CONTRACEPTION AMONGST SENIOR SECONDARY SCHOOL STUDENTS IN IBADAN NORTH-EAST LOCAL GOVERNMENT AREA OF OYO STATE

BY

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DEDICATION

This work is dedicated to:

- the Almighty God who created and has been sustaining me throughout my sojourn on earth thus far,
- my wife - Taye and
- my children - 'Wale, 'Deola, Kunle and Tola who were denied the much needed fatherly care during the period of my course of study for this programme.

ABSTRACT

Over the recent years, sexual activities among students in Secondary Schools in Nigeria, particularly those in urban areas, are thought to be high and increasing. The resultant unwanted pregnancies and illegal abortions among these young unmarried population are creating social and health problems (Nichols, et al, 1986). According to previous research findings, included in the causative factors responsible for this unfortunate situation, are the problems of poor knowledge of Family Life (Sex Education) and Reproductive Health Education and Contraception, negative attitude towards contraceptive services, low and ineffective use of contraceptives due to low accessibility to family planning services. Therefore, the present Knowledge, Attitude and Practices (KAP) study was carried out in order to assess the level of contraceptive awareness and utilization amongst Students in Secondary Schools in Ibadan North-East Local Government Area of Oyo State.

After the pretesting, a total number of 766 questionnaires were finally administered to students in the Senior Classes in four (4) Secondary Schools in the Local Government Area using a combination of proportional stratified and systematic random sampling techniques. The selected four (4) schools consists of one Boys' only, Girls' only and two mixed schools. Out of this number,

a total of 744 duly completed questionnaires were subsequently analysed.

The result showed that 484(65.1%) respondents had the correct knowledge of some modern methods of contraception, and out of this figure, 183(37.8%) mentioned condom as a popular method of contraception among them. Although, attitudinal disposition of the respondents towards contraceptive use was as high as 76.0%, however, the results showed a very low level of contraceptive utilization among them (15.7%).

Based on these findings, it is suggested that Family Life and Reproductive Health Education including contraceptive counselling services should be introduced in the secondary schools in the L.G.A.

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CERTIFICATION

I certify that this work was carried out by Mr. CALEB ADEREMI ADEGBENRO, in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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CHAPTER ONE

INTRODUCTION

Teenage sexual activity is worldwide and the age of initiation is rapidly decreasing. The consequences of sexual behaviour of teenagers are an enormous burden on themselves and the society at large. These are due mainly to the little or no preparation and guidance they receive on developing responsible sexual behaviour. Developmentally, adolescents reach physical maturity before they are cognitively able to appreciate the consequences of their behaviour (Grant et al 1988). This assertion is in line with that of Liskin, et al (1985), when they reported that, "whether young people are called teenagers, adolescents, or youths, they face new problems because they reach sexual maturity before they have reached physical, emotional, social, or economic maturity and that permarital sexual activity among them is now assuming an alarming rate".

The most important consequence of the increase in adolescents' sexual activities in many developed and developing countries of the world today is the increase in births to unmarried teenagers and the proportion of abortion-seekers among the teenagers (Akingba et al, 1969, Roemer, 1985, Liskin, et al, 1985, Focus Column: West African Journal of Medicine, 1990, Barker, 1991).

Adolescent sexual activity with its attendants problem of teenage pregnancy has been recorded as risky because of its serious health, social and economic implications. As far as the health implication is concerned, sexual activity at any early age among the adolescents may lead to contracting sexually transmitted diseases (STDS) including that deadly Acquired Immuned Deficiency Syndrome (AIDS). Also, from many studies, a pregnant teenager, because she is not fully developed physiologically, she is at greater risk of having complications during pregnancy than a woman of 20 - 24 years and is several times more likely to die as result of these complications. In addition, a very young mother is also more likely to bear an under-weight baby which has a lesser chance of survival.

On the aspect of social and economic implications, for girls, the unmarried teenage mother faces social and economic risks in the sense that a student who is pregnant may be forced to give up her education or post-pone it because most Schools do not permit pregnant school girls to remain enrolled in Schools. Also, the teenage pregnant mother may find herself subsequently trapped in poverty, with limited scope for earning a living and perhaps little social support to cater for herself and the pregnancy. Similarly, on social and economic implications for the boys, young men also may suffer educational and economic consequences from early fatherhood, although not as serious as that of girls (Akingba et al, 1969, Liskin, et al 1985, Nichols, et al, 1986 and 1987, Focus Column, 1990, Ajayi, et al, 1991, Boohene, et al, 1991 and Odujinrin, 1991).

Some reasons responsible for the increase in teenage pregnancies have been suggested. One of them is that Family Planning Services have always been closed to them (adolescents) which is a problem that is not peculiar to Nigeria alone nor to Africa as whole, but is common to both developed and developing countries of the world. The resultant effect of their (adolescent) low accessibility to Family Planning Services is that it leads to poor knowledge of and as well as low and ineffective use of safer methods of contraceptives. This reason has been documented from the studies of both Focus Column (1990) and Odujinrin (1991).

Another reason is that the teenagers are not adequately given any form of formal Reproductive Health and Family Life (Sex Education) Education both in the home and in the School setting. From the research findings, the reason advanced for by some societies in denying youths (adolescents) this important aspect of Education (Reproductive Health and Family Life Education) is that since adolescents are still very young, they should not be exposed to it. Moreover, adults perceive sex as an act for only the adults which should be performed in privacy. Therefore, to these societies exposing teenagers to Reproductive Health and Family Life Education would amount to encouraging sexual immorality among them (Feyisetan, et al, 1989, Focus Column, 1990, Ajayi, et al, 1991 and Barker, 1991).

Therefore, the objective of the study is to make recommendations that can be used in addressing the problems of adolescent sexual activity and teenage pregnancy through the:

(a) introduction of Reproductive Health and Family Life (Sex Education) Education in Secondary Schools;

(b) extension of Family Planning and Contraceptive Counselling Services to Students in the Secondary Schools.

BACKGROUND TO THE SOCIAL PROBLEM

One of the big problems of the youth in our society today which is gaining the attention of a large segment of the populace, is the increasing wave of early sexual activities. The phenomenon is most common among the unmarried students, particularly those in the Secondary Schools in urban areas. In fact, studies show that as much as 68 percent of males and 48 percent of females attending Secondary Schools in Nigeria are sexually experienced by age 19. Resultant effect of this unfortunate trend of adolescents' high incidences of sexual activities are the escalated rate of unwanted pregnancies and illegal abortions which are creating both social and health problems. (Nichols, et al, 1986, Ibekwe, 1992). Osagie (1992), also supports this notion, when he said that the big problem in the society today is that of adolescents who are pregnant and

that since they are both mentally and physically unprepared for motherhood, they usually practice abortion as an alternative solution.

A number of explanation both social and biological were offered and documented by some researchers in order to explain this unfortunate trend in rising adolescents' sexual activities. And these explanations are neither unique to Nigeria alone nor to Sub-Sahara Africa, but they cut across both developed and other developing countries of the world. Included in these explanations are:-

(a) earlier on-set of menarche among females and earlier initiation of sexual activities. For example, studies around the world document a drop of one to two years in age at menarche. Better nutrition and quicker accumulation of body fat probably account for this decline,

(b) social changes, urbanization and modernization including increased educational opportunities. From previous studies, this can encourage sexual promiscuity among the adolescents,

(c) in adequate knowledge of Reproductive Health and Family Life (Sex Education) Education. As a result of this, the youths enter into sexual activities through experimentation, the act which often becomes uncontrollable among them when there is no proper guidance,

(d) low accessibility of family planning services by the youths (adolescents) which consequently leads to low and ineffective

use of contraception among them. Various research studies documented that this has led to adolescents engaging in unprotected sexual activities that many at times result into unwanted teenage pregnancies, and

(e) deterioriation of the traditional family - centred constraint on sexuality. Also from studies, this again can be a contributory factor to high incidence of adolescents' sexual activities. (Wyshak et al, 1982, Oronsaye, et al, 1983; Population Reports, 1985, Nichols, et al, 1986; Feyisetan, et al, 1989; Odujinrin, 1991 and Barker, 1991).

Although, this present study is not meant to encourage and promote indiscriminate sexual promiscuity among the youths (especially those in the secondary schools), yet it is intended to make contribution towards the development and implementation of Reproductive Health and Family Life (Sex Education) Education programmes in the Secondary Schools. It will also encourage the provision of contraception counselling and methods for those who need them among the youths. All these will go a long way in checking the rate of unwanted pregnancies among the students in Secondary Schools and as well as reducing the incidence of STDs including AIDS among them.

SIGNIFICANCE OF THE STUDY

Results of previous research studies on knowledge, attitudes and practices of contraception among senior Secondary School Students in some parts of Nigeria (both in the Southern and Northern Parts), especially in urban areas, revealed that the Nigerian adolescent has a very poor knowledge of, a prejudiced attitude to and relatively very low use of contraception (Ezimokhai, et al, 1981, Oronsaye and Odiase, 1983, Ekele, et al, 1989 and Odujinrin, 1991). For example, in one of these studies (Odujinrin, 1991), it was discovered that only 56(20.3%) of the sexually active girls in her study group used reliable family planning methods and about a quarter of them (68) did not use of any form of contraception. The majority (52.9%) used such unreliable methods as the rythm and withdrawal methods. Similarly, another study (Ekele, et al, 1989) revealed that only 41 percent of females and 30 percent of females that are sexually active in their study group used any means of contraception, and that most of the respondents engage in sequlae of unprotected coitus.

Therefore, the significance of this present study was to assess the level of contraceptive awareness and utilization amongs students in Senior Secondary Schools in Nigeria, using an urban L.G.A. in Oyo State as a case study. This will serve as baseline for providing health education strategies that can be used in the context of the

School Health Programme in addressing the problems resulting from unprotected sexual activities amongst the in-school youths.

In addition, this study hopes to provide answers to the following questions;

1. What are the barriers to contraceptive awareness and utilization among the in-school youths?
2. What are factors that promote contraceptive awareness and use among the in-school youths.
3. What is (are) the reason(s) why the youths do not always use reliable contraceptive methods.

SCOPE OF THE STUDY

This study is limited to the initial stage (needs assessment variable) of evaluation of health education programme. Hence, the study is confined only to the assessment of the level of contraceptive awareness and utilization amongst Senior Secondary School Students in urban areas. It will also document information that can be used in promoting the use of reliable contraceptive methods in order to check the rate of unwanted pregnancies and illegal abortion and incidences of STDS including AIDS among the youths in Ibadan North-East Local Government Area.

CHAPTER TWO

LITERATURE REVIEW

This chapter touches the following areas:-

(i) A brief outline of the nature and magnitude of the problem of sexual activity among the youths, and consequences of this spurious sexual activity;

(ii) Factors responsible for the increasing sexual activity among the youth;

(iii) Factors inhibiting or promoting contraceptive awareness and utilization among the youths;

(iv) The role of knowledge of reproductive health and family life education in promoting contraceptive awareness and utilization among the students; and

(v) The School Health Programme and its role in the implementation of Reproductive Health and Family Life Education in Secondary School.

Nature of the Problem

The issue of pre-marital sexual activity among the youths, a problem that cuts across both developed and developing countries of the world is now assuming an alarming rate which is increasingly attracting the concern and anxiety of parents, medical professionals,

school personnel and policy makers. Recent studies have revealed that the age of initiation of sexual activities by the youths is now diminishing because of decrease in age of menarche which is now discovered as being a drop of one to two years. Reports from most countries show that the average age at menarche among girls is now 12 to 14 years, while sexual maturity in boys, as judged by emission of sperms, has been estimated to occur at an average age of 14. Better nutrition and quicker accumulation of body fat has been suggested to probably account for this decline in age at menarche and sexual maturity (Gyepi-Garbrah, 1985 and Population Reports, 1985).

The results of research studies on the extent of premarital sexuality among youths show that in the late 1970's in the U.S., the Netherlands, France, and England and Wales, 40 to 50 percent of girls had had intercourse by age 17, and in Sweden, about 80 percent. Also, surveys of unmarried young women in Urban Nigeria and Liberia found that 50 to 60 percent were sexually active by age 19. And in more recent studies, 45 percent of pregnant teenagers in Kenya had their first sexual experience by 15, and in Nigeria too, 48 percent of female are sexually experienced by 19 (Woods et al; 1985, Nichols, et al, 1986, Ajayi et al, 1991 and Daily Times, June 9, 1992). The prevalence of reported premarital sexual activity varies with gender and socio-economic status. In almost all areas, at any given age, males are more likely to have had intercourse and they report starting sexual

activity at an earlier age than females. Also, young men usually report having more sexual partners and having intercourse more frequently with casual acquintances. Several recent surveys focussing on young unmarried males and females of reproductive age yeild valuable data that support the claim of high incidence of sexual activity among males. For example, in Mexico city, 42 percent of boys age 15 - 19 reported that they were sexually experienced compared with 8 percent of girls. In Monrovia, Liberia, 62 percent of boys age 14 - 17 were sexually experienced compared with 46 percent of girls. And in Ibadan, Nigeria, 49 percent of 16 -19 year old boys reported premarital intercourse compared with 28 percent of their female counterparts. Furthermore, in a more recent study, in Nigeria, as much as 68 percent of males compared with 48 percent of females attending Secondary School are sexually experienced by age 19. On socio-economic determinants, studies have shown that premarital intercourse is usually more common among poorer and less educated young people (Zelnik et al, 1980, Kozakiewicz, 1981, Woods et al, 1985, Morris et al, 1985, Nichols et al, 1986 and Daily Times, June 4, 1992).

Consequences of Sexual Activities Among the Youths

The increasing wave of sexual activities among the youths in general and the in-school youths in particular nowadays, which in

most cases are performed in unprotected manners have been found to be associated with a lot of problems that can be classified into two major groups:- these are; (a) Medical/health problems and (b) Social and economic problems (Population Reports, 1985).

Medical/Health Problems (Implications)

As far as health problems is concerned unprotected premarital sexual unions among the unmarried people gives rise to increased number of unwanted pregnancies with its resultant effect of illegally induced abortion and high incidence of STDs including AIDS. High rates of unwanted pregnancies and illegal/induced abortions among the adolescent girls, especially the in-school ones in the urban areas have been reported by many research studies from both developed and developing countries of world, such as Austrialia, Britain, U.S., Mexico City, Kenya, Zimbabwe, Nigeria and some other countries in Sub-Saharan Africa (Akingba, 1969 , Zimbabwe Reproductive Health Survey, 1984, Nichols et al, 1986 and 1987, Barron, 1986, Alexander et al, 1987, Marciak et al, 1987, Weiss et al, 1991, Demographic and Health Surveys, 1992 and the Guardian, June 18, 1992).

Illegal abortion among the youths has been found to constitute a serious public health problem. Reports from previous studies, for example, show that induced abortion is the leading cause of admission to the emergency gyneacological ward in many hospitals world wide.

In one of such studies, it was shown that more than 115,000 abortions, most of them illegal, are performed among the young girls in Austria-lia every year. Also, about 434,000 adolescents terminate their pregnancies with an abortion in U.S. every year. Again, from recent studies, it was revealed that over half the pregnancies in girls under 16 years of age in Britain and America ended in induced abortion and those that continued had increased maternal and perinatal mortality (Allan Guttmacher Institute, 1980, Barron, 1986, Marciak et al, 1987).

Similarly, studies have shown that illegally induced abortion are very common among young women in Africa where contraceptives are not readily available, particularly to young unmarried ones. Hospital statistics from cities in Kenya, Liberia, Ghana, Mali, Gambia, Zaire and Nigeria among others, show that 38 to 68 percent of women hospitalized with abortion complications were 19 or younger (Population Reports, 1985). In the Liberian survey in 1985 for example, 18 percent of sexually active women age 21 or younger reported that they had had at least one induced abortion. In Kenya, in 1980, it was recorded that about 60 percent of abortion cases reported at Kenyatha National Hospital in Nairobi were under the age of 20. In Ghana, in 1985, 46 percent of 160 women age 19 or younger giving birth at Korle - Bu Hospital reported that their first pregnancy had ended in induced abortion. In Nigerian Survey in 1983, 41 percent of sexually active women age 14 to 25 reported that they had had induced

abortions. Also in another Nigerian study in 1983, involving 530 school girls, 30 percent said that they had had illegal abortion. Finally, a recent study in Nigeria in 1991 showed similar revelation that abortion is one of the leading causes of maternal mortality in Nigeria and other parts of Africa. (Allan Guttmacher Institute, 1980, Oronsaye et al, 1983, Aggarwal, 1980, Woods et al, 1985, Lamptey et al, 1985, Nichols, et al, 1986 and 1987, Gambia Family Planning Association, 1988 and Odujinrin, 1991).

Another dimension of medical implication of early pregnancy among the young women is the health risks to both the young pregnant mother and the baby in her womb. Studies around the world have proved that young women face greater risks of obstetric complications and are more likely to die during pregnancy and child birth than women in their 20s. The risks are greatest for the very poor, who have the worst diets and the least opportunity for prenatal care. The major life-threatening complications for the very young mothers are pregnancy - induced high blood pressure (also called pre-eclampsia, toxemia, or, if seizures occur, eclampsia), iron-deficiency anemia, and cephalopelvic disproportion (when the infants head is too large to pass easily through the mother's pelvis). In a recent survey in Nigeria, Ransome-Kuti (1991) pointed out that 50 percent of maternal deaths in clinics and hospitals were accounted for by teenage pregnancies. Also, according to Olukoya (1992), pregnant

teenage girls run an increased risk of prolonged obstructed labour, eclampsia, raised blood pressure and fits), haemorrage which very often leads to death and a higher rate of instrumental delivery. Again, she (Olukoya, 1992) pointed out that research has shown that pregnancy in young teenage girls, especially those below the age of 18 years, carries a higher risk of death to the mother and child (Arkutu, 1978, Allan Guttmacher Institute, 1980, Mocrman, 1982, Odujinrin, 1991. The Punch August 16, 1991 and Guardian, June 18, 1992).

In case of health risk of the baby, reports around the world (both developed and developing countries) reveal higher rates of low birth weight, prematurity and neonatal and infant mortality in children of young mothers than in children born to women age 20 - 29. For example, World Fertility Survey (WFS) data for 35 countries of Africa, Asia, Latin America, and the Carribean show that mortality rates are consistently higher among infants of young mothers under age 20, than among infants of mothers age 20 to 29. Olukoya (1992), in a recent interview in Nigeria supports the above claim, when she pointed out that, babies of young teenagers tend to be born earlier and are smaller, and such babies have a higher morbidity and mortality rate (Lawrence et al, 1983, Harroson et al, 1984, Rutstein, 1984, Marciak et al, 1987, The Guardian, June 18, 1992).

Social And Economic Problems/Consequences

High rate of early sexual activities among young unmarried people, especially the in-school youths, in addition to its health risks, equally has a very deep rooted social and economic consequences. The effect is mostly felt among the school-girls, because they are always at the receiving end in the sense that they are the ones who will pay the penalty of the resulting unwanted and unplanned pregnancies. According to the previous research findings, included in the social and economic consequences among others are:- (a) problem of limited educational opportunities, (b) limited job opportunities, (c) limited choices for the future, (d) a high degree of dependency, and (e) psychological depression in terms of feeling quilt, and ashamed which gives rise to 'baby dumping' or child abandonment.

The problem of limited educational opportunities as documented in many literatures has a far reaching effect on most of the school-girls in developing countries, because school-girls in Secondary School who become pregnant almost always leave school, whether or not they are married. This is so because most schools in these countries especially in African countries do not allow pregnant mothers to remain enrolled in schools. Therefore, their (pregnant school-girls) education have to be truncated or postponed until after delivery. But, many young girls resort to dangerous illegal abortions

to avoid leaving school. In 1983, a Nigerian study of 127 pregnant school-girls, found that, 52 percent were expelled from school, 20 percent were too ashamed to return, 15 percent could not return because their parents refused to pay their tuition and 8 percent were forced to marry. Similarly, in Kenya, pregnancy forces about 10 percent of the girls enrolled in Secondary Schools to drop out each year. And, in Swaziland about 5 percent of female students in urban schools and 6 percent in rural schools become pregnant each year. Also, in 1985, about 80 percent of Swazi girls who drop out of school leave because of pregnancy. Furthermore, results of recent studies carried out in some countries such as Nigeria, Zimbabwe, Tanzania support the claim that pregnant school girls usually have their education being distrupted as result of unwanted pregnancy (Oronsaye et al, 1983, Khasiani, 1985, Family Life Association of Swaziland (FLAS), 1984, Gule, 1985, Ferguson, 1988, Boohene et al, 1991, Barker, 1991, and Daily Times. June 4, 1992).

From all indications and available data, limited education opportunities will obviously lead to limited job opportunities which will in turn about high degree of dependency for economic sustanance. This so because education in most developing countries is an agent of upward social mobility and a means of attaining high economic status. Studies have proved that in most of the developing countries young mothers are often poor because they are not married

and have no husbands to help support the family. Also, these group of people are found to be living in poorer homes and have limited job opportunities because of low qualification. Hence, they may find themselves subsequently trapped in poverty with limited scope for earning a living and perhaps little social support. In some instances, these young unmarried mothers may be forced to turn prostitution to support themselves and their children (Engle, 1978, Jean-Bart, 1985, Gule, 1985, Focus Column, West African Journal of Medicine 1990 and Barker, 1991).

Another area of social consequence of unwanted pregnancies among young girls that attracts public health concerns is the problem of increased rate of child abandoment or "baby dumping". In Zimbabwe, in 1991 for example, a study carried out revealed that there is an increased newspaper coverage of episodes of "baby dumping" and abandoning new-born babies and infants. A similar study in 1989 in Nigeria supports this claim of incidences of abandoment of children by the adolescent mothers. Also, another study in 1991, supports the problem of child abandonment or baby dumping among young women in major African cities.

And a more recent survey in Nigeria reveals that there are high incidences of "baby dumping" among the Nigerian young mothers nowadays (World Population Reports, 1985, Feyisetan et al, 1989, Boohene et al, 1991, Barker et al, 1991 and Daily Times, February 26, 1992).

Factors Responsible for Increase In Sexual Activities Among Youths

According to numerous research studies, a number of explanations both social and biological, have been developed to elucidate the phenomenon of modern day sexual activities among the unmarried youths especially the in-school youths in urban areas. And these explanations have been found not to be unique to Nigeria nor even to sub-Saharan African (Nichols et al, 1986, Population Reports, 1985, United Nations, 1989, and Ajayi et al, 1991). Included in these factors among others are: viz;

(a) Rapid biological development among the youths nowadays as regards their reproductive organs;

(b) A lengthening of the socially defined period of adolescence due to increased educational opportunities;

(c) Social change and modernization which lead to a deterioriation of the traditional family - centred constraints on sexuality, and

(d) Mass media entertainment and advertisement and effect of peer group pressure.

(a) Rapid Biological Development:

According to Omoluabi (1992), increase in sexual activities among the youths could be as a result of biological development which he said might be to the advantage of some girls. This development, he (Omoluabi) believes, comes out of excessive secretions of some sex hormones which might improve the girls sexual desires and hence, might make them engage in sexual intercourse earlier than less precocious ones. This assertion of Omoluabi is identical to the findings from previous research studies which discovered that earlier on set of menarch among females and early sexual maturity in boys could be responsible for increase in sexual activities among the youths (Sogbanmu et al, 1979, Wyshak et al, 1982, Gyepi - Garbrah, 1985 and Population Reports, 1985).

(b) A Lengthening of the Socially Defined Period of Adolescence

The period of adolescence has been found to be a time of experimentation and a time of intense friendship among both sexes, and such relationship many times involves sexual intercourses which is forbidden by families and religious institutions. Such sexual unions are contracted in unprotected manner (that is without the benefit of contraception) which often lead to unwanted pregnancies (Lancaster, 1978, Oronsaye, et al, 1982 and Akinboye, 1983). Studies from developing countries especially in Nigeria and some other African countries have shown that

young people are now facing a longer period of transition from adolescence into adulthood because of the educational opportunities that avail to them. The reason for embracing the Western education in these developing countries is because education has become the vehicle for moving within one generation, from peasantry and poverty to the topmost ranks of society. This quest to acquire education has forced the youth to migrate to urban areas and perpetuate all forms of youthful desires (exhuberance) including premarital sexual activities (Population Reports, 1985 and World Bank, Education in Sub-Saharan Africa, 1988).

(c) Social Change and Modernization

The effect of social change and modernization on the premarital sexual activity among young people has been underscored by various research finding. World Population Reports (1985), for example, recorded that throughout the world, where rapid urbanization and modernization are occuring, young people are breaking away from constraints applied by their families and communities. This findings is identical to a recent finding in Nigeria by Odujinrin (1991), where it was reported that urbanization and modernization has led to changes in moral standard of the youth in favour of permissiveness, poor censorship of video films and foreign magazines that encourages sexual promiscuity among them. Similarly, Feyisetan et al (1989) also

documented that Nigeria Society has undergone marked social change and that premarital sexual behaviour appears to be more common among women who experienced non-traditional background as a result of urbanization and modernization. Studies from other parts of the world especially countries in Sub-Saharan African support the claim of increasing sexual activities among the youth as one of the consequences of urbanization, social change and modernization in the present day society (Mickay, 1983, Sarwono, 1983, Gule, 1985, Nichols et al 1986 and 1987, United Nations, New York, 1986 and 1988, Windokun, 1979, Fried man, 1985, Barker et al, 1990 and Ajayi et al 1991).

(d) Effect of Mass Media and Peer-group Pressure

Studies have proved that mass media entertainment and advertisement are filled with presentations of sex as glamorous, exciting and risk-free (that is a hobby with unrealistic or no consequences). Also, sex is seen as a pastime of the popular and affluent. Furthermore, rock music and other youth-oriented entertainment often seem designed to be sexually stimulating (Kreipe, 1983, Furstenberg et al, 1985 and Odujinrin, 1991).

As far as peer-group pressure is concerned, it was reported in a recent survey that, interaction with bad company is a most likely cause of teenage moral laxity including sexual promiscuity among the youth. Also, in the same survey, teenage girls are exposed to all forms of sexual advances from their mates in

School. And these people (peer-groups, and school mates) are said to resort to blackmail or excessive pressure that often times compels them (girls) to cave in to such immoral practices and requests (Omoluabi, 1992).

Knowledge, Attitude And Practice Of Contraception Amongst Unmarried Students in Secondary Schools

Knowledge of Contraception:

Students in Secondary Schools in Nigeria as in some other parts of Africa as a developing nation have been found to have poor knowledge of contraception. A survey conducted in Nigeria, in 1986 for example, 45 percent of the sexually active school-girls who had been pregnant, most often cited lack of information as the reason for non-use of contraception. Also, sexually active young men in the same study group cited this reason most often. In a similar study conducted in Kenya in 1985, of more than 100 Kenyan school-girls who became pregnant, 65 had never received any information about contraception. And in a more recent study in Kenya in 1991, the majority of respondents in the study group cited lack of information as the primary reason for non-contraceptive use. Also, in Zimbabwe in 1991, it was actually discovered that out of those who claimed recognition of at least one method of contraception, the percentage of young people who cited no knowledge of family planning method as their reason for non-use of contraception was high. Coming back to Nigeria, in a more recent

study conducted in 1991, it was discovered that, the Nigerian in-school teenager has very poor knowledge of and a prejudiced attitude to contraception. Findings from other countries like Liberia, Tanzanian, Gambia and Zimbabwe show identical results that majority of sexually active in-school youths cited lack of knowledge of contraception as the primary reason for non-use (Khasiani, 1985, Woods et al, 1985, Nichols et al, 1986 and 1987, Mbunda et al, 1987, Odujinrin, 1991, Boohene et al, 1991 and Ajayi, et al, 1991).

Attitude Towards Contraceptive Use:

In spite of the reported general poor knowledge of contraception amongst the young unmarried people, majority of those surveyed in many studies in Sub-Saharan Africa were found to favour contraceptive use. A study conducted in Ibadan, Nigeria, in 1986, for example, showed that the majority of those surveyed in the study group said that unmarried adolescents should use contraception if they are having sexual relations. Also, a similar study recently carried out in Jos, Nigeria, in 1989, reported that majority of adolescents (that is 70 percent) in the in - school study group said they will recommend contraception for unmarried partners. Studies from some other countries in Africa such as Kenya, Liberia and Tanzania yeilded similar results (Oronsaye et al, 1983, Woods et al, 1986, Nichols et al, 1986 and 1987, Mbunda et al, 1987 and Ekele, et al, 1989).

Contraceptive Practices:

Contraceptive use among the youths have been found to be low world wide. Even in developed countries where there is an improved extension of contraceptive services to the youths, contraceptive utilization among them is still very low especially during first sexual intercourse. For example, in U.S., Mexico city and West Germany, surveys found that 50 to 60 percent used no contraception the first time. Even after the first time of sexual union, young people are slow to seek protection from unwanted pregnancy. In another U.S. survey of 1,200 young clients of family planning clinics, 78 percent waited at least three months after their first sexual encounter before coming to clinics. The most common pattern was to delay almost one year. Thus, those most likely to risk becoming pregnant are those who would face the gravest consequences from unwanted pregnancy (Husskein, 1979, Zabin et al, 1981, Zelnik et al, 1983 and Morris et al, 1985). In a recent study, Gordon (1987) reported that fewer than one in seven U.S. teenagers use a reliable form of contraception the first time they have sex. It usually takes teenagers about a year after initiation of sex before they use contraceptives. Similarly, Johns Hopkins researchers found out that only about one in three sexually active American girls uses contraceptives at all. Those who use also do not use them consistently and correctly (Time Magazine, December 9, 1985). Coming to developing countries,

especially Sub-Saharan Africa in general and Nigeria in particular, where contraceptive services are not adequately extended to the youths, several surveys reported a very low patronage of contraceptives devices among them. For example, in Monrovia, Liberia, a survey conducted by Woods et al (1985) found that only 45 percent of female students age 14 - 17 who were having sexual relations at least once a month feported ever using contraceptives, while 37 percent were currently using contraception. In the same survey, among sexually active girls who had left school, only 14 percent had ever used contraception, and 12 percent were current users. Results were similar for males of the same age from the same survey. In Nigeria, similar surveys conducted in some parts of the country also revealed that majority of the sexually active students in Secondary Schools engage in sexual unions without the benefit of any reliable contraceptive devices which consequentially leads to high rate of unwanted pregnancies among them. In one of such survey. Odujinrin (1991) reported that only 20.3 percent of the sexually active girls in the study group used some form of reliable family planning methods. (Ayangade, 1982, Nichols et al, 1986, Ekete et al, 1989, Demographic and Health Surveys, 1992). Similar surveys conducted in other countries in Africa such as Kenya, Zimbabwe, Tanzania, Uganda, Gambia and Botswana yeilded identical result of poor contraceptive utilization among the youths (Mbunda et al, 1987, Kane et al, 1988, Agyei et al, 1990, Boohene et al, 1991, Ajayi et al, 1991 and Demographic Health Surveys, 1992).

Factors that Inhibit or Promote Contraceptive Awareness And Utilization Among Unmarried In-School Youths

Since contraceptive awareness and utilization among the youths has been documented as being generally very poor and too low across the world, the author will only examine the factors that serve as inhibition (barriers) to contraceptive awareness and utilization among these group people especially the in-school youths.

Barriers to Contraceptive Awareness

It is a generally held belief that adequate information about something will automatically enhance proper knowledge about it. Therefore, according to many research findings, the major barrier to contraceptive awareness among the youths especially in Africa and some other developing countries of the world is lack of information about and limited accessibility to family planning and contraceptive services (Population Reports, 1985, Nichols et al 1986 and 1987, Pick de Weiss et al 1988, Ajayi et al, 1991, Barker et al, 1991 and D.H.S., 1992).

Isaac et al (1984) supports this claim when they reported that, most laws in developing countries restrict young people's access to family planning information and services much more than they restrict that of older men and women. In Nigeria, Nichols, et al (1986) reported that most non - users of contraceptives in their study group said they weren't using a method because of lack of information about family planning methods. Also, the same study (Nichols et al, 1986)

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reports that provision of contraceptive services to adolescents in Ibadan, Nigeria, is limited because existing government and private programmes are not targeted to the young unmarried population. Similarly, a recent study in Mexico city, found that family planning services are often perceived (sometimes realistically) as inaccessible to the young unmarried people (Nichols et al, 1986 and Pick de Weiss et al; 1988c).

Barriers to Contraceptive Utilization Among the Youths

A number of factors have been found to be militating against contraceptive use among young unmarried people - one that is neither unique to Nigeria nor even to sub-Saharan Africa (Linderman, 1974, Clinkscales et al, 1976, Liskin et al, 1985, Time Magazine, December 9, 1985, Nichols, et al, 1986, Barker, et al, 1990, Ajayi et al, 1991 and Boohene et al, 1991). Included in these factors among others are following:-

(1) Lack of information and poor knowledge of contraception:

In the process of adoption of a new innovation "collection of information", is the second stage of the five stages developed by MacDonald et al (1984). According to them (MacDonald et al, 1984), information collected by an individual will increase his knowledge of the new innovation to be adopted and this will enable h to analyse and arrive at conclusion that will lead him to advantages disadvantages which will influence his adoption or rejection of it i

the final stage. Therefore, relating this theory to contraceptive use among the youths, adequate information about it can ignite a chain of reaction that may eventually lead to this final adoption of contraceptive methods. But this is not so, because youths have been found to lack information and have poor knowledge of contraception. In fact, several research findings proved that lack of information and poor knowledge is the leading reason for non - use of contraceptive among the youths in Nigeria and some other countries in Africa in comparison to what obtains in some of the developed countries of the world (Liskin, et al, 1985). For example, in Nigeria Nichols et al (1986) reported that lack of information about family planning and inadequate knowledge of contraceptives were the most common reasons for non-use of contraception given by those not using a method in their study group. And in a recent survey conducted by DHS (1992) in Nigeria and some other countries in Sub-Saharan Africa, lack of knowledge of contraceptive was one of the reasons cited for non-use of contraception among the youths. Other studies from Liberia, Kenya, Zimbabwe yeilded identical result of poor knowledge of contraception by non - users of contraceptives among the unmarried youths (Nichols et al 1987, Ajayi et al, 1991, Boohene, et al, 1991 and D.H.S., 1992).

(2) Limited Access to Contraceptive/Family Planning Services

This barrier is another important barrier that is peculiar to Africa in general and Nigeria in particular in recent times. Barker et al's Survey (1990), reports that one of the chief barriers to higher contraceptive use by teens in Africa is lack of access. And according to the Survey (Barker, et al, 1990), this barrier arises as a result of strong resistance on the part of governments, parents and service providers in Africa in promoting contraception among unmarried youths. The survey goes further to say that in some of these countries, this reluctance has been turned into a ban or limit on adolescent access to contraception. This findings was in line with that of Ajayi et al's (1991) study, where it was reported that granting of access is currently opposed in Kenya by policy makers, parents, community leaders, and even many service providers. And in another survey of programmes working in teen pregnancy prevention in Latin America, Asia and Africa, African programmes reported the lowest rate of contraceptive provision to unmarried youths (Baker et al, 1991). All these findings were similar to the earlier one obtained in a Nigerian Study, (Nichols, et al, 1986). In this study (Nichols, et al, 1986), it was reported that the provision of contraceptive services to adolescents in Ibadan, Nigeria is limited and that existing government and private programme are not targeted to the young unmarried population. As a consequence,

those with adequate means (and sufficient information and motivation) make use of the commercial sector like private physcians and pharmacies. Furthermore, recent studies find that Nigeria, like many other developing countries still provide inadequate family planning services to their teenagers (Ekele et al, 1989 and Odujinrin, 1991).

The problem of low accessibility of adolescents to contraceptive services in Nigeria arises as a result of opposition from parents, community leaders and as well as the society. Worried by this situation, Ransome-Kuti (1991), while addressing a conference, urged Nigerian parents to allow their daughters access to contraceptive services to arrest the high mortality rate resulting from teenage pregnancies (The Punch, August 16, 1991).

(3) Problem of Affordability:

Another barrier to contraceptive use among the youth is the problem of affordability of contraceptive devices. Schearer's (1981) study revealed that young people cannot afford any reliable method of contraceptives because of little or no income of their own. In developing countries, where these contraceptives had to be imported, the cost of purchasing them from the manufacturing developed countries may compound the youths' problem of affordability. For example, around 1980 the cost of a year's supply of Oral Contraceptives (OCs) in 20 developing countries ranged from about $6 (U.S.) in Egypt to about $90 in Nigeria. In Nigeria

this would have amounted to 22 percent of the average annual per capital income (Schearer, 1981). It should be noted that the current economic stagnation would likely worsen the situation in Nigeria.

The problem of affordance of contraceptive methods encountered by young unmarried people is also reported in identical research studies from Kenya, Zimbabwe and Liberia (Woods et al, 1987; Ajayi et al, 1991 and Boohene et al, 1991).

(4) Safety Concerns:

Safety concerns as a barrier to contraceptive use among the youths have been documented by a lot of research studies. In Liskin et al's (1984) study, for example, it was reported that mistaken notions about modern contraceptives are widespread among the young as they are among older people, hence its consequence in lowering rate of its (contraceptive) use among them (young unmarried people). Also, in a U.S. survey (Reichelt et al, 1975), it was reported that nearly half of girls interviewed thought that condoms can break easily and thus are ineffective. Similarly, unfounded fears about side effects of contraceptives are common among the youths, and these fears have been documented to lead sexually active young people to risk unwanted pregnancies. In Campinas, Brazil, 88 percent of young unmarried women giving birth in a teaching hospital had never

used contraception and fear of side effects was the major reason given by them. And in a U.S. study, 27 percent of sexually active young women delayed coming to family planning clinics because they thought that contraceptives were dangerous (Zelnik et al, 1979, Herold et al, 1981, Jagdeo 1981, Zabin et al, 1981, Zelnik et al, 1984).

In Benin City, Nigeria, a study conducted in 1983, revealed that over 70 percent of girls interviewed at a Secondary School thought contraceptives would harm their health and cause infertility. Also, another Nigerian Survey, in 1983 revealed that the second most often cited reason for not using contraceptives was concern about their safety. Furthermore, a more recent study in Nigeria reported that most females in the study group gave concern about safety as being the reason for non-use of contraceptives (Oronsaye, et al, 1983, Nichols, et al, 1986 and Ekele et al, 1989).

Studies from other African countries like Zimbabwe, Liberia and Kenya yeilded similar results (Nichols et al, 1987, Ajayi et al, 1991 and Boohene et al, 1991).

(5) Lack of cooperation from the male partner is another inhibitive factor to contraceptives use among the youths. In the study of Clinkscales et al, (1976), it was reported that a girl who knows much about birth control might arouse suspicion in the male part-

ner who may think she has been having affairs with other males. Liskin (1985) also reported that some men refuse to use contraceptives, some object to their partners' using them; and some simply do not think about contraception at all or discuss it with their partners. All these are due to the reason given above by Clinkscales (1976). Similar studies from Nigeria reported objection from male partners as one of the barriers to contraceptive among the youths (Oronsaye, et al, 1983, Nichols, et al, 1986 and Ekele et al, 1989).

(6) Another factor is that sex is mainly unprepared and unplanned for. According to Linderman (1974), the state of unpredictability of not knowing if and when sexual intercourse will take place inhibits the use of birth control especially by the youths. A corollary to this nowadays, is that most teenagers are already high on alcohol and drugs at the period of coitus and are therefore in no position to take decision on the use of contraceptives (Population Reports, 1985).

(7) Another barrier to contraceptive use is the notion that its use destroys the spontaneity in sex, thus prior preparation would interfere with the romantic aspects of sex (Akande, 1991).

(8) Poor knowledge of Reproductive Health and Family Life Education is another inhibitive factor which is of notable importance. Several studies have explained that the non-use of contraceptives

by youths is due to their lower level of cognitive development in the aspect of reproductive health and family life education (sex education). In one of such studies, it was reported that as a result of poor knowledge of reproductive health, many young people believe that pregnancy cannot occur if they are very young, or if they are having sex for the first time, or if they have intercourse infrequently. Few of them realise that the chances of pregnancy may be as high as one in three if intercourse takes place at the time of ovulation. In addition, some young people are reported to believe that they have special immunity to unwanted pregnancy if they have sex, hence they are always reluctant to use contraceptive during the act (Siedleckly, 1979, Jagdeo, 1981, Zabin et al, 1986 and Hofferth, 1987a).

Studies have also found that many youths could not describe correctly where the fertile part of the menstral cycle occurs. For example, Clark (1982) et al's study showed that among almost 700 black male Secondary School students in the U.S., only 10 percent know that a woman's fertile period occurs roughly midway between menstrual periods (Siedlecky, 1979 and Zabin et al, 1981).

Reports of similar studies carried out in Nigeria and some other African countries such as Kenya, Liberia and Gambia found that young unmarried people have poor knowledge of reproductive health and family life education (Nichols, et al, 1986 and 1987, Gambia Family Planning Association, 1988, Ekele et al, 1989,

Odujinrin, 1991 and Ajayi et al, 1991). In the study of Ekele et al, (1989) in Nigeria for example, only 10 percent of their study have the correct knowledge of reproductive health matters and that majority of them (90 percent) would wish to be properly educated on at least some aspects of reproductive health.

Therefore, from all available research findings stated above, it is evident that there is a close association between poor knowledge of reproductive health and family life education and low contraceptive use among the in-school unmarried youths.

Role of Knowledge of Reproductive Health and Family Life (Sex Education) Education In Promoting Contraceptive Awareness and Use Among the Youths

Realising the importance of knowledge of reproductive health and family life (sex education) education in steming down the rate of unwanted pregnancies among the youth, the International Conference on Population, during the meeting held in August, 1984 passed one recommendation that was directed to the needs of adolescents. This recommendation reads thus; "Governments are urged to ensure that adolescents both boys and girls, receive adequate education, including family-life and sex education, with due consideration given to the role, rights and obligations of parents and changing individual and cultural values. Suitable family planning information and services should be made available to adolescents within the changing socio-cultural frame work of each country" (United Nation, 1984).

After this recommendation, despite the fact that it became controversial by generating criticism from the society at large, some countries (both developed and developing countries) all the world over started to intensify their existing programmes of incorporating family life education (sex education) and family planning services to adolescent to Secondary Schools' curriculum. The controversy about it makes the extent of family life or reproductive health education in the formal school system to vary greatly, even within countries. For example, in both Europe and U.S., local governments usually control the content of courses. And in most Northern and Western countries, sex education (family life education) courses are required by national law and this law makes it to be taught in a cursory fashion (Kozakiewicz, 1981, Kenney et al, 1984, Lewin, 1984, Sonenstein et al, 1984 and Marsh, 1987).

Another consequence of the controversy is that some countries such as Pakistan and Bangladesh have modified their programmes by avoiding any reference to contraception, whereas others such as China, Hongkong, Thailand and U.S. include information about contraception in their own programme for the youths (Fraser, 1985, WHO, 1980, and Zabin et al, 1986).

According to some studies, one of the reasons for the society's opposition to giving family life education (sex education) to the youths is that it may give rise to sexual promiscuity among them.

But contrary to this notion, most research studies report that sex education courses do not lead to sexual experimentation or promiscuity among the youths, rather it does increase their knowledge about human sexuality and how to avoid unwanted pregnancy (Parcel et al, 1979, Zelnik et al, 1982 and Kirby, 1984). And in a more recent study, it has been found that witholding sex education (family life education) and family planning services has not led to less teenage sexual activity in the United States, neither has the provision of needed information and services in Europe and Canada resulted in increased sexual activity, but in heightened sexual responsibility (Edelman et al, 1986 and Berger et al, 1987).

In Nigeria, like many other countries in Africa, the christian traditions of the colonial powers coupled with the deep-seated adult discomfort and taboo of discussion of adolescent sexuality have been documented to be a major obstacle to implementing family life education in Schools. Also, this adult discomfort and taboo is at the root of laws and policies prohibiting the distribution of family planning information and methods to unmarried adolescents (Barker et al, 1990). The effect of the opposition of the adult to family life education is negatively reported to affect the in-school youths in Nigeria when the students in a study group said they received scanty information about reproduction in biology class.

Also in the same study group, one young man in a Secondary School in Ibadan was reported to say; "It is easier discussing it (sex) with young people because the older people want to know where you first heard about it and from whom. They shut us up and say that we want to start doing 'isekuse' (bad things) before growing up" (Barker et al, 1991).

Therefore, in Nigerian situation, like in most countries (especially developed ones), the implementation of family life education should be seen as a proper effort being made to promote contraceptive awareness and use among the youths. This will help to address the problem of ignorance of human reproductive health that sometimes make the youth to engage in unprotected sexual activities that leads to increasing rate of unwanted, pregnancies among them (Nichols, et al, 1986 and Odujinrin, 1991).

In conclusion, the truth about this situation is that whether or not the youths are denied knowledge of human reproductive health and family life education they will eventually discover it by gathering information from misleading sources like peer groups, friends, pornographic materials, video films etc which will automatically lead them to fall into great mistake. Also, from studies, majority of these youths are in their adolescence age, which has been documented as a period of experimentation of many things including sexual activities (Lancaster, 1978, Oronsaye et al, 1983 and Focus Column: West African Journal of Medicine, 1990).

The School Health Programme and Its Role In The Implementation Of Reproductive Health And Family Life Education in Secondary School

The school health programme embodies the total school programme in health. It involves all health activities that are planned, organized and conducted by the school and under the jurisdiction of the school (Cornaccohia et al, 1974). According to Ademuwagun (1969), it includes all the activities undertaken at school to influence the knowledge, attitude and behaviour of the school age children and the school teachers with regards to their personal and Community Health.

School Health programme is divided into four inter-related phases. These are: School Health Instruction; Healthful School Environment, School Health Services and Home, School and Community Cooperation for health (Nemir et al, 1975 and Ademuwagun et al 1986). Out of these four phases, the School Health Instruction is the one that is directly related to reproductive health and family life education because it is concerned with formal planned classroom teaching in health to prepare students and teachers to make proper decisions throughout their lives on matters affecting their health (Anderson, et al 1976).

Relating this to reproductive health and family life education therefore would involve given correct information to students in respect to how their reproductive organs function and as well as prevention of unwanted pregnancies through the use of contraceptive

devices. This is aimed at influencing their knowledge, attitude and behaviour towards their reproductive organs and making responsible decision on sexual behaviour. Similarly, school health education also involves (apart from conducting survey) the development of curriculum for students, in which family life and reproduction health education should be included. An important aspect of this phase involved the provision of health instruction resources such as material and human resources. Services of resource persons like doctors, nurses and family planning service providers could be employed from time to time to give lectures to students and teachers on the advantages and effective use of some simple and reliable contraceptive methods/ devices such as condom. This measure will help to prevent unwanted pregnancies and STDs including AIDs among the youths. Also, pre-service and in-service education of teachers could be organized whereby members of staff could be brought up to date on human reproductive health matters and family planning methods. This is necessary because studies have found that most teachers know very little about human reproduction and tend to be unconfortable talking to students about sexuality (WHO, 1980 and Oladepo et al 1991).

Although the author is not trying to encourage sexual promiscuity among the students by advocating for the implementation of family life education in the school curriculum, but it is necessary as a matter

of urgency so as to remove the myths and misconception among the youths as regards their reproductive health and contraceptive utilization.

Summary

It has been shown that sexual activities among the youths especially secondary students in urban areas is high and increasing which is now creating both medical, social and economic problems in the society. The problems highlighted are increase in unwanted pregnancy, induced illegal abortion, child abandonment or "baby dumping" truncated educational opportunities especially among girls, high rate of infant and maternal mortalities and as well as risk of STDs including AIDs.

Also discussed was the assessment of level of contraceptive awareness and utilization among these students (Secondary School Students). This was followed by the assessment of of factors which inhibit contraceptive awareness and uses among these group of people. Finally, the role of school health programme towards incorporation of reproductive health and family life education including family planning/contraceptive services into the school curriculum in order to combat the adverse effect of sequelae of unprotected sexual activities among the students, was also document.

CHAPTER THREE

METHODOLOGY

INTRODUCTION:

The author conducted a KAP study among the Senior Secondary Students in Ibadan North-East L.G.A. of Oyo State, in order to assess the factors that affect contraceptive awareness and utilization among Secondary School Students.

This chapter focuses on the description of the study area, objectives of the study, hypotheses tested, operational definitions, research design, target population, sampling method and instruments for data collection among others.

DESCRIPTION OF THE STUDY AREA:

Ibadan North-East Local Government Area (the study area) is one of the 5 new Local Government Areas (L.G.As) that were carved out of the former Ibadan Municipal Government (IMG) during the last quarter of 1991 by the Federal Military Government (Information Division, Ibadan North-East L.G.A).

Ibadan City, the Oyo State capital, is located at the South-Western part of the country, Nigeria, and is about 125 kilometers North of Lagos. The city is the largest indigenous city in West Africa and the most populous in black Africa belonging to the Oyo Yoruba Sub-group. The population of Ibadan was estimated at 100,000

in 1851, while the official census conducted in 1963 estimated the population as 627,739 (Mabogunje, 1968). The current provisional census figure which was conducted in November 1991 puts the population of Ibadan city in general as 1.2 million while that of Ibadan North-East Local Government (the study area) was recorded as being 272,979 (National Population Commission's census figure 1991).

The Ibadan North-East L.G.A. has its Headquarters at Old Army Barracks, Iwo Road. It is bounded on the North by Lagelu L.G.A., on the West by Ibadan North L.G.A., on the East by Egbeda and Ona-Ara L.G.As and on the South by Ibadan South-East L.G.A. (Appendix III). The major residential areas within the L.G.As include among others, Basorun, Radio OYO, Iwo Road, Abayomi, Yidi, Oke-Irefin, Motala Oke-Ofa, Ode-Aje, Agugu, Oje, Oja-Igbo, Aremo, Olorunsogo, Elekuro and Aperin.

As regards occupation, the populace consist of civil servants, artisans and traders who engage in trading activities such as clothing materials, provision, motor-vehicle spare parts and building materials. The two dominant religions of the people in the L.G.A. are Christianity and Islam (Information Division, Ibadan North-East L.G.A.).

In respect of secondary school education, the whole Local Government Area is endowed with 10 Secondary Schools, some of them are among the Oldest Secondary Schools in the entire Ibadan Land (Statistical and Planning Division, Oyo State Ministry of Education, 1991).

Before the state government took over schools from private organizations, majority of the schools in the L.G.A. were founded by the various religious organisations. But today, the schools are identified not only on the basis of religion but also on the sex identity of the students in the schools, and on the social status of the students' parents (Afolabi, 1978). Thus, today there are three boys' only schools, one girls' only school, and 6 mixed schools totalling 10 schools in the whole L.G.A.

OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE:

The overall objective of this study is to assess the level of knowledge, attitude and practices of contraception amongst Senior Secondary School Students in Ibadan North-East L.G.A. of Oyo State with a view to making contributions towards the development and implementation of Reproductive Health and Family Life (Sex Education) Education in Secondary Schools.

SPECIFIC OBJECTIVES:

(1) To assess level of contraceptive knowledge among Senior Secondary School Students in Ibadan North-East L.G.A. of Oyo State.

(2) To examine the attitude of these students towards contraceptive use.

(3) To identify the most frequently used contraceptive method(s) amongst the students.

(4) To document factors inhibiting or promoting contraceptive knowledge amongst the students.

(5) To document factors inhibiting or promoting contraceptive use amongst the students.

(6) Based on 1 - 5, to suggest appropriate health education strategies that could be used for developing and implementing Reproductive health and Family Life (Sex Education) Education programme in Secondary Schools.

HYPOTHESES

The following hypotheses were formulated and tested:-

(1) There is no significant association between the age of students and their knowledge of contraception.

(2) There is no significant association between the age of students and their attitudes towards contraceptive use.

(3) There is no significant association between the age of students and practices of contraception.

(4) There is no significant association between the sex of students and their knowledge of contraception.

(5) There is no significant association between the sex of students and their attitude towards contraceptive utilization.

(6) There is no significant association between the sex of students and practices of contraception.

(7) There is no significant association between type of school attended and students' knowledge of contraception.

(8) There is no significant association between type of school attended and practices of contraception amongst the students.

(9) There is no significant association between students' family type and their knowledge of contraception.

(10) There is no significant association between students' family type and practices of contraception.

(11) There is no significant association between students' parental socio-economic status and their knowledge of contraception.

(12) There is no significant association between students' parental socio-economic status and practices of contraception.

(13) There is no significant association between students' religion and practices of contraception.

OPERATIONAL DEFINITIONS:

1. Assessment: This is a process of appraising or evaluating the current situation of certain phenomenon using what obtained in the past as baseline. In this context, it is the current state of contraceptive awareness and utilization among Secondary School Students.

2. Knowledge of Contraception: The ability of students to identify currently the concept of contraception and recall correctly some of the methods of contraceptive devices.

3. Attitude towards contraceptive use: This refers to the constant feeling (may be positive or negative) of the students that is directed towards contraceptive use.

4. Practices of Contraception: The frequency of contraceptive use among the students.

5. Inhibition to Contraceptive Awareness and Utilization: This refers to the hinderances or set backs that tend to limit/lower the students' knowledge of and use of contraception.

6. Promotion of Contraceptive Awareness and Use: This refers to what enhances or encourages the students' knowledge of and use of contraceptive devices.

7. Family Planning Services: Refers to full services that help individuals or couples to avoid unwanted births, to control the time at which births occur in relation to the ages of the two individuals, to concern, to regulate the intervals between pregnancies and to determine the number.

8. Contraceptive Methods: According to this context refers to the devices being used by an individual or a couple to prevent pregnancies whenever sexual activity is being engaged.

9. Family Life Education: Refers to the type of education given to an individual which is related to human sexuality, dating, marriage, parenthood and later life.

10. Reproductive Health Education: A kind of education given to an individual which involves knowledge of the structures and functions of the human reproductive organs and as well as providing education and counselling services on how to take responsible decisions in taking care of and using them judiciously in order to avoid abuse of their use.

RESEARCH DESIGN:

The study is a cross-sectional evaluation survey. It assessess and documents the level of contraceptive awareness and utilization amongst the Senior Secondary Students in Ibadan North-East L.G.A. of Oyo State. The factors which influence the level of awareness and utilization of contraceptive methods among these students were established. The study further explains the relationship between demographic variables like age, sex, parental level of education and occupation, parental religious affliation as well as their family type. It also looks at the association between the dependent variables (adolescents) knowledge, attitude to and practices of contraception) and the independent variables (such as sex, age, parental socio-economic status, religious affliation, and family type).

TARGET POPULATION:

The target population are students who are currently attending Senior Secondary School classes in Ibadan North-East L.G.A. at the time this research study was carried out. This gategory of students

was chosen because they have completed junior secondary school education, hence, their level of intelligence is presumed to help them in understanding clearly the content of the instrument (questionnaire) used and responding accordingly.

SAMPLING PROCEDURE:

A multistage sampling procedure was employed in the selection of subjects. In the first stage, the list of all the 10 Secondary Schools in the L.G.A. was obtained and these were stratified according to the type of school - that is sex identity (single sex:- boys' only, girls' only and mixed schools) (See appendix II).

The next stage involved the selection of the participating schools which form the study population. The first step was the selection of the single sex schools (that is a boys' only school and a girls' only school) which was done as follows:- Since there is only one girls' school, therefore this only girls' school was taken while the selection of one out of the three boys' only schools was done through balloting. The second step was the selection of the remaining participating schools from the remaining 6 (mixed) schools. This was done by using ratio 1 to 3 as in case of boys' Only Schools. Therefore, using this criteria (1:3), two schools were randomly selected through balloting from the 6 mixed schools. Thus, the total number of schools selected was 44 (one each from both

Boys' only and girls' only and two from the mixed schools) out of the 10 existing ones in the whole L.G.A. for the 1991/92 school year.

The third stage was the selection of students from the 4 selected schools which constitutes the sample size. From my preliminary data collection of the school enrolment of senior secondary students in the study population, the total number of students in the 4 selected schools is 3,062 students during the 1991/92 school year when this study was carried out (courtesy of the principals of the schools selected). Therefore, to compute the sample size, 25 percent of this figure (3,062 students) was calculated which gives an approximation of 766 students being used for the data collected.

The final stage was the selection of this figure (766 students) from the respective arms in each of the classes (SSS1 - SSS3) of the selected schools in proportion to the number of students in each class using the class register. To do this selection, simple random technique through balloting was used, and in case of mixed schools, the selection was done according to the proportionate ratio of the number of girls to boys in each class. This was done to ensure a fair representation of the students (see table 1 below).

TABLE 1

List of Secondary Schools Selected/Number of Students Selected

CLASS / TYPES OF SCHOOL	SS1 M	SS1 F	SS1 TOTAL	SS2 M	SS2 F	SS2 TOTAL	SS3 M	SS3 F	SS3 TOTAL	TOTAL POPULATION M	TOTAL POPULATION F	TOTAL POPULATION TOTAL	TOTAL NO. SELECTED M	TOTAL NO. SELECTED F	TOTAL NO. SELECTED TOTAL	..	%
A. BOYS' ONLY																	
(1) Lagelu Grammar School, Agugu	435	–	435 (109)*	353	–	353 (88)	237	–	237 (59)	1025	–	1025	256	–	256		25
B. GIRLS' ONLY																	
(2) Queens' of Apostle Grammar School, Oluyoro.	–	480	480 (120)	–	425	425 (106)	–	275	275 (69)	–	1180	1180	–	295	295		25
C. MIXED																	
(3) Army Barracks Grammar School, Iwo Road.	134 (34)	141 (35)	275 (69)	89 (22)	61 (16)	150 (38)	45 (11)	20 (5)	65 (16)	268	222	490	67	56	123		25
(4) Basorun High School, Bode-Wasimi	91 (23)	65 (16)	156 (39)	50 (12)	78 (20)	128 (32)	45 (11)	38 (10)	83 (21)	186	181	367	47	45	92		25
									TOTAL			3062	370	396	766		100

* The figure in bracket gives the number of students selected in each class.

Hence, from the table, the number of boys in the sample size approximately equal to the number of girls; that is 370 to 396, which gives an approximation of ratio one to one (1:1).

This sample size of 766 which is 25% of the study population was considered adequate for the survey because of the logistic problems in terms of time factor, limitation of human and material resources among others.

INSTRUMENTS AND METHOD OF DATA COLLECTION

Instruments:-

A set of questionnaires was used as an instrument for data collection. This was designed in such a way so as to elicit information on the following:-

(a) demographic characteristics of the students such as age, sex, parental level of education and occupation and as well as their religious affliation and family types.

(b) knowledge of reproductive health and Sex Education (Family Life Education), and

(c) knowledge, attitudes and practices of contraception amongst Secondary School Students.

This method (use of questionnaire) was chosen because it is useful as a survey research method and also because it gives a vast amount of hard numerical data with extensive coverage (Abramson, 1979, Ramakrishma and Brieger, 1987).

Method:

A preliminary study was conducted in the study area (Ibadan North-East L.G.A.) in order to identify the location of the schools selected for the study and to collect data on the current figure of the school enrolment. Also during this period, arrangement was made with the principals of these schools for the appropriate periods to visit the schools for data collection.

In order to facilitate the progress of data collection, some selected and trained research assistants were used for the administration of the questionnaires to the respondents (students). These resesearch assistants were teachers in the respective selected schools who were closely supervised by the researcher so as to reduce the tendency of giving undue assistance to the respondents (students).

The administration of the questionnaires was done during the recess period of the students which fall during the school hours between 8.00a.m. and 2.00 p.m. daily. The recess periods were used so as not to interrupt the students' normal lessons period. Time taken to fill one questionnaire was approximately 30 minutes. The questions were in English because the target audience is literate (all of them have completed Junior Secondary School Education).

At the end of the exercise, a total of 744 out of 766 questionnaires administered were received and adequately completed and accepted for analysis.

VALIDITY AND RELIABILITY

To ensure that the instrument measures what it was intended to measure, 30 draft questionnaires were pretested in one of the schools not chosen for the study. This school which is a mixed school has similar characteristics with those selected for the study with respect to sex identity (that is co-educational consisting of boys and girls) and as well as having Senior Secondary (SS) classes. The respondents which comprised of 15 boys and 15 girls (5 each from SS classes one to three) were randomly chosen for the exercise.

After the pretesting, few of the questions in the questionnaire were re-cast while others were removed. The re-casting of some items was necessitated to ensure their clarity to the respondents. Examples of those questions re-cast are questions numbers 19, 20, 32 and 35, where the word "contraceptive methods/devices" in each of them was replaced with "methods of preventing unwanted pregnancies". While the rationale for eliminating some was due to their sensitivity which brings about high rate of non-respondent bias to the immediate questions that follow them. Example is the one requires them to report their frequency of sexual activities or experiences. This is common to most of the female respondents in the pretesting group who declined to respond to this aspect since previous research finding have proved that most women do not like to divulge their sexual experiences.

However, inspite of the few modification to some items in the questionnaire after the pretesting as stated above, the instrument (questionnaire) still retains its validity and reliability after the actual data collection. This is so, because the results after the actual data collection did not deviate significantly from the one obtained during the pretesting. Furthermore to enhance the validity and reliability of the instrument during the actual data collection, the research assistants in the respective schools selected for the study were properly trained on the administration of the questionnaire. They were finally closely supervised by the author throughout the periods of data collection.

Data Analysis

The data obtained were manually sorted out, edited, coded and entered into the computer for statistical analysis. Frequency distribution, means and percentages were computed for data description. Using computer and pocket calculator, statistical test (X^2) of association and significance were carried out in order to draw inferences and give meaningful description to the data analysed.

Limitation of the Study

The first noticeable limitation of the study was the one that stems out of the sensitive nature of the research study - that

is it deals with sexual activities/experiences among the respondents. From all available research findings, some people, especially women are not always ready to open up when it involves the issue of reporting their sexual activities/experiences (even married women dislike reporting their sexual activities with their legal husbands). Hence, as it would be expected, my study area would not be an exceptional case. In order to minimize this limitation, the questionnaire was designed in such a way to make it strictly confidential by asking the respondents to remain anonymous throughout (that is should not write their names).

The next limitation was the problem of respondents' low standard of education. This is due to falling standard of education in schools nowadays (observable experience of the author as a teacher of many years in secondary schools testifies to this). In order to address this problem, the research assistants were properly trained to read and interprete some aspects of the questionnaire where respondents need their clarification. Finally, another aspect of limitation was the logistic consideration in terms of resources available to the author as regards personnel, money and time. These did not allow for a sample size larger than the 766 being chosen for the study.

CHAPTER FOUR

4. RESULTS

The presentation of findings is done in six sections. First, the distribution of the demographic characteristics of the respondents in the study area. The second section reports knowledge of reproductive health and family life education (sex education) among the respondents. The third section is on knowledge of contraception among the students in the study area. The fourth section deals with the attitudinal disposition of the respondents towards contraception. The fifth section is on practices of contraception by the students, While the sixth section deals with the presentation of hypotheses tested.

4.1 Demographic characteristics of the Respondents

4.1.1 Type of School

The distribution of respondents to the three types of school (mixed, Girls' only and Boys' only schools) attended is presented in table 2 below:

TABLE 2

Distribution of Respondents Among the Three Types of School

Type of School	Number	Percentage (%)
Mixed - School (Co-educational)	205	27.6
Girls Only	284	38.1
Boys' Only	255	34.3
Total	744	100.0

4.1.2 Class in School

Out of the three classes (SS_1, SS_2 and SS_3), SS_1 has the highest number 338(45.4%) of the total 744 respondents while class SS_3 has the least number of respondents 173 (23.3%) (Table 3).

TABLE 3

Class Distribution of the Respondents

Class in School	Number	Percentage (%)
SS_1	338	45.4
SS_2	233	31.3
SS_3	173	23.3
Total	744	100.0

4.1.3 Age of Respondents

The distribution of respondents by age is as follows: Out of the 744 respondents, age group 16 - 19 years has the highest number 593(79.7%) of respondents and this was followed by age group 12 - 15 years with 99(13.3%) respondents. While age group 20 - 23 years has the least 22(3.0%) number, and lastly 30(4.0%) respondents did not indicate their age. It is important to note that most 692(93.0%) of the respondents are in the adolescence period (13 - 19 years) (Table 4).

TABLE 4

Distribution of Respondents by Age

&

Age	Frequency	Percentage (%)
12 - 15	99	13.3
16 - 19	593	79.7
20 - 23	22	3.0
*N/R	30	4.0
Total	744	100.0

* N/R = Non respondents

4.1.4 Sex of Respondents

Both sexes have equal number of respondents that is, 369 (49.6%) respondents for the boys and the same number for the girls in the study group. While 6(0.8%) did not indicate their sex identity (Table 5).

TABLE 5

Sex Distribution of the Respondents

Sex	Number	Percentage (%)
Male	369	49.6
Female	369	49.6
N/R	6	00.8
Total	744	100.0

4.1.5 Religion of Respondents

Christians formed a majority, 481(64.7%) of the respondents and this was followed by 251(33.7%) moslems. Traditional African Faith and others (Guru, Harekrisha) categories have 2(0.3%) respondents each while there were 8(1.0%) non-respondents (Table 6).

TABLE 6

Distribution of Religion of Respondents

Religion	Frequency	Percentage (%)
Christianity	481	64.7
Islam	251	33.7
Traditional African Faith	2	0.3
Others (e.g. Guru, Harekrisha, Eckankar etc.)	2	0.3
N/R	8	1.0
Total	744	100.0

4.1.6 Parental Occupation

As regards father's occupation, 186 (25.0%) were civil servants/teachers and 118(15.9%) were petty-traders, while those that fall into the category of 'Others' were 115(15.5%).

In case of mother's occupation on the contrary, 'petty - trading' forms the majority with 448 (60.2%) of the respondents which was followed by civil servants/teachers with 94 (12.6%), while 'business/contractor' category were 77(10.3%) (Table 7).

TABLE 7

Distribution of Respondents by Parental Occupation

Occupation	Father		Mother	
	* N	%	N	%
Petty Trading	118	15.9	448	60.2
Artisan	50	6.7	31	4.2
Farming	23	3.0	6	0.8
Full-time housewife	-	-	5	0.7
Business/Contractor	99	13.3	77	10.3
Civil Servants/Teachers	186	25.0	94	12.6
Professional (e.g. Doctors, Nurses etc.)	114	15.3	50	6.7
Others	115	15.5	16	2.2
Don't Know/No idea	21	2.8	2	0.3
N/R	18	2.5	15	2.0
Total	744	100.0	744	100.0

* Number of Respondents.

4.1.7 Parents' Level of Education

Of the 744 students interviewed, 315 (42.3%) reported that their fathers hold University/Polytechnic/N.C.E. Certificates and 195 (26.2%) of them were Modern 3/School Cert./Grade II/'O' Level certificate holders, while 79 (10.6%) were Primary/Standard Six Certificate holders.

On the contrary, majority 252 (33.9%) of their mothers hold Modern 3/School Cert./Grade II/'O' Level Certificates while the least 12 (1.6%) hold Professional Training (e.g. Nursing, Accounting, Medicine etc) Certificates. (Table 8).

TABLE 8

Distribution of Respondents by Parents' Level of Education

Educational Level of Parents	Father		Mother	
	N	%	N	%
No Education/Illiterate	25	3.4	67	9.0
Primary/Standard Six	79	10.6	136	18.3
Modern 3/School Cert./Grade II/'O' Level	195	26.2	252	33.9
Professional training e.g. Nursing, Medicine, Accounting	3	0.4	12	1.6
University/Polytechnic/N.C.E.	315	42.3	136	18.3
Others (e.g. N.D.A.*)	8	1.1	1	0.1
Don't know/No idea	76	10.2	78	10.5
N/R	43	5.8	62	8.3
Total	744	100.0	744	100.0

* Nigerian Defence Academy.

4.1.8 Type of Family

The distribution of respondents by type of family shows that more than half 415 (55.8%) of the respondents come from monogamous home, while those who come from polygamous home were 297 (39.9%) (see Table 9 for more details).

TABLE 9

Distribution of Respondents by Type of Family

Type of Family	Frequency	Percentage (%)
Polygamous Home	297	39.9
Monogamous Home	415	55.8
Fragmented (Separated, Divorced)	24	3.3
Others	3	0.4
N/R	5	0.6
Total	744	100.0

41.9 Current Living Arrangement

Majority of the respondents 573 (77.0%) reported that they are currently living with both parents, while 66(8.9%) live with their mothers only and 26 (3.6%) live with their fathers only. Table 10 gives more detail about this information.

TABLE 10

Distribution of Respondents by Current Living Arrangement

Current Living Arrangement	N	%
With both parents	573	77.0
With mother only	66	8.9
With father only	26	3.6
With another relative	70	9.4
With friend	4	0.5
Alone	1	0.1
Others	-	-
N/R	4	0.5
Total	744	100.0

Section Two

4.2 Respondents' Knowledge of Reproductive Health and Family Life Education (Sex Education)

4.2.1 Ever Heard About Reproductive Health and Sources of Information Among the Respondents

Most of the respondents 684 (91.9%) claimed they have ever heard about human reproductive organs, which comprises of 358 (48.1%) male and 326 (43.8%) female respondents. And as regards sources of information, majority of them 474 (63.7%) reported that they got their information from school. A break down of this shows

that there were 254 (34.1%) male and 220 (29.6%) female respondents in this category. The next source of information in order of magnitude is radio and T.V. programme 95 (12.8%) which consists of 52 (6.9%) male and 40 (5.4%) female respondents. Tables 11 and 12 give more details about the information.

TABLE 11

Ever Heard About Human Reproductive Organs

Information About Reproductive Health	Male N (%)	Female N (%)	N/R (Sex) N (%)	Total N (%)
Yes	358(48.1)	326(43.8)	-	684(91.9)
No	8(1.1)	35(4.7)	-	43(5.8)
N/R	3(0.4)	8(1.1)	6(0.8)	17(2.3)
	369(49.6)	369(49.6)	6(0.8)	744(100.0)

* N/R (Sex) = Means those respondents that failed to indicate Sex.

TABLE 12

Respondents' Sources of Information

Source of Information	Male N(%)	Female N (%)	N/R(Sex) N (%)	Total N(%)
School	254(34.1)	220(29.6)	-	474(63.7)
Radio and T.V. Programme	52(6.9)	40(5.4)	3(0.4)	95(12.8)
Boy/Girl Friend	19(2.6)	36(4.8)	2(0.3)	57(7.7)
Home (Parents/Relative)	8(1.1)	27(3.6)	1(0.1)	36(4.8)
Magazines and Pornographic Books	31(4.2)	27(3.6)	-	58(7.8)
Others (Social gathering)	2(0.3)	-	-	2(0.3)
N/R	3(0.4)	19(2.6)	-	22(3.0)
	369(49.6)	369(49.6)	6(0.8)	744(100.0)

4.2.2 Knowledge of Human Reproductive Organs

Only few 160(21.5%) respondents, out of which 93(12.5%) are male and 66(8.9%) are female respondents that could list correctly male human reproductive organs, while the majority 513(69.0%) of them, out of which 247 (33.2%) male and 266(35.8%) female could not correnctly list male human reproductive organs. Similarly, in the case of female human reproductive organs, only a few 202 (27.2%) of respondents out of which 59 (7.9%) are male and 141 (19.0%) are female could correctly list female repro-

ductive organs while a large proportion 455(61.2%) of them out of which 269(36.2%) are male and 185(24.9%) are female respondents could not do so.

In summary it appears that the males have more knowledge of their reproductive organs than the females, while the female have more knowledge of their reporoductive organs than the male (Table 13).

TABLE 13

Respondents' Knowledge of Human Reproductive Organs

Knowledge of Human Reproductive Organs	Male Reproductive Organs				Female Reproductive Organs			
	Male N (%)	Female N (%)	N/R N (%)	Total N (%)	Male N (%)	Female N (%)	N/R N (%)	Total N (%)
Correct Knowledge	93(12.5)	66(8.9)	01(0.1)	160(21.5)	59(7.9)	141(19.0)	2(0.3)	202(27.2)
Incorrect Knowledge	247(33.2)	266(35.8)	-	513(69.0)	269(36.2)	185(24.9)	1(0.1)	455(61.2)
N/R	49(3.9)	37(5.0)	5(0.7)	71(9.5)	41(5.5)	43(5.8)	3(0.4)	89(11.6)
Total	369(49.6)	369(49.7)	6(0.8)	744(100)	369(49.6)	369(49.7)	6(0.1)	744(100.0)

4.2.3 Knowledge of Age of Pubertal of a boy and a girl among the Respondents

The result of respondents' knowledge of pubertal age of a boy and a girl is as follows: as regards knowledge of boy's pubertal age, slightly above half 387 (52.0%) of the respondents, out of which 213 (28.6%) are male and 170 (22.8%) are female have correct knowledge of it. Whereas in case of a girl's pubertal age on the contrary, less than half 328 (44.2%) of the respondents, out of which 117 (15.7%) are male and 210 (28.2%) are female have correct knowledge of it (Table 14).

TABLE 14

Knowledge of a boy's and girl's age of peberty among the respondents

Adolescent's Puberty Age	Boy's Age of Puberty				Girl's Age of Puberty			
	Male N (%)	Female N (%)	N/R N (%)	Total N (%)	Male N (%)	Female N (%)	N/R N (%)	Total N (%)
Correct Knowledge	213(28.6)	170(22.8)	4(0.5)	387(52.0)	117(15.7)	210(28.2)	1(0.1)	328(44.2)
Incorrect Knowledge	133(17.9)	192(25.8)	1(0.1)	326(43.8)	225(30.2)	156(21.0)	2(0.3)	383(51.4)
N/R	23(3.1)	7(0.9)	1(0.1)	31(4.2)	27(3.6)	3(0.4)	3(0.4)	33(4.4)
	369(49.6)	369(49.5)	6(0.7)	744(100.0)	369(49.5)	369(49.6)	6(0.8)	744(100.00

4.2.4 Ever Heard About Family Life Education and Sources of Information Among the Respondents

Most of the respondents 610(82.0%) claimed that they have heard about family life education (FLE) or sex education. Out of this figure, 314(42.2%) are male, and 293(39.4%) are female respondents while 3(0.4%) did not indicate their sex identity (Table 15).

As regards their sources of information about FLE, the school as a source of information was the highest with 259(34.8%) while radio and T.V. programme as a source of information ranks next with 148(19.9%), this was followed by home as a source of information with 101(13.6%) respondents. (See figure 1 for more details).

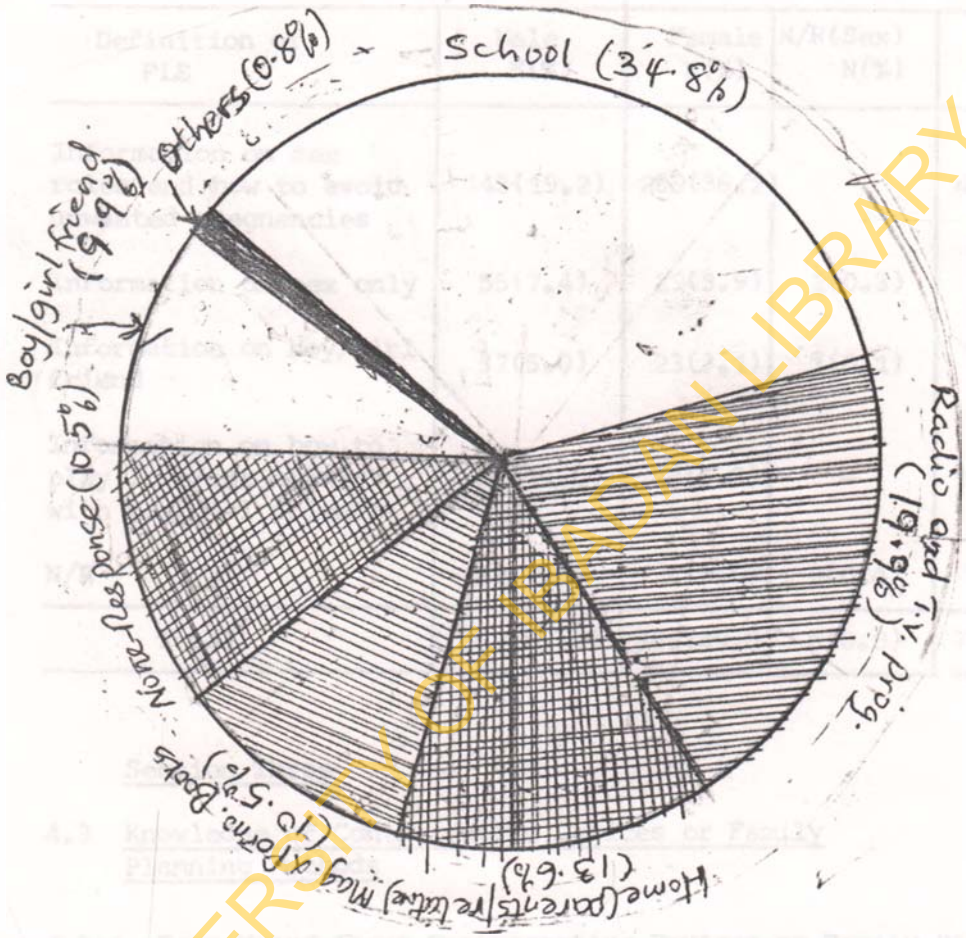
TABLE 15

Ever Heard About Family Life Education (FLE)

Ever Heard About FLE	Male N(%)	Female N(%)	N/R N(%)	Total N(%)
Yes	314(42.2)	293(39.4)	3(0.4)	610(82.0)
No	54(7.3)	71(9.5)	-	125(16.9)
N/R	1(0.1)	5(0.7)	3(0.4)	9(1.1)
Total	369(49.6)	369(49.6)	6(0.8)	744(100.0)

FIGURE 1

A Pie Chart Showing Sources of Information About Family Life Education



4.2.5 Knowledge of Family Life Education (FLE)/Sex Education Among the Respondents

As regards knowledge of FLE; "Information on sex roles and how to avoid unwanted pregnancies" as a component of FLE has the highest number 412(55.4%) of respondents, this was followed by information on how to play love/sex affair with boy/girl friends with 126(16.9%) respondents. (Table 16 gives more details of this).

TABLE 16

Respondents' Knowledge of FLE

Definition of FLE	Male N(%)	Female N(%)	N/R(Sex) N(%)	N(%)
Information on sex roles and how to avoid unwanted pregnancies	143(19.2)	269(36.2)		412(55.4)
Information on sex only	55(7.4)	29(3.9)	2(0.3)	86(11.6)
Information on boy/girl friend	37(5.0)	23(3.1)	1(0.1)	61(8.2)
Information on how to play love/sex affair with boy/girl friends	82(11.0)	44(5.9)	-	126(16.9)
N/R	52(7.0)	4(0.5)	3(0.4)	59(7.9)
Total	369(49.6)	369(49.6)	6(0.8)	744(100.0)

Section Three

4.3 Knowledge of Contraceptive Devices or Family Planning Methods

4.3.1 Ever Heard About Contraceptive Devices or Family Planning Methods and Sources of Information

Most 643(86.4%) of the respondents reported they have heard about contraceptive devices or family planning. And out of this figure, 303(40.7%) are male and 335(45.0%) are female respondents

(table 17). As regards sources of information about contraceptive devices; the analysis is as follows: radio and T.V. programmes - 393(52.8%), home (parents/relatives) - 127(17.1%), school - 95(12.8%), magazines and pomographic books - 41(5.5%), boy/girl friends - 31(4.2%), none response - 52(7.0%) and others (social gathering/health institution) - 5(0.6%).

In summary, it appears that Radio and T.V. programmes is the popular source of information (Figure 2).

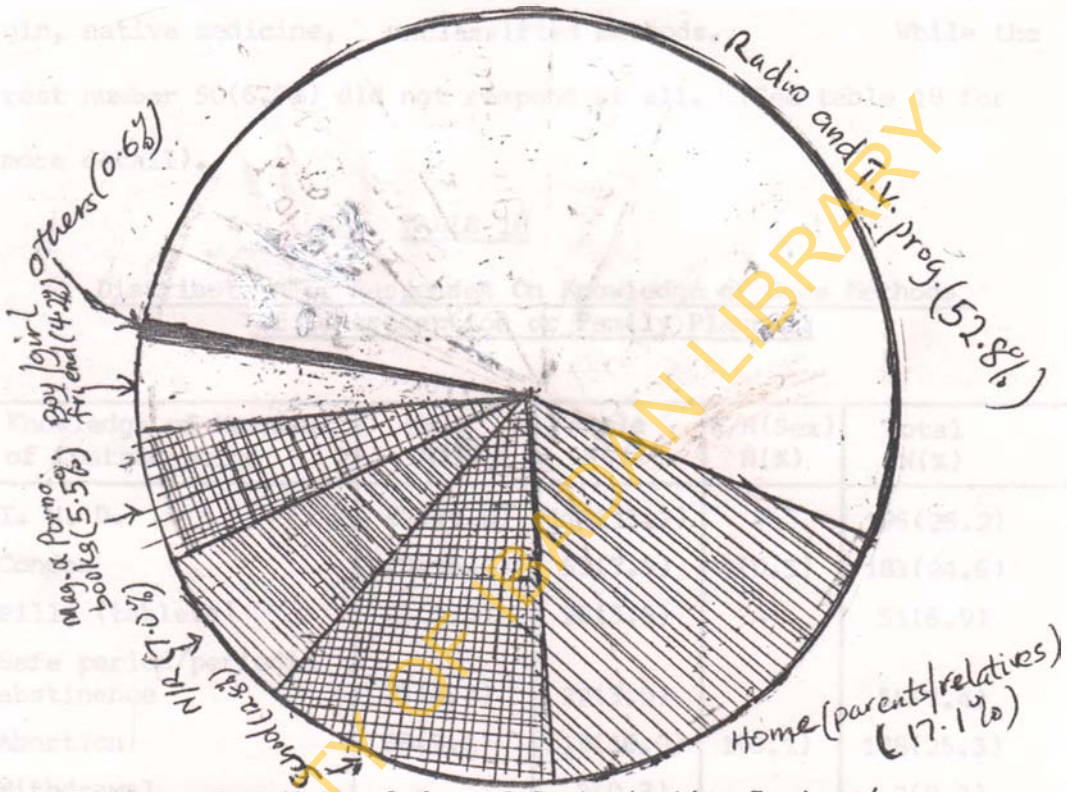
TABLE 17

Ever heard about contraceptive devices or family planning methods

Information about contraceptive devices	Male N(%)	Female N(%)	N/R(Sex) N(%)	Total N(%)
Yes	303(40.7)	335(45.0)	5(0.7)	643(86.4)
No	60(8.1)	29(3.9)	1(0.1)	90(12.1)
N/R	6(0.8)	5(0.7)	-	11(1.5)
Total	369(49.6)	369(49.6)	6(0.8)	744(100.0)

FIGURE 2

A Pie Chart Showing Respondents' Sources of Information About Contraceptive Devices



4.3.2 Respondents' Knowledge of Contraceptive Devices/ Family Planning Methods

Out of 694(93.3%) who responded to the question on knowledge of modern methods of contraceptive, a high number 484(65.1%) have correct knowledge of it. These methods include the following; I.U.D. - 195(26.2%), Condom - 183(24.6%),Pills - 51(6.9%) and safe period/periodic abstinence - 55(7.4%) respondents.

However, 210(28.2%) respondents have incorrect knowledge of modern contraceptive devices. The incorrect methods listed by them are; abortion, withdrawal, M & B 760 tablets, use of local gin, native medicine, unclassified methods. While the rest number 50(6.7%) did not respond at all. (See table 18 for more detail).

TABLE 18

Distribution of Responses On Knowledge of Some Methods Of Contraception or Family Planning

Knowledge of Methods of Contraception	Male N(%)	Female N(%)	N/R(Sex) N(%)	Total N(%)
I. U. D.	82(11.0)	113(15.2)	-	195(26.2)
Condom	120(16.1)	59(7.9)	4(0.5)	183(24.6)
Pills (tablets)	25(3.4)	26(3.5)	-	51(6.9)
Safe period/periodic abstinence	33(4.4)	22(3.0)	-	55(7.4)
Abortion	68(9.1)	119(16.0)	1(0.1)	188(25.3)
Withdrawal	-	2(0.3)	-	2(0.3)
None-Contraceptives (e.g. M & B 760 tablets, local gin)	4(0.5)	6(0.8)	-	10(1.3)
Native Medicine	5(0.7)	1(0.1)	-	6(0.8)
Unclassified Methods	3(0.4)	1(0.1)	-	4(0.5)
N/R	29(3.9)	20(2.7)	1(0.1)	50(6.7)
Total	369(49.6)	369(49.6)	6(0.7)	744(100.0)

Section Four

4.4 Respondents' Attitude Towards Sexual Behaviour And Contraceptive Use

Attitude of the respondents towards sexual behaviour, abortion and contraceptive use was measured on a scale of "Strongly Agree", "Agree" "Undecided", "Disagree" and "Strongly Disagree" applied to certain categories of popular statements about sexual behaviour and attitude towards contraceptive use. This aspect is divided into two sub-sections: namely,

(a) attitude of respondents towards sexual behaviour and abortion and,

(b) attitude of respondents towards contraceptive use.

4.4.1 Respondents' Attitude Towards Sexual Behaviour and Abortion

The result obtained on this aspect is as follows; less than half 264(35.5%) of respondents agreed that having opposite sex friend should start in the high school, while more than half 390(52.4%) disagreed, 50(6.7%) were undecided and 40(5.4%) did not respond: a minority 236(31.7%) of them agreed that students should have sexual intercourse as soon as they reach puberty age, while majority 428(57.5%) disagreed, 54(7.3%) were undecided and 26(3.5%) were none-respondents: majority 560(75.3%) agreed that one of the dangers of sexual activities among high school students is the

problem of unwanted pregnancies, while a very low number 125(16.8%) disagreed, 37(5.0%) were undecided and 22(3.0%) were none-respondents: minority 223(30.0%) agreed that abortion should be encouraged among the unmarried students in secondary school, while majority 461(62.0%) disagreed, 38(5.1%) were undecided and 22(3.0%) did not respond (Table 19).

TABLE 19

Distribution of Responses on Attitude Towards Sexual Behaviour and Abortion

Statement	SA N(%)	A N(%)	U N(%)	D N(%)	SD N(%)	N/R (N(%)	Total N(%)
1. Having opposite sex friend should start in the high school.	156(21.0)	108(14.5)	50(6.7)	127(17.1)	263(35.3)	40(5.4)	744(100.0)
2. Students should have sexual intercourse as soon as they reach puberty age.	121(16.2)	115(15.5)	54(7.3)	132(17.7)	296(39.9)	26(3.5)	744(100.0)
3. One of the dangers of sexual activities among high school students is the problem of unwanted pregnancies.	366(49.2)	194(26.1)	37(5.0)	45(6.0)	80(10.8)	22(3.0)	744(100.0)
4. Abortion should be encouraged among the unmarried students in high school.	118(15.9)	105(14.1)	38(5.1)	104(14.0)	357(48.0)	22(3.0)	744(100.0)

KEY:- SA = Strongly Agree, A = Agree, U = Undecided, D = Disagree, SD = Strongly Disagree and N/R = No Response.

4.4.2 Respondents' Attitude Towards Contraceptive Use

Respondents were requested to indicate whether they strongly agree, agree, undecided , disagree or strongly disagree to seven statements on contraceptive use in order to extrapolate their attitude towards contraceptive use. The results showed that; minority 209(28.1%) of the respondents agreed with the statement that contraception/family planning is meant for prostitutes and call girls Only, majority 419(56.3%) disagreed, while 188(25.3%) were undecided and 29(3.9%) did not respond; 244(32.8%) agreed with the statement that contraceptive method is good for only girls, less than half 329(44.2%) disagreed, while 104(14.0%) were undecided and 67(9.0%) were non-respondents; less than half 359(48.3%) agreed that contraceptive method should be practiced by both boys and girls, 238 (32.0%) disagreed, while 77(10.3%) were undecided and 70(9.4%) did not respond; less than half 303(40.7%) agreed with the statement that contraception is meant for married adults only, 292(39.2%) disagreed, while 73(9.8%) were for each of undecided and none respondents groups; slightly above half 386(51.9%) of them agreed that contraception should not be practiced without the parents' approval, 271(36.2%) diagreed, while 67(9.0%) were undecided and 20(2.7%) did not respond; majority 465(62.5%) agreed that contraception should be

practiced on the agreement of both sexes, 169(22.7%) disagreed, while 77(10.3%) were undecided and 33(4.4%) did not respond; and lastly, above half 416(55.9%) of them agreed with the statement that the practices of contraception is against certain religious rules, 217(29.2%) disagreed, while 57(7.7%) were undecided and 54(7.3%) were none-respondents (Table 20).

The responses to these statements were scored using Likert-Type Scale in order to ascertain the level of respondents' attitudinal disposition towards contraceptive use. The 7 items were grouped into positive statements(numbers 3, 5, 6 and 7) and negative statements (numbers 1, 2 and 4).

The following scores were assigned to positive items which indicate favourable attitude to contraceptive use - 5 for strongly agree, 4 for agree, 3 for undecided, 2 for disagree and one for strongly disagree. A reverse scoring was given to negative items which indicate unfavourable attitude. Zero score was assigned to non-response in each case. The possible highest score is 35(5 multiply by 7) indicating a highly positive attitude while the lowest score is 7 an indication of a highly negative attitude.

The mid-point of the expected mean score is 21 which is half the sum of the highest (35) and the lowest (7) scores. This expected mean score (21) will be used to determine the type of attitude

(either positive or nagative). An overall group mean score greater than 21 suggests positive attitude, if equals 21 is lukewarm attitude and while if it is less than 21, indicates negative atttitude.

From table 20, the overall group mean score of the respondents is 23.1. Based on this result, therefore, the respondents were found to have positive attitude towards contraceptive use.

TABLE 20

Respondents' Attitude Towards Contraceptive Use

STATEMENT	TYPE	SA			A			U			D			SD			N/R			TO-TAL	$\bar{X}$ SCORE
		F	%	SCO-RE	F	%	SCO-RE	F	%	SCO-RE	F	%	SCO-RE	F	%	SCO-RE	F	%	SCO-RE		
1. Contraception/family planning is meant for prostitutes and call girls only.	N	101	13.6	101	108	14.5	216	87	11.7	261	188	25.3	752	231	31.0	1155	29	3.9	0	2485	3.5
2. Contraceptive method is good for only girls.	N	106	14.2	106	138	18.5	276	104	14.0	312	180	24.2	720	149	20.0	745	67	9.0	0	2159	3.2
3. Contraceptive methods should be practiced by both boys and girls.	P	190	25.5	950	169	22.7	676	77	10.3	231	104	19.0	208	134	18.0	134	70	9.4	0	2199	3.3
4. Contraception is meant for married adults only.	N	174	23.4	174	129	17.3	258	73	9.8	219	151	20.2	604	141	19.4	705	73	9.8	0	1960	2.9
5. Contraception should not be practised without the parents approval.	P	194	26.1	970	192	25.8	768	67	9.0	201	127	17.1	254	144	19.4	144	20	2.7	0	2337	3.2
6. Contraceptive should be practiced on the agreement of both sexes.	P	249	33.5	1245	216	29.0	864	77	10.3	231	74	9.9	148	95	12.8	95	33	4.4	0	2583	3.6
7. Practices of contraception is against certain religious rules.	P	224	30.1	1120	192	25.8	768	57	7.7	171	73	9.8	146	144	19.6	144	54	7.3	0	2349	3.4
																Total $\bar{X}$ Score					23.1

KEY: - N = Negative, P = Positive, SA = Strongly Agree,
U = Undecided, D = Disagree, SD = Strongly Disagree.

Overall group mean score = 23.1
Expected mean score = 21
Respondents have positive attitude.

4.5 Section Five

Practices of Contraception Among the Respondents

4.5.1 Responses of the Respondents on Ever Used And Currently Used Method of Contraception

Few of the respondents 140(18.8%), out of which 93(12.5%) were male and 45(6.0%) were female reported that they have ever used any of the methods of contraception, while a large number 541(72.7%), out of which 242(32.5%) were male and 298(40.1%) were female claimed that they have never used any method. And similarly, in case of current users, a close number 131(17.6%) to the that of ever used groups, out of which 96(12.9%) were male and 33(4.4%) were female claimed they are currently using one method or the other.

(Table 21 gives more detail about this)

TABLE 21

Distribution of Responses on Ever Used and Currently Using Any Method of Contraception

	Ever Used Any Method				Currently Using Any Method			
Res-ponse	Male N(%)	Female N(%)	N/R N(%)	Total N(%)	Male N(%)	Female N(%)	N/R N(%)	Total N(%)
Yes	93(12.5)	45(6.0)	2(0.3)	140(18.8)	96(12.9)	33(4.4)	2(0.3)	131(17.6)
No	242(32.5)	298(40.1)	1(0.1)	541(72.7)	242(32.5)	312(41.9)	3(0.4)	557(74.9)
N/R	34(4.6)	26(3.5)	3(0.4)	63(8.5)	31(4.2)	24(3.2)	1(0.1)	56(7.5)
Total	369(49.6)	369(49.6)	6(0.8)	744(100.0)	369(49.6)	369(49.6)	6(0.8)	744(100.0)

4.5.2 Methods Of Contraception Being Used By Both Ever Users And Current Users

A very low number 121(16.3%) of the respondents, out of which 80(10.8%) were male and 39(5.2%) were female had ever used some modern methods of contraception. The methods include; condom - 89(12.0%), pills (tablets) - 20(2.6%), I.U.D. - 2(0.3%) and safe period/abstineace - 10(1.3%). Also, 39(4.4%) of them have used some unreliable methods such as abortion, withdrawal, dog/monkey/rear - entry, unclassified methods and M & B 760 tablets; while majority 564(75.8%) of them said they have never used any.

In case of current users, a slightly lower number 117(15.7%) than the ever-user-respondents reported they are currently using modern methods of contraception. Out of this number, 75(10.1%) were male and 41(5.5%) were female. These methods include; condom - 100(13.4%), pills (tablets) - 12(1.6%), I.U.D. - 3(0.4%) and safe period/abstinence - 2(0.3%). Again, 44(5.1%) of them are using the same unreliable methods listed among ever users group, while majority 567(76.2%) also said they are not using any method (See table 22 for the detail analysis).

In summary, condom appears to be a popular modern method being used by both sexes among the two groups of ever users and current users (See table 22).

TABLE 22

Distribution of Responses to Methods of Contraception Being Used by Both Ever - Users and Current Users

Method of Contraception	Ever Used Any Method				Currently Using Any Method			
	Male N(%)	Female N(%)	N/R N(%)	Total N(%)	Male N(%)	Female N(%)	N/R N(%)	Total N(%)
Condom	64(8.6)	23(3.1)	2(0.3)	89(12.0)	72(9.7)	25(3.4)	3(0.4)	100(13.4
Pills (tablets)	10(1.3)	10(1.3)	-	20(2.6)	2(0.3)	10(1.3)	-	12(1.6)
I.U.D.	-	2(0.3)	-	2(0.3)	-	3(0.4)	-	3(0.4)
Safe period/ abstinence	6(0.8)	4(0.5)	-	10(1.3)	1(0.1)	1(0.1)	-	2(0.3)
Abortion/D & C	10(1.3)	7(0.9)	-	17(2.3)	4(0.5)	9(1.2)	-	13(1.7)
Withdrawal	1(0.1)	1(0.1)	-	2(0.3)	6(0.8)	4(0.5)	-	10(1.3)
Dog/Monkey/rear-entry type	4(0.5)	2(0.3)	-	6(0.8)	4(0.5)	1(0.1)	-	5(0.7)
Unclassified Methods	1(0.1)	3(0.4)	-	4(0.5)	-	-	-	-
Use of non-contraception (e.g. local gin, M & B 760 tablets	2(0.3)	2(0.3)	-	4(0.5)	5(0.7)	7(0.9)	-	12(1.6)
Unspecified method	-	-	-	-	6(0.8)	-	-	6(0.8)
No ideal/don't know/NR	10(1.3)	16(2.2)	-	26(3.5)	8(1.1)	6(0.8)	-	14(2.0)
Don't use any	261(35.1)	299(40.2)	4(0.5)	564(75.8)	261(35.1)	303(40.1)	3(0.4)	567(76.2)
Total	369(49.6)	369(49.6)	6(0.8)	744(100.0	369(49.6	369(49.6)	6(0.8)	744(100.0)

4.5.3 Reasons Given by Respondents for Not Using Contraceptive Methods

As regards the reasons for not using contraception, the following reasons among others were advanced for by the respondents for not doing so; "No sexual partner" - 186(25.0%), "still small/ still a student - 80(10.7%), "Don't know/no idea" - 78(10.5%). Not good for students/is good for prostitutes" - 72(9.7%), "Is against religious practices" - 50(6.7%), "Safety concerns(causes damages to the womb)" - 49(6.6%). While there were 183(24.6%) none-respondents (Table 23 gives more detail of the analysis).

TABLE 23

Distribution of Responses on Reasons for Not Using Contraceptive Methods

Reasons	Male N(%)	Female N(%)	N/R N(%)	Total N(%)
1. No sexual partner	78(10.5)	105(14.1)	3(0.4)	186(25.0)
2. Still small/still a student	39(5.2)	41(5.5)	-	80(10.7)
3. Don't know/No idea	40(5.4)	35(4.7)	3(0.4)	78(10.5)
4. Not good for students/ is good for prostitutes	34(4.6)	38(5.1)	-	72(9.7)
5. Is against religions practices/I'm a child of God	21(2.8)	29(3.9)	-	50(6.7)
6. Safety concerns (causes damages to the womb/death)	22(3.0)	27(3.6)	-	49(6.6)
7. I don't like it/want a baby	7(0.9)	20(2.7)	-	27(3.6)
8. If the method fails	6(0.8)	2(0.3)	-	8(1.1)
9. Not enjoyable	5(0.7)	1(0.1)	-	6(0.8)
10. Not readily available	3(0.4)	2(0.3)	-	5(0.7)
11. N/R	114(15.3)	69(9.3)	-	183(24.6)
Total	369(49.6)	396(49.6)	6(0.8)	744(100.0)

Section Six

4.6 Presentation of Results of Hypotheses Tested

Hypothesis One:- States that there is no significant relationship between the age of students and their knowledge of contraception.

This hypothesis was tested by matching the age of students with their responses on knowledge of contraception. The results showed that age group 16 - 19 years appears to have a better knowledge in all the four modern contraceptive methods listed than any of the remaining two age groups 12 - 15 years and 20 - 23 years. These methods are: I.U.D. - 155(20.8%), condom - 153(20.6%), pills - 47(6.3%) and Safe period/abstinence - 39(5.3%).

However, when this result was statistically tested, it was found that there was no significant association between the age of students and their knowledge of modern contraceptive devices ($P > 0.05$) (Table 24).

TABLE 24

KNOWLEDGE OF CONTRACEPTIVES BY AGE OF STUDENTS

KNOWLEDGE OF CONTRACEPTIVE METHODS	AGE				
	12-15 Years	16-19 Years	20-23 YRS.	+N/R(Age)	Total
	N(%)	N(%)	N(%)	N(%)	N(%)
Use of I.U.D.	24(3.2)	155(20.8)	6(0.8)	10(1.3)	195(26.2)
Condom	19(2.6)	153(20.6)	7(0.9)	4(0.5)	183(24.6)
Tablets(pills)	1(0.1)	47(6.3)	1(0.1)	2(0.3)	51(6.8)
Safe period/periodic abstinence	14(1.9)	39(5.3)	0	2(0.3)	55(7.4)
+Abortion	29(3.9)	147(19.8)	5(0.7)	7(0.9)	188(25.3)
+Other methods (e.g. native medicine, local gin).	5(0.7)	17(2.3)	1(0.1)	3(0.4)	26(3.5)
+N/R	7(0.9)	35(4.7)	2(0.3)	2(0.3)	46(6.2)
Total	99(13.3)	593(79.7)	22(3.0)	30(4.0)	744(100.0)

+ Excluded from X^2 test.

df = 6, X^2 = 16.88 , P>0.05)

Hypothesis Two: It states that there is no significant relationship between the age of students and their attitude towards contraceptive use.

To test this hypothesis, a comparison was made between the age of students and their average scores on attitude rating scale towards contraceptive. These average scores were obtained from positive and negative attitudes.

When this was done, the results revealed that age group group 16 - 19 years has the highest 1386(60.7%) score, age 12 - 15 years ranks next with 307(13.4%) score, while age group 20 - 23 years comes last with 43(1.9%) score for positive attitude respectively. The same order was followed in case of negative attitude scale rating:- ages 16 - 19 years with 274(12.0%) score, ages 12 - 15 with 60(2.6%) score and ages 20 - 23 with 9(0.4%) score. But when this findings was tested statiscally, it was found that there was no significant association between the age and attitude of the respondents towards contraceptive use ($P > 0.05$) (Table 25).

TABLE 25

ATTITUDE TOWARDS CONTRACEPTION BY AGE OF STUDENTS

TYPE OF ATTITUDE	AGE			TOTAL (%)
	12-15 YRS. *AV. SCORE(%)	16-19 YRS. AV. SCORE(%)	20-23YRS. AV. SCORE (%)	
Positive attitude	307(13.4)	1386(60.7)	43(1.9)	1736(76.0)
Negative attitude	60(2.6)	274(12.0)	9(0.4)	343(15.0)
+Undecided	42(1.8)	156(6.8)	8(0.4)	206(9.0)
Total	409(17.8)	1816(79.5)	60(2.6)	2285(100.0)

* AV. Score = Average Score of responses to all the seven Statements.

\+ Excluded from X^2 calculation
df = 2, X^2 = 0.027 P>0.05

Hypothesis Three: States that there is no significant relationship between the age of students and their current practices of modern contraceptive methods. Here, the age of students were matched with their practices of modern contraceptive methods. The result showed that age group 16 - 19 years has the highest number of responses in all the three modern methods (condom - 80(10.8%), pills - 11(1.5%) and I.U.D. - 3(0.4%) that are popularly being currently practiced by the students (Table 26 gives detailed analysis).

However, statistical analysis of this result showed that there was no significant association between the age and current practices of modern methods of contraception among the students ($P > 0.05$) (Table 26).

TABLE 26

CURRENT USE OF CONTRACEPTIVE METHODS BY AGE OF STUDENTS

CONTRACEPTIVE METHODS BEING CURRENTLY USED	AGE IN YEARS				TOTAL
	12-15 YRS.	16-19 YRS.	20-23 YRS.	N/R(AGE)	
	N(%)	N(%)	N(%)	N(%)	N(%)
Condom	10(1.3)	80(10.8)	7(0.9)	3(0.4)	100(13.4)
Pills (tablets)	1(0.1)	11(1.5)	0(0)	-	12(1.6)
I.U.D.	0	3(0.4)	0	-	3(0.4)
+Safe period/abstinence	0	2(0.2)	0	-	2(0.3)
+Abortion/D & C	1(0.1)	12(1.6)	0	-	13(1.7)
+Other methods (e.g. Native medicine, local gin, M&B 760 tables).	9(1.2)	17(2.3)	7(0.9)	-	33(4.4)
+No idea/don't know/NR	1(0.1)	13(1.1)	0	-	14(2.0)
+Don't use any	77(10.3)	455(61.2)	8(1.1)	29(3.6)	567(76.2)
Total	99(13.3)	593(79.7)	22(3.0)	30(4.0)	744(100.0)

\+ Excluded from X^2 test

df = 4, X^2 = 1.51 P>0.05

Hypothesis Four: There is no significant relationship between sex of students and their knowledge of contraception. To determine this, a comparison was made between sex of students and their awareness (knowledge) of modern contraceptive methods.

When this was done, it was found that the females 113(15.2%) have more knowledge of the I.U.D. than their male 82(11.0%) counterparts. But in case of the condom as a contrast, the males 120(16.1%) have more knowledge of it than the female 59(7.9%) respondents. In case of knowledge of the pills, the number of females 28(3.5%) is slightly higher than that of males 25(3.4%). Lastly, 33(4.4%) males compared with 22(3.0%) female respondents have knowledge of the safe period/abstinence.

This findings showed a statistically significant relationship between sex of students and their knowledge of some modern methods of contraceptives ($P < 0.05$) (Table 27).

TABLE 27

KNOWLEDGE OF CONTRACEPTIVE METHODS BY SEX OF STUDENTS

STUDENTS KNOWLEDGE OF METHODS OF CONTRACEPTIVE	SEX			
	MALE N(%)	FEMALE N(%)	+ N/R(SEX) N(%)	TOTAL N(%)
I. U. D.	82(11.0)	113(15.2)		195(26.2)
Condom	120(16.1)	59(7.9)	4(0.5)	183(24.6)
Tablets (pills)	25(3.4)	28(3.5)	-	51(6.9)
Safe period/periodic abstinence	33(4.4)	22(3.0)	-	55(7.4)
+Abortion	68(9.1)	119(16.0)	1(0.1)	188(25.3)
+Other methods (e.g. Native medicine, M & B 760 tablets, local gins, etc.)	12(1.6)	10(1.3)	-	22(2.9)
+N/R	29(3.9)	20(2.7)	1(0.1)	50(6.7)
Total	369(49.6)	369(49.6)	6(0.7)	744(100.0)

+ Excluded from X^2 test

df = 3, X^2 = 24.78 $P < 0.05$

Hypothesis Five: There is no significant relationship between sex of students and their attitudes towards contraception.

To test this hypothesis, the sex of respondents was matched with the average score obtained from the attitude rating scale. The results obtained showed that the percentage of female (40.0%) is higher than that of male (34.7%) among those respondents with positive attitude towards contraceptive use. While in case of negative attitude, there was just a marginal difference between the percentage scores of male (7.7%) and that of the female (7.4%). These findings showed no statistical significant association as regards the sex and attitude of students towards contraceptive use ($P > 0.05$) (Table 28).

TABLE 28

ATTITUDES TOWARDS CONTRACEPTION BY SEX OF STUDENTS

TYPE OF ATTITUDE	SEX		TOTAL
	MALE	FEMALE	
	*AV.SCORE(%)	AV.SCORE(%)	TOTAL (%)
Positive Attitude	770(34.7)	889(40.0)	1659(74.7)
Negative Attitude	170(7.7)	165(7.4)	335(15.1)
+Undecided	132(5.9)	94(4.2)	226(10.2)
Total	1072(48.3)	1148(51.6)	2220(100.0)

* AV. Score - Average score of responses to all the seven statements.
\+ Excluded from x^2 test

df = 1, $X^2 = 2.1$, $P > 0.05$

Hypothesis Six: There would be no significant relationship between sex of students and their current practices of modern methods of contraception.

The hypothesis was tested by matching the sex of respondents with their practices of modern contraceptive methods. When this was done, the result showed that more male 72(9.7%) use condom than female 25(3.3%) while more female 10(1.3%) practice pill than male 2(0.3%) and only female 3(0.4%) are I.U.D. users. And when these findings were tested statistically, a significant relationship was found between sex of students and their current practices of some modern methods of contraception ($P < 0.05$) (Table 29).

TABLE 29

PRACTICES OF CONTRACEPTION BY SEX OF STUDENTS

CONTRACEPTIVE METHOD CURRENTLY USING	SEX			
	MALE	FEMALE	N^+/R(SEX)	TOTAL
	N (%)	N (%)	N (%)	N (%)
Condom	72 (9.7)	25 (3.4)	3 (0.4)	100(13.4)
Pills (Tablets)	2 (0.3)	10 (1.3)	-	12(1.6)
I.U.D.	-	3 (0.4)	-	3(0.4)
+ Safe period/ abstinence	1 (0.1)	1 (0.1)	-	2(0.3)
+ Abortion/D&C	4 (0.5)	9 (1.2)	-	13(1.7)
+ Others methods (e.g. Native medicine, local gin	22 (3.0)	12 (1.5)	-	33(4.5)
+ No idea, I don't know	8 (1.1)	6 (0.8)	-	14(1.9)
+ Don't use any	261 (35.1)	303 (40.1)	3 (0.4)	567(76.2)
Total	369 (49.6)	369 (49.6)	6 (0.8)	744(100.0)

+ Excluded from X^2 test
df = 2, X^2 = 21.79, P $<$ 0.05

Hypothesis Seven: States that there is no significant relationship between types of school attended and students knowledge of modern methods of contraceptives.

To determine this, a comparison was made between the types of school attended and students' knowledge of modern contraceptive methods.

The break down of the result shows that girls' only school 97(13.0%) appear to have better knowledge of I.U.D. than the other types of school. However, the Boys' only schools appear to have better knowledge of the condom 80(10.8%) and safe period/ abstinence 28(3.8%) than the other two types of School. And when these results were statistically tested, a significant association was found among the three types of School of the respondents and knowledge of contraceptive methods ($P<0.5$) (Table 30).

TABLE 30

KNOWLEDGE OF CONTRACEPTION BY TYPES OF SCHOOL ATTENDED

STUDENTS' KNOWLEDGE OF CONTRACEPTION	TYPES OF SCHOOL			
	Mixed N (%)	Girls' Only N (%)	Boys' Only N (%)	Total N (%)
I.U.D.	38 (5.1)	97 (13.0)	60 (8.1)	195(26.2)
Condom	63 (8.5)	40 (5.4)	80 (10.8)	183(24.6)
Pills (tablets)	11 (1.5)	21 (2.8)	19 (2.6)	51(6.9)
Safe period/ abstinence	6 (0.8)	21 (2.8)	28 (3.8)	55(7.4)
+ Abortion	65 (8.7)	85 (11.4)	38 (5.1)	188(25.2)
+ Other methods (e.g. Native medicine, local gin (etc)	13 (1.6)	14 (2.3)	17 (2.0)	44(5.9)
+ N/R	9 (1.2)	6 (0.8)	13 (1.7)	22(3.8)
Total	205 (27.6)	284 (38.2)	255 (34.3)	744(100.0)

+ Excluded from X^2 test
df = 6, $X^2 = 40.39$ $P < 0.05$

Hypothesis Eight: States that there is no significant relationship between types of school attended and students' current practices of modern contraceptive methods. In order to test this hypothesis, the types of school attended was matched with practices of modern contraceptive methods among the students. When this step was taken, the results showed that condom is popularly practised by both the mixed 48 (5.8%) and Boys' Only 41 (5.5%) types of school, while pills is being more practised by the Girls' Only school 9(1.2%) than the remaining two types of school [mixed - 1 (0.1%) and Boys' Only - 2 (0.3%)] and I.U.D is being practice among mixed and Girls' Only types of school. On testing these findings, it was found that there was a statistical significant relationship between types of school attended and current practices of modern methods of contraception by the students ($P < 0.05$) (Table 31)

TABLE 31

PRACTICES OF CONTRACEPTIVE BY TYPES OF SCHOOL ATTENDED

CONTRACEPTIVE METHODS CURRENTLY USING	TYPES OF SCHOOL			
	Mixed	Girls' Only	Boys' Only	Total
	N (%)	N (%)	N (%)	N (%)
Condom	43 (5.8)	16 (2.2)	41 (5.5)	100(13.4)
Pills (tablets)	1 (0.1)	9 (1.2)	2 (0.3)	12(1.6)
I.U.D.	2 (0.3)	1 (0.1)	0	3(0.4)
+ Safe period/ abstinence	2 (0.3)	0	0	2(0.3)
+ Abortion/D&C	4 (0.5)	5 (0.7)	4 (0.5)	13(1.7)
+ Other methods (e.g. Native medicine, local gin (etc)	10 (1.3)	8 (1.1)	15 (2.0)	33(4.5)
+ No idea/don't know	1 (0.1)	7 (0.9)	6 (0.8)	14(1.9)
+ Don't use any	142 (19.1)	238 (32.0)	187 (25.1)	567(76.2)
Total	205 (27.6)	284 (38.2)	255 (34.3)	744(100.0)

+ Excluded from X^2 test
df = 4, X^2 = 23.29 $P < 0.05$

Hypothesis Nine: There is no significant relationship between students family type and their knowledge (awareness) of modern contraceptive methods. Here the responses of students as regards their family type and their awareness of modern methods of contraception were matched together. The results obtained showed that among the three major types of home, monogamous home has the highest number of respondents who claimed to have knowledge of four of the modern methods of contraception. These are: I.U.D. - 111 (14.9%) respondents, Condom - 113 (15.2%) respondents, Pills - 26 (3.5%) respondents and safe period - 30 (4.0%) respondents. However, the differences in these figures were not statistically significant ($P > 0.05$) (Table 32).

Hypothesis Ten: There is no significant relationship between the students' family type and their current use of modern methods of contraception. In order to verify this, a comparison was made between the students' family type and their practices of modern contraceptive methods. Responses of polygamous and monogamous homes were used for the comparison because these were in the majority as other types of home account for only 0.9% of the sample size. The results showed that, for all three modern contraceptive methods being currently used by the respondents, the use of contraceptives in students who come from monogamous homes ranks higher with the following number of respondents: - 50(6.7%) were I.U.D. users. However, these findings showed no statistical significant relationship between the two (polygamous and monogamous homes) types of family and students' current uses of some modern methods of contraceptive ($P > 0.05$) (Table 33).

TABLE 32

KNOWLEDGE OF CONTRACEPTION BY FAMILY TYPE

KNOWLEDGE OF CONTRACEPTIVE METHODS	TYPE OF FAMILY					
	Polygamous Home	Monogamous Home	Fragmented (Separated	+ Others	+ N/R	Total
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
I.U.D.	75(10.1)	111(14.9)	8(1.1)	1(0.1)	-	195(26.2)
Condom	61(8.2)	113(15.2)	7(0.9)	1(0.1)	-	183(24.6)
Pills (tablets)	22(3.0)	26(3.5)	2(0.3)	1(0.1)	1(0.1)	51(6.9)
Safe period/ abstinence	23(3.1)	30(4.0)	2(0.3)	-	-	55(7.4)
+ Abortion	88(11.8)	99(13.3)	1(0.1)	-	-	188(25.3)
+ Others (e.g Native medicine, local gin, etc)	18(2.4)	25(3.4)	1(0.1)	-	-	44(5.9)
+ N/R	10(1.3)	11(1.5)	3(0.4)	-	4(0.5)	28(3.8)
Total	297(39.9)	415(55.8)	24(3.2)	3(0.4)	5(0.7)	744(100.2)

+ Excluded from X^2 test

df = 6, X^2 = 2.65 $P > 0.05$

TABLE 33

PRACTICES OF CONTRACEPTION BY FAMILY TYPE

CURRENT PRACTICES OF CONTRACEPTIVE METHODS	TYPE OF FAMILY					
	Polygamous Home N (%)	Monogamous Home N (%)	+Fragmented (Separated, Divorced) + N (%)	+Others + N (%)	+ N/R + N (%)	Total N (%)
Condom	43 (5.8)	50 (6.7)	4 (0.5)	2 (0.3)	1 (0.1)	100(13.4)
Pills (tablets)	6 (0.8)	6 (0.8)	-	-	-	12(1.6)
I.U.D.	-	3 (0.4)	-	-	-	3(0.4)
+ Safe period/ abstinence	1 (0.1)	1 (0.1)	-	-	-	2(0.3)
+ Abortion/D&C	9 (1.2)	4 (0.5)	-	-	-	13(1.7)
+ Other methods	10 (1.3)	20 (2.7)	2 (0.3)	-	1 (0.1)	33(4.5)
+ No idea/don't know	2 (0.3)	10 (1.3)	1 (0.1)	1 (0.1)	-	14(1.9)
+ Don't use any	226 (30.4)	321 (43.1)	17 (2.3)	-	3 (0.4)	567(76.2)
Total	297 (39.9)	415 (55.8)	24 (3.2)	3 (0.4)	5 (0.7)	744(100.0)

+ Excluded from X^2 test
df = 2, X^2 = 2.63 P > 0.05

Hypothesis Eleven: There is no significant relationship between parental socio-economic status (S.E.S) and students' knowledge of modern contraceptive methods. To test this hypothesis, the parental educational level was matched with the students' knowledge of contraceptives because educational attainment is a vechicle for moving from one socio-economic status to another in a Nigerian Society and other parts of Africa (World Bank: Education in Sub-Saharan Africa, 1988).

In the case of the fathers' level of education versus knowledge of contraceptive the result showed that out of the three major levels of education, the professional/University/Polythechnic/N.C.E group recorded the highest number of responses in each of the four modern methods of contraceptives that the respondents are familiar with. This analysis is as follows 85 (11.4%), 84 (11.3%), 17 (2.3%) and 25 (3.4%) of the I.U.D., Condom, Pills and Safe period/abstinence respectively. However, these findings statistically showed no significant relationship between fathers' educational level and students' knowledge of modern methods of contraceptive ($P > 0.05$) (Table 34). Hence, the first part of the hypothesis is accepted.

Also still testing this hypothesis, a comparison was made between mothers' level of education and the students' knowledge of modern contraceptives. In contrast to the fathers' case, the results showed that responses of School Certificate/Grade II/ O'level holders rank highest among the three major levels of education. These are: 68 (9.1%), 68 (9.1%), 20 (2.7%) and 16 (2.2%) of the I.U.D, Condom, Pills (tablets) and Safe period/abstinence respectively. But surprisingly, there was no statistical significant association between mothers' level of education and the students' knowledge of modern contraceptives in these findings ($P > 0.05$) (Table 35). Therefore, this second part of the hypothesis is also accepted and a conclusion is made that there is no significant relationship between parental S.E.S and students knowledge of modern contraceptive methods.

TABLE 34

KNOWLEDGE OF CONTRACEPTION BY FATHER'S LEVEL OF EDUCATION

KNOWLEDGE OF CONTRACEPTIVE BY STUDENTS	FATHERS' LEVEL OF EDUCATION						
	Illiterate Primary N(%)	School Cert./ Grd.II/ 'O'-L. N(%)	Professional/ University etc N(%)	+ Others N(%)	+ No idea don't know N(%)	+ N/R N(%)	Total N(%)
I.U.D.	31(4.2)	53(7.1)	85(11.4)	1(0.1)	17(2.3)	8(1.1)	195(26.2)
Condom	23(3.1)	49(6.5)	84(11.3)	4(0.5)	17(2.3)	6(0.8)	183(24.6)
Pills(tablets)	9(1.2)	13(1.7)	17(2.3)	0	7(0.9)	5(0.7)	51(6.7)
Safe period/ abstinence	4(0.5)	17(2.3)	25(3.4)	2(0.3)	4(0.5)	3(0.4)	55(7.4)
+ Abortion	23(3.1)	46(6.2)	83(11.2)	1(0.1)	22(3.0)	13(1.7)	188(25.3)
+ Others (e.g Native medicine)	11(1.5)	12(1.6)	14(1.9)	0	4(0.5)	3(0.4)	44(5.9)
+ N/R	3(0.4)	5(0.7)	10(1.3)	0	5(0.7)	5(0.7)	28(3.8)
Total	104(14.0)	195(26.2)	318(42.7)	8(1.1)	76(10.2)	43(5.8)	744(100.0)

+ Excluded from X^2 test
df = 6, X^2 = 4.55, P > 0.05

TABLE 35

KNOWLEDGE OF CONTRACEPTION BY MOTHERS' LEVEL OF EDUCATION

STUDENTS' KNOWLEDGE OF CONTRACEPTIVES	MOTHERS' LEVEL OF EDUCATION						
	Illiterate Primary N(%)	School Cert./ Grd.II 'O'.L. N(%)	Professional/ University etc. N(%)	+ Others N(%)	+ No idea don't know' N(%)	+ N/R N(%)	Total N(%)
I.U.D.	61(8.2)	68(9.1)	38(5.1)	1(0.1)	18(2.4)	9(1.2)	192(26.2)
Condom	49(6.9)	68(9.1)	41(5.5)	-	14(1.9)	11(1.5)	183(24.6)
Pills (tablets)	9(1.2)	20(2.7)	6(0.8)	-	7(0.9)	9(1.2)	51(6.8)
Safe period/ abstinence	9(1.2)	16(2.2)	16(2.2)	-	6(0.8)	8(1.1)	55(7.4)
+ Abortion	52(7.0)	62(8.3)	35(4.7)	-	24(3.2)	15(2.0)	188(25.3)
+ Others (e.g. Native Medicine local gin, etc)	18(2.4)	12(1.6)	6(0.8)	-	5(0.7)	3(0.4)	44(5.9)
+ N/R	5(0.7)	6(0.8)	6(0.8)	-	4(0.5)	7(0.9)	28(3.8)
Total	203(27.3)	252(33.9)	148(19.9)	1(0.1)	78(10.5)	62(8.3)	744(100.0)

+ Excluded from X^2 test
df = 6, X^2 = 9.27, P > 0.05

Hypothesis Twelve: There is no significant relationship between Parental S.E.S. and students current practices of contraceptive methods. To determine this, as in case of hypothesis eleven, the parental level of education was compared with current use of modern contraceptive methods among the students. On analysing this procedure, the results showed that 33 (4.4%) with professional/ University/Polythechnic/N.C.E, 27 (3.6%) with secondary/Grade II/ 'O' level and 16 (2.2%) with illiterate/Primary qualifications respectively were among Condom users. While in the case of pills users, Secondary School Certificate holders ranks highest 5 (0.7%) this followed by professional/University/Polythechnic/N.C.E holder 4 (0.5%) and with Illiterate/Primary holders coming last 2 (0.3%). Only professional/University/Poly/N.C.E. 2 (0.3%) were among the I.U.D. users. However, there was no statistical significant association in these findings ($P > 0.05$) (Table 36). Hence, the first part of the hypothesis was accepted.

Again, the hypothesis was tested by comparing the mothers' level of education with the students current use of contraceptive. The results obtained showed that those with Secondary/Grade II/ 'O' level education rank highest in two of the three (Condom,

pills and I.U.D) popularly used modern methods of contraceptive. The analysis is as follows: 30 (4.0%) with Secondary/Grade II 'O' level, 29 (3.9%) with Professional/University/Poly/N.C.E education and 19 (2.6%) with Illiterate/Primary Six education are among condom users, while 6 (0.8%), 5 (0.7%) and none (0%) in the same order are pill (tablets) users. But surprisingly as in fathers' case, there was no statistical significant relationship in the findings here ($P > 0.05$) (Table 37). Therefore this second part of the hypothesis was also accepted with a conclusion that in both cases, there is no significant relationship between parental S.E.S and current uses of modern contraceptive methods among the students in the study area.

TABLE 36

PRACTICES OF CONTRACEPTIVES BY FATHERS' LEVEL OF EDUCATION

STUDENTS' CURRENT PRACTICES OF CONTRA-CEPTIVES	FATHERS' LEVEL OF EDUCATION						
	Illiterate Primary N(%)	Secondary/ Grd.II 'O'.L. N(%)	Professional/ University/Poly/ N.C.E N(%)	+ Others N(%)	+ No idea/ don't know N(%)	+ N/R N(%)	Total N(%)
Condom	16(2.2)	27(3.6)	33(4.4)	1(0.1)	19(2.6)	4(0.5)	100(13.4)
Pills (tablets)	2(0.3)	5(0.7)	4(0.5)	0	1(0.1)	-	12(1.6)
I.U.D.	-	0	2(0.3)	0	1(0.1)	-	3(0.4)
+ Safe period/ abstinence	0	0	1(0.1)	1(0.1)	-	-	2(0.3)
+ Abortion/ D&C	5(0.7)	3(0.4)	5(0.7)	-	-	-	13(1.7)
+ Others/e.g Native Medicine	4(0.5)	11(1.5)	14(1.9)	-	1(0.1)	3(0.4)	33(4.4)
+ No idea/ don't know	2(0.3)	5(0.7)	5(0.7)	-	1(0.1)	1(0.1)	14(1.9)
Don't use any	75(10.1)	144(19.1)	254(34.1)	6(0.8)	53(7.1)	35(4.7)	567(76.2)
Total	104(14.1)	195(26.2)	318(42.7)	8(1.1)	76(10.2)	43(5.8)	744(100.0)

+ Excluded from X^2 test

df = 4, X^2 = 3.01, $P > 0.05$

TABLE 37

PRACTICES OF CONTRACEPTIVES BY MOTHERS' LEVEL OF EDUCATION

STUDENTS CURRENT PRACTICES OF CONTRACEPTIVE	MOTHERS' LEVEL OF EDUCATION: Illiterate Primary N(%)	Secondary/ Grd.II 'O'.L. N(%)	Professional/ University/Poly/ N.C.E N(%)	+ Others N(%)	+ No idea/ don't know N(%)	+ N/R N(%)	Total N(%)
Condom	19(2.6)	30(4.0)	29(3.9)	-	12(1.6)	10(1.3)	100(13.4)
Pills (tablets)	5(0.7)	6(0.8)	-	-	1(0.1)	-	12(1.6)
I.U.D	-	1(0.1)	2(0.3)	-	-	-	3(0.4)
+ Safe period/ abstinence	1(0.1)	1(0.1)	-	-	-	-	2(0.3)
+ Abortion/ D&C	6(0.8)	4(0.5)	3(0.4)	-	-	-	13(1.7)
+ Others (e.g Native Medicine)	12(1.6)	6(0.8)	6(0.8)	-	7(0.9)	2(0.3)	33(4.4)
+ No idea/ don't know	3(0.4)	7(0.9)	2(0.3)	-	1(0.1)	1(0.1)	14(1.9)
+ Don't use any	157(21.1)	197(26.5)	106(14.2)	1(0.1)	57(7.7)	49(6.6)	567(76.2)
Total	203(27.3)	252(33.9)	148(19.9)	1(0.1)	78(10.5)	62(8.3)	744(100.0)

+ Excluded from X^2 test

df = 4, X^2 = 8.07, P > 0.05

Hypothesis Thirteen: There is no significant relationship between the students' religion and their current practices of contraception. This hypothesis was tested by matching the students responses on religious affliation with that of current uses of modern contraceptive methods. This comparison was made between Christianity and Islam only because these were in the majority as the other religious groups accounted for only 0.5% of the sample. On doing this, the results showed that Christianity has more respondents than Islam in all the three popularly used modern Contraceptive methods. The analysis goes thus: 55(7.4%) were condom users, 10(1.3%) were pills users and 2(0.3%) were I.U.D. users among Christianity respondents, while 43(5.8%) were condom users, 2 (0.3%) were pills users and one (0.1%) were I.U.D. users among Islam respondents. However, the findings showed no statistical significant relationship ($P > 0.05$) (Table 38).

TABLE 38

PRACTICES OF CONTRACEPTIVE BY STUDENTS' RELIGION

CONTRACEPTIVE METHODS CURRENTLY USING	RELIGION					
	Christianity	Islam	+ Traditional African Faith	+ Others	+ N/R	Total
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
Condom	55(7.4)	43(5.8)	1(0.1)	-	1(0.1)	100(13.4)
Pills(tablets)	10(1.3)	2(0.3)	-	-	-	12(1.6)
I.U.D.	2(0.3)	1(0.1)	-	-	-	3(0.4)
+ Safe period/ abstinence	1(0.1)	1(0.1)	-	-	-	2(0.3)
+ Abortion/ D&C	7(0.9)	6(0.8)	-	-	-	13(1.7)
+ Others (e.g. Native medicine, M&B 760 tablets)	16(2.2)	11(1.5)	-	-	6(0.8)	33(4.4)
+ No idea/ don't know	8(1.1)	6(0.8)	-	-	-	14(1.9)
+ Don't use any	382(51.3)	181(24.3)	1(0.1)	2(0.3)	1(0.1)	567(76.2)
Total	481(64.1)	251(33.7)	2(0.3)	2(0.3)	8(1.1)	744(100.0)

+ Excluded from X^2 test

df = 2, X^2 = 3.34, $P > 0.05$

CHAPTER FIVE

DISCUSSION OF RESULTS

In this chapter, the results of the study are discussed under the following sub-headings:- demographic characteristics of respondents, knowledge of reproductive health and family life education (sex education), knowledge of contraception, respondents' attitudinal disposition towards contraceptive use, practices of contraception and barriers to contraceptive utilization. While the implications for health education and recommendations concluded the chapter.

Demographic Characteristics of Respondents

Results of the study showed that out of the three types (mixed, Girls' only and Boys' Only) of schools attended by the respondents, Girls' Only and Boys Only almost shared equal proportion of respondents (38.2% and 34.3% respectively) while the mixed school has the least proportion (27.9%).

As regards the age of respondents, the results showed that a large proportion of the respondents 692(93.1%) are in the adolescent period (13 - 19 years), and are presumed to have reached the age of puberty. This is so because the age of puberty has been documented to be declining among the adolescents (12 - 14 years among girls and 14 - 16 years among boys) nowadays (Population Reports, 1985).

This period is the time they are more likely to become aware of their sexual identities with the resultant effect of engaging in unprotected sexual intercourse experimentation (Akinboye, 1983).

In connection with the sex of respondents, it was found that both sexes (male and female) have equal number 369(49.6%) of respondents. On religion, it was found that out of the two dominant religions (Christianity and Islam), Christianity was in the majority with 481(64.7%) compared with Islam which has 251(33.7%) respondents. However, this finding is contrary to what prevail in the past, because Ibadan city in general was formerly known to be a muslim town. The splitting of former Ibadan Municipal Government (I.M.G.) into five new local government areas may account for this change, because the study areas (Ibadan North-East L.G.A.) may have fallen into christian dominated areas of the former I.M.G. These suggestions need further verification since there has been no official survey on the statistics of the religion of the people of this newly created L.G.A. (Ibadan North-East L.G.A.).

On types of family, the results showed that out of the two major types of family (polygamous and monogamous homes), monogamous home ranks higher with 415(55.8%) respondents than the polygamous home with 297(39.9%) respondents.

Lastly, as regards parental level of education, Professional/ University/Poly./N.C.E. holders are in the majority 318(42.7%) of

fathers' occupation while in case of mothers' occupation, Modern 3/ School Cert./Grade II/'O' Level category has the highest proportion (33.9%). This is in line with World Bank (1988) report that women education in Africa is found to be generally lower than that of men.

Knowledge of Reproductive Health and Family Life Education (Sex Education)

From the results, it was found that a large proportion of respondents 684(91.9%) reported to have heard about human reproductive organs, but when it came to specific knowledge of these organs, only a few 120(21.5%) could correctly identify male reproductive organs while 202(27.7%) could correctly list female reproductive organs. These findings are identical to that of Ekele et al (1989) study in Nigeria which found that while over 90% of their respondents claimed knowledge on reproductive matters, only 10% had the correct knowledge of it. In addition Ajayi et al (1991) a study in Kenya which found that 8% of the total majority of their respondents that claimed knowledge of reproductive matters, could correctly identify it.

In the case of knowledge of age of puberty, slightly above half (52.0%) of the respondents could identify the boy's age of puberty, while less than half of them (44.1%) could identify girls' age of puberty.

As regards knowledge of family life education (FLE), slightly above half 412(55.4%) of them appear to have knowledge of

"information on sex roles and how to avoid unwanted pregnancy when an individual attains puberty", which is just one of the components of FLE. This is an indication that the respondents have poor knowledge of FLE. This poor knowledge can be attributed to the fact that the study of Health Science which has FLE/Family Planning as one its components is now fading away from most Secondary Schools' curricula in Oyo State nowadays (as revealed by the author's investigation from some teachers).

Knowledge of Contraceptive Devices/Family Planning Methods

From the study, it was found that a high proportion 484(65.1%) of the respondents in the study area have knowledge of some modern methods of contraception. These methods include; I.U.D. - 195(26.2%), Condom - 183(24.6%); Pills (tablets) - 51(6.8%) and safe period/periodic abstinence - 55(7.4%) of respondents respectively. This findings is in contrast to that of Odujinrin's (1992) study which found that the Nigerian teenagers had very poor knowledge of contraception.

Also, the study revealed that the majority 393(52.8%) of respondents got their information about contraception from Radio and T.V. programmes, and that "Right-Time Condom" (a brand of condom) is the popular modern method of contraception being heard from this source (Radio and T.V. programmes).

Attitide of Respondents Towards Sexual Behaviour and Contraceptive Use

Sexual Behaviour:- The majority 428(57.5%) of respondents, out of which 180(24.2%) were male and 248(33.3%) were female were found to disapprove of premarital sexual behaviour among the students in high schools. This finding is consistent with that of the study of Nichols et al (1986) which found that in Ibadan, Nigeria, a high proportion (66.7%) of respondents in their study group were found to disapprove of premarital sexual union among secondary school students.

Attitude Towards Contraceptive Use:- As regards this, the study revealed that a high proportion (76.0%) of the respondents out of which were 34.7% male and 41.3% female favour the use of contraception by students in Secondary Schools. This result is identical to previous studies in Nigeria, Liberia, Kenya and Zimbabawe (Nichols et al, 1986 and 1987, Ajayi et al, 1991 and Boohene et al, 1991) where a high proportion of respondents in all these studies were found to favour contraceptive use among high school students.

Practices of Contraception (Contraceptive Use):- The study showed that contraceptive use among the respondents was extremely low (15.7%), especially the use of modern methods, despite the fact that their attitudinal disposition towards its use was found to be very high (76.0%). Four of these methods are being currently used by them. These are:- Condom (13.4%), Pills (tablets) (1.6%),

I.U.D. (0.4%) and safe period/periodic abstinence (0.3%). This finding is similar to that of Odujinrin (1990) study in Nigeria, which found that a very low percentage (20.3%) of respondent in her study group use contraceptives. It is also similar to the findings from Demographic Health Surveys (1992) which showed that contraceptive use among the unmarried youths was low in Sub-Saharan Africa with ranges from about 25 percent in Zimbabwe to one percent in Nigeria.

Furthermore, the study showed that the most frequently used modern method of contraception by the respondents is the condom which i 85.4% of the users of four of these methods. This situation is expected because the condom is the popular method being heard from Radio and T.V. programmes by the respondents. This findings of condom being the most commonly used methods is similar to that of Ekele et al (1989) study in Jos, Nigeria, which showed that condom is the most commonly used method among the respondents (both males and females) in their study group.

However, a small percentage (4.4%) of the respondents in the present study were found to be using non-contraceptive and unreliable methods. Examples of such methods are M & B 760 tablets (which is commonly practised among girls who are mis - using it as abortion drugs), native medicine, battery water and local gin. This finding is identical to that

of Ezimokhai et al (1981) study which discovered that in Nigeria some girls take large quantities of vitamin pills after intercourse, thinking that vitamins will prevent pregnancy.

Lastly, in this study, it was found that some girls practice abortion/D & C as a method of contraception which is a suggestive indication that induced abortion is being practised among the students nowadays.

Barriers to Contraceptive Use Among the Respondents

From the study, the reasons given by the respondents for non-use of contraception could be taken as barriers to contraceptive use among them. Topping the list of these reasons is, "I am still small/still a student/still with my parents (10.8%)". This finding is in line with that of Ekele et al (1989) study in Nigeria, which found that one of the reasons given by non-users of contraception in their study group is "I am still under the watchful eyes of my parents". Other reasons given by the respondents in this study in order of magnitude are:- "Don't know/No idea (lack of information) (10.5%)", Not good for student/is good for prostitutes (9.7%)", Is against religious practices (6.7%)", Safety Concerns (6.6%)", I don't like it/want a baby (3.6%)", "failure rate (1.1%)", "not enjoyable (0.8%)", and "not readily available (0.7%)". The above reasons given by the respondents are identical to the previous

findings from studies conducted in Nigeria, Liberia, Kenya, U.S.A. and some other developed countries of the world (Oronsaye et al, 1983, Nichols et al, 1986, Odujinrin, 1990, Nichols et al, 1987, Ajayi, et al, 1991, Liskin et al, 1984, Zelnik et al, 1984 and Demographic Health Survey, 1992).

Therefore, in summary, the study showed that the barriers to contraceptive use among the respondents include the following:-

(a) In adequate information and poor knowledge about reliable and safer methods of contraception. This is as a result of the absence of FLE/family planning counselling services in the curricula of most secondary schools in Oyo State.

(b) Anxiety/fear towards parents' objection and that it is not good for students. This is as result of ignorance among the parents because they think that the use of contraceptives will encourage sexual promiscuity among the students.

(c) Wrong notion that it is against religious practices/doctrines. This occurs as a result of strict adherence to religious dogmatism and as well as religious fanatism.

(d) Safety Concerns:- that is it may cause death or damage to the womb. This again is as a result of absence of proper guidance and counselling of youths on contraceptive use by the society.

(e) Anxiety about failure rate of the method when using it (for example condom is thought of being susceptible to breaking or leaking). This is also due to absence of guidance and counselling.

(f) That the method is not enjoyable - that is it may interfer with the romantic aspect of sex. Lack of proper guidance and counselling can also account for this.

(g) None availability and poor accessibility to these devices. This is as a result of refusal of health workers, policy makers and service providers to extend contraceptive services to the unmarried in-school youths.

IMPLICATIONS FOR HEALTH EDUCATION

Health Education is concerned with communication of factual information to people with the aim of helping them to develop desirable practices that would ensure an optimum well being. It also ensures a voluntary and lasting change in people. Its goal is to discourage human behaviour detrimental to health and to encourage positive behaviour that are believed would raise health levels. It should be pointed out that the factual information needed to be communicated to people cannot be done through a vacuum. It has to be transmitted through a proper medium/channel before it can produce the desired change/result. There are different media/channels through which information can be transmitted;- these

include; radio, T.V., newspapers, posters, film strips/charts, video tapes, cinema etc. Also, to enhance desired change/result, the selection of appropriate media/channel will depend upon the target audience (as regards level of education, their locality and available infrastructural facilities).

Sometimes, there may be adequate information which may have been transmitted to people through appropriate channel but yet may not produce any desirable result/change due to some underlying factors(barriers). These factors according to Green et al (1980b) can be grouped into three broad categories:- namely; (i) predisposing factors (which include knowledge, attitudes, beliefs and values), for example, there may be a conflict between an individual belief and the newly acquired knowledge/information, hence, this conflict may not give room for the information to produce any desirable change in him; (ii) enabling factors (skills, resources in term of cost, availability and accessiblity) for example, an individual may have adequate knowledge/information of contraceptive devices, but may not be able to purchase it due to problem of affordability or accessibility; and (iii) reinforcing factors (which may be co-workers, family members, peer groups, friends and members of the society), for example, family members or members of the society may discourage the adolescent from using contraceptives which he has got adequate knowledge about.

According to the context of the study, it was found that despite the fact that the respondents have high knowledge of contraception and favour its use as well, but contrary to what is being expected, it was found that the use of reliable, simple and effective ones was generally very low among them. Hence, majority of them are either not using any one or using unsafe and unreliable methods due to some of the barriers enumerated earlier. These barriers can be grouped into two main subgroups:- (i) low accessibility to contraceptive/family planning services (enabling factor) which occurs as a result of negative attitude of the society, parents and service providers to extend contraceptive counselling and services to students in Secondary Schools and (ii) insufficient knowledge of reproductive health and FLE (predisposing factor) among the respondents due to its fading away from the curricula of most Secondary Schools in Oyo State.

Therefore, based on these findings, health education intervention programme should be directed towards educating the society, parents, service providers as well as policy makers (reinforcing factors) to see the need to allow students free access (enabling factors) to contraceptive counselling services and effective use of reliable contraceptive devices by the needy ones. It could be pointed out here that one of the major reasons for refusing adolescents ready access to FLE and contraceptive services according to

previous research findings is the unneccessary anxiety and fears (predisposing factors) that it will encourage indiscriminate sexual promiscuity among them. But on the contrary, the programme (FLE and contraceptive services) has been found to heighten their sexual responsibility (Edelman et al, 1986).

To enhance the effective and functional education of those concerned, information on the consequences of denying students in the high school access to FLE and contraceptive services should be highlighted. These are social, economic and medical consequences which occur as a result of early pregnancies due to unprotected sexual union among the students. As a matter of fact, the theory of Health Belief Model (HBM) designed by Rosenstock (1984) should be linked with changing of the negative behaviour and attitude of the parents and society towards exposure of in-school youths to this vital aspect of education (FLE). According to this theory (HBM), perceived susceptibility of an individual to a problem (disease) and perceived serious effect of it should propel him to take an urgent action to combat it. Therefore, linking this theory to the situation in the study, perceived susceptibility of adolescents/ youths to unwanted pregnancies and STDS including AIDS and perceived serious consequences of unprotected premarital sexual activities among the students should be used to serve as a "cue to action" or

force parents to take an urgent action. In order to achieve this, the Federal Ministry of Health should mount a nation wide enlightenment campaign programme on the danger of increasing rate of adolescent pregnancy that results from unprotected sexual union which is now rampart among the unmarried in-school youth. The success of this enlightenment programme could be achieved through organised symposia, and seminars, workshops and the use of mass media communication channels such as radio, television and use of posters, and video tapes. Also, the instruction package in this programme among others should include the effect the cost of maintaining adolescent pregnancy would have on the limited budget voted for the health sector and as well on our country's present dwindling economy, problem of its adverse effect on the nation economy because some of the promising students who suddenly become pregnant may have their educational opportunities become terminated abruptly without any chance of furthering it; while many of them both boys and girls are at risk of contracting STDs including the deadly AIDS.

Another area of health education intervention programme is the one that is directed towards combating the problem of accessibility and affordability (enabling factors) of some simple contraceptive methods to the needy students in the Secondary Schools. The target audience involved here are the government (both local, State and Federal Governments), the policy makers, service providers and health

officials who need to extend contraceptive guidance and counselling services to students. This could be done by urging them to assist and finance the service providers to pay regular visits to schools to offer necessary contraceptive counselling services and as well as distributing some of these devices freely especially condom (which has no medical side effect and simple to use) to the needy ones.

Furthermore, another very important health education strategy is the one that should be directed towards educational policy-makers and the school authorities to make Reproductive health and FLE a compulsory subject in the Secondary School curriculum throughout the country in general and Oyo State in particular. If this is implemented, it would broaden the students' knowledge of reproductive health matters and as well as heighten their sexual responsibilities. Findings from previous studies have documented that some developed and developing countries have been able to effectively resolve the issue of teenage pregnancy by providing early reproductive health and FLE to their in-school youths (Eisen et al, 1986, Feldman et al, 1986, Marsiglio et al, 1986, Gyepi - Garbrah 1985a and 1985b). But in case of Nigeria on the contrary, inspite of the recommendation made by various research groups on problems of adolescent sexuality, the implementation of reproductive health and FLE has not gained ground in most schools in the country. This is evident in the

sense that most students in these study groups were found to lack correct knowledge of human reproductive organs and that they all would wish to receive more adequate knowledge of this subject matter (Nichols et al, 1986 and Ekele et al, 1989). Notwithstanding, it is worth mentioning that reproductive health and FLE is now been implemented by the Lagos State Government in some schools in Lagos State, the State which is just a small segment out of the remaining large segment that was left untorched (The Gardian, June 18, 1992).

Therefore, the situation calls for an urgent effort to implement the programme (FLE) in schools in the remaining large part of the country in general and Oyo State in particular so as to address the barriers to students' contraceptive use. One of such barriers is misconception that contraception is very dangerous to human reproductive organs. This is probably attributed to poor knowledge of human reproductive health and FLE on part of the students.

The instruction package to be included in FLE programme among others should be on how to help the students to make responsible decision on their sexual behaviour in order to guide against unsafe and unprotected sexual activities, contraceptive guidance and counselling services, simple skill training in using simple contraceptive method, especially condom, the girls should be advised to cultivate the habit of insisting on their male sexual partners to always use condom before each sexual union.

RECOMMENDATIONS:

In the light of the findings in this study, the following recommendations are made:

(1) As a matter of urgency, reproductive health and family life education instruction should be made a compulsory subject in Secondary Schools in Nigeria as a whole. The implementation of this should be the full responsibility of both State and Local Governments.

(2) The programme of instruction in this FLE in addition to human reproductive system, sexuality and sex education should also include family planning/contraceptive counselling services and utilization.

(3) Both the Ministries of Health, Education and Social Welfare should be involved in planning and implementation of reproductive health and FLE in Secondary Schools.

(4) There should be rapport between the home and school through the PTA to enlighten the parents and guardians on the need to allow their children/wards to receive proper education on reproductive health instruction and free access to contraceptive services in order to address the consequences of unprotected premarital sexual activities among the youths. They should be made to realise that if the youth are denied these necessary informations by the adults, they will eventually turn to mis-informed peers

groups for such information and they will also rely largely on untrained contraceptive service providers for unsafe abortion which is very risky.

(5) The service providers should extend contraceptive services to in - school youths by paying regular visits to schools to cater for those who realy need it especially the sexually active ones. Although few of such service providers have a programme for the youths, but it s implementation is yet to take off. Example of such providers is the Reproductive and Fertility Research Unit of Department of Obstetrics and Gyneacology, U.C.H. which have designed such a programme a long time age to reach the adolescent (Nichols et al, 1986), but it is yet to take off as of March, 1992, when this present research data was being collected.

(6) The school authorities should liase with medical personnel to come and give lectures and talks on human reproductive health and family planning on regular basis.

(7) There should be enlightenment programme on the mass media especially radio and television that will be directed towards meeting the needs of youths as regards FLE and contraceptive methods. These programme should always be broadcast at the time when they will always be available at home.

(8) The reproductive health and FLE should also be incorporated into the teacher training curricular at all levels of Education since the teachers themselves have been found to be uncomfortable when discussing the issue of human reproductive health (WHO, 1980, Oladepo et al, 1991).

(9) The role of Voluntary Organisation cannot be over-emphasized. Therefore, the various interested organisations and religious groups and clubs should be called upon to assist in addressing the problems of sexuality among the youths. They can do this by organising lectures and symposia on regular basis for the students to meet their needs and problems through regular visits to their schools.

(10) The government (both state and Local governments) should play a fatherly role in supporting all these programmes embarked upon by various sectors which are designed to meet the needs of youths (in-school youths) as regards human sexuality.

The message to all and sundry (Government, parents and service providers) is:- pay now for family life education and contraceptive services for youths, or pay later in terms of school drop-out rates and huge hospital costs associated with adolescent pregnancy and abortion complications.

CONCLUSION

This study set to assess the knowledge, attitude and practices of contraception amongst students in Secondary Schools. It was found among other things that their knowledge of contraceptive was high and they have positive attitude towards its use, but surprisingly their actual use of it was very low.

Although, the results obtained in this study may not represent the generality of all students in Secondary Schools in the country, but yet it is identical to all previous research studies conducted in different parts of the country (Oronsaye et al, 1982, Nichols et al, 1986, Ekele et al, 1989 and Odujinrin, 1991) which also revealed a very low contraceptive use among the Secondary School Students.

Therefore, the results in the study suggest an urgent need for the implementation of reproductive health and family life education including contraceptive counselling services in all Secondary Schools Ibadan North-East Local Government Area of Oyo State.

FUTURE STUDIES

Future studies may address the following areas:-

(1) An evaluation of the impact of current economic recession in Nigeria on the utilization of contraception by the students.

(2) The effect of cognitive development of adolescent students on utilization of modern methods of contraception among them.

FUTURE STUDIES

Future studies may address the following areas:-

(1) An evaluation of the impact of current economic recession in Nigeria on the utilization of contraception by the students.

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(3) A comparison of contraceptive awareness and utilization between high school students in rural and urban areas.

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APPENDIX I

CONTRACEPTION AMONGST SENIOR SECONDARY SCHOOL STUDENTS IN IBADAN NORTH-EAST LOCAL GOVERNMENT AREA OF OYO-STATE

QUESTIONNAIRE

Dear Students,

This study is on knowledge, attitude and practices of contraception amongst Senior Secondary School Students in Ibadan North-East Local Government Area of Oyo State.

Your cooperation in filling this questionnaire as faithfully as possible will be highly appreciated and there is assurance of strict confidentiality of all information given.

DO NOT write your name at all.

SECTION A

DEMOGRAPHIC INFORMATION

Tick the boxes or fill in the spaces as appropriate:

1. Type of School
   - (1) Mixed-School (Co-Education) ☐
   - (2) Girls only ☐
   - (3) Boys only ☐

2. Class in School
   - (1) SS_1 ☐
   - (2) SS_2 ☐
   - (3) SS_3 ☐

3. How old are you (age in years) .....

4. Sex

(1) Male ▱

(2) Female ▱

5. Religion

(1) Christianity ▱ Specify Donomination .....

(2) Islam ▱

(3) Traditional African faith ▱

(4) Others (Specify) .....

6. Parents Occupation

(1) Father .....

(2) Mother .....

7. Parents' level of Education

(1) Father .....

(2) Mother .....

8. Type of Family

Tick one from the following options

(1) Polygamous Home ▱

(2) Monogamous Home ▱

(3) Fragmented (Separated, Divorced) ▱

(4) Others (Specify) .....

9. Current living arrangement (i.e. the person you are currently living with).

(1) With both parents ▱

(2) With mother only ▱

(3) With father onlt ▱

(4) With another relative ▱

(5) With friend ▱

(6) Alone ▱

(7) Others (Specify) .....

SECTION B

KNOWLEDGE OF REPRODUCTIVE HEALTH, FAMILY LIFE EDUCATION - (SEX EDUCATION) AND CONTRACEPTION

10. Have you ever heard about human reproductive organs?

(1) Yes ▱

(2) No ▱

11. If Yes, what is the source of your information?

Tick from the following options

(1) School ▱

(2) Radio and Television Progfammes ▱

(3) Boy friend/girl friend ▱

(4) Home (Parents/relatives) ▱

(5) Magazines and Pornographic books ▱

(6) Others (Specify) .....

12. List some parts of human reproductive organs

Male: (1) _____ (2) _____ (3)_____(4) _____

Female: (1) _____ (2) _____ (3)_____(4) _____

13. At what age does a girl and a boy have his/her reproductive organs fully grown?

(1) Boy .....

(2) Girl .....

14. Have you ever heard of Family Life Education (Sex Education)?

(1) Yes ☐

(2) No ☐

15. If Yes, what is the source of your information?

(1) School ☐

(2) Home (Parents/relatives) ☐

(3) Boy friend/Girl friend ☐

(4) Radio and Television Programmes ☐

(5) Magazines and Pornographic books ☐

(6) Other (Specify) .....

16. What is family Life Education (Sex Education)?

Tick from the following statements;

(1) Information on Sex only

(2) Information on boy/girl friend

(3) Information on sex roles and how to avoid unwanted Pregnancies when and individual attains Puberty.

(4) Information on how to play love/sex affair with boy/girl friends.

17. Have you heard of Contraceptive devices or Family Planning?

(1) Yes ☐

(2) No ☐

18. If Yes, what is the source of your information?

(1) Home (Parents/relatives) ▱

(2) School ▱

(3) Radio and Television Programme ▱

(4) Boy friend/girl friend ▱

(5) Magazines and Pornographic books ▱

(6) Others (Specify) .....

19. What do people do to prevent unwanted pregnancies?

_____

_____

20. List the ways of preventing unwanted pregnancies that you are familiar with

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

(7) _____

SECTION C

ATTITUDES TOWARDS SEXUAL BEHAVIOURS AND CONTRACEPTIVE PRACTICES

Tick in only one appropriate space in the following

Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Desirability of Sexual Activity					
21. Having opposite sex friends should start in the high school.					
22. Students should have sexual intercourse as soon as they reach puberty age.					
Danger of Sexual Activity					
23. One of the dangers of sexual activities among the high School Students is the problem of unwanted pregnancies.					
24. Abortion should be encouraged among the unmarried students in Secondary Schools.					
Who should practice contraceptive/ Family Planning					
25. Contraceptive/Family Planning is meant for prostitutes and call girls only.					
26. Contraceptive method is good for only girls.					
27. Contraceptive methods should be practiced by both boys and girls.					
28. Contraception is meant for married adult only.					

Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Responsibility for Decision to Accept Contraception					
29. Contraception should not be practised without the parent approval.					
30. Contraception should be practised on the agreement of both sexes (i.e. both boy's and girl friends).					
Religious Influence on Practice Contraception					
31. Practices of Contraception is against certain religion rules.					

SECTION D

USE OF CONTRACEPTION

32. Have you ever used any method with your sexual partners to present unwanted Pregnancies?

(1) Yes

(2) No

33. If Yes, which method did you use? .....

34. If No, give reason(s) .....

.....

35. Are you currently using any method with your sex partner(s) to prevent unwanted pregnancies? .....

(1) Yes

(2) No

36. If Yes, which method do you use most frequently?

.....

.....

37. If No, give reason (s) .....

.....

APPENDIX II

LIST OF SECONDARY SCHOOLS IN STUDY AREA (IBADAN NORTH-EAST L. G. A.) FOR 1991/92 SESSION

TYPE OF SCHOOL		NAME OF SCHOOL
A. BOY'S ONLY		
	1.	Loyola College, Old Ife Road.
	* 2.	Lagelu Grammar School, Agugu.
	3.	Oke-Badan High School, Oluyoro.
B. GIRL'S ONLY		
	* 4.	Queen of Apostle Grammar School, Oluyoro, Ibadan.
C. MIXED SCHOOLS		
	5.	Renascent High School, Aremo.
	6.	Holy Trinity Grammar School, Old Ife Road.
	* 7.	Army Barracks Grammar School, Iwo Road.
	8.	Olubadan High School, Aperin.
	9.	United Secondary School, Agugu.
	* 10.	Basorun High School, Bode Wasimi.

* Selected Schools for the Study.

APPENDIX III

MAP OF THE STUDY AREA (IBADAN NORTH-EAST L.G.A.)