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# Awareness of STIs and Contraceptives Use among Out-of-School Youths in Nigeria

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**ABSTRACT** The educational system in Nigeria is characterised by high incidence of dropping out of schools with adverse implications for the youths, who are sexually hyper-active without adequate knowledge about reproductive health decision making. What are the factors influencing contraceptive practices among out of school youths? These and other questions are what the study is set out to address. Triangulation of both quantitative and qualitative techniques was employed for data collection. Specifically, 200 individual based questionnaires were employed for collecting quantitative data from the youths, while 4 in-depth interviews (2 each-1 male and 1 female on youths and adults) and 4 focus group discussions (2 each- 1 male and 1 female on youths and adults) were employed for collecting qualitative data. In terms of data analysis, frequency distribution and chi-square (at 0.05 alpha level of significance) were employed for quantitative data, while content analysis and ethnographic summary were used for qualitative data. The results showed high awareness about STIs and HIV/AIDS but low level of contraceptive practices among the majority of out-of-school youths in the study area. It was found that many out-of school youths engaged in risky sexual behaviour with prevalence of unprotected sexual intercourse. However, the results of cross tabulation showed that the level of awareness about STIs and HIV/AIDS and contraceptive practices were significantly influenced by socio-demographic characteristics (education, sex, income and marital status). Considering the adverse implications of STIs and HIV/AIDS on sustainable human development, contraceptive use should be promoted among out of school youths in motor parks.

## INTRODUCTION

The increasing number of pregnancies, abortions and sexually transmitted infections including HIV / AIDS among the youths in sub-Saharan Africa indicates that successive efforts towards preventing the scourge remain inadequate in the continent. It is obvious that many young people are sexually active with low level of contraceptive use. This is a factor contributing to the increasing spread of sexually transmitted infections and HIV/AIDS among the youths (Okekearu 2004; Juarez and LeGrand 2005).

Since the early 1980s, research about adolescent sexual behaviour has attracted considerable attention and the paucity of adequate information about the reproductive health status of adolescents is widely acclaimed. Evidences from different studies continue to confirm the existence of increasing sexual activities among the youths globally, with those in developing countries perceived to be at greater risk because of their low level of access to medical facilities and other problems associated with the Third world (Nwafor and Madu 2002; Ghuman 2005).

The age at which the youths engage in sexual activities varies considerably depending on the various socializing influences and the opportunities available for practicing sexual behaviours. Studies on adolescent sexual behavior in several parts of Nigeria have shown that pre-marital sexual activities are quite common especially in the urban areas (Adekunle and Ladipo 1992; Araoye and Adegoke 1996).

Dare and Deland (1994) reported a high level of unprotected sexual activities varying from 72.7 per cent among out of school adolescents to more than 50 per cent among their in-school counterparts. Asuzu (1994) and Adekunle and Ladipo (1992) in a survey of urban Nigeria found that 50 to 60 per cent of adolescents by age 19 were sexually active. Asuzu (1994) reported further that in Ibadan, 49 per cent of 16 years old boys reported premarital intercourse compared to 28 percent of 16 years old girls.

However, the prevalence of premarital sexual activities among adolescents is higher in developed countries as well as Africa and the

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Caribbean than in Latin America, Asia and Middle East. In the late 1970s in the United States, France and England, 40-50 per cent of girls have had sexual intercourse by age 17; while in Sweden about 80 per cent of girls have had sexual intercourse by age 17. Similarly, by age 16, over 90 per cent of American adolescents have had some sexual experience and at age 16-19, 72 per cent of boys and 57 per cent of girls had experienced sexual intercourse (Haralambos et al. 2004).

Similarly, Araoye and Adegoke (1996) studied 970 students aged 10-19 and reported that 56 per cent had never used any method of contraception due to lack of knowledge of the methods available. The study also revealed that out of school students had a higher rate of sexual activities and contraceptive use than in school adolescents' youths.

Jinadu and Odesanmi (1993) revealed that despite increased contraceptive knowledge among adolescents, many of them still had unprotected sexual relations. For instance, in a small town in southeast Nigeria, 80 per cent of the girls under age 20 were sexually active but only 5 per cent of these girls reported to have used a contraceptive and 20 per cent of these girls had HIV infection. This may be a reason for the high rate of abortion among schoolgirls in Nigeria.

It is obvious that many youths still lacked basic information on HIV/AIDS and many of them do not plan for sexual activities. They demonstrate low level of knowledge about reproductive matters. However, many youths are familiar with some modern contraceptive methods but their knowledge of HIV/AIDS is incomplete and inaccurate. Thus, sexual activity is sporadic among sexually active youths with grave consequences such as low level of contraceptives use and high rate of Sexually Transmitted Infections / HIV / AIDS (Centre for Health Sciences Training Research and Development 1997).

Sexually transmitted infections (STIs) including HIV are most common among young people aged 15-24 and it has been estimated that half of HIV infections worldwide have occurred among people aged less than 25 years (World Health Organisation 1995). In some developing countries about 60 per cent of new HIV infection occurs among those aged 15 to 24. Yet vulnerability to STIs including HIV is systematically patterned so as to render some young people more likely to become infected than others. Socio-economic status like age and sex are important factors structuring such vulnerability (Aggleton and Warwick 1997; Rivers and Aggleton 1998).

The consequences of STIs and HIV /AIDS can be far reaching for young people because they can result to serious illness, stigmatization and sudden death. Approximately, one-third of the world's young people are between 10-24 years of age and four out of every five young people live in developing countries where the majority of young people are sexually experienced by age 20. The number of young people living in developing countries is expected to increase to 87 per cent by the year 2020 (Friedman 1993; Ebong 1994; Fred 1994; Ainsworth and Over 1997).

It is obvious that STIs and HIV/AIDS contribute to loss of household income due to medical, funeral and mourning expenses. However, many households live on small income. This therefore means that STIs and HIV/AIDS are likely to increase poverty rate and deteriorating living standard for the households affected by the epidemic. In fact, HIV/AIDS has doubled the prevalence of orphans and infant mortality in African countries. In the early 1980s, 2 percent of all children below 15 years were orphans in developing countries but as at 2000, the figure jumped to 7-12 percent in many sub-Saharan African countries (Okekearu 2004).

Given the significant number of young people living in developing countries who are seriously affected by the epidemics it is crucial that research work is undertaken to understand the prevalence and ensure that ameliorative measures are suggested. However, many youths associate contraceptive use with promiscuity and despite their awareness of STIs and HIV/AIDS, they sometimes fail to use contraceptives due to institutional barriers, which may make access to contraceptive difficult (Makinwa 1992;Barker and Rich 1999).

Different studies have shown that knowledge of HIV/AIDS among youths in sub-Sahara Africa is relatively high but contraceptives prevalence among them is low. In the 1982 National Fertility Survey in Nigeria, it was discovered that only 5 per cent of married youths aged 15-19 perceived that unprotected sex could lead to STIs and HIV/AIDS and were using efficient contraceptive. The Nigerian Demographic and Health Survey (1992) in its report, revealed that 31 percent of Nigerian youths aged 15-19 perceived HIV/AIDS as deadly.

An important factor underlying STIs and HIV/AIDS decline is the desire, willingness and ability to undertake contraceptive practices. Therefore, the research on the attitude of out-of-school youths towards contraceptive practices is a worthy research goal. It is against the backdrop of the foregoing that this paper examines STIs and HIV/AIDS and contraceptives practices among out of school youths in the motor parks of Lagos, Southwestern Nigeria.

## DATA AND METHODS

The study was situated among out-of-school youths in the motor parks Lagos, South-western Nigeria. The domain of the study was Oshodi Motor Parks, which cut across three (Ikeja, Ilupeju, Isolo and Oshodi) local government areas. These areas, which are the hubs of transport, constitute centre points of commercial activities in Lagos State and they are notorious for anti-social behaviours due to their thick heterogeneous population structure. Motor parks in the areas serve as terminals for vehicles plying virtually all parts of Nigeria. The areas harbor many out-of-school youths, who flee their various homes and engage in different economic activities in order to earn living.

In the light of the above, the study population is drawn from the youth groups settled in motor parks in the study area. The study population includes all out-of school youths aged 10 to 24 in the study setting. Data was collected at the individual level. Purposive and accidental random sampling procedures were used in the administration of 200 well-structured question-naires among out-of-school youths. These sampling procedures were undertaken due to the absence of reliable sampling frame and the need to generate self-sampling frame that is representative of motor parks in Lagos State.

Survey design was adopted and primary data was collected in April and May 2006 from 200 male and female youths aged 10 to 24. Also, 14 qualitative interviews were conducted involving male and female adults aged 25 to 60 in four local government areas of Lagos State. Triangulation of both quantitative and qualitative techniques was employed for data collection. Specifically, 200 individual based well-structured questionnaires comprising 142 questions under six sub-sections were employed for collecting quantitative data from the same number of out-of-school youths, while 4 in-depth interviews (2 each-1 male and 1 female for youths and adults) comprising 23 questions and 4 focus group discussions (2 each-1 male and 1 female for youths and adults) comprising 21 questions were employed for collecting qualitative data from 14 youths and 14 adults to attain residual certainties about the issues under study. Each focus group discussion comprised 6 homogeneous individuals. In terms of data analysis, frequency distribution and chi-square were employed for quantitative data, while content analysis and ethnographic summary were used for qualitative data.

Trained field officers and research assistants administered all the 200 copies of the well-structured questionnaires and after data editing and cleaning all of them were useful, so the analysis was based on 200 cases. The unit of analysis was individual male and female out of school youths. The analyses were carried out using the Statistical Package for Social Sciences (SPSS) computer software. Cross-tabulation was employed in summarizing and describing the data in line with study objectives. The Chi-square technique aided the test of the significance of association between knowledge of STIs, HIV/AIDS and contraceptive practices.

## RESULTS AND DISCUSSIONS

The study found that male respondents out-numbered their female counterpart with 71.5%, whereas there were 28.5% of the respondents being female. This implies that there were more male out-of-school youths in the study area as at the time of the survey.

In terms of the age of the respondents those aged 16 - 24 pre-dominated with 84%, while the remaining few were in the age bracket of 10 – 15 years. From this data it is obvious that the magnitude of out-of-school youths studied were adolescent and young adults. This finding could have implications for vocational training opportunity because many of the youths in that age category are expected to get involved in one vocation or another since they have attained the legal age for participating in economic activities.

About the ethnic group of the respondents, the Yoruba recorded 81.5%, while the Hausa recorded 1% as against the Igbo with 15.1%. However, very few respondents noted that they belong to other ethnic groups such as the Igala, Tiv, Ijaw and Itsekiri. This finding is not far from

expectations giving the geographical setting of the survey.

Concerning the religion of the respondents, 45.5% were Christians, 51% were Muslims while those affiliated with traditional and other religion recorded 1% each. However, just 1.5% of the respondents refused to disclose their religious identity. This finding shows that there were more Muslims out-of-school youths than their counterparts in other religions. This could be attributed to the significant relationship between Islam and Polygyny, which is a major factor for marital problems in which some youths are adversely affected.

There is a significant relationship between the age of the respondents and their marital status given the following data. Almost 88% of the respondents were single while 8% were married as against 2% who disclosed that they were separated. Also, 1.5% was already 'divorced'. The pre-dominance of the respondents who are single is in consonance with their age, which is below 25 years.

In terms of the respondents' educational qualification, 32% had WASC/NECO, 23.5% completed Primary school while about 44% never attended school. From this finding it can be deduced that the majority of the respondents did not go beyond secondary school due to problems such as financial constraint, family crisis, peer influence and personal reasons. In view of respondents' perception about their low educational qualification 64% disclosed that they would go back to school if they had opportunities while the remaining were not ready to go back to school due to preference for vocational training.

In the light of the foregoing, some socio-demographic characteristics of the respondents were isolated and cross-examined with information about STIs, HIV/AIDS and contraceptive practices to find out the strength of relationship between independent, dependent and intervening variables. The results of the cross tabulation are presented in table 1.

Table 1 presents the frequency distribution and cross tabulation of the respondents' selected socio-demographic characteristics with know-ledge about STIs, while table 2 depicts the interface between the respondents selected socio-demographic characteristics and knowledge about ways of contacting HIV/AIDS and contraceptive practices. The knowledge about treatment of STIs is clearly higher among the single than the married respondents. Also, the knowledge about treatment of STIs increases as the magnitude of educational qualification increases among out of school youths.

On adequacy of income and treatment of STIs, majority of the out-of-school youths with inadequate income preferred medicine hawkers followed by traditional healer and self-medication. However, few out-of-school youths with adequate income preferred self-medication followed by attending regular hospitals and medicine hawkers. The relationship between adequate income and treatment of STIs is expected in view of the fact that the cost of procuring different methods of treating STIs differs. However, considering the predominant treatment preference among the out-of-school youths with relatively adequate income, it is obvious that income level is not the only determinant of STIs' treatment. Therefore, the interplay of educational qualification, marital status and income level could be collapsed to provide indepth understanding about factors influencing STIs' treatment among out-of-school youths.

The relationship between educational qualifications and knowledge about STIs is noteworthy. The largest proportions of out-of-school youths had knowledge of gonorrhea followed by other STIs such as syphilis, candidiasis and staphylococcus. The out-of-school youths who attended both senior and junior secondary schools demonstrated more knowledge about STIs than their counterparts who had lower educational quali-fications. For instance, the out-of-school youths with primary education provided little information (relatively average knowledge) about STIs. Therefore, knowledge about STIs increases with rising educational qualifications especially from primary to secondary schools. This result is expected within the context of the impact of western education on information about reproductive health.

The relationship between educational qualifications and knowledge about ways of contacting HIV/AIDS reflected the above findings such that different ways of contacting HIV/AIDS such as unprotected sexual intercourse, sharing of sharp objects and blood transfusion increase with the proportion of respondents in each hierarchical level of educational qualification. Thus, the high level of awareness about the modes of contacting HIV/AIDS is not in doubt among out-of-school youths in the study area.

The relationship between employment status and frequency of condom use shows that the

**Table 1: Frequency distribution and cross-tabulation of out-of-school youths' knowledge about treatment of STIs with selected socio-demographic characteristics**

| *Marital status* | *Treatment of Sexually Transmitted Infections (STIS)* | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *No response* | | *Regular hospital* | | *Medicine hawkers* | | *Self medication* | | *Traditional healers* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| Single | 152 | 90.5 | 8 | 57.1 | 2 | 50.0 | 7 | 100.0 | 7 | 100.0 | 176 | 88.0 |
| Married | 8 | 4.8 | 6 | 42.9 | 2 | 50.0 | 0 | 0.0 | 0 | 0.0 | 16 | 8.0 |
| Separated | 4 | 2.4 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 4 | 2.0 |
| Divorced | 3 | 1.8 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 1.5 |
| Widowed | 1 | 0.6 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 0.5 |
| Total | 168 | 100.0 | 14 | 100.0 | 4 | 100.0 | 7 | 100.0 | 7 | 100.0 | 200 | 100.0 |

| *Educational qualifications* | *Treatment of Sexually Transmitted Infections (STIS)* | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *No response* | | *Regular hospital* | | *Medicine hawkers* | | *Self medication* | | *Traditional healers* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| None | 18 | 8.7 | 1 | 7.1 | 3 | 75.0 | 0 | 0.0 | 4 | 57.1 | 26 | 13.0 |
| Primary | 38 | 22.6 | 3 | 21.4 | 1 | 25.0 | 5 | 71.4 | 0 | 0.0 | 47 | 23.5 |
| Junior Secondary | 42 | 25.0 | 4 | 28.6 | 0 | 0.0 | 1 | 14.3 | 2 | 28.6 | 49 | 24.5 |
| Technical | 3 | 1.8 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 1.5 |
| Senior Secondary | 58 | 34.5 | 5 | 35.7 | 0 | 0.0 | 0 | 0.0 | 1 | 14.3 | 64 | 32.0 |
| NCE/OND | 3 | 1.8 | 0 | 0.0 | 0 | 0.0 | 1 | 14.3 | 0 | 0.0 | 4 | 2.0 |
| HND/BSC | 2 | 1.2 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 2 | 1.0 |
| Others | 4 | 2.4 | 1 | 7.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 5 | 2.5 |
| Total | 168 | 100.0 | 14 | 100.0 | 4 | 100.0 | 7 | 100.0 | 7 | 100.0 | 200 | 100.0 |

| *Educaional qualifications* | *Knowledge of Sexually Transmitted Infections (STIS)* | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *No response* | | *Gonorrhea* | | *Syphilis* | | *Candidiasis* | | *Staphy-lococcus* | | *Others* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| None | 11 | 17.8 | 27 | 31.9 | 4 | 14.2 | 2 | 22.2 | 0 | 0.0 | 2 | 40.0 | 48 | 24.0 |
| Primary | 25 | 40.3 | 12 | 13.2 | 4 | 14.3 | 6 | 66.7 | 0 | 0.0 | 0 | 0.0 | 47 | 23.5 |
| Junior Secondary | 16 | 25.8 | 19 | 20.9 | 10 | 35.7 | 0 | 0.0 | 0 | 0.0 | 4 | 80.0 | 49 | 24.5 |
| Technical | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 60.0 | 0 | 0.0 | 3 | 1.5 |
| Senior Secondary | 15 | 24.5 | 36 | 39.6 | 10 | 35.7 | 2 | 22.2 | 1 | 20.0 | 0 | 0.0 | 64 | 32.0 |
| NCE/OND | 0 | 0.0 | 3 | 3.3 | 1 | 3.6 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 4 | 2.0 |
| HND/BSC | 0 | 0.0 | 1 | 1.1 | 1 | 36.0 | 0 | 0.0 | 1 | 20.0 | 0 | 0.0 | 2 | 1.0 |
| Others | 0 | 0.0 | 4 | 4.4 | 0 | 0.0 | 0 | 0.0 | 1 | 20.0 | 0 | 0.0 | 5 | 2.5 |
| Total | 62 | 100.0 | 91 | 100.0 | 28 | 100.0 | 9 | 100.0 | 5 | 100.0 | 5 | 100.0 | 200 | 100.0 |

| *Adequate income* | *Treatment of Sexually Transmitted Infections (STIS)* | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *No response* | | *Regular hospital* | | *Medicine hawkers* | | *Self medication* | | *Traditional healers* | | *Others* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| No Response | 6 | 13.0 | 2 | 5.1 | 5 | 11.1 | 2 | 8.0 | 2 | 40.0 | 19 | 9.5 | | |
| Yes | 16 | 34.8 | 10 | 25.6 | 8 | 17.8 | 20 | 50.0 | 2 | 8.0 | 0 | 0.0 | 56 | 28.0 |
| No | 24 | 52.2 | 27 | 69.2 | 32 | 71.1 | 18 | 45.0 | 21 | 84.0 | 3 | 60.0 | 125 | 62.5 |
| Total | 46 | 100.0 | 39 | 100.0 | 45 | 100.0 | 40 | 100.0 | 25 | 100.0 | 5 | 100.0 | 200 | 100.0 |

working respondents used condoms more often than their non-working counterparts due to inequality in affordability of contraceptive (condom). The majority of the working respondents have used condom at every sexual intercourse while few used it occasionally. In addition, information about condom availability, accessibility and affordability was embraced more by male than female during the survey. Thus, the above gender differential response could be due to high premium placed on male condom.

All the Pearsons' chi-square ($\chi^2$) values are statistically significant at different levels of degree of freedom indicating that the selected socio-

**Table 2: Frequency distribution and cross tabulation of out-of-school youths' knowledge on ways of contacting and preventing HIV/AIDS with selected socio-demographic characteristics**

| *Educaional qualifications* | *Knowledge about ways of contacting HIV/AIDS* | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *No response* | | *Unprotected sex* | | *Sharing of sharp objects* | | *Blood transfusion* | | *Others* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| None | 8 | 19.1 | 15 | 13.4 | 0 | 0.0 | 2 | 16.7 | 1 | 8.3 | 26 | 13.0 |
| Primary | 11 | 26.2 | 26 | 23.2 | 2 | 9.1 | 4 | 33.3 | 4 | 33.3 | 47 | 23.5 |
| Junior Secondary | 11 | 26.2 | 27 | 24.1 | 10 | 45.5 | 0 | 0.0 | 1 | 8.3 | 49 | 24.5 |
| Technical | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 25.0 | 0 | 0.0 | 3 | 1.5 |
| Senior Secondary | 12 | 28.6 | 34 | 30.4 | 9 | 40.9 | 3 | 25.0 | 3 | 50.0 | 64 | 32.0 |
| NCE/OND | 0 | 0.0 | 4 | 3.6 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 4 | 2.0 |
| HND/BSC | 0 | 0.0 | 2 | 1.8 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 2 | 1.0 |
| Others | 0 | 0.0 | 4 | 3.6 | 1 | 4.5 | 0 | 0.0 | 0 | 0.0 | 5 | 2.5 |
| Total | 42 | 100.0 | 112 | 100.0 | 22 | 100.0 | 12 | 100.0 | 12 | 100.0 | 200 | 100.0 |
| *Employment status* | *Frequency of condom use* | | | | | | | | | | | |
| | *No response* | | *At every sexual intercourse* | | *Occasionally* | | *When I like* | | *Others* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| Working | 65 | 72.2 | 63 | 90.0 | 19 | 100.0 | 10 | 100.0 | 11 | 100.0 | 108 | 84.0 |
| Not Working | 25 | 27.8 | 7 | 10.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 32 | 16.0 |
| Total | 90 | 100.0 | 70 | 100.0 | 19 | 100.0 | 10 | 100.0 | 11 | 100.0 | 200 | 100.0 |
| *Gender* | *Condom availability, accessibility and affordability* | | | | | | | | | | | |
| | *No response* | | *Availability* | | *Accessibility* | | *Affordability* | | *All of the above* | | *None of the above* | | *Total* | |
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| Male | 31 | 75.6 | 47 | 79.7 | 2 | 16.7 | 24 | 80.0 | 38 | 69.1 | 1 | 33.3 | 143 | 71.5 |
| Female | 10 | 24.4 | 12 | 20.3 | 10 | 83.3 | 6 | 20.0 | 17 | 30.17 | 2 | 66.7 | 57 | 28.5 |
| Total | 41 | 100.0 | 59 | 100.0 | 12 | 100.0 | 30 | 100.0 | 55 | 100.0 | 3 | 100.0 | 200 | 100.0 |

**Table 3: Result of Chi-square tests**

| *Test* | *Pearson $\chi^2$ value* | *df* | *Asymp. Sig.* | *Decision* | *Conclusion* |
|---|---|---|---|---|---|
| 1 | 37.446a | 16 | .002 | Reject Ho | Marital status is significantly related to method of treating STIs |
| 2 | 53.303a | 32 | .008 | Reject Ho | Educational qualification is significantly related to method of treating STIs |
| 3 | 175.649a | 40 | .000 | Reject Ho | Educational qualification is significantly related to knowledge about types of STIs |
| 4 | 73.014a | 32 | .000 | Reject Ho | Educational qualification is significantly related to knowledge about ways of contacting HIV/AIDS |
| 5 | 27.137a | 10 | .002 | Reject Ho | Adequacy of income is significantly related to method of treating STIs |
| 6 | 18.783a | 4 | .002 | Reject Ho | Employment status is significantly related to frequency of condom use |
| 7 | 23.339a | 5 | .000 | Reject Ho | If the availability, accessibility and affordability of different condoms were understood and compared, male would be more likely to use condom for preventing STIs and HIV/AIDS |

demographic characteristics are significantly related to STIs / HIV/ AIDS and contraceptive practices (Table 3). The fact that the Pearsons' chi-square values are significant corroborates the issues articulated above. This suggests that innovative reproductive health awareness is urgently needed in motor parks where a multitude of out-of-school youths resides.

## CONCLUSION AND POLICY RECOMMENDATIONS

The paper addressed the relationship between STIs, HIV/AIDS and contraceptives practices among out-of-school youths in Lagos motor parks. The desire, willingness and ability to use contraceptives depend on gender perception about implications of different contraceptives, level of educational qualifications, marital status, employment status and adequacy of income as well as availability, accessibility and affordability of different condoms. In a society where STIs, HIV/AIDS are increasing among the youths, much emphasis should be placed on contraceptive practices to limit the prevalence of the epidemics. The descriptive and inferential analyses indicate the existence of a directly proportional relationship between marital status, educational qualification, adequacy of income and method of treating STIs. Also, educational qualifications are coterminous with knowledge about different ways of contracting STIs and HIV/AIDS. Similarly, the knowledge about STIs rises with the level of educational qualifications; employment status determines the frequency of condom use among out-of-school youths and if the availability, accessibility and affordability of different condoms were understood and compared, male would be more likely to use condom for preventing STIs and HIV/AIDS.

## POLICY RECOMMENDATION

On a general note, the results suggest that most out-of-school youths will be willing to engage in contraceptive practices for preventing STIs and HIV/AIDS. This may be attributed to high level of awareness about the epidemics. Therefore, contraceptive practices among out-of-school youths would be enhanced if they were given opportunities that could strengthen their decision-making about reproductive health issues. In view of the adverse implications of STIs and HIV/AIDS on sustainable human development, community leaders and employers of out-of-school youths should make contracep-tive practices appreciably compulsory in all motor parks so that the prevalence of STIs and HIV/AIDS could be drastically reduced since prevention remain the available solution to the epidemics. In other words, regular advocacy programmes such as public campaign, mass education and re-orientation of youths in motor parks is urgently needed to raise their low level of contraceptive practices.

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