also a major concern. Another participant said that 'girls are really scared of going out at night because of rapists, now men even attempt to rape girls in their own hostels'.

There was a consensus of opinion among focus group discussion participants that many female students at the university had had sexual experience. With regards to number of sexual partners, the discussants were of the opinion that having multiple partners was a common practice among the students as a whole. Many, however, believed that this behaviour occurred more frequently in males than in females. This was exemplified by a student who said that 'most girls usually have only one boyfriend on campus, but some would in addition have other men in town, in Lagos and in other places, but the guys are more daring, they can have up to four girlfriends within a hostel'.

With respect to survey results, more than half of the respondents (55·1%) had had sexual intercourse. Age at first intercourse ranged from 10 to 23 years with a mean of 18·6 years. More than half of those with sexual experience (56·4%) had their last sexual encounter three months before the study, 38·5% had it over 6 months ago; and 5·1% did not recall the time. The number of life time sexual partners ranged from 1 to 20 with a mean of 3·4; 14·4% could not remember the number. The number of current partners ranged from 1 to 10 with a mean of 1·1. Table I presents the type of partners the students had during the first and last sexual encounters. About 70% reported that their first sexual encounter was with a steady partner, 54·4% had their last encounter with a steady partner while others had it with a fiancé (24·6%) and a casual partner (26·1%).

Use of condom and its negotiation

The general belief of the focus group discussants was that many female students preferred to use the condom. However, because many male partners disliked the condom, participants pointed out that it was always difficult to negotiate its use with partners. As one of the discussants said 'Guys are very wicked and selfish, they don't like condoms because they don't want to lose any pleasure even at the detriment of their partners'. Students also believed that lack of cooperation was usually exhibited in deceit because 'some guys play tricks, they will agree to use condom, but when the girl closes her eyes during sex he may remove or tear it off'. The fear of violence was another disincentive to negotiate condom use. As one student narrated her experience 'The first time I ever asked my boyfriend to use a condom, he slapped me asking who taught me about condoms'.

Table I. Students' type of partner during first and last sexual episodes

	First sexual episode		*Last sexual episode*	
Type of partner	*n*	%	*n*	%
Steady partner	136	69·7	106	54·4
Fiancé	18	9·2	48	24·6
Casual	30	14·9	26	13·3
Relative	3	1·5	–	–
Rape	2	1·0	1	0·5
No response	7	3·6	14	7·2
Total	195	100	195	100

Students who insisted on use of condom faced a dilemma between losing their partners and risking being infected with STD because male partners associated condom use with distrust by the female. This dilemma was exemplified by one participant who said that 'I know it is safer to use condom, but you are supposed to love and trust your boyfriend. By insisting on condom use, one is damaging the trust upon which a steady relationship is built' Discussants also claimed that men took advantage of women's emotions and may threaten to discontinue the relationship when a girl insisted on the use of a condom. One student put it this way 'some guys use emotional blackmail by questioning your love for them if you insist, they will threaten to leave you for another girl, they wont take you for a serious relationship'. The financial implication of losing a boyfriend was also pointed out as male partners may 'dump' i.e. jilt or fail to provide financial support to a girl who insists on the use of a condom. Some girls also disliked the condom because it made sex 'unnatural'.

About three-quarters (74·9%) of students with sexual experience had ever used a condom. Users of the condom were asked how consistently they had used it in the past; 34·3% used it always, 45·2% used it occasionally while 29·8% rarely used it. Only 16·9% used a condom during their first sexual episode, 39% did so during the last. Concerning what they did to prevent pregnancy during their last sexual intercourse, the majority (76·9%) took a precaution, 23·1% did not. Of those who used a contraceptive, condom was the most popular (44·7%) followed by rhythm method (26·7%) and withdrawal (13·3%) (Table II).

With respect to the prevention of STD during the last sexual encounter, 42·6% took a precaution to forestall infection, 57·4% did not. Of those who did, a condom was the main option (91·6%). The reasons given for using the condom during the first and last sexual episodes are presented in Table III. It was used mainly to prevent pregnancy and STD. Seventy-five per cent of those who did not use condom during their last sexual episode provided reasons why they did not do so and these are presented in Table IV. Partners dislike (28·4%) and the belief that the partner was not infected with STD (24·7%) were the main reasons.

Condom negotiation

The majority (73·3%) of those with sexual experience had negotiated condom use at some time 26·7% had not. Of the 76 who negotiated condom use during the last sexual episode, the initiative for it was mutual (45%), by the respondents (35%) and from the partner (10%). The respondents were more likely to negotiate condom use with a casual partner than with a fiancee or a steady partner as shown in Table V. About two-thirds (67·8%) of condom negotiators reported that their partners readily agreed to use a condom when they were requested to do so, 10·5% said they reluctantly agreed after complaining and expressing anger, while 21·7% said their partners disagreed totally. The main reasons given for never negotiating condom use were the belief that partners was not infected with STD, the embarrassment about bringing up the idea, a personal dislike of condoms, the fear of losing him and fear that he may become violent.

The relationship between condom use and its negotiation was explored. A significant association was found between condom negotiation and ever using a condom ($P<0·05$); more students who had ever used a condom negotiated its use. A significant association was also found between condom negotiation and use of condom during the last sexual episode ($P<0·05$). However, no significant association was found between condom negotiation and consistency of condom use ($P>0·05$).

Table II. Contraceptive method used during last sexual intercourse

Contraceptives	*n*	*%*
Condom	67	44·7
Safe period/rhythm	40	26·7
Withdrawal	20	13·3
The pill	16	10·7
Condom and the pill	4	2·7
Drugs (type not specified)	2	1·3
Vaginal foaming tablets	1	0·7
Total	150	100

Factors influencing condom negotiation

No significant association was found between condom negotiation and age ($P>0·05$), religion ($P>0·05$), ethnic origin ($P>0·05$), and main source of income ($P>0·05$). Although those who had never negotiated condom use had a greater number of lifetime sexual partners (4·3) than those who had done so (3·2), the difference was not significant ($P>0·05$). No significant association was found with the current number of sexual numbers ($P>0·05$).

Knowledge about AIDS and condom negotiation

A 6-point AIDS Knowledge Score was constructed. The overall mean knowledge score obtained by the student was 4·2. A comparison between knowledge score and condom negotiation show that those who had ever negotiated condom use scored significantly higher (4·58) than those who had never done so (4·06) ($P<0·05$). All the respondents were asked whether or not they could convince a steady and casual partner to use condom. For a steady partner 60·7% claimed that they could do so, 29·3% could not and the corresponding figures for a casual partner were 55·4% and 44·6% respectively. The key negotiation theme for a steady partner was pregnancy prevention and that it was a matter of policy for a causal partner. A significant association was found between condom negotiation and knowledge of condom negotiation theme for a steady partner ($P<0·05$) but no association was found between condom negotiation and knowledge of condom negotiation theme for a causal partner ($P<0·05$).

The practice of buying and carrying a condom

The focus group discussion findings revealed a split in opinion with regards to buying, carrying and discussing the use with a partner. On the one hand, a faction of the students believed that since it is the male who wears the condom, he should be solely responsible for

Table III. Reasons for using condom

Reasons for using condom	First sexual episode n	First sexual episode %	Use during last episode n	Use during last episode %
Pregnancy prevention	54	37·0	8	10·5
STD prevention	19	13·0	26	34·2
STD and pregnancy prevention	54	37·0	42	55·3
Just experimenting	8	5·3	–	–
No response	11	7·5	–	–
Total	146	100	76	100

Table IV. Reasons for not using condoms during last episode of sex

Reasons	n	%
Partner disliked it	23	28·4
Partner not infected with STD	20	24·7
Personal dislike	11	13·6
Never thought of it	11	13·6
Sex occurred during safe period	9	11·1
Condom was not available	7	8·6
Total	81	100

Table V. Initiator of condom use during last sex and type of sex partner

Type of partner	Initiator of condom use: Self	Partner	Mutual	Total
Casual	9	2	2	13
Steady	14	5	22	41
Fiancé	3	3	8	14
Total	26	10	32	68

providing it. Therefore, a girl has no business buying or carrying it. As one student said, 'It is very disgusting for a girl to buy condom. I will regard any girl who carries a condom as a prostitute, if a girl must use condom, let her boyfriend provide it.' A similar comment was that, 'It is very hard to summon courage to buy condom, people in the shop will look at you with funny eyes. Personally I can't do it.' The other faction saw buying condoms as a responsible thing for a sexually active girl to do. As one student put it, 'I consider a girl who buys condom as a responsible person who is concerned about her health. I don't see anything wrong in a girl buying condom irrespective of what people would say, it is her health, her life that is important.' In a similar vein, another student said that, 'I don't think carrying condom is bad, what is bad is our judgmental attitude.'

Survey results show that 26·7% of students with sexual experience had ever bought a condom, 38·5% had ever carried one. Further analysis, show that more of those who had bought a condom had negotiated its use ($P<0·05$), a similar finding was noted for those who had ever carried one ($P<0·05$). The main reasons given by the 120 students with sexual experience who had never carried a condom were that it was not feminine to do so (37·5%), that it was embarrassing (26·7%) and that partner may suspect that she is promiscuous (20·8%).

Discussion

More than half of the students had sexual experience. This confirms the results of previous surveys that show that premarital sexual activity is a common practice among young people in Nigeria (Olaseha and Alao, 1993; Oloko and Omoboye, 1993; MUDAFEM, 1994; Oladepo and Brieger, 1994; Makinwa-Adebusoye, 1997; Dada *et al.*, 1998). This is partly explained by the long years of continued education which had created a big gap between the age of puberty and age at marriage, thus increasing the likelihood of sexual initiation. Other contributory factors include the impact of the mass media which glamorises sex and the weakening of traditional and religious norms which hitherto regulated premarital sexual behaviour (Adekunle and Ladipo, 1992; Makinwa-Adebusoye, 1997; Dada *et al.*, 1998).

The practice of having multiple sexual partners as reported by some of the students is a source of concern because of the risks involved including unwanted pregnancy, STD and their complications. The fact that 5·1% of the sexually active students could not remember the number of partners in the last three months suggest that these partners were probably causal friends. This is likely to be the case because 13·3% reported that their last sexual partner was a casual friend.

Although the majority of those with sexual experience had ever used a condom, the proportion of those who used it consistently remains low. This agrees with results from previous studies that consistent use of the male condom remains low among young females who engaged in risky sexual behaviour (Nichols *et al.*, 1986; Ajuwon *et al.*, 1998; Dada *et al.*, 1998). Yet, a condom needs to be used consistently and correctly in order to ensure that it provides protection against STD and unwanted pregnancy. More than a quarter (28%) of

those who did not use a condom during the last episode of sex attributed this to partner's dislike. The explanation lies in the prevailing gender norm expectation in Nigeria where females are expected to defer to the opinion and preferences of the males in a sexual relationship. This is unfortunate because such behaviour may place women at risk of infection with STD when they have sex with men who have multiple partners. One option for addressing the problem will be the subsidisation of the cost of the female condom, a method that provides protection against pregnancy and STD (World Health Organisation, 1997) and is under the control of women.

Contrary to the widely held belief that those who are able to negotiate condom use would be more promiscuous, the study found that those who had ever negotiated condom use had fewer sexual partners than those who had not. This confirms the World Health Organisations (1992) and Baldo's (1993) assertion that the ability to negotiate condom use motivates young people to practice safer sex.

The students had a high level of knowledge about HIV transmission. One possible explanation is the fact that university students had a greater opportunity for AIDS education than other young Nigerians such as secondary school students. This is so because several youths serving non-governmental organisations in southwestern Nigeria had targeted youths in tertiary institutions in the country. Unfortunately, however, only a few of the students practised what they knew given the proportion that used the condom inconsistently.

More students had carried a condom than those who had bought it. The poor incidence of buying and carrying a condom found in this study is consistent with the findings of Hayward (1995) in Britain, Wilson and Lavelle (1992) in Zimbabwe, and Akinyemi *et al.* (1996) in Nigeria. Many of the students had found it easier to carry than to buy the condom since the product is often distributed free of charge at seminars and workshops organised on the university campus.

Implications for a health education programme

The study had laid a foundation for developing appropriate intervention to address the risky sexual practices found among the university's female students. Two intervention strategies are proposed to influence the risky behaviour identified in this study. The first is a general education programme on STD/AIDS prevention which should be organised by the students' affairs unit of the university in collaboration with the health centre. Such education can also be provided through the General Education Studies, a compulsory course for all first-year students of the university. The main goal of the programme will be to reinforce the high level of knowledge of AIDS demonstrated by the students and correct any misconceptions that the students have about STD/HIV.

However, information alone is not always enough to influence risky behaviour. Therefore, a second intervention, which is peer driven, is proposed. This is appropriate in view of the sensitive nature of the behaviour to be promoted and the powerful influence of peers in influencing reproductive health behaviour among young people (Howard and McCable, 1992). Volunteers for the programme can be recruited from the halls of residence and the departments. Their training will include a factual component of STD/HIV/AIDS, skills required for assertiveness and negotiating condom use. Following training, the peer educators will conduct individual and group counselling and distribute educational materials. They can also be charged with retailing the female condom, the price of which must be subsidised in order to encourage students to use it on a large scale.

In conclusion, the results of this study showed that the university's female students had a high level of knowledge of how to protect themselves from infections with STD/HIV, unfortunately, many of them do not practice what they know. Although many had used the condom at some time, the product was not used consistently thereby increasing their risk of exposure to the negative outcomes of unprotected sex. A combination of a general education and peer education interventions are likely to equip the students with necessary information and skills needed to protect this population.

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