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Factors in the Choice of Contraceptives among University Undergraduates

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Abstract
This study investigated the effect of gender and age on choice of contraceptives among university undergraduates from the population of Enugu State Urban Universities namely; Enugu State University of Science and Technology, Institute of Management and Technology, Caritas University and University of Nigeria Enugu campus. The findings revealed that males and females differ significantly in their choice of contraceptive and older adolescents differed significantly in their choice of contraceptives. An individual's choice of contraceptive is significantly determined by his or her age and gender. One major implication of this study is that experience among the participants who are much older played a role in understanding the importance and making good choice of contraceptives; especially among those who were sexually active. The findings in the study would be used in sensitizing policy makers and service providers by forging new partnership between non-governmental organization (NGOs), government institutions and end users. It will also be useful in bringing about behavioral change in men situated in diverse social and cultural backgrounds against women on reproductive health issues.
Keywords: *Reproductive health; Sexually transmitted disease; Choice of Contraceptive*

Introduction

The choice and use of contraceptives until recently has been and is still a very sensitive and controversial issue in traditional African society (Ebuehi & Ebuehi, 2006). Contraception is a technique for preventing pregnancy. This may be done with a drug, device, or by blocking a process of reproduction. It permits sexual union without resulting in pregnancy and sometimes prevents sexually transmitted infections (Gilliam Holmquist and Berlin, 2007). Men egoistic behavior and their general attitude towards sexuality and reproductive health have strong bearing on their female partners' reproductive health. A number of surveys indicate that men do not want to regulate their fertility. They are not concerned about their partner contracting sexually transmitted diseases (STDs). They usually blame their wives in case of infertility, perpetrate violence against them, and not concerned about their well-being and raising of family. Choice of contraceptives either by male or female partners depends on men's perception about the method and willingness to use it (Koenig and Falkenstein, 1972). Any attempt by the female partner to influence men might invite accusation of infidelity, physical abuse or even divorce. Many men claim that using a condom reduces sexual pleasure (Senf Jeff and Price, 1994). Many of them think that a condom is meant for professional sex workers and not for their wives. Some men think that vasectomy reduces sexual potency and has side effects. The major burden of reproductive ill-health falls on women. Hence, in bearing the major burden of reproductive ill-health, women have a much bigger responsibility to choose appropriate methods of family planning (thus by contraception). It is estimated that as a consequence of

non-use or failure of contraception; 40 – 60 million women resort to pregnancy women are to be improved, men must be involved in the entire spectrum of reproductive health. Health programmes should conduct campaigns to educate men about reproductive health and the role they can assume in family planning (Osemwenkha Solo, 2004). Pregnancy and sexually transmitted diseases among youths continue to be a public health problem of immense concern in developed and developing countries. Most of these pregnancies are unplanned and unwanted; often terminated illegally by charlatans in secrecy (Ikeme & Uzodinma, 2005). It is evident that increased sexuality among youths would be responsible for increased unwanted pregnancies and subsequent clandestine abortions (Orji & Olalekan, 2005). Therefore counseling and correct choice of modern contraceptives should prevent the sequence of these abortions. Thirteen years ago, it was reported that about half of all HIV infections occurred among individuals younger than 25 years worldwide. The risk of HIV infection is especially high among those with multiple or risky sexual partners and who engage in unprotected sexual intercourse. The lower age limit for admission into most Nigerian higher institutions is 16 -17 years. This means that majority of the undergraduates are in their late teens and early twenties. Most of them live away from home, in school hostels or rented apartments close to their schools. This arrangement weakens the parental control and supervision of student's activities. They are often exposed to influences that encourage casual sexual relationships and have to take important personal decisions about their social and reproductive lives. These include decisions about sexuality and choice of contraceptives (Aziken & Ande, 2003). The risk of any contraceptive method should be weighed against the risk of unwanted pregnancy, which for young adolescent is a significant one. If contraception is to be successful, however, termination, of which 50% are carried out under unsafe conditions (Osemwenkha Solo, 2004). However, most family planning programmes are women oriented and men are left out. About 85% of contraceptive users in India are women, 97.2% opting for sterilization. In contrast, only 2.8% men undergo vasectomy. Thus if the reproductive life and quality of life of every effort must be made to individualize the method to the needs of each patient. Studies have shown that sexually active adolescents are at greater risk of acquiring STD`s than their adult counterpart (Poppen P.J., 1994). This results from sexual experimentation that characterizes psychosocial development at this time as well as from certain aspect of biologic development. Allgeier and Allgeier, (1991) listed four conditions they believe to be essential for acceptance of contraception by young people; birth control education, motivation to employ contraception, existence of reliable contraceptives and easy access to them. In a study by Steinfirst, Cowell, Presley and Reifler; (1985), the condom was the most frequently chosen item in vending machines dispensing contraceptives and the over-the-counter medicines in a 24-hour health service facility. It is possible that contraceptives are not chosen consistently because they are not easily available. According to Richwald, Friedland, and Morisky (1989), action could be taken to increase condom distribution to young people; more extensive marketing programmes may also be needed to enhance good choice of contraceptives especially among the youths. In a study by Buchta (1989); 92% of adolescent males, 89% of adolescent females and 83% of their parents approved of condom and other contraceptive advertisement on television. The literature on socio-economic status portrays female adolescents of low socio-economic status as more likely to be poor contraceptive choosers than are more affluent young women. (Algeier and Algeier, 1991; Bardis, 1982; Lethbridge, 1990; Radeck and Bernstein, 1990; Varela Orgando, 1982) Andres (1983) noted that males whose partners were using a contraceptive reported a higher frequency of coitus than did those whose partners were going to have

abortions due to non- use of any contraceptive method; suggesting that greater frequency of intercourse is associated with more effective contraceptive practices. Discipline of study has an important influence on contraceptive choice and usage; as was done in a study in south eastern Nigeria (Orji, Fajewonyomi & Adetunji, 2005) where 387 undergraduates were investigated between medical and non-medical discipline. More students from non- medical discipline (62%) became pregnant despite contraceptive use compared to those from medical discipline (5.1%) ($p < 0.05$). This is a pointer to the absolute need for adequate contraceptive education for every student, irrespective of the discipline of study. Relative to gender, Stewart and Robinson (1989) observed that only recently have women acquired the power to make the decision to delay or avoid childbearing. An investigation by Hare, Bennett and Broderick (1983) revealed that males accept a woman's right to reproductive freedom less than do females. Females seem to be more knowledgeable about contraception than males (Collins and Robinson, 1986). According to Jacobs (1978), males assume birth control responsibility significantly less often than do females. A study by Mcdermott and Gold (1985) confirmed such findings; the five means selected by college males required that the females assume principal contraceptive responsibility. No single contraceptive method is ideal, although all are safer than carrying an unintended pregnancy to term. The effectiveness of a given method of contraception is dependent on the efficacy of the method itself, compliance and appropriate use. Discrepancies between theoretical and actual effectiveness emphasizes the importance of patient's education and compliance when choosing various forms of contraceptives. Against the above background, this study was carried out to determine the effect of gender and age on the choice of contraceptives among university undergraduates in Enugu urban. The aims of this study are to examine the effect of gender on choice of contraceptives among university undergraduates and to determine whether there would be a significant effect of age on their choice of contraceptives.

The choice of contraceptive has been a very big problem in our society, appropriate and correct contraceptive methods either for males or females are being confusing by the users in our environment. People tend to make wrong choice of contraceptive and it promotes some side effects on the users, unwanted pregnancies, sexually transmitted diseases etc.

Types of Contraceptives

The type of contraception one chooses depends on ones need. Some people only need to prevent unwanted pregnancy; other people may also want to protect themselves or their partners from diseases that can be passed by having sex. These are called sexually transmitted diseases (STDs). Some contraceptives are more effective at preventing pregnancy than others. Barrier methods are not as effective as hormonal methods or sterilization. Natural family planning can be just as effective if it is practiced with great care and commitment. However, the only way to make sure you do not get pregnant or get someone pregnant is by abstinence.

Barrier Methods

This includes condoms, the diaphragm, the sponge and the cervical cap. These methods prevent pregnancy by blocking sperm from getting into the uterus to fertilize an egg. One has to remember to use them the right way every time for them to be effective. Barrier methods

can be made even more effective by putting spermicides on them. Spermicides come as a foam, jelly or cream; and kills sperm. Some barrier methods are packaged with spermicides already in them. Condoms are an especially good choice if one of the partners has had sex with other people in the past. Condoms can help prevent the spread of STDs. A condom is a barrier device most commonly used during sexual intercourse to reduce the probability of pregnancy and spreading sexually transmitted diseases (STD's) such as gonorrhea, syphilis and HIV). It is put on a man's erect penis and physically blocks ejaculated semen from entering the body of a sexual partner. Because condoms are waterproof, elastic and durable, they are also used in a variety of secondary applications. These include collection of semen for use in infertility treatment as well as non-sexual uses such as creating waterproof microphones and protecting riffle barrels from clogging.

Condoms are widely available and inexpensive contraceptives that also provide the best available barriers to sexually transmitted infections (STI's), such as Chlamydia, gonorrhea, syphilis and HIV. Health Canada (2012). Preventing (STI's) is critical because viral and incurable infections (as well as the occurrence of bacterial STI's) have been steadily increasing in Canada. (Haworth, Brockman,& Domer Isfeld, 2011).

Condoms are the only barrier protection against HIV transmission during vaginal and anal intercourse, Health Canada (2012). Male condoms are most commonly available and used for mutual protection in vaginal and anal intercourse and are sometimes used by partners for oral sex. When used correctly, male condoms are effective in preventing pregnancy. Female condoms have been available for some time in North America and are the most effective women-controlled prevention against (STI's).

Sex Issues

Fewer than half of women report using condoms as their primary form of contraception, although 31% of women aged 18-19 and 34% of women aged 20-24 reported using condoms as their birth control of choice, Canadian Community Health Survey (2005). Young males (15-24) were less likely to report using a contraceptive. About one third of young adults in Canada have had sex with more than one partner in the past year, (Domer, Isfeld, Haworth-Brokeman & Forsey, 2008).

In Canada, fewer than 25% of women at any age between 15 and 49 who were at high risk for STI's (users with more than one sexual partner in the past 12 months) reported using a condom during the last time they had sexual intercourse, Canadian Community Health Survey (2005). In every age group, women were less likely to report using a condom during last intercourse than were men. For females, but not for males, earlier first intercourse was associated with reduced likelihood of using condoms, (Donner, Isfeld, Haworth Brockman, Forsey, 2008).

Gender Issues

Condoms as the primary choice for contraception declines as women get older, which presumably coincides with women being in more stable relationships where the risk of disease transmission is lower. Despite their effectiveness as contraceptives and in preventing STI's and HIV/AIDS, many women considered high risk for STI's do not use condoms, particularly after the age of 25 years. Women may not be able to negotiate safer sex and condom use because men decide whether or not a male condom is used. Power differences and potential or real threats of violence may prevent women from protecting themselves, (Wong Singh, Mann

Hansen & Memahon 2012). Condom use can often be a point of contention between partners, (Miccall & Wicol 2012). Female condoms are available in Canada but have not been well received by women because they are difficult to use and expensive, (O'Grady, 2012).

Diversity

Young women with more education and more income were more likely to report regular use of condoms. Condom use declines dramatically with age. In 2005, young women were most likely to report using a condom and the rate decreases with every age group, (Canadian Community Health Survey 2003).

Women over 30 years with more than one sexual partner in the past year were half as likely to use condoms as women aged 15- 29 years, (Donner, Isfeld, and Haworth Brockman & Forsey 2008). Older women may be more likely to behave that they are not at risk from unprotected sex. Fewer women used condoms in 2002 (18%) than in 1995 (25%), (Fisher Boroditsky & Morris, 2012).

The decline in condom use was not accompanied by increased abstinence nor was it balanced by corresponding numbers of women and their partners testing for STI's. However, the prevalence of sexually transmitted infection – including Chlamydia, gonorrhea, syphilis and HIV/AIDS – has increased, (Fisher Boroditsky & Morris 2012). A survey by researchers on injecting drugs users showed that women varied in their use of condoms, depending if their sexual encounters were with regular partners, casual partners or paying clients, (public Health Agency of Canada 2006). Women in sex trade, women who engage in survival sex violence are disproportionately likely to acquire HIV although specific rates of condom use in these populations is unknown.

Equity

Women with more education have a greater likelihood of using condoms during high-risk encounters, particularly women with at least some post-secondary education, (Canadian Community Health Survey 2005).

Researchers have found that young women and men were less likely to engage in risky behaviour if they were motivated to pursue their education, (Cowan 2012).

As noted, women's ability to negotiate condom use can be compromised by threats of violence and other power differences with their partners. An “Invisible condom”, an application with spermicidal gel, has been tested, in Canada with a sample or young women between within the age range of 20 to 25, (Trottier, Donner, Desormeaux, Drovin, Gagnon, Vezina 2012). These testers found both the gel formulation and the applicator were acceptable by women and their male sexual partners. As it is possible to use applicator and gel without a sexual partner appearing to notice, it may be an effective contraceptive and preventive for women whose male partners refuse to wear a male condom, (Mboi-Keou, Trottier Omar, Nkele, Fokoua, Mbu 2009).

Survey data available on contraceptive use and condom use specifically, are limited despite the fundamental importance to individual and population health. The Canadian community Health Survey asked about contraceptive use among 15-24 year olds but only asked high-risk survey respondents under 50years of age about condom use, (Statistics Canada 2005).

Given that condom use declines with age, while the risks of unprotected sexual intercourse remain unchanged across life span, it would be valuable to ask about unprotected high-risk sex among all respondents (Donner, Isfeld, Haworth- Brockman, Forsey 2008). Other

limitations to the survey include that respondents may only have replied about male condom use, "sexual intercourse" was not defined in the question, and respondents who are asked about personal behaviour may not be fully forthcoming about high risk behaviour (Rotermann 2012).

Birth Control Pills

Birth control pills work mostly by preventing ovulation (the release of an egg by the ovary). Most pills include two hormones called estrogen and progesterone. Birth control pills cause some side effects such as Nausea, Headache, Breast heaviness, water retention, weight gain and depression. For the pills to work, one has to take it everyday. The pills may reduce abdominal cramping and may shorten the number of days of bleeding during menstrual flow.

Hormones, Implants, Patches and Shots.

Hormones, implants, patches and shots work much like the pills. They may have some side effects such as Headaches, and changes in menstrual cycle, mood change and weight gain. With implants and shots, one does not need to think about birth control everyday. The implants prevent pregnancy for 3 months. With the patch, one has to remember to put a new patch on the body every week.

An Intra-uterine Device (IUD)

An intra-uterine device is made of flexible plastic which is inert. It is inserted into a woman's uterus by a doctor. It seems to stop sperm from reaching the egg or prevent the fertilized egg from attaching to the uterus. Some IUDs used in the past were related to serious health problems. Today IUDs are safer, but they still have some risks. Most doctors prefer to reserve IUDs for women who have already had a baby. The most common side effect includes heavier bleeding and stronger abdominal cramps during menstrual flow.

Sterilization

Sterilization is an operation done to permanently prevent pregnancy. If one is sure that he or she does not want to have children or do not want more children, sterilization can be a good choice. Tubal ligation involves closing off the fallopian tube in a woman so that eggs cannot reach the uterus. The fallopian tubes are passage way for the eggs to reach the uterus. Men are sterilized via vasectomy. The man's vas deferens (sperm duct) are closed off so that sperm cannot get through.

Natural Family Planning

Natural family planning requires a couple to learn when in a woman's cycle she can get pregnant (usually 4 days before and 2 days after ovulation) and use another kind of birth control or abstain from having sex during those days. Natural family planning requires careful planning and commitment. However, there are number of ways to help track off ovulation. The most effective way involves using devices to determine when the woman is ovulating such as a saliva tester, or a cervical mucus tester; in combination in helping track off the woman's menstrual cycle (Murstein Mercy, 1994). Many hospitals and churches offer courses in natural family planning.

Withdrawal.

Withdrawal is not very effective. When a man tries to pull out before ejaculation, he usually

leaves behind a small amount of fluid that leaks from the penis before ejaculation. This fluid has enough sperm in it to cause pregnancy (Bryan Aiken West, 1997).

Emergency contraceptive

Emergency contraceptive (also called the morning-after pill) is a dose of certain birth control pills that prevent the sperm from reaching the egg or prevent a fertilized egg from attaching to the uterus. One has to take these pills within 72 hours of having unprotected intercourse and another dose usually 12 hours after the first set of pills. Some doses have two, four or five tablets. The side effects include nausea, vomiting, breast tenderness and headache. Moreover emergency contraceptive should not be used as a regular birth control method. It is used only for emergency; just as when a condom breaks or slips off, if a diaphragm or cervical cap slips out of place during sex or if one forgot a birth control pill 2 days in a row and after rape.
Emergency contraceptive usually must be prescribed by a doctor (Ikeme Ezegwui, Uzodinma Achonam; 2005). However, societal ambivalence concerning the availability and accessibility of contraception might be creating confusion in young peoples mind concerning the appropriateness of making a good choice or using contraceptive. Nevertheless, adolescent sexual activity is a reality that should be addressed. Societal acknowledgement could lead to both acceptance of adolescence sexuality and willingness to improve youths choice and access to the contraception they need. (Layana and Hayes, 1993).

Theoretical Background

A contraceptive is any device or technique that prevents conception. There are two broad groups – Natural and Artificial. The natural method include Rhythm / Safe periods, Withdrawal / coitus interruptus; while the artificial methods include condoms, cervical cap / contraceptive diaphragm, intra-uterine devices, injectables, oral contraceptives, spermatocides / foaming tablets, implants, tubal ligation, vasectomy and post coital pills. Albert Bandura, the father of learning theories, gave two basic theories of leaning, Behavioral and cognitive learning theories.
The behavioural approach says that the environment can predict a person behavior. According to Watson (1910), reinforcement and punishment along with other basic principles such as generalization and discrimination can explain even the most advanced type of human learning such as learning to solve complex problems.
This explains how the choice of contraceptive can be learnt by imitation. i.e. imitating people in their environment. Edward C. Tolman believes that, it is essential to study an individuals thought and expectations in order to understand the learning process. This also emphasizes on the basic principles of classical conditioning, reinforcement and punishment, as they can provide explanation why people behave the way they do and how they choose between different possible courses of action. Certain factors that influence learning include age, motivation, prior experience etc. Ivan Pavlov in early 1990s explained classical conditioning, reflex or autonomic response transfer from one stimulus to another. It occurs when a person forms a mental association between two stimuli. Classical conditioning explains learning with some principles, acquisition, extinction, generalization and discrimination. Thorndike Edward and B.F. Skinner's Operant conditioning explains learning as a product either reward or punishment. Here, people learn new behavior or change existing behavior. Classical and operant conditioning also said that people learn by observation. It does not require direct

personal experience with stimuli reinforcement. Bandura's theory of imitation which is also called social learning theory is also an important point to be mentioned. People in the environment are being easily influenced with what they see and therefore, imitation takes place.

Hypotheses

1. There will be no significant effect of gender as a factor in the choice of contraceptives among university undergraduates.
2. There will be no significant effect of age as a factor in the choice of contraceptives among university undergraduates.

Methods

Participants

A total number of 198 participants comprising 108 males and 90 female university undergraduate students were selected using incidental sampling technique. The participants were between the ages of 16 – 34 years and 35 years – above; with a mean age of 25.9 years, and standard deviation of 0.65. They were drawn from the population of Enugu State Urban universities. (Enugu State University of Science and Technology, ESUT; Institute of Management and Technology, IMT-Enugu; University of Nigeria Enugu campus, UNEC; and Caritas University)

Measure

A 2(Gender: male Vs female) X 2 (Age: 16-34 and 35years above) factorial design was adopted as independent variables on effects towards choice of contraceptives as a dependent variable.

Procedure

A 13- item questionnaire with Likert type response format designed to measure the choice of contraceptives was used. The items of the questionnaire were exposed to face validity whereby all the 13 items were accepted. Also, a pilot study was carried out using 30 participants drawn from Nnamdi Azikiwe University Awka (randomly selected) before the researcher embarked on the main study to establish the reliability of the instrument. The observed scores were analyzed by the application of Pearson Product Moment Correlation Coefficient that yielded a split-half reliability coefficient of 0.64, in comparison to the critical value of 0.32 at $p < 0.05$ and 0.45 at $p < 0.01$, while a full scale reliability coefficient using the Spearman Brown yielded a reliability coefficient of 0.78, indicating an appreciable high degree of reliability. A total of 200 copies of the questionnaire on the effect towards choice of contraceptives were incidentally distributed within a period of one week for the target population. As much as 198 copies that were correctly filled were scored and analyzed; and only two which were not completely filled were discarded.

Results

A total of 198 undergraduates responded, out of which ninety (45.5%) were females and one hundred and eight (54.5%) were males as shown in figure one. The participants were drawn between the ages of 16 – 34years and 35years – above. Only 18 (9.1%) participants were above 35years of age while 180 (90.9%) participants fall within the 16 – 34 years age bracket. The mean age of the respondents was 25.9 ± 0.65 years.(as shown in table one).

Summary Table of Mean on the Effect of Gender And Age on Choice of Contraceptives

		Gender		
		Males	Females	
Age	16 –34years	T_{11} = 234 N_{11} = 108 X_{11} = 2.17	T_{12} = 468 N_{12} = 90 $\underline{X_{12}}$ = 5.20	T_1 = 702 X_1 = 3.55
	35- Above	T_{21} = 0 N_{21} = 0 X_{21} = 0	T_{22} = 18 N_{22} = 18 X_{22} = 1	T_2 = 18 X_2 = 1

T_{11} = 234 T_2 = 468 T = 720
X_{11} = 2.17 X_2= 4.5 X = 6.67

Summary Table of two-way anova on the Effect of Gender and Age on the Choice of Contraceptives among University Undergraduates.

Source of variation	Sum of squares	df	Means Square	Calculated F	Critical F	P value
Rows (Age)	-335.18	1	-335.18	-0.93	5.61	< 0.01
Columns (Gender)	13545.8	1	13545.8	37.42	5.61	< 0. 01
Interaction (R x C)	-6830.24	1	-6830.24	-18.87	5.61	< 0. 01
Within cells	285225.18	195	361.96			
Total	291605.56	198				

This table shows the summary of all the findings, after which the calculation has taken place. The two way-Anova F-test on the effect of gender and age on choice of contraceptives. The sum of squares was found; degree of freedom, mean square, F-calculated values, F-critical values and then P-values were all calculated.

Discussion

A total of 198 university undergraduates drawn from four tertiary institutions in Enugu urban responded to the 13 item questionnaire with Likert type response format designed to measure towards the choice of contraceptives. One hundred and eighty (90.9%) of the respondents were between 16 - 34year age bracket and only 18 respondents (9.09%) fell into 35years - above age bracket. This could be as a result of numerous adolescents in the Nigerian universities and probably due to the fact that most respondents were drawn from Non-sandwich programmed faculties, otherwise who mostly are into their second degrees in the university and would be expected to be much older than fresh undergraduates from high school. The mean age of respondents was 25.9±0.65years.This should be expected because most of

the respondents (54.6%) were drawn from 300L and 400 levels of study, where in some universities sampled, they are already in their semi-final /final years of their study. The male participants (54.5%) slightly predominate the females (45.5%) in the study. This could be due to the fact that most females shy away from any discussion about sexuality and a few did not give their consent for recruitment into the study. The slight predominance of males could also be accounted for by the involvement of 2 schools of technology (IMT and ESUT) that have predominance of males. About 60% of the female respondents strongly agreed (SA) that a contraceptive is chosen based on convenience; while 83.3% of the males agreed that the fear of STDs / pregnancy is the determining factor for choice and use of a contraceptive. This could also be as a result of fear of unwanted pregnancy and sexually transmitted diseases / HIV-AIDS which has been in the increase in recent times. All the female participants agreed that choice of a contraceptive is individual specific while 66.7% of males share the same opinion. Simply put, that one chooses what he or she feels is appropriate for himself. Half (50%) of male participants disagreed that cost is the strongest factor which determines choice of a contraceptive, while 40% of female participants in the contrary agreed to the same opinion. The reasons for this relatively more negative response to cost as the strongest factor which determines choice of contraceptive would be because some contraceptives are being given out free of charge, but still a good number of people still have problem of choice of contraceptives. Male condom was strongly agreed by most females (80%) participants and 66.7% of the male participants as the cheapest, easily accessible and most available contraceptive. This could be as a result of the popularity it has gained since advent of HIV-AIDS and the effect of the subsidy put on it by government and non-governmental organizations, in a bid to prevent the spread of HIV-AIDS. All (100%) of participants above 35 years of age strongly agreed that a contraceptive is only chosen based on convenience and agreed it is individual specific. They also all (100%) agreed that people easily switch between choices of contraceptive types and that regular sexual exposure is a factor that affect such switching between choices of contraceptives. All of them agreed also that fear of STDs and unwanted pregnancy determines the choice of contraceptives. This could be accounted for, by the fact that most of them are already married and as such well experienced. The choice of contraceptive type must have been well settled in their earlier years of marriage either for the prevention of unwanted pregnancy or sexually transmitted diseases / HIV-AIDS. As such, switching between different choices of contraceptive types must have taken place before finally adopting one contraceptive choice that is the most appropriate for them. Hence, all (100%) agreed strongly that it is individual specific. All the participants above 35years of age disagreed that a contraceptive choice is dependent upon a sexual partner and should not be discussed openly / freely. This could be as a result of maturity and experience they must have acquired over the years. Hence, they believe that if discussed freely and openly probably the mistakes which most of them must have made in the past could have been avoided. They also all agreed that some persons find it difficult to enjoy sexual intercourse when using contraceptives and that it is difficult for young people to make a good contraceptive choice. This could be from their wealth of knowledge, because most must have attended family planning clinics, antenatal clinics or seminar, where different contraceptive types must have been taught and there mechanisms of action well explained to them. They believe that young people should be able to make a good choice of contraceptive because of the effect of mass media / bill boards, Newspapers and sex-education in schools that bring to fore different contraceptive types and methods where these young people are exposed to. Most (80%) participants below the age of

35years strongly agreed that male condom is the cheapest, easily accessible and most available contraceptive, probably because it is commonly distributed freely and at no cost by government and Non-governmental agencies that fight against STDs / HIV-AIDS. It could also be as a result of the fine packaging of condom by manufacturers as well as numerous nicknames which makes it more convenient for young people to acquire. Half (50%) of the participants below the age of 35years disagreed on the issue of not discussing choice of contraceptive freely / openly, while about 70% of them were undecided on whether multiple sexual partners is a factor that affects choice and switching between contraceptive types. Believing in discussing freely contraceptive choices should be due to experience and maturity, as well as exposure and knowledge which must have been acquired by some of the participants; while for majority being undecided on whether multiple sexual partners is a factor that affects choice and switching between contraceptive types could be due to religiosity among the chosen population and inexperience when most of them might not even have had a sexual debut. Some males feel that purchasing contraceptives; particularly condoms are embarrassing (Bernard Herbert de Man and Farrar, 1989). The situation is not very different for females regarding the issue of choosing a contraceptive method and adopting it. Benn and Richardson (1984) found that for many women, contraception provokes feeling of anxiety and discomfort. Lowe and Radius (1987) reported that when discussing contraception, comfort level is an indicator for making a good choice. Adolescents who felt comfortable discussing contraceptives were more likely to make good choices than were those who felt less at ease with the topic. Also peers may influence choices of contraceptives. Allens Meares (1984) found that majority of effective female adolescent contractors made contraceptive choices based on their beliefs, those of their boyfriends, or their best female friends' beliefs. According to Fabes and Strause (1987), undergraduates who selected either educators or parents as models of sexual responsibility were more likely to engage in contraception than were those who chose peers. Age appears to be related to the choice of contraceptives. An inverse relationship has been found between pregnancy rate of adolescents and their age at first intercourse (Allen Meares, 1984; Baldwin and Baldwin, 1988; Melchert and Burnett, 1990). Females who experience coitus at a later age might be more likely to have good contraceptive choice (Chilman, 1980; Cvetkovich Grote; Lieberman Miller; 1990). Also, communication with a sexual partner about contraception has been found to be positively related to the choice of contraceptive (Burger and Inderbitzen, 1985; Wilson, 1994) to be adopted. Frequency of intercourse has been found to be related to choice of contraceptive and switching between different contraceptive types. (Durant Seymore and Pendergrast Beckman, 1990). Also there is a high level of sexual activity among undergraduates. Many are aware of family planning and the condom is the most commonly known and chosen method, though not consistently (Orji, Adegbenro Olalekan, 2005). Therefore, reproductive –health education should be promoted among youths in Nigeria.

One major implication of this study is that experience among the participants who are much older played a role in understanding the importance and making good choice of contraceptives; especially among those who were sexually active. Gender as a factor was found to yield a significant relationship on the choice of contraceptive among participants, as indicated by the significant difference that occurred between male and female University undergraduates used in the study. The findings in the study would be used in sensitizing policy makers and service providers by forging new partnership between non-governmental organization (NGOs), government institutions and end users. Also, the findings in this study

would be useful in bringing about behavioral change in men situated in diverse social and cultural backgrounds against women on reproductive health issues. The outcome of this study would be used to better the understanding of the sexual attitudes and believes associated with contraceptives, in order to improve programme seeking to increase the choice and use of contraceptives among this rapidly expanding high risk population. Finally, the outcome of this study would serve as a useful contribution to the present body of knowledge in the area of making good choice of contraceptives.

Conclusion

The findings of this study are as follows; Gender as a factor was found to yield a significant effect on the choice of contraceptives among university undergraduates. Also age as a factor was found to yield a significant effect on the choice of contraceptives among university undergraduate, as those respondents who are matured and older, were at the same time more experience in making contraceptive choices. One major way of preventing clandestine abortions in Nigeria is the provision of family planning services. Despite the availability of family planning services in Nigeria since the early sixties, acceptance by youths is still very poor. This study shows that Age (Experience) and Gender affect choice of contraceptives by undergraduates. One can confidently argue that once condom is used to prevent unwanted pregnancies, it provides protection against HIV transmission and other sexually transmitted diseases at the same time. Counseling on making good choice of contraceptives should be encouraged especially among youths who mostly engage in indiscriminate sexual intercourse that not only expose them to unwanted pregnancies in addition to the risk of sexually transmitted diseases, especially where it involves multiple sexual partners. Therefore enlightenment is required in this regard as students (youth) would be equipped to making good choice of contraceptives, especially condoms as it is cheap and readily available. The fact that pharmacy shops and patent medicine stores that correct information, should be available in these stations by way of leaflets, advertisement and posters. Information centers and family health clinics should be made available in higher institutions to encourage users and non- users alike to seek adequate knowledge for making good choice of contraceptives. Various organizations and researches have shown that information about sex and contraception are obtained from many sources including peer groups, parents and older siblings. Wrong information about health and choice of contraceptives is bound to prevent potential users from trying out a method or making good choice. Therefore, it is recommended that in other to effect a change of attitude, access to correct information dissemination is a necessary strategy. One major short comings of this study was the use of individual testing which did not enhance data collection easily. Some students approached to be recruited during the study refused to give their consent. Some of those who were eventually recruited either did not return or did not properly fill the questionnaires.

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QUESTIONNAIRE

INSTRUCTIONS- YOU ARE REQUIRED TO EXPRESS YOUR OPINION TOWARDS THE ITEMS BELOW IN ALL SINCERITY

-TICK ONE OUT OF THE FIVE OPTIONS THAT BEST DESCRIBE YOUR OPINION

SA- MEANS YOU **STRONGLYAGREE, A**- MEANS YOU **AGREE**;

U- MEANS YOU ARE **UNDECIDED**; **D**- MEANS YOU **DISAGREE;**

SD- MEANS YOU **STRONGLY DISAGREE.**

A. BIODATA

? GENDER: …… (a) MALE ( ) (b) FEMALE ( )

? AGE BRACKET ……. (a) 16 - 34 YEARS ( ) (b) 35YEARS - ABOVE ( )

? LEVEL OF STUDY …….(a) 100L ( ) (b) 200L ( ) (c) 300L ( )

(d) 400L ( ) (e) 500L ( )

B. ITEMS.

	ITEMS	SA	A	U	D	SD
1	A CONTRACEPTIVE-TYPE IS CHOSEN BASED ON CONVENIENCE					
2	CHOICE OF A CONTRACEPTIVE IS DEPENDENT UPON SEXUAL PARTNERS WILLINGNESS TO USE.					
3	CHOICE OF A CONTRACEPTIVE SHOULD NOT BE DISCUSSED OPENLY / FREELY					
4	THE CHOICE OF A CONTRACEPTIVE IS INDIVIDUAL SPECIFIC					
5	SOME PERSONS FIND IT DIFFICULT TO ENJOY SEXUAL INTERCOURSE WHEN USING CONTRACEPTIVES					
6	MALES ARE MORE SCEPTICAL ABOUT THE CHOICE AND USE OF A CONTRACEPTIVE					
7	MALE CONDOM IS THE CHEAPEST, EASILY ACCESSIBLE AND MOST AVAILABLE CONTRACEPTIVE					
8	FEAR OF STDs / PREGNANCY DETERMINES CHOICE AND USE OF CONTRACEPTIVES					
9	COST IS THE STRONGEST FACTOR THAT DETERMINES CHOICE OF A CONTRACEPTIVE					

10	IT IS DIFFICULT FOR YOUNG PEOPLE TO MAKE AGOOD CHOICE OF CONTRACEPTIVE					
11	PEOPLE EASILY SWITCH BETWEEN DIFFERENT CHOICES OF CONTRACEPTIVE-TYPES					
12	REGULAR SEXUAL EXPOSURE IS A FACTOR THAT AFFECTS SWITCHING BETWEEN DIFFERENT CHOICES OF CONTRACEPTIVE – TYPES					
13	MULTIPLE SEXUAL PARTNERS IS A FACTOR THAT AFFECTS CHOICE AND SWITCHING BETWEEN CONTRACEPTIVE -TYPES					

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