SEXUAL KNOWLEDGE AND BEHAVIOUR TOWARDS SEXUALLY TRANSMITTED DISEASES (STDS) AMONG STUDENTS OF SENIOR SECONDARY SCHOOLS AND UNIVERSITY IN AKURE, ONDO STATE, NIGERIA

By

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DECLARATION

I hereby declare that the work in the thesis entitled: Sexual Behaviour and Knowledge Towards Sexually Transmitted Diseases (STDS) Among Students of Senior Secondary Schools And University in Akure, Ondo State, Nigeria, has been performed by me in the Department of Physical and Health Education, under the supervision of Prof. K. Venkateswarlu and Dr. (Mrs.) M. A. Suleiman. The information derived from the literature has been duly acknowledged in the text and a list of references provided.

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Amos, Ann Nwahizu **Date**

CERTIFICATION

This thesis entitled 'Sexual Knowledge and Behaviour Towards Sexually Transmitted Diseases (STD's) Among Students of Senior Secondary and University Students in Akure, Ondo State', meets the regulations governing the award of the Degree of Master of Education in Health Education of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to the glory of the Almighty God who has been my source and strength. In addition, I dedicate this work to my husband and children (John and Jonathan).

ACKNOWLEDGEMENT

The researcher wishes to specially thank her supervisor Prof. K. Venkateswarlu, who, in spite of his very busy schedule provided the much-needed guidance for the completion of this thesis. She also wishes to thank Dr. (Mrs.) M.A. Suleiman for her consistent assistance and encouragement towards the completion of this work. Her sincere gratitude also goes to their families for the warm affections given to her in the course of her programme while in Zaria, may God reward them. Her sincere gratitude also goes to Mr. & Mrs. Ajayi for their kind contribution towards the completion of this work.

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ABSTRACT

The study examined the sexual behaviour and knowledge towards Sexually Transmitted Diseases among students of senior Secondary Schools and university in Akure, Ondo State.

The sexual behaviour of the respondents and their knowledge consisted the dependent variables. While demographic characteristics of age, gender, geographical location, marital status, religion, class, socio economic status, family type and sex patterns consisted the independent variables. Ex-post facto research design was adopted to collect the information required to test the hypotheses of the study. A multi-stage sampling technique involving stratified, purposive and random sampling techniques were used in the selection of respondents for this study.

In the first stage, two urban and two rural secondary schools were selected purposely from each of the two Local Government Areas (LGAs) of Akure north and south Local Government Areas respectively, making a total of eight secondary schools. The second stage involved the selection of 269 students randomly selected from the secondary schools and 111 students were selected from the University of Technology Akure making a total of 380 respondents in all, to collect the needed data.

A set of well-structured questionnaire was administered on the respondents on issues bordering on their demographic characteristics, sexual behaviour, practices and knowledge about sexual education in schools, knowledge about prevention and control of sexually transmitted diseases.

Descriptive statistics of frequency tables, percentages, standard deviation and standard error were used for the analysis of data generated. Econometric analysis involving multiple regression analysis was also used to analyze the data generated. Results of the analysis showed that age of respondents, marital status, type of settlement/accommodation and number of sexual partners of the respondents were observed to significantly determine whether respondents had sex before marriage. A significant (at 5% level) F-value of 130.315 and an R^2 of 0.906 implied that about 90% variability in the dependent variable were explained by the independent variables. It was also observed that an inverse relationship existed between age of respondents and their sexual behaviour i.e. younger respondents were more sexually active than their older counterparts. The major hypothesis and the two sub- hypotheses were subjected to descriptive statistical analysis. It is therefore recommended that age (i.e. the adolescent group) should be considered in any policy measure designed to enlighten the citizens about Sexually Transmitted Diseases. Also it is recommended that sound moral teachings should be promoted in schools and homes. Also religious leaders and teachers have duty to teach and help the adolescents on sound moral conducts in society.

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ABBREVIATIONS

1.	S.F.H.	-	Society for Family Health
2.	HIV	-	Human Immuno Deficiency Virus
3.	AIDS	-	Acquired Immuno Deficiency Syndrome
4.	N.G.T.F.	-	National Guidelines Task Force
5.	V. D.	-	Veneral Disease
6.	S.T.D.	-	Sexually Transmitted Infectious Diseases
7.	W.H.O.	-	World Health Organization
8.	I.P.P.F.	-	International Parent Planning Federation
9.	A.R.F.H.	-	Association for Reproductive Family Health
10.	N.G.U.	-	Non-Gonococcal Urethritis

CHAPTER ONE

1.0 INTRODUCTION

National Guidelines Task Force (1996) defines sexual behaviour, as outward expression of one's feelings about sexual issues. It is a behaviour that produces arousal and increases the chances of orgasm. Persons may exhibit such sexual acts in the form of heterosexuality, or homosexuality. Maria, (1999) viewed adolescent's sexuality in general (and students in particular) as problem to be dealt with rather than part of his or her normal growth and development as he or she moves towards adulthood. Students have many reasons for wanting to be sexually active. These include to experiment, to care and to be loved by someone, to express peer group pressure, to feel grownup, and to feel happy and good (Mundigo, 1995).

Anas-Kolo (1996) observed that lack of information on sexual issues contributes greatly to the increase in sexual activity among students. Students are ignorant about the physiological and psychological developments of their bodies. Mundigo (1995) observed that many young girls were ignorant of their bodies. He stated that they were not aware of safe option for pregnancy prevention. Ladipo, (1993) explained that the traditional act, which prevented students from acquiring education on sexual matters in the belief that ignorance would encourage chastity, had been proven wrong, judging by high rate of teenage pregnancy. Gorgen et al., (1998) supports this view by saying that two (2) out of every five (5) secondary and university girls had had at least one pregnancy, 150 out of every

1,000 women who gave birth are 19 years and above, and 60% of patients admitted into Nigeria hospitals with abortion complications are girls.

(Ladipo, 1989; Georgina, 1995; Network, 1993) showed that sexuality education does not encourage sexual act among youths, but rather delays the age of initiation of sex. Most parents and adults, however, erroneously believed that providing information on sexuality and contraception will promote sexuality among students (Kirstan and Bayeligne, 1994). Consequently, many young people get their information on sexual matters from peer groups or media, which often give sensational portrayal of sexuality (Network, 1993). Those adolescents want to live like the adults. Since they are in their prime age of life, they want to experiment every aspect of their lives (Network, 1993).

The behaviours of that group of humans in sex and sexually transmitted diseases differ in comparison to the adults. The behaviour of the students, to a large extent, affects their habit to sex and sexually related health problems. The subject of Sexually Transmitted Diseases (STDs), formally known as venereal diseases, has become increasingly important during the past twenty-five years because of the rise in the incidence of many of the sexually transmitted diseases during that period. Acquired Immune Deficiency Syndrome (AIDS) is now one of the commonest infectious diseases in the world and the number of cases or incidences is on the increase (Ransome-Kuti, 1996). Formally, people were only aware of gonorrhea and syphilis, but now much more deadly infection is on the increase (Ransome-Kuti, 1996).

Some studies (Ladipo, 1989; Georgina, 1999; Ransome-Kuti, 1996) have shown that in many African countries, adolescents (60-70%) were sexually active and as many as 70% of girls have been pregnant at least once by the time they are 18 years old (Ladipo, 1989). Sexual activity at an early age is associated with several serious risks and complications (Arkutu, 1995). The majorities of sexually active adolescents are unaware of these risks or are dangerously misinformed about the consequences of their behaviour (Arkutu, 1995). There is growing recognition of the public health importance of Sexually Transmitted Infectious Diseases (STDs) because of serious rate of morbidity associated with them; especially that (STDs) facilitate the transmission of infection with Human Immunodeficiency Virus (HIV) International Family Planning Perspective (1997). Some studies such as (Adebajo, 1997; Ariba, 2000; Georgina, 1999; Gorgen, et al, 1998) indicated early sexual initiation among Nigerian students. The needs of young people have traditionally been given low priority in our communities. Sex is considered a cultural taboo and dirty for discussion in both public and private areas. The prejudice that exists against issues of sexuality in our culture undermines the possibility for implementing sex education programmes (National Guidelines Task Force, 1996). The National Guidelines Task Force, (NGTF) (1996) observed that a great number of school heads and teachers do not have the knowledge of sex education. The NGTF (1996) identifies further the two following barriers:

a) Most teachers do not receive training on sex education

b) The overbearing influence of culture and religion, which make such open discussion on sexuality a taboo,

In order to arrest these situations, it is necessary to understand the patterns of sexual behaviour and knowledge of and attitude towards Sexually Transmitted Disease (STDs) among the youths.

1.1 Statement of the problem

Knowledge of sexually transmitted diseases does not only influence sexual behaviour, but also affects the attitude towards these diseases. In Nigeria, as in many African countries, most people are not aware of how sexually transmitted diseases are spread, how they affect health and social lives and the sexual behaviour. Very little research evidence has been reported on the relationship between sexual behaviour and knowledge, between sexually transmitted diseases (STDs) among Nigerian youths. This study was therefore conducted to find out sexual behaviour and knowledge towards sexually transmitted diseases among adolescents in Akure. Specifically, the focus of this investigation was to find answers to the following research questions.

1. Are there differences between male and female adolescents in their sexual behaviour and knowledge about causes of sexually transmitted diseases (STD's)?
2. What are the influences of religion, socio-economic status and residential location on the sexual behaviour of adolescents and their knowledge about causes and prevention of sexually transmitted diseases (STD's) in Ondo State?

1.2 Purpose of the study

The purpose of this study was to examine the sexual knowledge and behaviour of adolescents in Akure towards Sexually Transmitted Diseases (STDs). To determine the factors e.g. age, sex, marital status, family type, social class, religion, and socio-economic status affecting the involvement of the respondents in sexual act.

1.3 Objectives of the study

The main objective of the study was to assess the level of awareness and knowledge of sexual behavior among adolescents and undergraduate students in Akure, Ondo State.

The specific objectives of this study are to:

a) Examine the demographic factors of the respondents. These include sex, age, religion, class, marital status, socio-economic status, and family type;

b) Examine the sexual behavior and practice of the respondents;

c) Determine the relationship between socio-economic factors and their sexual acts among the students in Akure; and

d) Assess the level of awareness of Sexually Transmitted Diseases (STDs) among adolescents in Akure, Ondo State;

1.4 Significance of the study

This study was justified on the following basis. It is necessary to understand the sexual behaviour of adolescents, to identify any abnormality in the behaviour so as to make appropriate suggestions for better behaviour. There seems to be very scanty information about adolescents' sexual behaviour in Akure, Ondo State. The results of this study would therefore provide the missing link so as to show the pattern of sexual behaviour of the adolescents.

Knowledge of sexually transmitted diseases makes individuals to understand and apprehend consequential effect of these diseases on health which will motivate them to practice safe sex. It is not known whether adolescents of Akure, Ondo State are knowledgeable about sexually transmitted diseases. The study will show their awareness of such diseases.

Knowledge towards sexually transmitted diseases determines to a large extent, the pattern of sexual behaviour and sexual practice. This study would show the influence of age, gender, religion and the socio-economic status of the adolescents on sexual behaviour. Knowledge towards sexual behaviour and Sexually Transmitted Diseases is not clear in the State. The results would reveal this. This study would also show areas that require further research on patterns of sexual behaviour and sexually transmitted diseases.

1.5 Basic assumptions

On the basis of available research evidence, the following assumptions were made for the purpose of this study.

1. Sexual behaviour is determined by social, economic, psychological and biological factors.
2. The incidence of sexually transmitted diseases depends on sexual behaviour.
3. Sexual behaviour changes with advance in years.
4. Knowledge towards sexually transmitted diseases is developed through interaction with environmental factors.
5. Knowledge towards sexually transmitted diseases is measurable.
6. Sexual behaviour and knowledge of sexually transmitted infectious diseases (STDs) can be assessed.

1.6 Hypotheses

On the basis of research questions and assumptions, the following hypotheses were made for the purpose of this study.

Major hypothesis

There are no differences between adolescence in their sexual behaviour and knowledge about the causes and prevention of sexually transmitted diseases (STD's).

Sub-hypotheses

1. There are no significant differences between male and female adolescents in their sexual behaviour and knowledge about causes and prevention of Sexual Transmitted Diseases (STD's)
2. Religion, Socio-economic status and residential location have no significant influence on the sexual behaviour of adolescents and their knowledge about causes and prevention of Sexually transmitted Diseases (STD's) in Ondo State.

1.7 Delimitations

The study was delimitated to the following;

This research investigated sexual behaviour of adolescents in addition to finding out the knowledge and behaviour of adolescents about STDs. The study was conducted on the adolescents' students from selected senior secondary schools and the Federal University of Technology, Akure, from both rural and urban areas of Akure, Ondo State.

1.8 Limitations

This study had the following limitations, which would be considered while interpreting the results:

1. As this study was conducted on adolescents, the generalizability of the findings would be very much limited to only adolescents. This was taken into consideration while interpreting the results.
2. The instrument used in this study was a questionnaire. This study had therefore all the limitations of a questionnaire such as limitation of responses to only questions asked in the questionnaire and misunderstanding of question asked by the interviewer.
3. Due to time and economic constraints, it was not possible to use a combination of both interview and discussion to verify all data collected from the adolescents.

1.9 Operational Definitions

1) Puberty: This is a sexual characteristics possessed by adolescents.
2) Trepone mapallidum – bacteria that causes syphilis.
3) Income: wages earned by a person.
4) Erotic: Tending to arouse sexual desire.
5) Behaviour: This is an act exhibited by a person.
6) Heterosexuality: sexual attraction towards opposite sex.
7) Homosexuality: sexual attraction toward the same sex.

8) Adolescent: that period of psychosexual development between the onset of sexual maturation (puberty) and early adulthood.
9) Sexuality: Is the life long process of acquiring information and forming habit, beliefs and values about identifying relationships and intimacy.
10) Sexual Behaviour: define as outward expression of one's feelings about sexual issues. It is also a behaviour that produces arousal and increases the chances of orgasm.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Sexually transmitted infectious diseases (STDS) are a group of infections in which the principal way of transmission is by sexual contact. They were previously called venereal diseases (VDS). Initially, it was believed that gonorrhea and syphilis were the only infections that could be transmitted by sex; hence the name venereal disease (VD) was given to them. As time went on, it became clear that there are more than 20 other diseases that are sexually transmissible. Although the size of the problem is unknown, particularly in Nigeria, STDs are very common and are one of the top five infections for which people seek care. STDs remain a public health problem of major significance in most parts of the world and their consequences can be devastating (NGTF; 1996).. These include infertility and cervical cancer. Infant could die from congenital syphilis or be born with severe eye infections or life threatening pneumonia.

According to World Health Organisation (WHO, 1991) STDs are the most common diseases and the prevalence rates are particularly high in developing countries like Nigeria. Adolescent's ages 15 to 24 years have the highest infection rates of sexually transmitted diseases (STDs), including HIV/AIDS. Literature relating to adolescent sexual behaviour and knowledge is critically reviewed and presented in this chapter under the following subtitles.

2.2 Sexual behaviour of adolescents and practices

2.3 Awareness of adolescents about sexuality education or STDs

2.4 Types of STDs/symptoms

2.5 Occurrences of STDs

2.6 Prevention of STDs

2.7 Summary

2.2 Sexual Behaviour Of Adolescents And Practices

Sexual behaviour is such that produces arousal and increases the chances of orgasm (NGTF, 1996). Such sexual acts are exhibited by persons (e.g. heterosexuality or homosexuality). A heterosexual person is a person who is sexually attracted to, or who engages in sexual activity with persons of the other gender. Homosexual person also is a person who is sexually attracted to, or engages in sexual activity with members of his or her own gender (NGTF; 1996).

A study of the sexual behaviour of adolescents in Nigeria's urban centers, where there has been rapid social and economic change in recent years, is both important and necessary, in the sense that adolescent sexual behaviour in Nigeria has become a problem not only because of the health, but also due to social and economic repercussions of adolescent sexuality. About one person out of every five in Nigeria is currently between ages 10 and 19 (International Family Planning Perspectives, 1992). From 1980 to 1990, the number of young people aged 10-19 increased by about 42%, from 18.5 million to a little over 26 million. In the next

10 years, their number has increased to 39.2 million. The size of this cohort of young people is projected to increase about 6% faster than the country's total population by the year 2003 (International Family Planning Perspectives, 1992). The current situation is not known with certainty.

Adolescence is largely established when the growing child reaches puberty and expresses certain secondary sexual characteristics. This is probably why almost all manifested behavioural social, peer and developmental problems of the adolescent may be intimately or remotely associated with his or her attempt to adjust to the various demands of puberty and sex maturation (National Guidelines Task Force, 1996). He further explained that the changes brought about by puberty and significant changes in the body structures and composition may be largely responsible for they sometimes observed increased urge for heterosexual activities in adolescents. The child may also want to be like his peers who are seen having friends of the opposite sex. Hence social forces may be operating to compound the problem of the adolescent. The important issue, however, is that the adolescent desires an active engagement in heterosexual activities which often get him involved in lots of problems. This can affect his achievement in school, ability to maintain a home, and increase vulnerability to venereal diseases, with a consequent destruction of reproductive organs, and create conflicts over the use of contraceptives to abort unplanned pregnancies, alienation from family members, social sanctions by the adults, society and so on. For example, studies have indicated that adolescents are not generally concerned about pregnancy and its consequences when they explore the heterosexual affairs. The main concerns

are the pleasure, amorous satisfactions and the youthful exuberance accompanying sex behaviours that the young seem to be having during this period (Oladapo, et al 1997; The World's Youth, 2000; NGTF, 1996).

Sexual behaviour expresses one's sexuality in ways congruent with and in accordance to the law of the land (The World's Youth, 2000). It also discriminates between life – enhancing sexual behaviours and those that are harmful to self and others. It expresses one's sexuality while respecting the rights of others. Sexual behaviour seeks new information to enhance one's sexuality and engage in sexual relations that are characterized by honesty, equity and responsibility (NGTF, 1999).

The World's Youth (2000) stated that cultural standards about what is acceptable sexual behaviour for adolescent boys and girls complicate the issue of adolescent reproductive health. For instance, some young men believe that they should use condoms when having intercourse with sex workers but not with girlfriends.

Program efforts to reach young men are now under way in many countries. Reproductive health programs for young men primarily encourage responsible sexual behaviour. They can also support other positive behaviours, such as staying in school, re-examining their perceptions of gender roles and responsibilities, supporting adolescents' girls partners in their reproductive health needs and decisions, and avoiding violence and drug and alcohol abuse. Program planners

need to distinguish adolescent needs from those of adults (Ariba, 2000). Sexual behaviour, like habits, generally derived from unspoken and often unconscious premises. Creative thoughts, which are always articulate and precise, result from frustration when a man sees that a problem must be solved and he creates new thoughts in solving it. But the overwhelming preponderance of human thought is not of this purposive, articulate, and creative mind. Most of what we consider our mental activity consists of sub-articulate, half-conscious semantic reflexive reactions (Ariba, 2000).

According to Encyclopedia (1973), studies of behaviour about adolescents or premarital sexual behaviour have usually been either in terms of the extent to which persons approve or disapprove of this behaviour as an abstract proposition. Reasons why young people do not engage in premarital sexual behaviour are the fear of pregnancy (Action Health Incorporated, 1995). In general, studies of the first type have reflected the traditional norms even among adolescents, in that they have tended to condemn sexual act among adolescents. Differences in the findings of research into the reasons for abstaining from premarital coitus suggest that, even though different techniques of investigation will produce different results, there may have been an actual shift in the behaviour of adolescents in recent years. For example, fear of pregnancy was cited as a much more important reason for not having premarital intercourse among adolescents (Ariya, et al, 1986). For example, Adebajo (1997) asserted that "A pragmatic behaviour exists in Africa toward (female sexuality), with a fair degree of permissiveness toward premarital relations that are not too blatantly public, and a degree of acceptance

that surreptitious extramarital relations are not the high point of sin and usually should not be severely punished. Since there is often a gap between knowledge and behaviour, our respondents may be at greater risk of STDs infection than these data indicate. Their results also showed that many adolescents hold negative behaviour towards people infected with STDs. Very many people do not want to work with them, associate with them, or let their children attend school with them, and many felt that no one should treat them. Substantial educational efforts are needed to improve societal attitudes toward sex and people with STDs (Ariba, 2000).

International Family Planning Perspective (1999) stated that all of the intermediate variables except attitude toward sex in general were significantly associated with young men's sexual behaviour. Those with liberal attitudes toward premarital sex and high levels of social interaction and erotic exposure were significantly more likely than their peers with lower scores on these indices to have had any sexual experience and to have had sexual intercourse. Notably, adolescent boys with a high level of knowledge about sexuality related issues were the most likely to be sexually experienced (62%), and the proportion who had had a sexual encounter declined as the level of knowledge dropped; in contrast, those with a moderate level of knowledge were more likely to have had intercourse (31%) than those with either a high or low level of knowledge (24% and 15%, respectively) Suleiman and Venkateswarlu, (2002). Findings were similar for female adolescents, except a liberal attitude toward sex in general was associated

with the greatest likelihood of having had any sexual act (32% vs. 9-17%) and attitude toward premarital sex had no significant effect (International Family Planning Perspective, 1999).

Venkateswarlu, (2002) explained that the behaiour of adolescents towards sexual practices can be influenced by the knowledge they have. The character of the adolescents will depend on the personality of the adolescent – sexual activity creates problem because the most active adolescents are not sexually informed. The information the adolescent attain will help them to have either negative or positive attitude towards sex. In order to make them responsible adults they must have a positive changed of habit towards sexual behaviour.

The adolescent's behaviour will influence their lives and affect how they will judge or react towards sexual acts Venkateswarlu, (2002). Getting pregnant during schooling hinders adolescents from completing their education or becoming drop-out since they have to send for their unintended families Venkateswarlu, (2005). Nass and Fisher, (1988) described public habit towards sex swinging back and forth between valuing freedom in sexual choices and valuing restrictions on sexual expression, which also affect the habit of adolescent towards sexual act. Inadequate information about sexuality has led to the adolescents forming a negative approach towards sexual act.

The knowledge of adolescent sexual behaviour is emotional response that expresses different degrees of acceptance and rejection. In sum total the behaviour which adolescent develops towards sexual act will determine the extent to which he/she will be sexually active (Uwakwa, *et al*., 2001). Behaviours are formed from membership of groups the adolescent affiliates with, and the knowledge about sex education which can be derived from many sources such as teachers, family, peer group, religious or voluntary organizations, mass media. The type of habit formed can be negative or positive. A positive attitude towards sexual behaviour will lead to the avoidance of premarital sexual intercourse while on the other hand negative habit will lead to unintended pregnancies and its complications.

2.3 Awareness of adolescents about sexuality education and STDs:

A recent survey in Nigeria by the Ministry of Health stated that through purposive sampling technique, 41 Volunteers (11 female and 30 male respondents) participated in the study. Through indepth interview during Focus Group Discussions, it was revealed that 78% of them were aware of Gonorrhea and AIDS but majority were not aware of other STDs. Another recent survey by the Action Health Incorporated,1995) on sexual behaviour, STDs awareness and condom use showed that among some interviewed 2,111 females and 2,049 males, who are sexually active 17.43% women, could not resist having sex with their boy-friends while 40.4% of the men had sex with girl-friends or concubine within two months. The most sexually active age groups are 18-24 years. Also in the result of the

survey of the 2,111 female respondents 3.1% experienced some symptoms of STDs within two months of relationship (Susan 2001)..

Uwakwa et al (2001) said that, a number of senior government officials have attended STDs and HIV/AIDs awareness events. He further noted that it is important because there remains a wide range of misconceptions about how HIV/AIDs and other STDs is transmitted and how to treat persons who are free, (Choices Magazine, 2001). NGTF (1996) also provided technical assistance to a mobile theatre launched by Partners for Development (PAD), 2001.

World's Youth (2000) have also carried out surveys on the question of STDs in a Yemeni Prison. Six (6) HIV positive cases were found, out of 2,922 tested in Sana'a Central prison in 2000. The International Family Planning, (1997) explained that sexuality also arose in discussions about the risks of contracting STDs. The female acknowledged that most male were aware that certain infectious diseases could be contracted sexually. The female were also aware that if they suspected their partners, then they too were potentially at risk of an STDs. However, this awareness did not guarantee that men would protect themselves by using condoms in other relationships or that the female themselves would insist on condom use.

Sexuality Education

World's Youth, (2000) stated that adult who expressed concerns that knowledge will promote promiscuity among adolescents has long hampered sexuality education for adolescents. However, World wide reviews of studies by WHO

(1991) concluded that sexuality education does not encourage early initiation of intercourse, but instead can delay first intercourse and lead to more consistent contraceptive use and safer sex practices (Suleiman and Venkateswarlu, 2002; Adeyemo, 1995).

It is vital to reach adolescents early with information before the onset of sexual activity. Schools are a key location for reaching large numbers of adolescents; however, as many adolescents are not in school, community – based approaches are also needed in many areas. World's Youth, (2000) further explained that specialists in adolescent reproductive health suggested the following elements for a successful sex and STDs education program:

- Give a clear message on risky sexual behaviours. Focus on reducing a few key behaviours that lead to unintended pregnancy or STD's infection.
- Use a behaviour change framework to define and evaluate activities.
- Provide basic accurate information about the risks of unprotected intercourse and ways to avoid unprotected intercourse.
- Include activities that address social pressures on sexual behaviour. Provides modeling and practice of communication, negotiation, and refusal skills.
- Employ variety of teaching methods design to involve the participants and have them personalize the information. Use teachers and peers who believe in the program they are implementing and provide training for them.
- Incorporate behavioural goals, teaching methods, and materials that are appropriate to the age, sexual experience and culture of the students.

Guidelines for comprehensive Sexuality Education in Nigeria, (1995) explained that sexuality education is a life long process of acquiring information and forming habits beliefs, and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health interpersonal relationships affection, intimacy, body image, and gender roles, sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from: 1) the cognitive domain, 2) the affective domain, and 3) the behavioral domain (Suleiman and Venkateswarlu, 2002).

The primary goal of sexuality education is the promotion of sexual health. In 1975, the World Health Organisation (WHO) (1991) defined sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhances personality, communication, and love, every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation.

Sexuality education seeks to:- assist individuals in having a clear and factual view of sexuality; provide them with information and skills about taking care of their sexual health and help them acquire skills to make decisions now and in the future (Adeyemo, 1995).

Sexuality, in its broadest sense, encompasses the search for identity, role as men and women, sexual habit, behaviour and feelings, relationship affection, caring,

and the need to touch and be touched, recognition and acceptance as sexual being (Taver, 1983; Action Health Incorporated, 1995). Karjicek (1982) refers to sexuality as the physical psychological, social, emotional and spiritual make-ups of each individual; in addition, she refers to sexuality as the way that individuals utilize their own roles, relationships, values, customs and maleness or femaleness.

Eduvie, (1999) stated that sexuality education involves two main perspectives: mostly of imparting knowledge of anatomy, and physiology of human body including reproduction, pregnancy, childbirth and learning about the physical aspect of sexual behaviour and knowledge. The other perspective of sexuality education includes true discussion in the concrete experience of everyday life, the role and meaning of sexuality and love in the life of a couple and society in which they live. Sexuality is an important aspect of human life (Ogwu, 2003).

International family planning perspective (1993), stated that, the work status and personal income of the family – related variables expected to be significant were parents education and occupation, family income, type of residence, religiosity in the family (very religious", "religious or not religious"). Family environment (comfortable, uncomfortable" or neither) and family re-structiveness (very strict, strict, not strict or not at all strict). The intermediate variables, which may be dependent on individual level and familial ones, were adolescents level of knowledge about issues related to sexual behaviour, their approach towards sex in

general and toward premarital sex in particular; the degree of their social interaction; and their exposure to erotic materials (Ogwu 2003; Shuyler, 1976).

Ariba (2000) stated that sex education might be regarded as a method of achieving appropriate and safe sexual behaviour by a given population through systematic persuasion. An elaborate definition of sex education is given by Emenike (1981) that it is education for effective living with an understanding of human sexuality as an integral, inseparable part of it. The creation of satisfying inter-personal relationships rather than simply the exercise of sex would be the goal, and it would involve the whole population and the total life span, going far beyond genital behaviour to include roles and inter sex expression of love and affection. On the other hand, Ogwu, (2003) defines sexuality as education which teaches the young person what he or she should know for his or her personal conduct and relationships with others.

Need for Sexuality Education

Ogwu, (2003) showed that there are many reasons why sexuality education should be taken seriously since our world today has become just, a global village, events occurring in part of the world that were previously remote are now becoming instant influences on patterns of behaviour in other parts. When these influences are negative, their impact on the recipient population could be catastrophic unless such population are well informed and have involved the appropriate behaviour to cope with such information. Through the media (both print and electronic and most recently the Internet), and direct interaction with

foreigners and visitors to other countries, our citizenry is becoming exposed to many sexuality problems (Ariba), 2000).

Adebajo, (1997) and Ariba, (2000) have shown that the increasing incidence of teenage pregnancies, STDs, HIV/AIDs, induced abortions, sexual violence's, harmful traditional practices (i.e. early marriage, female genital mutilation) divorce and teenage prostitution have drawn the attention of health policy makers toward the need for more education in the area of adolescent reproductive health.

Advantages of Sexuality Education

Emenike (1981) argued that sexuality education prevents both physical and mental health traumatic experiences. Due to occurrences experienced by both adolescents and adults as a result of ignorance, the teaching of sexuality education has become paramount in both schools and the communities. Emenike (1981) enumerated the importance of sexuality education as follows:

Knowledge of Human Reproduction

The adolescents have the understanding of human reproduction. They need to know that human begins when fertilization has taken place, that the father determines the sex of the baby. Apart from acquiring this body of knowledge, students should know what to do when they find themselves in a predicament during later years. Sex education, therefore, should help young people to

understand their own sexuality and enable them to enjoy stable and harmonious sexual relationships in their adulthood.

Arrest of misuse of Sex

The sex drive in man is very powerful when not satisfied could lead to some serious mental instability. Through sex education, the consequences of prostitution are made known to the adolescents. The evil effects of adultery such as shame, guilt and hurt, the dangers of criminal abortion, the agonies of unmarried mothers and the hate of sex perversions are spelt out to the students. Experiences such as these expose an individual to an intense mental imbalances and lack of productivity. Sex education will provide knowledge of the evil consequences of the sex ignorance, and in addition will warn, counsel and expose the ills the misuse of sex has. It provides youths with adequate information to be able to make balance moral decisions about their own behaviour.

A check on the spread of STDs

These are so called because of the main way through which they are spread, through direct or indirect contact sex education when introduced in all Nigerian schools, the students, victims and unaffected alike will know the possible dangers to themselves and the society as a whole.

Reduction of the dangers of Adolescence Pregnancy

Adolescence pregnancy is defined by Deschamps (1974), as pregnancy applied to future mothers under 15 years old. Deschamps (1974) observed that pregnancy on the adolescence is becoming one of the components of social maladjustment of youth raising new problems, and acute social problems are today added to the obstetric and nutritional problems already recognized in countries where girls marry very young. He identifies the following problems associated with adolescence pregnancy: -

- Disorders of pregnancy are more common in adolescence pregnancy than in adult.
- Psychological, social and educational problems include illegitimacy and its accompanying finally into mental malfunctioning.
- All these predicaments could lead a girl to indulge in prostitution, etc.

Good Interpersonal Relationships

Sexuality education when taught prepares the adolescents to develop good inter-personal relationship with both members of one's sex and those of the opposite sex. Emenike (1981) indicates that inter-personal relationship, involves such issues as dating, cultivating steady friendship, consideration in choice of marriage partners, the dos and don'ts of married life.

Disadvantages of Sexuality Education

The most obvious negative effect of sexuality education would be the tendency to sexual promiscuity among adolescents arising from their knowledge of how to prevent unwanted pregnancy. It could also lead to breakdown in marriages when couples disagree on when and when not to have children.

2.4 Types of STDs/Symptoms

Sexually transmitted infectious diseases (STDs) are a group of infections in which the principal way of transmission is by sexual contact. They were previously called Venereal Disease (VD) (Obionu, 2001).

Mark, (2001) stated that Sexually Transmitted Diseases (STDs) are simply diseases that can be contacted from an infected person by means of sexual intercourse. Again sexually transmitted diseases (STDs) are human infections that are transmissible by sexual intercourse, which may be vaginal, anal or oral (National AIDS/STDs Control Programme, 1992).

Initially it was believed that Gonorrhea and syphilis were the only infections, which could be transmitted by sex, hence, the name Venereal Disease (VD) was given to them. As time went on, it became clear that there are more than 20 other conditions, which are sexually transmissible. Although the size of the problem is unknown, particularly in Nigeria, STDs are very common and are of the top five (5) infections for which people seek cure.

STDs remain a public health problem of major significance in most parts of the world and their consequences can be devastating; these include adolescent female suffering chronic abdominal pain, ectopic pregnancy, infertility or cervical cancer. Male could develop urethral stricture and infertility and infants could die from congenital syphilis or be born with severe eye infections or life threatening pneumonia.

Evidence of the affiliation of STDs in published history is poor, and indeed, specific general disease were not identified in the middle ages and earlier amongst the famous people known to have suffered from STDs. According to the World Health Organisation (WHO) (1991), STDs are the most common diseases and the prevalence rates are particularly high in developing countries like Nigeria. Some STDs account for major tragedy for young women in Africa because they promote the transmission of Human Immune Deficiency virus/Acquired Immune Deficiency syndrome (HIV/AIDs). Many STDs and in particular HIV can be vertically transmitted in pregnancy with devastating effects on the newborn. The rate of vertical transmission of HIV are believed to be 25 to 30%. The major dilemma now is the scourge of HIV/AIDs as it affects even more female than male in Africa today. The male to female ration of 1:1 at the beginning of the epidemic has now shifted to 1:1-4 in Africans as against 8:1 in USA and 5:1 in Western Europe. The incubation period of HIV infection to develop into AIDs (which in the past was believed to be up to 10 years in the past) in male is believed to be shorter in female. Factors such as poor health and social status, polygamy, other STDs,

malnutrition, poor access to care and genital mutilation are responsible for easy transmission of HIV in women (Women Health, 2001).

The numbers of the sexually transmitted diseases that have been identified in the recent years are many including Gonorrhea, Syphilis, Genital Warts, Chancroid, Lymphogramulona, HIV/AIDS, Trichonomiasis. It would be presumptuous to attempt to cover all of them in this study. This write-up will therefore show concern with those in which the whole world are mostly concern with.

Gonorrhea

Gonorrhea is an old bacterial disease that is almost exclusively acquired through sexual intercourse. It is among the most common and widely recognized STDs throughout the world.

Gonorrhea is said to be the commonest communicable disease. The causative organism is Neisseria gonorrhea, which is delicate like treponema pallidum of syphilis; the organism dies quickly outside the human body. Gonorrhea is in many ways different in males and females. In the females there are often no symptoms. Feming *et al.* (1970), in the study of VDs estimated that upwards of 90 percent of females with Gonorrhea are completely without symptoms. However it has been observed that women with gonorrhea may feel a little pain when urinating or have slight vaginal discharge. After months or even years, there may be pain in the lower belly leading to menstrual problems, urethritis and abscess with vulval dedema. The spread of infection to the uterine tube, when it occurs is usually at the time of menstruation. This gives rise to salpingit in inflammation of the

fallopian tube). This may lead to sterility (Michael, 1981). It further explained that in males, the first signs of gonorrhea begin 2-3 days, at times between 1-31 days. There is readily identifiably early symptoms of painful urination and drops of pus from the penis. Infection in males may remain confined to the anterior urethra and becomes self – limited disease of weeks or months duration even without treatment if the infection remains for a long time untreated, it may lead to hard and tender swelling of the knee and or joint, accompanied by other complications. It is important to note that the difficulty in passing urine may be due to causes other than gonorrhea. Examples may be enlargement of the prostate gland, kidney or bladder stones and most commonly infection caused by blood flukes (Schistosomiasis and Bilharzia). A young man who has had sexual intercourse within few days experiencing penile pain, difficulty in urination and bloodstains should check for gonorrhea.

Syphilis

Syphilis is one of the most dangerous sexually transmitted diseases. It is caused by a bacteria called Treponemapallidum (Sporehete) transmitted by sexual intercourse, oral or oral contact with an infected person it can also be transmitted from an infected mother to the unborn child in the case of congenital syphilis (WHO, 1991).

i) Stages of Syphilis

Primary syphilis: - Primary lesions known as chancre appear 10-90 days (Average of 30 weeks) from exposure (Sparking, 1984). The Chancre looks

like pimples or sores that are usually painless on the genitals or site of infection. If untreated, the primary lesions disappear and progress into the next stage (Sparking, 1984).

ii) Latent Syphilis

The symptoms of the secondary syphilis disappear but the disease goes into a dormant or latent phase with no observable symptoms and may last 80 years. However, this is a more dangerous stage because it damages the deeper tissue (Panos institute, 1988).

iii) Tertiary Syphilis

This stage is characterized by irreversible or permanent damage to the body organs.

iv) Complications

Complications are serious and they include heart problems, improper bone growth, dementia, paralysis and even death, congenital syphilis can lead to abortion, still birth, blindness, deafness, facial abnormalities (WHO, 1991). Syphilis can be treated using antibiotics such as tetracycline.

Genital Warts

Genital warts are painless out growth on the male and female genitals usually caused by virus. The virus is spread through genital – oval or oval genital contact with an infected person (Ernest, 1995).

i) Complication:- There are no major complications some warts can be treated by freezing with Liquid Nitrogen or substance called

podophyclin while the large ones can be surgically removed (Ernest, 1995).

Chancroid

Chancroid is caused by a bacterial *Henophilia ducregi* spread by sexual contact through a skin abrasion. It is a localized general disease characterized by soft sores or ulceration at the anus vulva, urethra, elitors, and cervix, (Domokos, 1971) it is very common in the tropics.

i) Signs and Symptoms:

Small red spots appear at the side of the infection. They may grow like pimple like structures that break down into ulcer or open sores full of pus.

ii) Complications:

The ulcer may spread causing damage to local tissues but do not spread to other body tissues. It can be treated with antibiotics and be prevented by good hygiene (Ernest, 1995).

Lymphogramulona (LGV)

It is one of the STDs caused by *Chlamidia trachomatics*. It is a chronic disease that has many manifestations similar to that of syphilis (Ernest, 1995). It is transmitted during sexual intercourse, but may also be spread by close physical contact. It is a disease found mainly in the tropics (Ernest, 1995).

Trichonomiasis

Trichonomiasis is caused by protozoa and germ called *trichononas vaginitis*, which is a STD that lives in the urethra of the male, and female it is transmitted through sexual intercourse or contact. It is one of the most common STDs (Ariya, *et al.,* 1988). Also infection through contaminated instrument, gloves, toilet, and seats (Ariya, *et al.,* 1988).

Signs and Symptoms

The exact incubation period of trichonomiasis is unknown. Most men are asymptomatic (without symptom) though some may have urethritis. In female the infection is characterized by foul smelling, greenish grey vagina discharge.

Complications

There are no major complications in female. In male this may result in epidedymitis or prostatics. It can be treated with a drug called flagyl or metronidazole. This disease cannot be regarded as minor (STD) in the tropical countries notable Africa and Nigeria in particular because they are very common (Ernest, 1995).

AIDS

Obionu, (2001) stated that Acquired Immune Deficiency Syndrome (AIDS) is the most recent addition to the group of diseases that are primarily transmitted by sexual contact. Since its recognition as a new disease in 1981, AIDS has been and

remain a global problem, and the spread of the disease has continued at a dramatic pace.

The causative agent is a retrovirus called human T lymphotropic virus Type III (HTLV III) or Human Immono deficiency virus (HIV), or lymphadenopathy Associated Virus (LAV). As at 1990, more than 200,000 cases have been reported to the WHO from 157 countries in all continents including Africa. This statistics is clearly an under–estimation as some countries for political and socio–economic reasons play down on the prevalence of AIDS in their border, while others lack accurate case–detection or case–reporting, as well as show a lot of delay in reporting cases to WHO (Obionu, 2001.

Mode of Transmission

Regardless of the area of the World from which cases are reported, the modes of HIV transmission are fundamentally the same.

- Sexual contact with infected person
- Transfusion of contaminated blood or blood products.
- Sharing of contaminated needles or other skin piercing instruments.
- From infected mother to child mainly at the end of pregnancy during labour and shortly after birth.

Obionu, (2001) further explained that some cases of HIV/AIDs originating form organ transplantation have been recorded but by far sexual contact is of primary importance to HIV transmission throughout the World. All age groups can be

infected but incidence is higher between 18-29 years groups. High risk factors include among others, multiple sex partners, prostitution, homosexual practices, unprotected transfusion of blood and blood products, and intravenous drug abuse, especially with needle changing. Whether or not an infected person becomes ill with disease. Such person remains a potential source of infection to others.

Symptoms

The disease is due to a gradual deterioration of the host's immune system characterized by the depletion of the CD4 element of the immune system the loss of which can explain most of the pathological consequences of the HIV infection soon after a person becomes infected, the number of T. lymphocytes begin to drop from its normal value of about 1000 cells permm^3, at a variable rate of 40 to 80 cells per mm^3 per year. This progressive deterioration of the immune system is initially manifested by less severe clinical conditions, including generalized lymphadenopathy, chronic fever, diarrhea, weight loss and oval candidiasis. These are classified as AIDs – Related complex (ARC) usually most AIDs – defining conditions occur in patients with less than 200 CD4 lymphocytes permm^3. AIDs, the most severe currently recognized consequence of HIV infection, is characterized by severe, and ultimately fatal opportunistic infection and malignancies.

Major Signs

- Weight loss greater than 10 percent of body weight.
- Chronic diarrhea longer than one month.

- Prolonged fever

Minor Signs

- Persistent cough
- Generalized pruritic dermatitis.
- Recurrent Herpes zoster
- Oro-pharyngeal candidiasis.
- Chronic progressive and disseminated Herpes simplex infection
- Body rashes.

Nongonococal Urethritis (NGU)

NGU is the inflammation of the urethra caused primarily by bacterial behaved to be chlamidiatrachematis NGU is spread through sexual intercourse. Other organisms are also known to cause NGU. Chlamidia-trachematis is one of the most common STDs in Western Countries (Ariya and Bennett, 1988).

Signs and Symptoms:

The incubation period exceeds 20 days in most of the cases. In the male the symptoms include burning and itching around the opening of penis. The NGU discharge is slightly white, while that of gonorrhea is white or yellow. White in female the NGU causes pain burning or itching on or around the vagina.

Complication

If untreated NGU can cause steriity, epididymitics Urethral spontaneous abortion, stillbirth or damage to the baby's eyes tissue. Chlamidia-tropomatics is common cause of female infertility (Ariya and Bennett, (1988). NGU can be treated with antibiotics.

2.5 Occurrences of STDs

Obionu, (2001), explained that it is important to note that STDs organisms mentioned above can also be transmitted in ways other than sexual contact. Some of these infections, e.g. syphilis, gonorrhea, HIV/AIDs etc. can be transmitted during pregnancy or at birth from the infected mother to infant. Non-sexual transmission of syphilis, AIDs or hepatitis infection may also occur through infected blood, blood products or unsterilised instruments.

The occurrences of STDs is increasing throughout the world over and is highest during the ages of highest sexual activities usually 20-24 years old age groups followed by 25-29 and 15-19 age groups. The incidence of most STDs are higher for men than female even though the morbidity caused by STDs are generally more severe in women and homosexually active male than in heterosexual males. Mark, (2001) stated that, to confront these occurrences of STDs there is the need to:

- Drive home the message, based on objectives consistent with the epidemiological reality in our country.
- Devise strategies that have a scientific basis, founded in research and international domestic experience.

- Develop firm political support for activities to combat STID (HIV/AIDs) by ensuring multi-sectoral participation.
- Bring together the various ministries involved in policy for controlling the problem, the advancement of women, work, and education, among others – with civil society to lay down standards and launch activities at the national level.
- Promote solidarity and support for people affected by the epidemic, to give them better access to health care and lower costs for medicines, special tests and examinations, not forgetting anti-retroviral treatments.

Factors Associated with STDs Transmission

Socio-economic and socio-cultural factors affect the occurrence of STDs and the incidence is higher among single, divorced and separated than among married people and in individuals of lower than higher socio-economic status (Obionu, 2001). Some diseases such as chancroid are associated with poverty and poor hygiene. Other high-risk groups are those with inadequate personalities. Ogwu, (2003).

Social and family disruption caused by rapid industrialization and urbanization in many countries as well as resultant migration of labor from rural to urban cities, housing problems and loneliness, are all contributory factors in the high occurrence of STDs in some countries. Furthermore, culture and attitudes to sex play important roles in the transmission of STDs. Recent changes in norms and cultural habits to sex have led to greater tolerance and permissiveness towards

sexual relations which were previously unacceptable, thus encouraging promiscuity, indiscriminate sexual activity and frequent changes in sexual partners. Consequently STDs are more frequent in those who indulge in promiscuous sexual behaviours.

Other factors that seem to affect transmission of STD are ignorance and lack of knowledge of their transmission mode, occupation (e.g. prostitutes, barbing, musicians, sailors, salesmen, taxi drivers, adolescents etc.), and high intake of alcohol that may remove inhibition and lead to increased casual sexual encounter. Finally, development of effective forms of contraception and increase access to them has by removing the fear of pregnancy also led to some changes in sexual behaviour of adolescents female which may have an influence on the transmission of STDs.

2.6 Prevention of STDs

Since STDs are caused by different pathogens (some viral and some bacterial). We need some preventive measures that will limit the occurrence or incidence of STDs in our community.

- Promoting general awareness, education and behavioral change. Essential steps in the prevention of STDs transmission are promoting a community norm of STDs prevention and educating the adolescents about STDs and adults on how to protect themselves. Family planning program efforts have extensive experience in mass media and behaviour change mass media spots, community–based communication efforts and sports promotions among others, can help educate and motivate the general population. The popular culture's obsession with themes of love

and sex can be a major advantage for those seeking to promote reproductive health related topics. STDs awareness and education can be covered directly in family planning and maternal and child health service delivery, through counseling and education. Unfortunately, such contacts often reach relatively few women for brief periods of time. Moreover, clinic time and other resources are scarce. In addition sexual topics remain highly taboo in many countries, ignorance among providers is widespread and women themselves are often powerless to affect their STD risk even with the best of counseling (Obionu, 2001).

- Promoting condoms aggressively:- making condoms very easily available in clinics, community-based distribution programs and other settings is another priority. In other countries like Kenya, for example, condoms are very readily available in clinics (e.g. in waiting rooms, examination rooms and rest rooms). They are thus available not only to the female clientele of these facilities, but also to their partners and anyone who come to the clinic (Mark, 2001).

Other preventive methods are as follows:-

Mark, (2001) stated that the best prevention is to avoid sex with multiple partners. Another method of preventing sexually transmitted pathogen is a healthy living (Hygiene). He further argued that women can help protect themselves by seeking prompt treatment for all reproductive tract infections. Scientists have now shown conclusively that the risk of contracting (and transmitting) HIV increases in the

presence of a reproductive tract infection. This includes a wide range of STDs such as gonorrhea, Chlamydia, chancroid, bacterial gaginosis and trichonomiasis.

2.7 Summary

This section summarized the literature review. From the previous research work carried out, it was observed that the awareness of adolescents about sexuality education and STDs appear to be low. The researchers concluded that the barrier not to be aware is due to ignorance of health workers. There is the general consensus that there is the need for sexuality education in various schools across the country. Such factors as poor health and social status, polygamy, other STDs, malnutrition, poor access to care and genital mutilation are responsible for easy transmission of STDs. Some of the adolescents can not easily identify types of STDs, since STDs remain a public health problem of major significance in most parts of the world and their consequences can be devastating like the occurrence. Primary Health Care for Developing Countries (2001) explained that STDs can also be transmitted during pregnancy or at birth from the infected mother to infant or blood products or unsterilised instruments. Adolescents between the ages of 18-24 years are more sexually active, and the occurrences of STDs are more on these age groups.

So many adolescents were observed not to know whether they have been affected by STDs. Even the occurrences stage formerly was shorter in women and longer

in men i.e. in terms of duration or period. But these days within a few weeks the disease will manifest.

Mark, (2001) stated the need to confront the occurrence of STDs, drive home the message, based on objectives consistent with the epidemiological reality in our country. There is the need to devise a better strategy that has a scientific basis in research and international domestic experience.

The available literatures showed that better access to health care and lower costs for medicines, special test and examinations should be taken serious and anti-retroviral treatments. There is the need for some preventive measures that will limit the occurrences of STDs in our country. Such as:

- Promoting general awareness, education and behaviour change.
- Promoting community norms of STDs and educating the adolescents about STDs and adults on how to protect themselves.
- Socio-economic and socio-cultural factors affect the occurrence of STDs. Incidence is higher among single, divorced and separated than among married people and in individuals of lower than higher socio-economic status. Some diseases such as Cancroids are associated with poverty and poor hygiene. Other high-risk groups are those with inadequate personalities.

- Promoting condoms aggressively:- making condoms very easily available in clinics, community-based distribution programs and other settings is another priority.
- General hygiene should be taught in our community to help the populace and adolescent to have a good healthy living.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the design of the study, the population and the method of selection of sample and sample size. The chapter includes a description of the research instrument used for the identification of the current position of sexual behaviour, and knowledge of adolescents in secondary schools and undergraduates of higher institutions of learning. It also covers validation and administration of instrument, procedure for data analysis and the result of the pilot study conducted.

3.1 Research Design

As the purpose of this study was to assess the sexual behaviour and knowledge of adolescents in secondary schools and undergraduates of higher institutions of learning in Akure, Ondo State, the information required to achieve the purpose was already available. Therefore ex-post factor research design was used to collect the information required to test the hypotheses of the study.

In this design, information on level of understanding of sexually transmitted diseases, experiences on sexual behaviour, perception about sexually transmitted diseases and infection, sexuality education, knowledge of contraception and prevention of unwanted pregnancies and STD's effects of religion on sexual behaviour, socio-economic status behaviour and the effects of location of schools

on sexual behaviour and knowledge among adolescents in secondary schools and higher institution students were collected. The information thus collected were analysed to answer the research questions and to test the hypotheses of the study.

3.2 Population

The population for this study consisted of all senior secondary school students and students of higher institution of learning in Akure, Ondo State.

3.3 Sample and Sampling Techniques

Stratified random and purposive sampling techniques were used in the selection of samples for this study. Akure was divided into two (2) strata on the basis of the local government zoning system as follows:

a) Akure North this zone consists of the following schools

Anglican Grammar School, Ita gbolu

Ejioba High School, Oballe

Elu-Iju Comprehensive High School, Iju

Alamo Grammar School, Itagbolu

Comprehensive High School, Ayede-Ogbese

Igbatoro High School, Igbatoro

b) Akure South

Aquinas College, Akure

Oyemekun Commercial School, Akure

Fiwasaye Girls Grammar School, Akure

St. Louis Grammar School, Akure

Akure High School

Omo _ Oluoroagbo Grammar School

Adegbola Memorial Grammar School

Akure Muslim College Akure

A/C Comprehensive High School Akure

Alakwe Comprehensive High School Akure

Army Comprehensive High School, Akure etc.

From each zone, two schools considered as urban school, and two schools considered as rural school, were selected randomly. The only university considered as higher institution was selected as higher institution. Thus a total of eight (8) secondary schools and one university were used. In the secondary schools, a total of 269 students were randomly selected from all the institutions to serve as subjects in this study, while a total of 111 students were randomly selected from the only federal university in Akure. Thus a total of 380 subjects (189 males and 191 females) were selected, the breakdown of which is shown in Table 1. These represent those questionnaires that were adequately and correctly filled and returned.

Table 1: Summary of Selected Schools and Number of Students from Each Zone

S/N	ZONE A	NUMBER OF STUDENTS		TOTAL
	A. URBAN SCHOOL	MALE	FEMALE	
1.	Oyemekun Gram. School, Akure	16	16	32
2.	St. Louis Gram. School, Akure	17	17	34
	B. RURAL SCHOOL			
1.	Ejioba High School, Obaile	17	17	34
2.	Alamo Gram. School	17	17	34
ZONE B				
	A. URBAN SCHOOL			
1.	Akure High School	17	17	34
2.	St. Francis High School	17	17	34
	B. RURAL SCHOOL			
1.	Alamo Gram. School, Itaogbolu	17	17	34
2.	Elu-Iju Comp. High School	16	17	33
ZONE C: HIGHER INSTITUTION				
	Fed. Univ. of Tech. Akure (FUTA)	55	56	111
	GRAND TOTAL	189	191	380

3.4 Instrumentation

In order to achieve the purpose of this study, a questionnaire was developed that contained 33 statements divided into four sections. Section A consisted of nine statements on demographic characteristics of the respondents, section B consisted of six statements on sexual behaviour and practices of the respondents, section C ten statements on knowledge about sexual education in their various schools, while section D consisted of eight statements on knowledge about prevention and control of sexually transmitted diseases.

The instrument thus developed was submitted to five professional experts from the Department of community medicine, Institute of Education, and Department of Physical and Health Education of Ahmadu Bello University, Zaria, for validity

and reliability of the instrument. On the basis of their suggestions and opinion, some of the items on the questionnaire were restructured and modified to make them more valid and reliable. On the basis of this, the final draft of the questionnaire was prepared for the study.

3.5 Administration of Instruments

A stratified random sampling technique was used in the selection of adolescents for the study. The list of students in the secondary schools (public) in the State was obtained from the State Ministry of Education, Akure. Apart from two schools (in which one comprised of 32 adolescents of 16 males and 16 females and the other comprised of 33 respondents composed of 16 males and 17 females) were selected randomly. Every other secondary school had 34 student respondents randomly selected in the ratio of 17 male and 17 females students were randomly selected making a total of 269 adolescents from the secondary schools in Akure. For the undergraduates, 22 adolescents were sampled from each of the Schools of the Federal University of Technology, Akure, i.e. School of Engineering, School of Environmental Technology, School of Sciences and School of Earth and Mining Sciences. In addition, 23 students were selected from the School of Agriculture and Agricultural Technology thus making a total of 111 respondents. In all, a total of 380 respondents were used for this study.

3.6 Analytical Technique

The data collected were analysed at the Federal University of Technology, Akure. The SPSS software package was used for the analysis. Descriptive statistics such as frequency tables, percentages and standard deviation were used; multiple regression analysis was computed to determine the factors affecting the involvement of the respondents in sexual activities before marriage.

The data generated were further analyzed using multiple regression analysis to determine the factors affecting the involvement of the respondents in sexual activity. To also find the relationship that existed between some demographic variables, the correlation analysis was used.

In order to determine the factors influencing the sexual behaviour of the respondents, a multiple regression function was fitted to the data generated. It is as presented below:

$Y = a_0 + a_1X_1 + a_2X_2 + a_3X_3 + a_4X_4 + a_5X_5 + a_6X_6 + a_7X_7 + e$.

Where

Y = Involvement in sex before (1 if yes, 0 if otherwise)

X_1 = Age of the respondents (years)

X_2 = Sex of the respondents (1=male, 2=female)

X_3 = Marital status of the respondents (1=single, 2=married)

X_4 = Settlement of the respondents (1=Self-contained, 2=Common Facility Accommodation, 3=No Convenience such as toilet)

X_5 = Level of education of respondents (number of years in school)

X_6 = Family type of the respondents (1=poor, 2=average, 3=rich)

X_7 = Sex partner of the respondents (numbers)

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Introduction

The purpose of the study was to investigate sexual behaviour and knowledge towards STDs among Secondary Schools and University in Akure, Ondo State. To achieve this purpose, the data collected was statistically analyzed, the result of which are presented and discussed according to the hypotheses in this chapter.

4.2 Results

Information regarding the demographic characteristics of the respondent is shown in the table 4.1

Table 4.1: Demographic Characteristics of Respondents

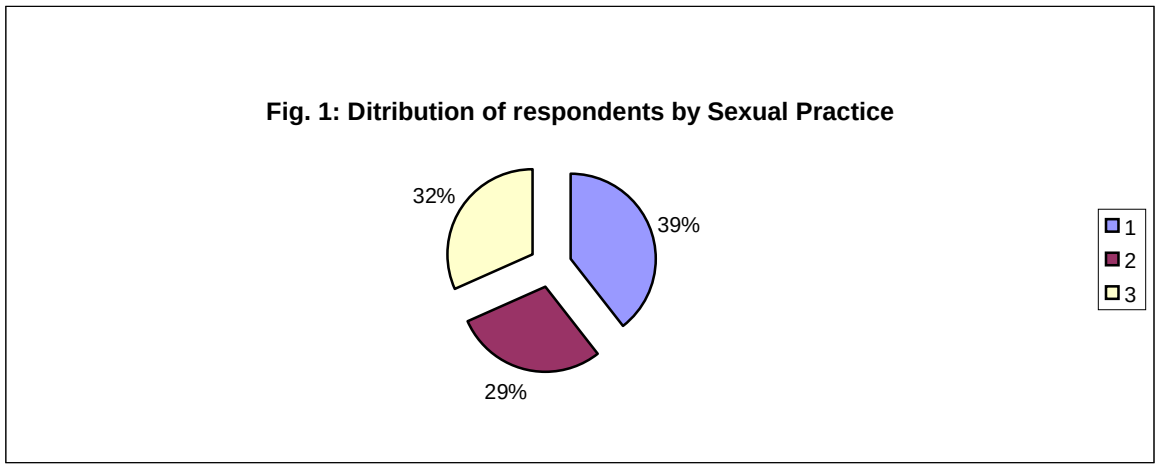
S.NO	CHARACTERISTICS	FREQUENCY	PERCENTAGE
1.	**AGE(YEARS)**		
	a. < 15	82	21.58
	b. 16 – 20	207	54.47
	c. 21 – 25	78	20.53
	d. > 25	13	3.42
	Total	**380**	**100**
2.	**SEX**		
	a. Male	200	53
	b. Female	180	47
	Total	**380**	**100**
3.	**MARITAL STATUS**		
	a. Single	374	98.4
	b. Married	6	1.6
	Total	**380**	**100**
4.	**RELIGION**		
	a. Christianity	351	92.4
	b. Islam	22	5.8
	c. Traditional Worship	7	1.8
	Total	**380**	**100**
5.	**CLASS**		
	a. Senior Secondary I	70	26
	b. Senior Secondary II	105	39
	c. Senior Secondary III	94	34.9
	Total	**269**	**100**
6.	**LEVEL OF UNIVERSITY**		
	a. 100	21	18.9
	b. 200	26	23.4
	c. 300	33	29.7
	d. 400	21	18.9
	e. 500	10	9.7
	Total	**111**	**100**
7.	**TYPE OF SCHOOL**		
	a. Day Co-education	236	62.1
	b. Day Girls only	10	2.6
	c. Day Boys only	20	5.3
	d. Boarding Girls	10	2.6
	e. Boarding Boys	11	2.9
	f. Boarding Co-education	93	24.5
	Total	**380**	**100**
8.	**SETTLEMENT**		
	a. Self-Contained	180	47.4
	b. Common Facility Acco.	115	30.3
	c. No convenience such as toilet	44	11.6
	d. Others	41	10.7
	Total	**380**	**100**
9.	**FAMILY TYPE**		
	a. Rich	169	44.5
	b. Average	198	52.1
	c. Poor	13	3.4
	Total	**380**	**100**

Table 4.1 shows that out of a total of 380 respondents, 207 (54.47%) were between 15 and 20 years of age. 200 (53%) were males and 180 (47%) were females. Most of them (374, 98.4%) were single and 1.6 of them were married. (351, 92.4%) were Christians, 22, 5.8% were Muslims and 1.8% were traditional worshippers. 39% of the respondents were in SS2 while 34% of the respondents were in SS3. Majority of the respondents 29.7% and 23.4% were in 200 and 300 levels in the university respectively. 62.1% shows that they were in 'Day' co-education and 24.5% shows that they were in boarding co-education. 47.4% lives in self-contained apartment, while 52.1% were from average families. Akure is now a designated millennium city by the United Nations. This has far reaching implications for the development of the town and the youths especially.

The study showed that the mean age of the respondents was 18.4 years with majority of the respondents being within the age bracket of 16 to 20 years. Majority (98.4) were still single. A mixed distribution was observed as regarded the religion of the respondents. In terms of the type of school the respondents attended, the most common type of School was Day co-educational.

When asked whether they have ever had sexual intercourse, some (40%) answered in affirmation. Thus the virtue of chastity before marriage seems to have been lost among the respondents. From the study, it could be observed that many of the respondents were lured into having sex by the desire to have money and by

implication of material things. Though majority did not consider the issue of money or material things as important before having sex, however, some were lured into sex through the use of money. This findings was in-line with that of Obionu, (2001) and Ogwu, (2003) which stated that socio-economic factors affects the occurrences of pre-marital sex, an incidence of Sexually Transmitted Diseases which is higher among singles, divorced and separated than among married people and in individuals of lower socio-economic status.



Sexual Intercourse

When asked whether they had ever had sexual intercourse, 32% did not respond while 39% answered in affirmation (Fig. 1). Thus the virtue of chastity before marriage seems to have been lost among the respondents. However, 29% said they have never had sex before. This may be partly due to the level of awareness on the part of their school management and parents as regards the dangers in sexual intercourse (Premature) such as unwanted pregnancy and sexually transmitted diseases as well as the high level of sensitization on radio and TV on sexually transmitted diseases.

Age Distribution

Table 4.2: Distribution of Respondents by Age at First Sex

Age	Frequency	Percentage
<10	22	14.7
10-15	56	37.5
16-20	65	43.6
21-25	5	3.4
>25	2	0.8
Total	**150**	**100**

The table shows that 43.6% of the respondents had their first sexual intercourse at the age of 16 to 20 years of age, while 37.5% had their first sexual intercourse at the age of 10 to 15 of age, 14.7% had their first sexual intercourse at age 10, these may be rape cases.

Sexual Partners

Table 4.3: Distribution of Respondents by Sex Partners

Partners	Frequency	Percentage
1	118	55.9
2	22	10.4
3	20	9.5
4	15	7.1
>5	36	17.1
Total	**211**	**100**

Table 4.3 shows that 55.9% indicated that they have only one sexual partner whereas 17.1 and 7.1% indicated to have multiple sexual partners. This could predispose them to STDs.

Awareness about Sex

Table 4.4: Distribution of respondents by Knowledge of Sex

Knowledge	Frequency	Percentage
Friends	165	33.9
Parents	45	11.8
TV & Video	79	25.0
Older relations	21	5.53
School teaching	70	22.2
Total	**316**	**100**

Table 4.4 shows that 33.9% attested that their modal source of awareness about sex was through friends. Whereas 25 and 22.2% of the respondents attested that their source of knowing about sex was through T.V, Video and from school teaching. This is in consonance with the adage that evil mind corrupts others as well as the influence of peer group.

Table 4.5: Distribution of Respondents by Motivation to Sexual Act

Material	Frequency	Percentage
Yes	143	45.1
No	174	54.9
Total	**317**	**100**

Table 4.5 shows that many of the respondents were lured into having sex by the desire to have money and by implication, material things. The table reveals that the desire for material things does lead to STDs as attested to by 54.9% of the respondents. This may be so because the desire for material things may lead the respondents to involve/engage in immoralities such as casual sex or indiscriminate sex for money that may result in their contacting STDs. Majority did not consider the issue of money or material things as important before having sex.

Information about STDs

Table 4.6: Distribution of respondents by Source of Information on STDs

Knowledge	Frequency	Percentage
TV/Radio	208	61.7
Print materials	40	11.9
Peer groups	26	7.7
Teachers	25	7.4
Parents	21	6.2
Others	17	5.1
Total	**337**	**100**

Table 4.6 shows that 61.7% indicated that T.V/Radio were their sources of information about Sexual Transmitted Diseases (STD's), whereas, 7.4 and 6.1% indicated that their sources were teachers and parents. From this report, one can infer that majority of teenagers in this study rely on T.V/Radio for information about STD's. This shows the importance and reliability of the media – Television and Radio as means of communication. Again, this may be due to high level of

sensitization on radio and Television by the Government and Non-Governmental Organizations (NGOs)

Causes of STDs

Table 4.7: Distribution of Respondents by Perceived Causes of STDs

Causes	**Frequency**	**Percentage**
Bacteria	5	1.3
Virus	92	24.7
HIV	198	53.1
Not sure	24	6.3
Do not know	61	16.2
Total	**380**	**100**
STDS are caused by bacteria	**Frequency**	**Percentage**
Yes	143	39.6
No	64	17.7
Not sure	84	23.3
Don't know	70	19.4
Total	**361**	**100**

Table 4.7 shows that 53.1% of the respondents are still not sure of the cause of STD's / AIDS and so need to be educated to avoid being a victim of the deadly disease.

Table 4.8: Distributions of Respondents by Knowledge of the Mode of Transmission

Mode	**Frequency**	**Percentage**
Sharing Needles	28	7.4
Mother child	19	5.0
Sharing Toilet	240	63.2
Sexual Contact	62	16.2
Contaminated blood	31	8.2
Total	**380**	**100**

Table 4.8 shows that 63.2% of the respondents are not too sure about the major mode of transmission of STD's. Thus there is still need for enlightenment on issue relating to STDs especially HIV/AIDS.

Table 4.9: Distribution of Respondents by Knowledge of the Symptoms of STDs

Symptoms	**Frequency**	**Percentage**
No	41	11.2
Yes	181	49.3
Not sure	54	14.7

Don't know	91	24.8
Total	**367**	**100**
Awareness of Symptoms	**Frequency**	**Percentage**
Yes	213	56.05
No	83	21.84
Not sure	84	21.84
Total	**380**	**100**

Table 4.9 shows that 49.3% are aware that bacterial causes certain STD's and about 56.05% of the respondents are aware of the symptoms of STD's and that may likely discourage them from engaging in immoral acts such as indiscriminate sex to avoid contacting the deadly disease.

Table 4.10: Distribution of Respondents by whether Sex Education is in School Curriculum

Sex Education in School Curriculum	**Frequency**	**Percentage**
Yes	269	72.1
No	10	2.7
Not sure	13	3.5
Don't know	81	21.7
Total	**373**	**100**

As shown in table 4.10, 72.1% of the respondents are positive that Sex Education is in school curriculum, 2.7% totally disagree to this, while the rest 25.2% are either not sure or don't know if Sex Education should be introduced into the school curriculum.

Table 4.11: Distribution of Respondents by Ineffective Sex Education in Schools

Ineffective Sex Education in School	**Frequency**	**Percentage**
Religious Problem	85	23.7
Inadequate number of Health Educators	86	24.0
Lack of Materials/Funds	57	15.9
Not in School Curriculum	109	30.5
Others	21	5.9
Total	**358**	**100**

The major reason why Schools are not efficient in the control of sexually transmitted infectious diseases is because it is not in the School Curriculum as attested to by 30.5% of the respondents. Also, 24% of them felt that inadequate number of Health Educators in the schools led to the problems.

Provision of Sexual Information by Place of Worship

Table 4.12: Distribution or Respondents by Education on Sexual Issues and STDs from place of Worship

Place of Worship	Frequency	Percentage
Yes	204	44.7
No	165	55.3
Total	**369**	**100**

As shown in Table 4.12, it could be seen that 55.3% said that their place of worship do not give them information/lecture on STDs.

Opinion of Misinformation about STDs

Table 4.13: Distribution of Respondents by Misinformation

Misinformation Leads to STDs	Frequency	Percentage
Yes	244	67.8
No	67	18.6
Don't know	49	13.6
Total	**360**	**100**

Table 4.13 shows that 67.8% of the respondents felt that misinformation could lead to contacting STD's. They could thus source for information from any available means to them.

Prevention of STDs

Table 4.14: Distribution of Respondents by Preventive Measure

Prevention	Frequency	Percentage
Abstinence from Sex	185	50.7
Early Marriage	11	3.0
Oral Sex	12	3.3
Taking Antibiotics	9	2.5
Use of Condom	145	39.7

Any other	3	0.8
Total	**365**	**100**

Table 4.14 illustrates that the major way of preventing sexually transmitted infectious diseases is abstinence from sex as reported by 50.7% of the respondents. Others felt that use of the condoms and early marriage could be good methods for self-protection..

Table 4.15: Distribution of Respondents by Self Protection

Self Protection	Frequency	Percentage
Avoid Sex	200	55.6
Contraceptive	18	5.0
Traditional Medication	7	1.9
Early Marriage	8	2.2
Use of Condom	127	35.3
Total	**360**	**100**

For self-protection, 55.6% of the respondents felt that the best and the most common means is to avoid casual sex as seen in Table 4.15. These methods may not be full-prove if proper care is not taken in their usage

Disadvantages of Condom Use as Preventive Method against STDs

Table 4.16: Distribution of Respondents According to Reasons Why Condoms May Not Effectively Prevent Sexually Transmitted Infectious Diseases.

Reasons	Frequency	Percentage
Protection is not 100%	235	61.85
It is Expensive	36	9.47
Interferes with Sexual Satisfaction	95	25
Not readily available	14	03.68
Total	**365**	**100**

About 39.7% of the respondents said that the use of condom could protect self/one from contacting Sexually Transmitted Diseases STDs (Table 4.15). Among this category of respondents, 61.85% of them added that the use of condom does not guarantee 100% protection. This may be due to "tearing" of the condoms and the

low quality in terms of expired condoms dumped in the Nigerian Markets (Table 4.16).

Control of STDs

Table 4.17: Distribution of Respondents according to Control Methods of Sexually Transmitted Diseases

Method Of Control	**Frequency**	**Percentage**
Abolishing Prostitution	63	16.58
Prohibition of Casual Sex	125	32.89
Educating youths on Health matters	107	26.58
Sex Education in Schools	67	17.32
Campaign/Symposium	24	6.32
Total	**380**	**100**

The various ways by which sexually transmitted diseases can be controlled are as listed in Table 4.17. As Shown in the table, it could be seen that the modal method of control of sexually transmitted infectious diseases is prohibited of casual sex as attested to by 32.89% of the respondents. Another major way of controlling the disease is through educating the youths on health matters. Above all, a combination of so many control methods will do at the expense of only one single method. From the foregoing hypothesis 1 is rejected.

Major hypothesis

There are no differences between adolescence in their sexual behaviour and knowledge about the causes and prevention of sexually transmitted diseases (STD's).

Sub-hypotheses

1 There are no significant differences between male and female adolescents in their sexual behaviour and knowledge about causes and prevention of Sexual Transmitted Diseases (STD's)

2 Religion, Socio-economical status, residential location have no significant influence on the sexual behaviour of adolescents and their

knowledge about causes and prevention of Sexually transmitted Diseases (STD's) in Ondo State.

In order to test these hypotheses, the response of the subject on sexual intercourse, sexual behaviour, sexual partner, awareness about sex, information about STDs, knowledge of causes of HIV/AIDS, knowledge of the mode of transmission of STDs, symptoms of STDs, inclusion of sexual information by place of worship, misinformation of STDs and control of STDs, disadvantages of condom use against STDs and control of STDs are statistically analyzed, the result of which are presented in the section.

Determinants of Sexual behavior

The Results of the Regression analysis is as shown below

$$Y = 0.0089 - 0.0133X_1 - 0.0366X_2 + 0.194X_3 - 0.00313X_4 + 1.601X_5$$
$$(-2.731)^* \quad (-1.492) \quad (2.598)^* \quad (-0.109) \quad (0.945)$$
$$- 0.0034X_6 + 0.0547 X_7$$
$$(-0.151) \quad (7.008)^*$$
$$F = 130.315^* \quad R^2 = 90.6$$

*Significant at 5% level of significance figures in parentless are the t – ratios.

4.3 Discussion

The Regression result revealed that the explanatory variables accounted for 90.6% variation in the dependent variable – involvement and participation in sexual act.

Four (4) out of the variables namely Age of the respondents in year (X_1), Marital status of the respondents (X_3), type of settlement/accommodation (X_4) and number of Sexual partner of the respondents (X_7) were significant in determining whether a respondent had sex before marriage.

Age of the respondents in years (X_1) had a negatively signed coefficient meaning that there is an inverse relationship between age and involvement in sex before. Among the youths and in most cases, the adolescents, the urge to take the forbidden fruit is high due to peer group influence and watching of sex pornographic films. People of older ages had got the experience and the urge for sex may not be there except for the sake of procreation.

Marital status (X_3) has a positive sign attached to the coefficient indicating that marital status and involvement in sex before is positively correlated. Both sexes male and female do have urge for sexual intercourse but with males having more urge as puberty stage is reached.

The results of this findings is in line with those of Ogwu (2003) and Ariba (2000) and Emenike (1981) which stated that Adolescent had inadequate information regarding reproductive health, human sexuality, and safe sexual practices and inadequate knowledge about other sexually transmitted diseases and infections apart from that of gonorrhea.

These findings also agreed with that of Obionu (2001), which stated that socio-economic and cultural factors affect the occurrence of STDS among adolescents. Adeyemo, (1995) also support this findings that attitude of the adolescents towards sexual practices are influenced by the knowledge they have. This has also been said to have influenced their lives and significantly affects how they react to sexual acts.

Recent changes, norms and culture as viewed by Obionu; (2001); towards sex have led to greater tolerance and permissiveness towards sexual relation which were previously unacceptable, thus encouraging promiscuity, indiscriminate sexual activity and frequent changes in sexual partners. This is in line with this study as there were frequent changes in sexual partners, which consequently made STD's more frequent in those who indulge in promiscuous sexual behaviours.

The results of this findings is also inline with that of Uwakwe, Moronkola and Ogundiran (2001) that behaviour are formed from membership of groups the adolescent affiliates with, and the knowledge about sex education which can be derived from many sources such as teachers, family, peer group, religious or voluntary organizations and mass media. They are also of the views that the type of behaviour formed can be negative or positive.

Type of settlement (X_4) had a positive and significant relationship with having sex before. Those living in accommodation with common conveniences with neighbors or without conveniences at all tend to have had sex more than those living in self-contained apartments. Sex partner of the respondents (X_7) has a positive sign attached to it indicating that sex partner and involvement in sex are positively correlated. This is so because the more sex partner one has, the more the tendency for one of them to have the urge for sex. Having a sex partner that is not ready to wait till appropriate time (he/she is in a hurry to take the forbidden fruit), this may result in one having pre-marital sex at a very tender age. The

contrary is also traced. With a sex partner that has low libido and is ready to wait till the appropriate time, pre-marital sex may be delayed until marriage. In addition, if the libido of the sex partner is high, this may result in high frequent of sexual intercourse and vice versa.

Hypothesis two (X_4) supports the findings of International family planning perspective (1993) and Ogwu (2003) which stated that the work status and personal income of the family, type of residence, religiosity and family environment significantly affects adolescents sexual behaviour, their attitude toward set in general and towards premarital sex in particular. The degree of their social interaction, and their exposure to erotic materials.

The result of these findings is in line with Ariba, (2000), Shuyler (1976) and Emenike (1981) which stated that sex education may be regarded as a method of achieving appropriate and safe sexual behaviour by a given population through systematic persuasion and conviction rather than a forceful approach. They are also of the view that an elaborate sex education for effective living with an understanding of human sexuality should be made an integral part of the total education of the adolescent at all levels of education. This finding also supports the views of Adebajo 1997 and Ariba (2000) that there is an increasing incidence of teenage pregnancies, STDS, HIV/AIDS induced abortion, sexual violence harmful traditional practices in both rural and urban cities as a result of social and family disruption caused by rapid industrialization and urbanization. It is however in the

view of the researcher that these conditions may probably be due to migration of labor from rural to urban cities housing problems and loneliness, which have all contributed to high occurrence of STD's in the different societies. The researcher also viewed that culture and attitudes to sex play significant roles in the transmission of STD's.

A significant F-value indicates that all the independent variables considered jointly influence the involvement in sex before marriage. Though the coefficient of sex of the respondents (X_2) was not significant, a negative coefficient tends to suggest that male respondents have higher tendency to have had sex before compared to their female counterpart. Also, the coefficient of family type is negatively related to the involvement in sex before that is that the Christians and those from poor households tend not to have sex before. From the foregoing, hypothesis 2 is rejected.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

Most people view sexuality of adolescent as a problem that should be dealt with rather than a part of the normal growth and development of adolescent. A variety of factors, including lack of information on sexual issues contributed to the increased sexual activities among adolescents. In Akure, respondents were observed to be knowledgeable about sexual activities and in particular, STDs. The behaviour affects their response to sex and sexually related health problems, because of which there has been an increase in the incidence of sexually transmitted diseases during adolescent. This increased in sexual activity at such an early age has several serious risk and complications, about which most adolescents are ignorant.

There is thus a growing recognition of importance of the problem of STDs. The problem is made more serious because of cultural practices and prejudices. In order to find suitable intervention to solve this problem, it is essential to understand the sexual behaviour of the adolescent. This study was therefore conducted, to assess the level of awareness of sexually transmitted infectious diseases among adolescents in Akure and the knowledge about these diseases.

To achieve the purpose of this study, two schools from each of the two zones of Akure were selected at random from urban areas and two schools from each of the

zones from rural areas were randomly selected. In addition, a total of 111 students from each schools of the Federal University of Technology in Akure were randomly selected. Thus, the sample for this study consisted of students from secondary schools and the Federal university of Technology, Akure. A questionnaire containing 33 statements under four sections was developed and standardized by the investigation on sexual behaviour and knowledge towards sexually transmitted diseases among secondary school students and university. The questionnaire was then administered personally, with the help of teachers in charge of the different classes and the heads of departments within the university, the results shows the following:

The results of data analysis showed that the major means of awareness of STDs among the respondents was through Television/Radio as reported by 61.05% of them. This shows the importance and reliability of the media – Television and Radio as means of communication.

On the factors affecting/influencing the decision to have sex, the multiple regression model fitted to the data collected revealed that all the variables considered were jointly significant in determining whether respondents would have had sex before marriage with a significant F-value of 130.315 at 1% of significance. The Regression results revealed that the explanatory variables accounted for 90.6% (R^2 = 0.906) of variability in the dependent variable i.e.

involvement and participation in sexual act before marriage. Four (4) out of the variables considered namely age of respondents in years (X_1), Marital status of respondents (X_3), Type of settlement/accommodation (X_4) and Number of sexual partners of the respondents (X_7) were the major determinants of whether a respondent had sex before marriage.

With the above, some conclusions could be made from the study.

5.2 Conclusion

On the basis of the results of this study and in view of its limitations, the following conclusions are drawn:

This study revealed that majority of teenagers of age range between 16 and 20 years are more exposed to high risk of STDs. It also reveals that there was a generally high level of awareness about the various STDs among the respondents. It also revealed that the knowledge about the predisposing factors, symptoms, complications, preventions and health seeking behaviours among students of secondary school and University in Akure were not adequate. The results also showed that some students still hold erroneous views about prevention of STDs. For example, the use of contraceptive was viewed as not being effective in prevention of STDs. Also it has been observed that most of the students do not follow the principles of their religion about moral standards strictly.

Including sex education in school curriculum and campaigns through the mass media are major tools for increasing the level of awareness about STDs among the respondents. Some variables such as age of respondents, type of settlements,

marital status and multiple sexual partnerships are policy variables that could be taken into consideration when considering campaigns about STDs among students.

5.3 Recommendation

On the basis of the findings of this study the following recommendations are made:

1. There is an urgent need for sexuality education to be included in the senior secondary schools and universities curriculum in Nigeria. This will make them knowledgeable about the conventional ways of STDs and pregnancy prevention.
2. Condom use along with other contraceptive methods needs to be promoted. It's benefit; the protective effect against STD's especially HIV/AIDS should be emphasized. The unrealistic fears of female's folk should be addressed during such condom promotions.
3. An all-embracing approach is needed for the control of STDs/HIV/AIDs in Akure and indeed, Nigeria; socio economic factors that predispose people to STDs infection such as, poverty (measured by housing type and family type) should be eliminated. It is hoped that the Poverty Alleviation Programmed by the government will assist in this regards especially in providing decent accommodation for the citizens.
4. Sound moral teachings are needed both at schools and homes. Teachers and parents have a role to play by leading exemplary lives. Also religious

leaders have duty to teach and help them to be faithful and to obey God's commandments about moral chastity.

5. Since the prevalence rates are particularly high in developing countries like Nigeria, there is need to educate the populace on factors that can lead to STDs/HIV.

Finally, the electronics media (TV/Radio) and health talks by Health Education Personnel are better means of reaching students in Akure, Ondo State with information on STDs and sexuality.

5.4 Recommendation for Further Research

A study of this nature could be better understood if a further study is carried out among the adults in the study area.

Also, more Local Government Areas should be covered in subsequent studies on this topic.

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APPENDIX

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QUESTIONNAIRE

ON SEXUAL KNOWLEDGE AND BEHAVIOUR TOWARDS SEXUALLY TRANSMITTED INFECTIOUS DISEASES (STDs) AMONG STUDENTS OF SENIOR SECONDARY SCHOOLS AND UNIVERSITY IN AKURE, ONDO STATE

The aim of this research is to find out the sexual behaviour, knowledge of and attitudes towards Sexually Transmitted Infectious Diseases (STDs) among students in Senior Secondary Schools and University in Ondo State. Your candid opinion is of great value. Please, give few minutes of your time to complete the questionnaire as accurately as you can. All information supplied will be treated as confidential.

Please place a tick (✓) in the box provided against each statement that is appropriate to you. If you wish to comment on any question, please feel free to use the space in the margin or at the back of the questionnaire.

SECTION A: BACKGROUND INFORMATION

Please tick (✓) the status that best fits you

1. What is your age? …….. (years)
2. What is your sex? a. Male [ ] b. Female [ ]
3. What is your marital status? a. Single [ ] b. Married [ ]
4. What Religion do you practice? a. Christianity [ ] b. Islam [ ] c. Traditional [ ]
5. If in Senior Secondary School, tick appropriate class
   a. SSI [ ]
   b. SSII [ ]
   c. SSIII [ ]

6. If undergraduate, what level are you?.....
7. Types of school
    a. Day co-education [ ]
    b. Day girls only [ ]
    c. Day boys only [ ]
    d. Boarding girls only [ ]
    e. Boarding boys only [ ]
    f. Boarding co-education [ ]
8. What type of settlement do you live in
    a. Self-contained apartment
    b. Apartment with common facilities e.g. toilet
    c. Apartment without conveniences such as toilets etc [ ]
9. What category would you classify your family
    a. Rich family [ ]
    b. Average family [ ]
    c. Poor family [ ]

SECTION B: SEXUAL BEHAVIOUR AND PRACTICE

10. Have you ever had sexual intercourse

a. Yes [ ] b. No [ ]

11. At what age did you have your first sexual intercourse? ……. Years
12. How often do you have sexual intercourse, after your first experience?
    a. Once a week [ ]
    b. Twice a week [ ]
    c. Once a month [ ]
    d. Every day [ ]
    e. Not at all [ ]
13. How many sex partners do you have?
    a. 1 [ ]
    b. 2 [ ]
    c. 3 [ ]
    d. 4 [ ]

e. 5 and above [ ]

14. How did you come to know about sex?
    a. From friends and peers [ ]
    b. From parents [ ]
    c. From television and video films [ ]
    d. From older relatives [ ]
    e. Teaching from the school [ ]
15. Does the desire for material things lead to sexual transmitted infectious diseases (STDs)? Yes [ ] No [ ]

SECTION C: KNOWLEDGE ABOUT SEXUALLY TRANSMITTED INFECTIOUS DISEASES (STDs) AND SEXUAL EDUCATION

16. Does Health Education taught in secondary schools and university provide enough information on sexual matters? a. Yes [ ] b. No [ ]
17. What is your major source of information Sexually Transmitted Infectious Diseases (STDs) and sexual issues?
    a. TV/Radio [ ]
    b. Printed materials (leaflet and posters) [ ]
    c. Peer groups [ ]
    d. Teachers/lecturers [ ]
    e. Parents [ ]
    f. Any (specify) ----------
18. What causes AIDS?
    a. Bacteria [ ]
    b. Virus [ ]
    c. Human Immunodeficiency Virus [ ]
    d. Not sure [ ]
    e. Do not know [ ]
19. Which of these is not the mode of transmission of HIV/AIDS?

a. Sharing of contaminated needled or skin piercing instrument [ ]
b. From infected mother to her child mainly at birth [ ]
c. Sharing the same toilet [ ]
d. Sexual contact
e. Transfusion with contaminated blood

20. Symptoms of gonorrhea include pain, difficulty in urination and blood stain

a. Yes [ ] b. No [ ] Not sure [ ] d. Don't know [ ]

21. Syphilis is a sexually transmitted disease caused by bacteria a. Yes [ ] b. No [ ] c. Not sure [ ] d. Don't know [ ]

22. Is it good to include sex education in your school curriculum as a general subject? Yes [ ] b. No [ ] c. Not sure [ ] d. Don't know [ ]

23. Does your place of worship educate you on sexual issues and Sexually Transmitted Infection (STI)? a. Yes [ ] No [ ]

24. Sex education is not effectively carried out in our school today because of:

a. Religious problem [ ]
b. Inadequate number of health educators [ ]
c. Lack of materials/fund [ ]
d. Not in school curriculum
e. Any other (specify)----------

25. Can misinformation about sex lead to Sexually Transmitted Infectious Diseases (STDIs)? Yes [ ] b. No [ ] c. Not sure [ ] d. Don't know [ ]

SECTION D: KNOWLEDGE ABOUT PREVENTION/CONTROL OF SEXUALLY TRANSMITTED INFECTION (STI)

26. Sexually transmitted infection can be prevented through the following:

a. Abstinence from sex [ ]
b. Early marriage [ ]
c. Oral sex [ ]

d. Taking antibiotics [ ]

e. Use of condoms [ ]

f. Any other (specify) ----------

27. What advice would you give on how to protect oneself from contracting Sexually Transmitted Infection (STI)?

a. Avoiding sex [ ]

b. Using contraceptive pills [ ]

c. Using traditional medication [ ]

d. Early marriage [ ]

e. Use of condoms [ ]

28. Can Sexually Transmitted Infection (STI) be avoided while having sex? Yes [ ] b. No [ ] c. Not sure [ ] d. Don't know [ ]

29. If No why?

a. Protection is not 100% [ ]

b. It is expensive [ ]

c. Interferes with sexual satisfaction [ ]

d. Not readily available [ ]

e. Any other (specify) ----------

30. Is it possible to control Sexual Transmitted Infection (STI)? a. Yes [ ] No [ ]

31. If Yes, how?

a. Abolishing prostitution [ ]

b. Prohibition of casual sex [ ]

c. Educating the youth on health matters [ ]

d. Sex education in schools [ ]

e. Campaigns / symposia [ ]

f. Any other (specify) ----------

32. Do you think you can protect yourself from Sexually Transmitted Infection (STI)? Yes [ ] b. No [ ] c. Not sure [ ] d. Don't know [ ]

33. If Yes how?

a. Abstinence [ ]

b. Faithful to your partner [ ]

c. Using condom [ ]

d. Any other (specify) ----------