ASSESSMENT OF PARENTAL ATTITUDE TOWARDS THE TEACHING OF SEX EDUCATION IN SECONDARY SCHOOLS IN KADUNA STATE

BY

MUSA PAUL HANNATU

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA
NIGERIA

MAY, 2009

ASSESSMENT OF PARENTAL ATTITUDE TOWARDS THE TEACHING OF SEX EDUCATION IN SECONDARY SCHOOLS IN KADUNA STATE

BY

MUSA PAUL HANNATU, B.Sc. (ABU 2002)
M.Ed/EDUC/40819/2004-2005

A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL, AHMADU BELLO UNIVERSITY, ZARIA NIGERIA

IN PARTIAL FULFILLMENT FOR THE AWARD OF THE DEGREE OF MASTER OF EDUCATION (M.Ed) IN HEALTH EDUCATION

DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA
NIGERIA

MAY, 2009.

DECLARATION

I declare that the work in the thesis entitled "Assessment of Parental Attitude Towards the Teaching of Sex Education in Secondary Schools in Kaduna State", has been performed by me in the Department of Physical and Health Education under the supervision of Drs. (Mrs) C. O. Adegbite and M. A. Suleiman.

The information derived from the literature has been duly acknowledged in the text and list of references provided. No part of this thesis was previously presented for another degree or diploma at any university.

MUSA, Paul Hannatu		
Name of Student	Signature	Date

CERTIFICATION

This thesis entitled "ASSESSMENT OF PARENTAL ATTITUDE TOWARDS THE TEACHING OF SEX EDUCATION IN SECONDARY SCHOOLS IN KADUNA STATE", by Musa, Paul Hannatu meets the regulations governing the award of Master Degree in Health Education of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

_____ _____

Dr. (Mrs) C. O. Adegbite — Date
Chairman, Supervisory Committee

_____ _____

Dr. (Mrs) M. A. Suleiman — Date
Member, Supervisory Committee

_____ _____

Dr. A. I. Kabido — Date
Head of Department

_____ _____

Prof. S. A. Nkom — Date
Dean, Post Graduate School

DEDICATION

This work is dedicated to the glory of Almighty God who has been my source and strength. In addition this research is dedicated to my mother (Hauwa Musa) and to the memory of my late father Musa Hai.

ACKNOWLEDGEMENT

The researcher sincerely appreciates the efforts and the contribution of her major supervisor, Dr. (Mrs) C. O. Adegbite, first, for her motherly assistance and also for putting in all that made this thesis a reality. Thank you Ma, I am grateful.

The researcher also wishes to express her gratitude to her second supervisor Dr. (Mrs) M. A. Suleiman for her guidance, encouragement and conducive atmosphere for the completion of this work. May God bless you abundantly. Sincere gratitudes also go to Prof. J. A. Gwani and Dr. (Mrs) T.N. Ogwu for their parental love and advice.

She is also grateful to Dr. Isuwa Kari Adamu and family, Mr. and Mrs. I. Samangoro, Mrs. Florence, T. Nyam, Mr. Paul Ezekiel Yusuf, Pastor Jonathan and family for their prayers and contributions to the completion of this work. Utmost thanks and gratitude goes to her sisters and brothers for their contributions and care. Her thanks also go to her beloved mother Hauwa and Kande Musa as well as her in-laws for their prayers. Her thanks go to her colleagues in the University and all the lecturers in her Department for their love, care, and help they showed in the course of this programme. She equally thanked her Principal,

Mr. Ayuba Musa who also provided enabling environment in the course of this work. She cannot forget the encouragement and prayers of her beloved friend Chilly Bwai, may Almighty God bless you all (Amen). And to those of you who have contributed in one way or the other towards the success of her research great is your reward.

ABSTRACT

The purpose of the study was to assess parental attitude towards the teaching of sex education in secondary schools in Kaduna State. To achieve the purpose of this study ex-post facto research design was used; the instrument used for the study was questionnaire which contains statements on personal data of the respondents and thirty (30) items with four sections. The questionnaire was administered on a total of four hundred and sixty (460) parents of students from the selected government secondary schools in Kaduna State. Though only three hundred and sixty two questionnaire were returned, meaning 78.7% response rate.

The data collected was statistically analysed at Institute of Agricultural Research (I.A.R) of Ahmadu Bello University, Zaria, using t-test for parental attitude towards teaching of sex education and ANOVA for differences between the attitude of parents of different age groups. The hypothesis stated showed there is no significant difference between parental attitude towards the teaching of sex education and it was tested at alpha level of 0.05. The results of the studies revealed that majority of the respondents support the teaching of sex education in secondary schools.

The result of the studies also revealed that most of the respondents agreed that teaching of sex education is an important form of social services.

The results of the ANOVA revealed no significant difference in the attitude of parent towards the teaching of sex education in secondary schools in Kaduna State.

On the basis of the findings, it was recommended among others that:

- The teaching of sex education should be encouraged at all levels of education especially at the secondary schools level.
- Sex education should be used as a means or opportunity for proper counseling in secondary schools.

TABLE OF CONTENTS

		PAGE
Cover Page	.. ..	i
Title Page	.. ..	ii
Declaration	.. ..	iii
Certification	.. ..	iv
Dedication	.. ..	v
Acknowledgement	.. ..	vi
Abstract	.. ..	viii
Table of Contents	.. ..	x
List of Tables	.. ..	xiv
Abbreviations	.. ..	xv
Definition of Terms	.. ..	xvi
CHAPTER ONE:		
1.1 Introduction	.. ..	1
1.2 Statement of the Problem	.. ..	4
1.3 Research Questions	.. ..	5
1.4 Basic Assumptions	.. ..	6
1.5 Hypothesis	.. ..	6

PAGE

1.6 Purpose of the Study 7

1.7 Significance of the Study 8

1.8 Delimitation of the Study 9

1.9 Limitation of the Study 9

CHAPTER TWO: REVIEW OF RELATED LITERATRUE

2.0 Introduction 10

2.1 Social Attitude and Related Theories 11

2.2 Theories Related to Teaching 21

2.3 Attitude and Attitude Formation 23

2.4 Parental Attitude Toward Teaching of Sex Education 26

2.5 Factors Influencing Parental Attitude Towards Teaching of Sex Education in Secondary Schools .. 28

2.6 Parents Awareness about Sexuality Education/STIs 35

2.7 Sexual behaviour and practice of Adolescents .. 37

2.8 Sex Education 41

2.9 Sexually transmitted infection (STIs)/Types and Symptoms 59

2.10 Occurrences of STIs 75

2.11 Prevention of STIs …. 77

2.12 Summary 79

PAGE

CHAPTER THREE: METHODOLOGY

3.0 Introduction .. .. …. 83

3.1 Research Design 83

3.2 Population for the Study 83

3.3 Sample and Sampling Technique 83

3.4 Instrument for Data Collection 85

3.5 Validation of Instrument 86

3.6 Procedure for Data Collection 86

3.7 Method for data Analysis 87

CHAPTER FOUR: RESULTS AND DISCUSSIONS

4.1 Introduction .. .. …. 88

4.2 Results 88

4.3 Test of Hypothesis 100

4.4 Discussion 104

PAGE

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction 109

5.2 Summary 109

5.3 Conclusion 111

5.4 Recommendations 111

5.5 Suggestion for further research 112

References .. .. .. …. 113

Appendix 123

LIST OF TABLES

TABLE		PAGE
Table 4.1	Demographic characteristics of respondents	88
Table 4.2	Frequencies and percentages of responses on assessment of parental attitude towards the teaching of sex sex education	91
Table 4.3	Frequencies and percentages of responses on teaching of sex education in secondary schools	94
Table 4.4	Frequencies and percentages of responses on parental opinions about sex education	98
Table 4.5	t-test for difference between male and female parents in their attitude toward teaching of sex education in secondary schools .. ….	100
Table 4.6	Summary of ANOVA for differences between the attitude of parents of different age groups	101
Table 4.7	t-test for difference between parents in their attitude in teaching of sex education in secondary schools in urban and rural areas	102
Table 4.8	Summary of ANOVA for difference between the attitude of parent in teaching of sex education in secondary schools based marital status	103

ABBREVIATIONS

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

OPERATIONAL DEFINITION OF TERMS

1. **SEX EDUCATION:-** Could be any instruction in the processes and consequences of sexual activity ordinarily given to children and adolescents.

2. **ATTITUDE:-** Is the opinions and feelings that one usually has about something or the way that one behaves towards someone or in a particular situation.

5. **UNWANTED PREGNANCY:-** Carrying or having an unborn baby that is not planned for.

CHAPTER ONE

1.1 Introduction

The concept of sex education is viewed from different perspectives. The concept is erroneously interpreted to mean the education given to a child about the act of "sex". This is contrary to the idea of exposing the child to the natural, physiological as well as physical differences between a male and a female child or the physical sound relationship that may exist between male and female children, as well as that integral part of education dealing with the inculcation of the knowledge of family living and sexual behaviour which is embedded in the principle of good health (Dubos, 1968).

Health, according to the World Health Organization (WHO, 1991) is the state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Health education is an activity aimed at improving health related knowledge, attitude and behaviour. It is used in schools to help students/pupils make intelligent decision about health related issues. There are many ways to teach health in schools; usually instructors create and facilitate learning experiences that develop the students' decision making skills. Above all, teachers provide health information and a concern for factors that influence the

quality of life, an example of which is the teaching of sex education in schools (Dubos, 1968). However, these youths sometimes put at risk their health by indulging in behaviours with serious short and long term consequences, including sudden death. There is significant morbidity rate and other social problems which could have been handled by the parents and schools if sex education teaching had been encouraged and effectively used. The neglect and/or inadequate teaching of this significant aspect of the education of the child and the attendant behaviours culminate into incidence of HIV, other sexually transmitted infections, unwanted pregnancy, AIDS and sometimes actions related to homicides, suicides and other unpleasant health related problems (Collins, 2002 & Robin, 2002).

Sex education, broadly defined, therefore could mean any instruction in the processes and consequences of sexual activity, ordinarily given to children and adolescents (Microsoft Corporation, 1998 – 2003). Today the term usually refers to classroom lessons about sex taught in primary and secondary schools, usually as part of the biology class. Historically, the task of educating adolescents about sex has been seen as the responsibility of parents. However, parent – child communication in sexual matters may be hindered by parental inhibitions

or by various inter-generation tensions. Some studies have shown that children rarely receive adequate information on sexual matters from their parents (Microsoft Corporation, 2003). Consequent upon this, the schools have taken the responsibility of giving the children first hand information about sex so as to equip them adequately on how to relate with other children of the opposite sex, processes of human reproduction, the workings of male and female sex organs, the origin, spread and the effects of sexually transmitted infections as well as family roles and structures. Historically, and in fact up till the present time the issue of sex education has been a controversy as parents do not seem to agree as to how, when and what to teach children regarding sex education. The attitude of parents towards the teaching of sex education in school has been a matter of serious concern and it is affecting the dissemination of vital information which has led to the spread of sexually transmitted infections especially HIV and AIDS as well as unwanted pregnancy (Collins, 2002 & Robins, 2002).

It is against this background that this study assesses the attitude of parents towards the teaching of sex education in secondary schools in Kaduna State.

1.2 Statement of the Problem

Sex education is vital to any civilized society no matter the class and people of that society. The benefit of sex education is unquantifiable because the knowledge gained will contribute towards reducing significantly or eradicating completely the spread of the Acquired Immune Deficiency Syndrome and similar deadly sexually transmitted infections. Though advances have been made in medical sciences including technological breakthroughs in some instances, the deadly disease has confined to ravage the whole world now more than before. The role that the teaching of sex education could play in schools should not be overlooked.

It is perhaps in realization of this that school, health related agencies, non-governmental organizations and development partners have been making efforts to educate people particularly the youths about the ravaging effects and consequences of the dreaded sexually transmitted infections of gonorrhea, syphilis, HIV and Acquired Immune Deficiency Syndrome (AIDS). However, despite the concerted efforts made by these various bodies, (W.H.O., UNICEF, WARAPA., etc)

Inspite of this concerted effort by individuals, international and national organization in health related areas to arrest this ugly situation

vices related to sexual behaviours are still common among secondary school students. As this is not expected to be so, people begin to wonder what type of sex education these children are having. Whether or not parents are alive to their responsibility which may be why the problem associated with children sexual behaviour continued unabated becomes the problem of the present study to the extent that the present study is predicated on what the attitude of the parents is to what the teaching of sex education is in secondary schools.

1.3 Research Questions

1. What is the attitude of parents towards the teaching of sex education in secondary schools in secondary schools in Kaduna State?
2. What is the attitude of parents of different age groups towards the teaching of sex education in secondary schools in Kaduna State?
3. What is the attitude of parents in urban and rural areas towards the teaching of sex education in secondary schools in Kaduna State?
4. What is the attitude of parents of various marital status towards the teaching of sex education in secondary schools in Kaduna State?

1.4 Basic Assumptions

On the basis of the research questions and the hypotheses, the following assumptions are made in this study.

1. Lack of adequate teaching of sex education can be dangerous to the youth.
2. Cultural taboo is an inhibiting factor in the teaching of sex education of the youths.
3. Appropriate and adequate sex education of youths would contribute to the prevention of sex related problems in children.
4. Parental attitude is a deciding factor in success of any sex education efforts in schools.

1.5 Hypotheses

In this research study, the following null hypotheses are hereby formulated to test the item used to collect data as well as make inference at the end of the study.

Major Hypothesis

There is no significant difference among parents in their attitude towards the teaching of sex education in secondary schools in Kaduna State.

Sub-Hypotheses

1. There is no significant difference in the attitude of male and female parents towards the teaching of sex education in secondary schools in Kaduna State.
2. There is no significant difference in the attitude of parents of different age groups toward the teaching of sex education in secondary schools in Kaduna State.
3. There is no significant difference between parents in urban and rural areas in their attitude towards the teaching of sex education in secondary schools in Kaduna State.
4. There is no significant difference in the attitude of parents of various marital statuses towards the teaching of sex education in secondary schools in Kaduna State.

1.6 Purpose of the Study

The purposes of the study are as follows:

1. To assess the attitude of parents towards the teaching of sex education in secondary schools in Kaduna State.
2. To determine whether there is a difference in opinions between male and female parents towards the teaching of sex education in secondary schools in Kaduna State.

3. To identify factors that are responsible for attitudinal differences between parents towards the teaching of sex education in secondary schools in Kaduna State.

1.7 Significance of the Study

The research study is focused on assessment of parental attitude towards the teaching of sex education in secondary schools. Expectedly the outcome of this study will be significant in the following respects:

1. Create awareness for parents in understanding that negative attitude towards the teaching of sex education are neither government nor society friendly.
2. Expose the parents to the reality that, they are partners in progress with the teachers, the school and the society at large in the effort to avert and completely curb the menace of sexual abuse, and sexually related diseases in the society.
3. Provide understanding about the complexities involved in the teaching of sex education, thereby contributing towards the designing of an effective curriculum to suit the teaching of sex education.

4. To encourage non governmental organizations to participate in the education of the youth in the area of sex education in secondary schools.

5. Encourage schools, and other health related agencies to intensify efforts towards the teaching of sex education in secondary schools.

1.8 Delimitation of the Study

The study was delimited to parents' attitude towards the teaching of sex education in secondary schools in Kaduna State. Only secondary schools in Kaduna State were represented by 115 selected secondary schools in the three senatorial zones of Kaduna State. Only parents who have children in secondary schools were used in this study.

1.9 Limitation of the Study

Issues of sex and sexuality are considered confidential by many people which made the respondents unwilling to fill the questionnaire. To overcome this limitation, the respondents were reassured that their responses would be treated confidentially. Also, respondents were not asked their names nor the names of their children/wards.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

This chapter deals with the review of related literatures and or materials on the subject of this study. The review was done after a thorough exposition and exploration of avenues to identify literature related to the topic of investigation. Available relevant literatures was reviewed in the following order:

2.1 social attitude and related theories
2.2 theories related to teaching
2.3 attitude and attitude formation
2.4 parents' attitude towards the teaching of sex education
2.5 Factors influencing parental attitude towards teaching of sex education
2.6 Parents' awareness about sex education/STIs
2.7 Sexual behaviour of adolescents and practices.
2.8 Sex education
2.9 Sexually transmitted infections
2.10 Occurrence of STIs
2.11 Prevention of STIs
2.12 Summary of the literature review

2.1 Social Attitude and Related Theories

There are many definitions of attitude. The theories of attitude on which this study is based are mainly those of Mitton Rokeach and Milton Rosenberg.

To Rokeach (1998), "an attitude is a relatively enduring organization of beliefs around an object or situation predisposing one to respond in some preferential manner." Rosenberg (1990) defines attitude as "predispositions to respond in a particular way towards a specific class of objects".

According to Rosenberg (1990), when attitude are studied, what are observed are the evoking stimuli on the one hand and the various types of response on the other. Rokeach (1990) maintains that each belief within an attitude organization is conceived to have three components: a cognitive component; an affective component and a behavioural component. The chart below shows a conception of attitude.

Rokeach (1998) offers a clear explanation of each component. Under suitable conditions, an affect belief is capable of arousing affect of varying intensity centering around the object of belief, around other objects (individuals and groups) and around the belief itself when its validity is seriously questioned as in argument. Roseherg (1990) sees the affect component as sympathetic nervous responses while Maclver (1999) asserts that affect responses suggest fear, hatred, love or pity.

The cognitive component represents a person's knowledge held with varying degrees of attitude about what is true or false, good or bad, desirable or undesirable. It also includes perceptions, conceptions and beliefs about the attitude. Rokeach (1998) feels strongly that an attitude must have behavioural component because a belief being a response predisposition must lead to some action when it is suitably activated.

It is very important to note however that not all of the three predispositions need necessarily become activated by an attitude or situation. Which ones are activated depends on the particular situation within which a particular attitude object is encountered. In fact Rosenberg (1990) asserts that for certain types of research it may be sufficient to use a single response as an index of an individual's attitude.

For this study, an attempt was made to measure aspects of the three components of attitude through written and verbal statements.

To understand the characteristics of attitude, it is necessary to know how an attitude is formed. While there may be a possible hereditary basis for attitude as Gordon Allport (in Neil warren (1996), suggested, Rokeach (1998) asserts that attitude are acquired through the principles of learning. The major determinants of attitude formation, according to Krency (1962) are the individual's wants, information, group affiliation and personality.

In coping with various problems the individual develops favourable attitude toward objects and people that satisfy his wants. For example, if a patient evaluates his final goal object (being alive is good) favourably, he will also evaluate his means goal object (his doctor) favourably. Conversely, the individual will develop unfavourable attitude towards objects and persons that block the achievement of his goals.

Attitude is also shaped by the information to which the individual is exposed. The validity of the attitude held by people will depend to a large extent on how sufficiently well informed they are. They nature of sources of information is also crucial to the formation of valid attitude.

Krency (1962) stresses this point when he asserts that for all individuals, facts are frequently mediated by other people as authorities, and the amount of discrepancy between the facts and the individual's beliefs will be dependent upon the validity of the assertions of authorities.

Another factor that determines an individual's attitude is group affiliations. Many of the attitude of the individual have their sources and their support in the groups to which the individual gives his allegiance. His attitude, therefore, tend to reflect the beliefs, values, and norms of the groups. To maintain this attitude, the individual must have the support of like-minded persons.

Personality also determines an individual's attitude. While group influences upon attitude development is to produce uniformity of attitude among the members of particular social groups, diversity could be noticed in the midst of uniformity. A major factor responsible for diversity is the existence of personality differences among individuals. Warren (1996) defines personality as "the general principles and organization of internal psychological functioning". While one's personality will reflect in almost everything one does, one's attitude has reference outside the person to the specific social object of the attitude.

To Campbell (1993) however, there are six ways of acquiring information upon which dispositions are based. These are (1) blind trial and error, (2) general perception, (3) perception of others' explorations, (5) verbal instructions relevant to behaviours and (6) verbal instructions about objects' characteristics. Campbell, like Rosenberg (1990), believes that dispositions acquired by these different modes are psychologically equivalent and that the several modes combine additively to result in stronger dispositions.

Other concepts with which the concept of attitude is often confused are belief system, ideology, value, opinion, faith, delusion, stereotype and sentiment. Rokeach (1998) maintains that of all the above concepts only sentiment is more or less synonymous with attitude. Attitude and sentiment are indistinguishable. According to Rokeach, a belief system represents the total universe of a person's beliefs about the physical world and about himself. An attitude is therefore a part of a belief system.

A value is a type of belief centrally located within one's total belief system about how one ought or ought not to behave or about some end-state of existence worth or not work attaining. Values are, thus, abstract ideals, positive or negative, not tied to any specific attitude object. To

seek truth, beauty, sincerity, justice, happiness, freedoms are examples of values:

An opinion usually represents a public belief, attitude or value but it may come closer to private ones when verbally expressed under increasing conditions of privacy.

Faith refers to one or more beliefs a person accepts as true, good or desirable, regardless of social consensus or objective evidence which are perceived as irrelevant.

A delusion is a belief held on faith judged by an external observer to have no objective basis and which is in fact wrong.

A stereotype is a socially shared belief that describes and, or evaluates an attitude object in an oversimplified or undifferentiated manner.

The measure of attitude is a complex matter. By predisposition is meant preparedness or state of readiness to respond. Rosenberg (1990) asserts that being predispositions, attitude is not directly observable or measurable. Instead they are inferred from the way we react to particular stimuli. According to Rokeach (1998), a person with a particular attitude is predisposed to selective perceive, recognize, judge, interpret, learn, forget, recall and think in ways congruent with his attitude. Rokeach

maintains that while there is agreement on the view that attitude lead to a preferential or discriminatory response there is little agreement on the basis for the preferential response. That is, it is not clear whether a positive or negative preference is due to the fact that the attitude object or situation is affectively liked or disliked or because it is cognitively evaluated as good or bad. For example, cigarette smoking is bad but many people enjoy it; medicine is good but one might dislike the taste. Whether or not the preferential response will be positive or negative will therefore depend on the relative strength of one's evaluative beliefs and one's positive or negative feelings. A person may make favorable response to an object toward which he harbours negative feelings if he believes the object to be sufficiently good for him. How a person responds to an attitude object or situation may involve both positive and negative or it may be a resolution of opposing forces between affection and evaluation. Lending weight to this position, Smith (in Warren 1996) says that attitude are customarily measured by eliciting acts of judgment; agreement or disagreement with standard statement of opinion. He suggests that a person's attitude on a controversial issue may be coordinated to the range of distrainable opinion positions hat he finds acceptable. The person's latitude of acceptance will typically be

narrower than the accompanying latitude of rejection when he is highly ego-involved with the issue or when his position is extreme. Smith goes further to say that in responding to a persuasive communication that advocates some position on the issue. The respondent places it on a subjective pro-con scale of factorability with respect to the issue. Maximum persuasive effects are to be expected when the position advocated falls near the boundary of the recipient's latitude of acceptance. Under such conditions, the recipient is likely to minimize its judged distance from his own position and to be open to its influence. When the position of the communication falls within the respondent's latitude of rejection, he is likely to exaggerate its judged distance form his own stand and to resist influence.

Krency (1962) argues that the fact that a person's attitude may always be characterized as pro or con, for or against the object means that attitude scales have a region where that sign changes. This he calls the neutral region to one side of which attitude grow more positive; to the other side of which they grow more negative. A score falling within the neutral region must indicate the absence of any attitude.

Maclver (2003) is of the opinion that it is difficult, if not impossible, to measure in any mathematical sense, degrees of favour and

disfavour, or liking and disliking in attitude. He maintains that attitude-measures are generally concerned with attitude not in their full significance, but in a simplified form, as merely expressing favour or disfavour of some object. It is imperative, therefore, according to him, to ensure that the object or situation itself has precisely the same significance for the various persons who exhibit attitude towards it. In this study, it is believed that teaching has the same significance for all categories of primary school teachers.

Although attitude measurement has its limitations, attitude scales do permit us to sort out the favouring and disfavouring, liking and disliking of a group of people as exhibited at any one time towards some particular interest in a series of grades or rates. Such scales when carefully constructed and expertly used, should provide very useful information about social situations. Such information has practical utility. For this study, the grading or ranking of primary school teachers according to their attitude towards teaching as a career should give useful information about their self evaluation of their service and reward systems.

2.2 Theories Related to Teaching

A definition of teaching is a difficult task because teaching is an activity that takes many forms. According to Peters (2002), the relations between teaching and activities such as indoctrinating, preaching, advertising and propagandizing are not very clear. He maintains that what a particular activity depends on how the person performing it sees the activity. That is, it depends on the purpose or intention that lies behind the activity. He asserts therefore that the notion of teaching is totally dependent for its characterization on the concept of learning. While there could be unintended learning, that is learning without teaching, most of the learning that does on in schools is intended learning.

Geer (in Cosin 1991) like George Homans earlier and Willard Waller supports the conflict model of teaching. The conflict model of teaching perceives teaching as a tension-filled, chance process which attempts to change the student by introducing him to new ideas. In this model, teaching is an assault on the self and resistance to it can be explained as unwillingness to upset one's inner status quo. According to Geer, (1991) this conflict is brought about by the fact that in any teaching situation, the teacher is, at least temporarily, superior and his student the

subordinate. This involves the teacher originating interaction for the student, seeing to it that the student responds to his wishes and evaluating to correctness of the student's response. The teacher's task in this model therefore is one of managing conflict; his actions may provoke a temporary reaction in which the student's personality will be undamaged.

Nicholls (1975) seems also to believe in the conflict theory of teaching. He classifies teaching activities into four types – (1) imitating new learning; (2) furthering learning already started (3) speeding up learning and (4) correcting deviation.

Teaching, in the conflict model becomes a problem when the student has very high social status or is older than the teacher. Geer argues that while in everyday teaching we minimize potential conflict by limiting the teacher's power or pretend it does not exist, schools do the opposite. The educational system, other teachers and examinations support and legitimatize the teacher's authority. Perhaps the inherent tension in teaching as explained by the conflict model is partly responsible for the apparent unpopularity of teaching as a career.

Bases for Personal Variable

The bases for the personal variables used in the study are derived from the sociological concepts of class and status. An individual's status

is his social position as determined by a specific attribute, a cluster of attributes or the generalized summation.

2.3 Attitude and Attitude Formation

The most significant and notable characteristic of human thought and behaviour is the tendency to exhibit some form of attitude toward self, object, issues and situations. Several attempts have been made by various psychologists and sociologists, for instance Kendler (1963), Keyon (1968), Satin (1973), and Frost (1975), to define attitude. The striking features of their definitions are that an individual is predisposed to respond in a particular way and that the behaviour is either positive or negative towards a social institution, a person, situation, or an idea.

There are indications that attitude are learned and if learned can be unlearned. However, attitude remains relatively stable and come in several ways such as through an accumulation of experiences. Some psychologists and social scientists in recent times have c concerned themselves with critical questions in the dynamics of personality development which seek to know how an individual develops an attitude towards himself, objects, issues and situations. The developed attitude could be classified as either positive or negative in orientation. The major determinants of attitude formation as expressed by Krency (1962)

are the individual wants, information and group affiliation and personality. An individual develops a favourable attitude towards people that satisfy his wants. On the importance of attitude, Tyler (1949) asserts that it rises from the fact that it has strong influence upon behaviour and also strongly influences the kinds of satisfaction and values the individual chooses. In conclusion, he suggests that there are four means by which attitude are commonly developed:

(a) Through assimilation from environment

(b) Through emotional effects

(c) Through traumatic experiences

(d) Through direct intellectual process.

However, social psychologists have approached the term "attitude" differently and have come not with different meanings that Berkowitz (1980), concludes there are three basic usage in several definitions given. The simplest conception holds that an attitude is an evaluation or feeling reaction. Another conceives attitude to mean readiness to respond in a particular way to attitudinal objective and cognitive dimension. Thus an individual attitude is a composition of how he understands, what he feels about and how he acts towards a given object or an issue.

A research work by Seidenberg et al (1976) has been done on the relationship of the multicomponent views of attitude. From this work it can be concluded that the affective and cognitive components were similar, as such, they should correlate and produce identical behaviour. It seems clear that the way an individual feels about objects, issues or people depends upon what he knows about them. That is to say, attitude (feelings) depends somehow or belief (knowledge). Also Fishbein & Ajzeu in Perlman et al (1983) presented a comprehensive model on the relations among attitude, belief, behavioural intentions and behaviour. Basically, they suggested that a person feels towards the object and in turn the attitude determines the individual's behavioural intentions with respect to the object. Finally, however, these behaviour intentions can be said to determine how the person actually behaves towards the object. The model assumes that human beings are usually quiet and rational, thereby making systematic approach to whatever information is made available to them. Perlman et al (1983) finally sums up the model when he said, people consider the implication of their actions before they decide to engage or not to engage in a given behaviour. This approach of attitude formation is also tagged a theory of reasoned action.

2.4 **Parental Attitude Toward Teaching of Sex Education**

The attitude of parents towards teaching of sex education is emotional response that expresses different degrees of acceptance and rejection. In sum total, the attitude of parents determines the success of the teaching of sex education. Attitude are formed from membership of groups. Teachers, family, peer groups, religious or voluntary organizations and the mass media are some of the sources which impart sex education to the youth.

The type of attitude formed by parents can be negative or positive. A positive attitude towards the teaching of sex education will lead to the avoidance of premarital sexual intercourse while on the other hand negative attitude will lead to unwanted pregnancies and their complications. Bobak & Jenson (1989) also state that some youths become promiscuous as a result of the negative effects of sex education.

Sexual attitude, like other attitude which generally result from frustration, are derived from unspoken and often unconscious premises and creative thoughts, which are always articulate and precise. Most of what we consider our mental activity consists of sub-articulate, half-conscious semantic reflexive reactions.

Study of sex education has usually been either in terms of the extent to which it is approved or disapproved of as an abstract proposition. The reason for parent's attitude towards teaching of sex education in schools is the fear of pregnancy. The traditional norms have tended to condemn sex education in schools. Variation in the findings of research into the reasons for abstaining from premarital coitus suggests that even though different techniques of investigation produce different results there may have been as actual shift in the attitude of parents in recent years. For example fear of pregnancy was cited as a much more important reason than parental influence for children not having premarital intercourse (Bromleu & Britten, (1938). For example, Caldwell et al, (1989) assert that "A pragmatic attitude exists in Africa toward sex education with a fair degree of permissiveness toward premarital relations, are not the high point of sin and usually should not be severely punished, substantial educational efforts are needed to improve societal attitude towards sex education. Adeyemo's (1995), writes-up on attitude towards sex education. He explained that the attitude of parents towards sex education can be influence by the knowledge. The attitude of parents will depend on the personality of parent-attitude. Activity creates problem because the most active

information obtain will help to have either negative or positive attitude towards sex education. Nass & Fisher (1988) described public attitude towards sex education swinging back and forth between valuing freedom in sexual choices and valuing restriction on sexual expression which also affect the attitude of parents towards sex education. Inadequate information about sex has led to the parents forming a negative attitude towards sex education.

International Planned Parenthood Federation (IPPF) (1997) states that over 70% youths (girls) in Africa become pregnant between the ages of 15-19 years. In Nigeria so many youths (girls) aborted in schools. Ciray (1993) described attitude as relating stable judgments of values which pass certain objects of experience in things heard or found.

2.5 Factors Influencing Parental Attitude Towards Teaching of Sex Education in Secondary Schools.

Even if teachers are allowed to cover topics as sensitive as sex education, they may avoid them because they fear adverse community reaction; more than one-third such concerns have been reported. All in all, these pressures and limitations lead one in four teachers to believe that they are not meeting the students' needs for information. A similar percentage of fifth and sixth grade teachers who teach sexuality education believe that schools are not doing enough to prepare students

for puberty or to deal with pressures and decisions regarding sexual activity. Finally, a year 2000 study by the Center for Disease Control and Prevention found that a significant proportion of health educators in secondary schools want additional training in the areas of pregnancy, STI and HIV prevention (Darroch, Landry & Singh, 2000).

Most parents (65%) believe that sex education should encourage young people to delay sexual activity but also prepare them to use birth control and practice safe sex once they do become sexually active, according to interviews conducted for the (Kaiser Family Foundation, 2000). In fact, public opinion is overwhelmingly supportive of sexuality education that goes beyond abstinence. Moreover, public opinion polls over the years have routinely showed that the vast majority of Americans favour broader sex education programs over those that teach only abstinence (Darroch, Ladry & Singh, 2000).

(a) **Cultural Factors**

The Ahmadu Bello University is a plural society consisting of three main subcultures, which include celibacy, monogamy and free experimentation, as has been reported for other universities elsewhere (Netting, 1997; Netting & Brunett, 2004). Within each subculture, students found support from those who adopted a

similar life style. Across these groups, students were very emphatic on having freedom of sexual expression. One of the main questions that this research attempted to answer is how do the members of each subculture differ from each other in their interpretation of and responses to the charging health environment (Suleiman & Venkateswarlu, 2006). In their research about students in A.B.U.

Students were assigned into categories on the basis of the number of sexual partners they have. Three subcultures were identified through this process. Of the three subcultures, celibacy was the most stable. About ⅓ of the subjects fall into the group of students who had never been married. Celibates included virgins, who said they never had sexual intercourse and those who said they did not have sexual partners within the preceding year. The reasons given by the subjects for adopting a celibate life were almost the same (Suleiman & Venkateswarlu, 2006).

All education about harassment needs to be age and grade appropriate. It should describe what types of conduct constitute harassment. However, to reduce the possibility of establishing a climate of fear, the curriculum should help students distinguish

between contact perceived as menacing (and a violation of the target's privacy) and flirting, which can be desired, feels good, makes the recipient happy, and increases self-esteem (Shoop & Hayhow, 1994; Steineger, 1997).

A curriculum on human sexuality can easily cover harassment, but the problem can also be discussed in other courses: history, social studies, contemporary issues, English, and health education. Co-teaching by males and females sends "a powerful message … about the relevance of sexual harassment to both sexes" (Stein & Sjostrom, 1994, P.3). Classes should include both male and female students so they can gain an understanding of each other's perceptions. It is critical not to make the males feel threatened (Brandenburg, 1997).

(b) **Factor of Religion**

The most obvious thing about sex education in the churches is the great increase in the amount of sex education that is going on in many Protestant churches such as the Baptist and the Missouri Lutherans. The reasons for this increase are numerous. As already suggested it is believed that as a good gift of God, sex is to be

accepted and affirmed as part of the good life. But with such a long history of rejecting sex as sin, the churches are mindful that they have many errors to correct and a lot of negative conditioning to overcome, and they are serious about doing an effective affirmative job now. Also, with so much confusion and uncertainty in the society regarding sexuality, churches are trying to find ways of helping persons develop ethical principles and discover guidelines for living as responsible sexual beings (Collins, 2000).

The results also showed a significant difference between male and female students' attitude towards sex education. However, the attitude of females seemed to be more positive and this may be due to their eagemess to understand and know about sex.

(c) **Educational Factor**

Strategies in combating HIV/AIDS in women, men and youths

Information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for women, men and youths with HIV/AIDS. Effective education can contribute to the capacity of these individuals to protect

themselves against HIV infection. The training programme should be delivered by trusted and respected individuals like teachers, health workers and lecturers in tertiary and higher institutions of learning. Knowledge can promote health and prevent diseases through behavioural modification and skills that reduces risks. As a former President of Nigeria, General Olusegun Obasanjo once remarked, "education provides knowledge and fosters attitudinal change" (National AIDS/STIs Control Programmes, 1992).

Conferences and workshops should be conditionally and intensively organized to increase awareness about HIV/AIDS, to strengthen worldwide efforts to stop AIDS by highlighting the impact of HIV/AIDS on all persons especially women, not only as a medical problem, but also as it affects them as care givers, health workers, educators and mothers.

Government should embark on more extensive, intensive, and sustained public enlightenment programme to educate the populace at all levels of the society on the causes and prevention of AIDS and how to relate to victims of AIDS. Such enlightenments should purge erroneous superstitious beliefs discourage sexual promiscuity and encourage women to exert control over their

sexual and reproductive lives. Enlightenment should involve proper reproductive education, examination of causes, prevention, and cure of impotence and infertility and cause of extra-marital sex, fonication and adultery.

Counseling is needed to sort out genuine fears from irrational ones, because anxiety and worries affect health. Accessible social services should be provided for women in need. Often the man is free to use available money in the family to live well. Many women have no money to afford a balanced diet, let alone medical care. Counseling services should be provided for zero-positive mothers and their families.

Those who would suggest that no research into sexuality should be conducted or that no public information about sexuality be published fail to make this distinction between knowledge and the use of knowledge. Shutting off the flow of information would not solve the problems based on sexuality that are faced in our culture; it might only intensify them. What is needed more than censorship of information about sexuality is some guidance about how to use the information received. The scientist can report his discoveries and supply new data and information. But as a

scientist, he does not make moral judgments about how those discoveries are to be used. That is not the job of the scientist. Making moral judgments, determining how to use new insights as God would have them used is the task of the Christians.

2.6 Parents Awareness about Sexuality Education/STIs

A recent survey in Nigeria by the Ministry of Health stated that through purposive sampling technique, 41 volunteers (respondents) participated in the study. Through indepth interview during focused group discussions, it was revealed that 87% of the respondents were aware of gonorrhea and AIDS but majority were not aware of other STIs. Another recent survey by the Action Health incorporated (1995) on sexual behaviour, STIs awareness and the use of condom showed that among some sexually active persons interviewed, 17.43% women could not resist having sex with their boy friends, while 40.4% of the men had sex with girl-friends or concubines within the two immediately preceding months. The most sexually active groups are 18-24 years. The result of the survey also showed that 3.1% of the respondents experienced some symptoms of sexually transmitted infections (STIs) within two months of relationship (Susan, 2001).

In another study conducted in Benin City, Unvigbe & Osfafu found that 94% of the study population were aware of STIs (HIV/AIDS), 64% knew that the disease could be transmitted through sex and that some of the STIs is curable while only 8.7% knew that STIs are caused by organisms e.g. virus, bacteria, chlamidia, trachomatics, protozoa and germs etc.

Uwakwa et al, (2001), says a number of senior government officials have attended STIs and HIV/AIDS awareness events. As Uwakwa et al, (2001), notes, this is important because there remains a wide range of misconceptions about how HIV/AIDS and other STIs are transmitted and how to treat persons who are infected. UNDP also provided technical assistance to a mobile theatre launched by Partners for Development (PAD, 2001), an international non-governmental organization, in May and June 2001. Cindy Isaac, 2001, PAD coordinator confirmed this when she said: "We were assisted by UNDP in developing our plans". The troupe has spread 30 HIV-awareness messages throughout the country.

World's Youth (2000) have also carried out surveys of STIs 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 Perspectives (2007) explained that sexuality also arose in discussions about the risks of contracting STIs. The female acknowledged that most male were aware that certain infectious diseases could be contacted sexually. The female were also aware that if they suspected their partners, then they too were potentially at risk of an STIs. 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.

2.7 Sexual behaviour and practice of Adolescents

Sexual behaviour is any activity that produces arousal and increases the chances of orgasm (NGTF 1996). Such sexual acts are exhibited by persons (e.g. heterosexuals). A heterosexual person is a person who is sexually attracted to or who engages in sexual activity with persons of the other gender. A Homo-sexual person is a person who is sexually attracted to or who engages in sexual activity with members of his or her own gender (National Guidelines Task Force, 1996).

A study of sexual behaviour of adolescents in Nigeria's urban centers, where there has been rapid and economic change in recent years, is both important and necessary, in the sense that the sexual behaviour of adolescents in Nigeria has become a problem not only because of the

health implications but also due to the social and economic repercussions of adolescents' sexuality. About one person out of five in Nigeria is currently between ages 10 and 19. (International Family Planning Prospective 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, the number witnessed a rapid increase 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).

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).

Akinboye (1987) explained that the changes brought about by puberty and significant changes in the body structures and compositions may be largely responsible for the sometimes observed increased urged 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 achievements 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 adult society and so on. For example, studies have indicated that adolescents are not generally concerned about pregnancy and its consequence when they explore heterosexual affairs. The main concerns are the pleasure, amorous satisfactions and the youthful exuberance accompanying sex behaviours which the young seem to be having during this period (Oladapo, et al 1997, the World Youth, 2000, NGTF, 1996). Sexual behaviour expresses one's sexuality in ways congruent with and in accordance to the law of the land. It also discriminates between life-enhancing sexual behaviours while respecting the rights of others. Sexual behaviour also includes search for new information to enhance one's sexuality and engaged in sexual relations that are characterized by honesty, equity and responsibility (NGTF, 1996).

The World's Youth (2002) states that cultural standards about what constitutes acceptable sexual behaviour for adolescent boys and girls complicate the issue of adolescent reproductive health. In some societies, adolescents are encouraged or pressured to take part in risky sexual behaviours such as having multiple partners or having their first sexual experience with a sex worker. Yet such services often do not provide adolescents with the means to protect themselves and their partners from infections and unintended pregnancies. Limited access to condoms and other contraceptives, even where they are affordable, remains a major barrier. Other barriers include attitudes and misconceptions. For instance, some young men believe that they should use condoms when having intercourse with sex workers but not with their girl friends.

Programme efforts to reach young men are now underway in many countries. Reproductive health programs for young men primarily encourage responsible sexual behaviour. They can also support other positive behaviours and attitudes, such as staying in school, and helping the adolescents to re-examine their perceptions of gender roles and responsibilities, supporting adolescent girls and their partners in their reproductive health needs and decisions. Such programme efforts can also assist young people to avoid violence, drug and alcohol abuse.

Programme planners need to distinguish adolescent needs from those of adults (Ariba, 2000).

2.8 Sex Education

Sex education is broadly defined as any instruction in the processes and consequences of sexual activity, ordinarily given to children and adolescents. Today the term usually refers to classroom lessons about sex taught in primary and secondary school, usually as part of biology class (Microsoft Corporation, 2003).

Historically, the task of educating adolescents about sex has been seen as the responsibility of the parents. However, parent-child communication in sexual matters may be hindered by parental inhibitions or by various inter-generational tensions. Moreover, studies have shown that children's rarely receive their first information on sexual matters from their parents (Microsoft Corporation, 1993).

In the late 19th century, attempts by educators and social workers to supplement parental sex instruction concentrated on what was then known as "social hygiene" basically, biological and medical information about human reproduction and venereal disease (Microsoft Corporation, 2003).

In the post World War II era, however, the relaxation of traditional social norms governing sexual activity, as well as the torment of sex-related information available to children via mass media, made a mere sophisticated and comprehensive programme of sex education seem desirable to many.

The subjects explained and discussed as part of sex education include the physical processes of human reproduction, the working of male and female organs, the origin, dissemination and effect of sexually transmitted infections, family roles structures, the ethics of relationships, and the emotional and psychological causes and consequences of sex (including under-age sex), marriage and parenting.

Safe sexual practice is being increasingly focused on with the advent of the Acquired Immune Deficiency Syndrome (AIDS). Frequently, however, the larger societal and ethical question stemming from sexual behaviour, being highly subjective in nature, is not regarded as appropriate to a strictly factual approach. At all levels of instruction, teaching methods may include visual aids, lectures and moderated discussions.

Although many parents approve of some type of sex education in schools, in practice there has always been some opposition to such

classes. In many schools in Britain the policy is to send a letter of consent to the parents of each child before the study is embarked upon to enable the parents to remove their children from classes should they so wish. Some parents object to sex education on the grounds of religion and morality (Microsoft Corporation, 1993 and 2003).

According to World's Youth (2001) sexuality education for youths has long been hampered by adults who are concerned that such knowledge will promote promiscuity among the youths. However, world wide reviews of studies by WHO and USAID (2001) concluded that sexuality education does not encourage early initiation of intercourse, but can delay first intercourse and lead to more consistent contraceptive use and safer sex practices.

It is vital to reach youths early with information before the onset of sexual activity. Schools are a key location for reaching large numbers of youths. However, because many youths are not in school, community-based approaches are also needed in many areas. World's Youth (2001) further explains that specialists in adolescence productive health suggest the following elements for a successful sex and STIs education programme.

- Give a clear message on risky sexual acts. Focus on reducing a few key acts that lead to unintended pregnancy or STI 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 act.
- Provide modeling and practice of communication, negotiation and refusal skills.
- Employ variety for teaching methods designed to involve 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) explains that sexuality education is a life long process of acquiring information and forming attitude, 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 and socio-cultural, psychological and spiritual dimensions of sexuality from:

1. The cognitive domain
2. The affective domain
3. The behavioural domain

It also includes the skills to communicate effectively and make responsible decision. The primary goal of sexuality education is the promotion of sexual health. The World Health Organization (1975) defines sexual health as "the integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance 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 individual 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.

Sexuality, in its broadest sense encompasses the search for identity, gender roles, sexual attitude, behaviours and feelings, relationship, affection, are and the need to touch and be touched, recognition and acceptance as sexual being (Taver; 1983, Action Health Incorporated, 1995).

Karjicek (1983) 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.

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 behaviors and attitude. 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 (Crugni, 1996 cited in Eduvie, 1999). Sexuality is an important aspect of human life.

Family related variables expected to be significant were parents' education and occupation, family income, type of residence, religiosity in the family, family environment and family restrictiveness.

Sex education as shown by Ariba (2000) may 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 in a paper written by Emenike (1981) who argues that it is education for effective living with an understanding of human sexuality is an integral, inseparable part of it. The creation of satisfying interpersonal 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. Shuyler, (1976) defines it as education which teaches the young person what he or she should know for his or her personal conduct and relationship with others.

Need for Sexuality Education

Ariba (2000) & Emenike, (1981) show 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 parts 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 appropriate behaviour to

cope with such information. Through the media (both print and electronic and most recently the interment), and direct interaction with foreigners and visitors to other countries, the citizenry are becoming exposed to many sexuality problems.

Adebajo, (1997) & Ariba, (2000) have shown that the increasing incidents of teenage pregnancies, STIs, HIV/AIDS, induced-abortions, sexual violence, harmful traditional practices (i.e. earl marriage, female genital mutilation) divorce and teenage prostitution have drawn the attention of health policy makers towards the need for more education in the area of adolescent reproductive health. It has been revealed by research conducted by the Association for Reproductive and Family Health (ARFH), Ibadan that a lot of sexual behaviour patterns and high risk reproductive practices are due to ignorance.

The research further reveals that many people, particularly youths had inadequate information regarding reproductive health, human sexuality and safe sexual practices.

- **Advantages of Sexuality Education**

  For the avoidance of both physical and mental health traumatic occurrences experienced by both youths and adults due to ignorance, the teaching of sexuality education has become

paramount in schools and the communities. (Emenike 1981) enumerates the importance of sexuality education as follows.

- **Knowledge of Human Reproduction**

The youths have the understanding of human reproduction. They need to know that human life begins when fertilization has taken place and that the sex of the baby is determined by the father (Emenike 1981). Apart from acquiring this body of knowledge, students should know what to do when they find themselves in a predicament during their latter years. Sex education, therefore should help young people understand their sexuality and enable them to enjoy stable and harmonious sexual relationship in their adulthood (Emenike 1981).

- **Arrest of misuse of Sex**

The sex drive in man is very powerful and when not satisfied could lead to some serious mental instability. Through sex education, the consequences of prostitution are made known to the students (Emenike 1981). 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

intense mental imbalances and lack of productivity. Sex education will not only provide knowledge of the evil consequences of sex ignorance, but in addition will counsel and expose the ills which the misuse of sex has. It provides youths with adequate information to be able to make balance moral decisions about their own behaviour (Ariba 2002).

- **A check of the spread of STIs**

  These are so called because of the many ways through which they spread direct or indirect contact. Sex education when introduced in all Nigerian schools will enable the students, victims and unaffected alike will know the possible dangers to themselves and the society as a whole (Emenike 1981).

- **Good Interpersonal Relationships**

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

- **Disadvantages of Sexual Education**

The most obvious negative effect of sexuality education would be the tendency to sexual promiscuity among students arising from their knowledge of how to prevent unwanted pregnancy (Adebayo 1997).

- **Reduction of the dangers of adolescent Pregnancy**

Adolescent pregnancy is defined by (Deschamps 1974), as pregnancy applied to future mothers under 15 years old. Dechamps observes that pregnancy in the adolescent is becoming one of the components of social maladjustment of youth. These 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 pregnancy:

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

Process of Sex Education

According to Suleiman & Dominic (2006) the vulnerable mostly become victims of sexual abuse and sexual exploitation; and once sexually abused or exploited, such victims, whether children or athletes, become even more vulnerable as they have been stripped of their self-esteem, are faced with threats to their person and humiliated by the exploiters. This is a common phenomenon all over the world. According to the Federal Government's plan of action for the protection of young children and youths (athletes inclusive) from sexual violence and exploitation (FGN, 2003). The subject of sexual abuse and sexually exploitation of children has become a far stronger focus of public interest since the mid 1980s. Various governments and non governmental organizations have done some trend-setting work. But there is still a need for action in various sectors for the protection of youth from sexual abuse and exploitation (Ibrahim and Ogunsanwo, 2005 in Suleiman & Dominic (2006).

It is important to appraise what really happens in the process of sex education of the young and to emphasize that at birth the human young is not a sexual blank page. As Money and Ehrhardi (1973) clearly point out, newborns are already well advanced sexually, and except for those

who may have one or another kind of congenital sexual disturbance, every child is born with its sexual (not its reproductive) system already functioning: within 24 hours after birth, the boy erects, the girl's vagina lubricates. It is also clear that human sexuality even in early childhood is not a "free-floating" condition of being, because very early that sexuality becomes polarized or paged down to a state of maleness or femaleness. This happens in the overwhelming number of cases because of the congruence of the sex assignment behaviour by the parents at birth and during early rearing with the given chromosomal and anatomical sex of the baby.

The debate over teenage pregnancy and STIs has spurred some research into the effectiveness of different sex education approaches. In a meta-analysis, DiCenso (2000) have compared comprehensive sex education programs with abstinence-only programs. His review of several studies shows that abstinence-only programs did not reduce the likelihood of pregnancy of women who participated in the programs, but that abstinence-only actually increased it. The researchers conclude that four abstinence programs and one school program were associated with a pooled increase of 54% in the partners of men and 46% in women (confidence interval 95% 0.95 to 2.25 and 0.98 to 2.26 respectively).

The results of the study revealed that male adolescents had some knowledge of sexual maturity and sexual behaviour while most of the female students lacked basic and essential knowledge on these matters. About 45% - 60% of the males had some knowledge about wet dreams, masturbation and homosexuality, while most of the females did not have any knowledge, and this could be attributed to cultural factors.

It was also noted that the vast majority of both males and females knew about AIDS. This probably reflects the mass media interest in this subject. On the other hand, the vast majority of them knew nothing about other sexually transmitted infections. This highlights the need for education in this area and the role the mass media and school seminars can play.

Does Sex Education work?

The question is no longer should sex education be taught, but rather how should it be taught. Over 93% of all public high schools currently offer courses on sexuality or HIV (1) more than 510 junior or senior high schools have school-linked health clinics, and more than 300 schools make condoms available on campus. The question now is: are these programs effective and if not, how can we make them better? (Robin 2002).

Kids need the right information for their protection. The US has more than doubled the teenage pregnancy rate of any western industrialized country, with more than a million teenagers becoming pregnant each year. (2) Teenagers have the highest rates of sexually transmitted infections (STIs) of any age group, with one in four young people contracting an STI by the age of 21. (3) STIs, including HIV, can damage teenagers' health and reproductive ability; and there is still no cure for AIDS.

HIV infection is increasing most rapidly among young people. One in four new infections in the US occurs in people younger than 22. (4) In 1994, 417 new AIDS cases were diagnosed among 13 – 19 years old, and 2,684 new cases among 20 – 24 years old. (5) Since infection may occur up to 10 years before an AIDS diagnosis, most of those people were infected with HIV either as adolescents or pre-adolescents.

In the elementary grades, students generally have one regular classroom teacher. In these grades, education about AIDS should be provided by the regular classroom teacher because that person ideally should be trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, the elementary teacher usually is sensitive to

normal variations in a child especially in a situation where there is a different teacher for each subject. In these grades, the secondary school health education teacher preferably should provide education about AIDS, because a qualified health education teacher will have training and experience in adolescent development, age-appropriate teaching methods, adolescent health, and secondary school health education methods and materials (including methods and materials for teaching about such topics as human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education.

Sex education that works starts early, before young people reach puberty, and before they have developed established patterns of behavior. The precise age at which information should be provided depends on the physical, emotional and intellectual development of the young people as well as their level of understanding. What is covered and how depends on who is providing the sex education, when they are providing it, and in what context, as well as what the individual young person wants to know about.

It is important not to delay providing information to young people but to begin when they are young. Providing basic information provides the foundation on which more complex knowledge is built up over time. This also means that sex education has to be sustained. For example, when they are very young, children can be informed about how people grow and change over time, and how babies become children and their adults, and this provides the basis on which they understand more detailed information about puberty provided in the pre-teenage years. They can also be provided with information about viruses and germs that attack the body. This provides the basis for talking to them later about infections that can be caught through sexual contact.

What Do Parents Want Taught in Sex Education Programs?

Debates about sex education have focused on two different approaches: "safe Sex" courses, which encourage teens to use contraceptives, especially condoms, when having sex, and abstinence education which encourages teens to delay sexual activity.

In recent years, advocacy groups such as SIECUS (the Sex Information and Education Council of the United States) and Advocates for Youth have promoted another apparent alternative, entitled "comprehensive sexuality education" or "abstinence plus". These

curricula allegedly take a middle position, providing a strong abstinence message while also teaching about contraception. In reality, education curricula contain little or no meaningful abstinence material; they are simply safe-sex programs repackaged under a new, deceptive late.

Abstinence programs teach that:

- Human sexuality is primarily emotional and psychological, not physical in nature;
- In proper circumstances, sexual activity leads to long term emotional bonding between two individuals; and
- Sexual happiness is inherently linked to intimacy, love, and commitment – qualities found primarily within marriage.

Abstinence programs strongly encourage abstinence during the teen years, and preferably until marriage. They teach that casual sex at an early age not only poses serious threats of pregnancy and infection by sexually transmitted infections, but also can undermine an individual's capacity to build loving, intimate relationships as an adult. These programs therefore encourage teen abstinence as a preparation and pathway to healthy adult marriage.

By contrast, comprehensive sex-ed curricula focus almost exclusively on teaching about contraception and encouraging teens to use

it. These curricula neither discourage nor criticize teen sex and do not encourage teens to wait until they are older to initiate sexual activity. For example, the curricula do not encourage teens to abstain until they have finished high school. "Protected" sex at an early age and sex with many different partners are not treated as problems. Sex is treated primarily as a physical problem of sexually transmitted infections and pregnancy. Comprehensive sexed curricula ignore the vital linkages between sexuality, love, intimacy, and commitment. There is no discussion of the idea that sex is best within marriage.

2.9 **Sexually transmitted infection (STIs)/Types and Symptoms.**

Sexually transmitted Infections (STI) formerly called venereal diseases, but now called STIs are spread by sexual contact. Some are also transmitted not by sexual contact alone, but blood transfusion. These are group of infections in which the principle was of transmission is by casual contact. They were previously called venereal diseases (V.D) (Obinu, 2001). Several kinds of STIs are epidemic including gonorrhea, infections of urethra, not caused by gonorrhea (non-gonococcal urethritis); non specific urethritis (NSV); genital herpes virus; genital warts (Candy Loma Accumineta); scabies (mites) and urethral and vaginal infections caused by the bacterium, chlamydiatrahomatis, the

protozoan trichomoas, and the yeast monillia. AIDS and hepatitis are also transmitted by unprotected sexual contact that is penetrative sex without the use of condom.

Large numbers of infections are transmitted largely or exclusively by sexual contact. In addition to those epidemic diseases already mentioned, such diseases include syphilis, crablike, (pediculosis pubis), vaginal infection caused by the haemophilus bacterium; molluscum contagious, chanchroid (soft sore); lymphogranulema venereum and grand Loma inguiraler. These and so many others are transmitted only by intimate contact with an infected person. A few of these diseases notably cancroids and scabies can be spread by the infected person from one area of skin to another. Scabies, lice, genital herpes and vaginitis caused by trichomones and monilla may also be acquired by means other than sexual contact (Obinu, 2001).

The epidemic nature of STIs makes it difficult to control them. Some public health officials attribute the increase in many of these diseases to increasing sexual activity. Preventing these ugly situations require among other measures of investigating the causative factors, education of the populace and specifically too, the teaching of sex education at the grassroots which includes schools, market places,

organizing workshops and seminars for the people at the work place and even the parents themselves.

Michael (1981) states that sexually transmitted infections (STIs) are simply those diseases which can be contacted from an infected person by means of sexual intercourse.

Again sexually transmitted infections (STIs) are human infections that are transmissible by sexual intercourse which may be vaginal, anal or oral.

Initially it was believed that gonorrhea and syphilis were the only infections which could be transmitted by sex hence the name venereal disease (V.D) was given to them. As time went on, it became clear that there are more than 20 other conditions which are sexually transmissible (Michael, 1981). Although the size of the problem is unknown, particularly in Nigeria, STIs are very common and are among the top five infections for which people seek care.

STIs remain a public health problem of major significance in most parts of the work and their consequences can be devastating: these include adolescent female suffering chronic abdominal pain, entopic 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 manifestation of STIs in published history is poor and indeed specific general diseases were not identified in the middle ages and earlier amongst the famous people known to have suffered from STIs.

According to the World Health Organization (WHO 1992), STIs are the most common diseases and the prevalence rates are particularly high in developing countries like Nigeria. Every year, there are 250 million new cases and some of these are complicated by the above mentioned complications of young women. Some STIS 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 STIs and in particular HIV can be vertically transmitted in pregnancy with devastating effect on the unborn child. The rate of vertical transmission of HIV is believed to be 25% to 30%. The major dilemma now is the scourge of AIDS as it affects even more female than male in Africa to-day. The male to female ratio of 1:1 at the beginning of the epidemic has now shifted to 1:4 in Africa as against 8:1 in USA and

5:1 in Western Europe. The incubation period for HIV infection to develop into AIDS which is up to 10 years in male is believed to be shorter in female. Factors such as poor health and social status, polygamy, other STIS, malnutrition, poor access to care and genital mutilation are responsible for easy transmission of HIV in women.

The number of the sexually transmitted infection which have been identified in recent years is high. It would be presumptuous to attempt to cover all of them in this study. Therefore focus in this study is on HIV/AIDS which has received universal attention.

Acquire Immune Deficiency Syndrome (AIDS)

AIDS is a clinical syndrome (a group of various illness that together characterize a disease) resulting from damage to the immune system caused by infection with the human immunodeficiency virus (HIV) (Microsoft, Corporation, 1993 and 2003). In HIV – infected individuals there is a gradual loss of immune cell (called CD4 + T Lymphocytes) and immune function. The mechanisms by which HIV causes this immune deficiency are still not completely understood although direct infection of CD4 +T – Lymphocytes by HIV certainly plays a role. The loss of immune function, if untreated, results eventually in the development of opportunistic diseases caused by common

infections that do not ordinarily present a threat to healthy individuals. In the early 1980s, death by opportunistic infection, previously observed mainly in transplant recipients receiving immune suppressive therapy, merely recognized in otherwise healthy homosexual men. In 1983, Luc Montagnier a scientists at the Pasteur Institute in Paris isolated what appeared to be a new human retrovirus from the lymph node of a man at a risk of developing AIDS. Almost simultaneously both Robber Gallo's group at the National Cancer Institute (NCI), and a group headed by Tay Levy at the University of California, San Francisco isolated a retrovirus from AIDS patients and from people who had sexual contact with AIDS patients. All three groups had isolated what is now known as HIV, the aetiological (causatie) agent of AIDS. More than 30 million people around the world are currently infected with the Human Immunodeficiency Virus (HIV) the virus that causes Acquired Immune Deficiency Syndrome (AIDS). Now HIV infections have leveled off or even declined in most developed countries, but the virus is spreading rapidly. Through much of the developing world in some areas of Sub-Saharan Africa, one in four adults is carrying the virus (Microsoft Corporation, 1993). To prevent this scourge, since the rates of HIV transmission are so well documented, it is clear that a reliable protective

vaccine will not be available for many years. In the absence of a vaccine the only means of preventing the spread of infection is to avoid personal behaviours that carry a risk of transmission. This has been the focus of AIDS education campaigns throughout the world.

Preventive efforts to promote sexual awareness through sex education in schools have faced opposition from certain groups in society on the unfounded grounds that these efforts promote sexual promiscuity among young adults. Approaches such as requiring HIV infected individuals (or their doctors) to disclose their HIV status to sexual partners, or mandating. HIV testing at the time of marriage or pregnancy, have been criticized on the grounds that they may discouraged HIV – infected individuals from coming forward for HIV testing. In these cases, issues of individual rights and personal privacy have to be weighed against their possible role in controlling the spread of HIV (Microsoft Corporation 1993 and 2003).

Primary Health Care for Developing Countries states that Acquired Immune Deficiency Syndrome (AIDS) is the most recent addition to the group diseases that are primarily transmitted by sexual contact. Since its recognition as a new disease in 1981 AIDS has been and remains 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 (HTL VIII), Human Immune deficiency Virus (HIV), or lymphadenopathy associated virus (Lav). As at 1990 more than 200,000 cases had been reported to the World Health Organization (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 boarder while others lack accurate case – detection or case – reporting, as well as show a lot of delay in reporting cases to WHO (Microsoft Corporation, 1993 – 2003).

Mode of Transmission

Regardless of the area of the world from which cases are reported, the modes of HIV transmission are fundamentally the same National AIDS/STIs Control Programme (1992).

- Sexual contact with infected person
- Transmission of contaminated blood or blood borne products
- Sharing of contaminated needless or other skin piercing instruments.
- Mother to child transmission mainly at the end of pregnancy, during labour and shortly after birth.

Some cases of AIDS originating from organ transplant have been recorded but sexual contact is the primary source of HIV transmission throughout the world. All age groups can be infected but incidence is higher between 18 – 29 age groups. High risk factors include among others, multiple sex partners, prostitution, homosexual practice, and unprotected sex, transfusion of blood and blood products, and intravenous drug abuse especially with needle. Whether or not an infected person becomes ill with disease, such a person remains a potential source of infection to others.

Symptoms HIV/AIDS

The disease is due to gradual deterioration of the host's immune system characterized by the depletion of the CD4 count (Enerst, 1995).

Element of the immune system the loss of weight which can plain most of the pathological consequences of HIV infection soon after a person becomes infected leads to a a drop of T-lymphocytes from its normal value of about 1000 cells per mm at a variable rate of 40 to 80 cells per mm per year. This progressive deterioration of the immune system is initially manifested b less severe clinical conditions including generalized Lymphadenopathy, chronic fever, diarrhoea, 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 perm (National AIDS/STIs Control Programme, 1992):-

AIDS, the most severe 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 for more than one month.

Minor Signs

- Persistent cough
- Generalized pruitic dermatitis
- Recurrent Herpes Zoster
- Oro-pharyngeal candidiasis
- Chronic progressive and disseminated Herpes Simplex Infection. (HSI) (Nigeria School Health Journal, 1981).

Nongonococcal Urethritis (NGU)

NGU is the inflammation of the urethra caused primarily by bacterial believed to be Chlamydia-trachomatis. NGU is spread through

sexual intercourse. Other organisms are also known to cause NGU. Chlamydia-trachomatis is one of the most common STIs in western countries (Ariya, & Bennet, (1988).

Signs and Symptoms

The incubation period exceeds 20 days in most of the cases. In the male the symptoms include bumming and itching around the opening of the penis. The NGU discharge is slightly white, while that of gonorrhea is white or yellow while in female the NGU causes pain, burning or itching in or around the vagina (Ariya & Bennet, 1988).

Complication

If untreated NGU can cause sterility, epididymitis urethritis spontaneous abortion, still birth or damage to the baby's eyes tissue. Chlamydia-trachomatis is a common cause of female infertility (Ariya & Bennet 1988). NGU can be treated with antibiotics.

Gonorrhea

Gonorrhea is an old bacterial that is almost exclusively acquired through sexual intercourse. It is among the most common and widely recognized STIs throughout the world (Feming & Colleagues, 1970).

Gonorrhea is said to be the commonest communicable disease. The causative organisms are 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 & Collegues (1970), in the study of VDs estimate 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 oedema. The spread of infection to the uterine tube, when it occurs is usually at the time of menstruation. This gives rise to sapling it in (inflammation of the fallopian tube). This may lead to sterility, (Nigeria School Health Journal 1981). In males, the first signs of gonorrhea begin 2 – 3 days, at times between 1 – 31 days. There are readily identifiable early symptoms of painful urination and drops of pus from the penis. Infection in males may remain confined to the anterior urethra and become a self-limited disease of weeks or months duration even without treatment. 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 (schistosmia-asos and Nojazia). A young man who has had sexual intercourse and experience penile pain within a few days or difficulty in urination and blood stains should check for gonorrhea (Karjicek 1983).

Syphilis

Syphilis is one of the most dangerous sexually transmitted infections. It is caused by a bacteria called Treponema pallidum (Spirochete) transmitted by sexual intercourse, oral or anal contact with an infected mother to unborn child in the case of congenital syphilis (WHO 1991).

(a) **Stages of Syphilis**

Primary syphilis:- Primary lesions known as cancer appears 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 side of infection. If untreated, the primary lesions disappear and progress into the next stage (Curan Jus, 1984).

(b) **Lantent Syphilis**

The symptoms of the secondary syphilis disappear but the disease goes into a domant 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 (Internal Organs panes Institute, 1988).

(c) **Tertiary Syphilis**

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

(d) **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, deadness and 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 b virus. The virus is spread through genital-oval genital contact with an infected person (Enerst, 1995).

Chancroid

Chancroid is caused by a bacterial, Hemophilia 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, clitoris, cervix (Domokes 1971). It is very common in the tropics

Signs and Symptoms

Small red spots appear at the site of the infection. They may grow like pimple-like structures that break down into ulcer or open sores full of pus (Domokes, 1971).

Complications

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

Lymphogranulema (LGV)

It is one of the STS caused by chlamida-trachomatics. It is a chronic disease that has many manifestations similar to that of syphilis (Perine & Osoba, 1984). It is transmitted during sexual intercourse, but may also be spread by other close physical contact. It is a disease found mainly in the tropics (Enerst, 1995).

Trichomaniasis

Trichomoniasis is caused by protozoa and a germ called trichomonas virginities which is a sexually transmitted infection 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 STIs (Rein & Muller, 1984) which can also be contacted through contaminated instruments, gloves, and toilet seats, etc (Ariya, Bennett & PF 1988).

Signs and Symptoms

The exact incubation period of trichomoniasis is unknown. Most men are asymptomatic (without symptom) though, some may have arthritis. In female the infection is characterized by fou smell and greenish grey vegans vagina discharge (Rein & Muller, 1984).

Complications

There are no major complications in female. In male this may result in epideymits or postatics. It can be treated with a drug called Flaggy or Metronidazole. The disease can be regarded as minor STI which is prevalent in the tropical countries of Africa and in Nigeria in particular (Enerst 1995).

2.10 **Occurrences of STIs**

According to Primary health Care of Developing Countries (2001) it is important to note that the STI/organisms mentioned above can also be transmitted in ways other than sexual contact. Some of this infections, e.g. syphilis, gonorrhea, HIV/AIDS etc can be transmitted during pregnancy or at birth from an infected mother to the infant. Non-sexual transmission of syphilis, AIDS or hepatitis infection may also occur through infected blood, blood products or unstrilized instruments.

The occurrence of STIs is increasing the world over and is highest during the ages of active sexual activities usually 20 – 24 years followed by people between ages 25 and 15 – 19 in that order. The incidents of most STIs are higher for men than female even though the motility caused by STIs are generally more severe in women and homosexually active male than in heterosexual males

According to the UNDP & Choices Magazine (2001) to confront these occurrences of STIs there is need to:

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

- Develop firm political support for activities to combat STI (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 play down standards and launch activities at the national level.
- Promote solidarity and support for people affected by the epidemics, to give them better access to health care and lower cost for medicines, special test and examinations, not forgetting anti-retroviral treatments.

Factors of STIs

Socio-economic and socio-cultural factors affect the occurrence of STIs. The incidence is higher among single, divorced and separated people than among married people and in individuals of lower than higher socio-economic status. For instance, some diseases such as chanatiod are associated with poverty and poor hygiene. Other high risk groups are those with inadequate personalities (UNDP & Choices Magazine, 2001).

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 to the high occurrence of STIs in some countries. Further more, cultural attitude 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, STIs are more frequent in those who indulge in promiscuous sexual behaviours.

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

2.11 **Prevention of STIs**

Since STIs are caused by different pathogens (some viral, some bacterial), there is need for some preventive measures that will limit the occurrence or incidence of STIs in the community (Primary Health Care of Development Countries, 2001).

Promoting general awareness, education and behaviour change are essential steps in the prevention of STIs transmission. Promoting a community norm of STIs prevention and educating the students about STIs and adult on how to protect themselves could also help in the control of STIs. Family planning program efforts which have extensive experience in mass media and behaviour change can also 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. STI 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. More ever, clinic time and other resources are scarce. In addition sexual topics remain taboo in many countries, ignorance among providers is widespread and women themselves are often incapable of preventing risks of STI even with the best of counseling (Women's Health Journal, 2000).

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 else who comes to the clinic.

Other preventive methods are as follows:

Women's Health Journal (2000) states that the best prevention of sexually transmitted infections is to avoid multiple sex partners. Another method of preventing sexually transmitted pathogen is healthy living (hygiene).

It is 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 STIs such as gonorrhea, Chlamydia, chancroid, bacterial gaginosis and trichomoniasis.

2.12 Summary

This chapter summarizes the literature review from previous research. It shows that the awareness of parents about sex education and STIs was low. Just more than one third of parents were aware of sex education and STIs. The researcher concludes that ignorance on the part

of health workers is the major barrier to parent's knowledge in this regard. The review shows that there is need for sex education in the various schools. Since the prevalence rates of STIs and HIV are particularly higher in developing countries like Nigeria, there is need to educate the populace on factors that can lead to these diseases. Poor health and social status, polygamy, other STIs, malnutrition, poor access to care and genital mutilation are responsible for easy transmission of STIs. Therefore, undoubtedly, STIs remain a public health problem of major significance in most parts of the world and their consequence can be devastating. Primary Health Care for Developing Countries (2001) explains that STIs can also be transmitted during pregnancy or at birth from an infected mother to her infant or through blood products or unsterilised instrument. Youth between the ages of 18 – 24 are more sexually active and are more prone to the occurrences of STIs.

United Nation Development Programmes & Choice Magazine (2001) states the need to confront these occurrences of STIs, drive home the message, based on objectives which are consistent with the epidemiological reality in the country. Therefore, better strategies that have a scientific basis in research and internal/domestic experience must be devised to cope with the prevalence of STIs and HIV.

Better access to health care and low cost for medicines, special test, examination and adequate provision of anti-retroviral treatments should be taken serious. Measures such as the following are required to limit the occurrences of STIs in the country:

- Promoting general awareness education and behaviour change.
- Promoting community norms of STIs and educating the youths about STIs and adult on how to protect themselves.
- Socio-economic and socio-cultural factors which affect the occurrences of STIs incidence are higher among single, divorced and separated people than among married people and in individuals of lower than higher socio-economic status. Indeed, 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. In other countries like Kenya for example, condoms are very readily available in clinics (e.g. in waiting rooms, examinations rooms and rest rooms). They are thus

available not only to the female clientele of these facilities, but also to their partners and anyone else who comes to the clinic.

- General Hygiene should be taught in our schools and community to help the populace and the youth have a good living.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research design, population, sample and sampling technique, instrumentation, procedure for data collection and methods of data analysis. The structure of the chapter therefore reflects these concerns.

3.1 Research Design

The research design used for this research was ex-post facto research design, this was used because it was non experimental research and the information required for the research was already with the respondents.

3.2 Population for the Study

The population for this study comprised all the parents of the students in all the selected government secondary schools in Kaduna

3.3 Sample and Sampling technique

Cluster sampling technique was adopted such that the existing three senatorial zones of the state were used. There are a total of 23 Local government Areas in the 3 senatorial zones:

(i) Southern senatorial zone has eight Local government areas with 159 schools.

(ii) Central senatorial zone has seven local government areas with 116 schools.

(iii) Northern senatorial zone has eight Local government Areas with 114 schools, five schools were selected from each Local government areas of the 3 Senatorial zones.

To select the schools used, the names of all the secondary schools in each Local government Area were written on pieces of paper and squeezed. This was done local government by local government area. A total of 115 schools were picked from the three zones. In each of the selected schools four copies of the questionnaire were administered i.e. twenty questionnaire per local government area of the three senatorial zones.

Also, stratification was made by grouping the students into SS_1, SS_2, SS_3 and JSS_3. The reason why this was done is to ensure that only students, who are able to explain to their parents about how to fill the questionnaire, were given copies of the questionnaire. These students were briefed on how to fill the questionnaire. Copies of the questionnaire were given on a total of 460 students, for onward transmission to their

parents from the selected schools. However only 362 copies of the questionnaire were returned meaning 78.7% responses rate. In the selection of students from their classes, i.e. SS_1, SS_2, SS_3 and JSS_3. Simple random method was used. In using this method only one yes was written and so many Nos. were written on pieces of paper for the students to pick. A student, who picked yes out of the rolled pieces of paper from the hat, was given a copy of the questionnaire to give his/her parents. This process was repeated until the required numbers of students were selected from the schools and in each class.

The break down of the Local government area and names of school is in Appendix B.

3.4 **Instrument for Data Collection**

To achieve the purpose of this study, a questionnaire was developed that contained thirty (30) statements in four (4) sections. Section A consisted of five (5) statements on personal information, section B Eight (8) statements on parental attitude, section C Eleven (11) statements on the teaching of sex education in secondary school, section D six (6) statements on parental opinion about sex education.

3.5 Validation of Instrument

In order to validate the instrument for this study, a draft questionnaire prepared by the researcher was submitted to four (4) professional experts from the field of health education to vet the questionnaire in order to establish face validity. On the basis of the suggestions, made by these experts the statements were restructured wherever necessary and a final draft questionnaire was produced for the study.

3.6 Procedure for Data Collection

In the administration of this instrument, the researcher reached out to parents through their children. In doing this, the researcher and 3 research assistants after obtaining permission from the relevant authorities visited selected schools and gave copies of the questionnaire to the students for onward transmission to their parents. The children returned the filled questionnaire from their parents to the researcher 7 days after administration. Period of one week was given for the students to return the filled questionnaire in order to allow parents to whom questionnaire were given enough time to complete the questionnaire.

3.7 **Method for data Analysis**

The data collected was analyzed at the Institute of agricultural research (IAR) of the Ahmadu Bello University Zaria. Statistical Package for Social Sciences (SPSS) was used. The data was tabulated into frequency distribution tables and percentages. The scores were then subjected to a t-test and ANOVA in order to test the hypothesis of the study and to find relationships and or differences between the variables at equals = 0.05 level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

The purpose of the study was to assess parents' attitude towards the teaching of sex education in secondary schools in Kaduna State. To achieve this purpose, a total of 460 copies of questionnaire were distributed but 362 were returned, meaning 78.7% response rate. The data collected were statistically analysed, the results of which are presented and discussed in this chapter.

4.2 Results

The demographic characteristics of respondents include Age, Gender, Marital Status, Location and Number of children used for the study.

Table 4.1: **Demographic characteristics of respondents**

S/NO	VARIABLE	AGE GROUP	FREQ.	PERCEN-TAGE (%)
1.	Age	No response	3	8
		20 - 30 years	57	15.7
		31 - 40 years	75	20.7
		41 - 50 years	74	20.4
		51 - 60 years	79	21.8
		61 years and above	74	20.4
		Total	**362**	**100.0**

S/NO	VARIABLE	AGE GROUP	FREQ.	PERCEN-TAGE (%)
2.	Gender	No response	3	8
		Male	165	45.6
		Female	194	53.6
		Total	**362**	**100.0**
3.	Marital Status	Married	197	54.4
		Divorced	64	17.4
		Widow/Widower	39	10.8
		Single	2	6
		Separated	61	16.9
		Total	**362**	**100.0**
4.	Location	Rural	179	49.4
		Urban	183	50.6
		Total	**362**	**100.0**
5.	Number of children	1 - 2	87	24.0
		3 - 4	141	39.0
		5 - 6	89	24.6
		7 and above	45	12.4
		Total	**362**	**100.0**

Column 1: showed 79 (21.8%) of the respondents fell within the age range of 51 – 60 years, 75 (20.7%) were between 31 – 40 years of age and 74 (20.4%) were within 41 – 50 years and above. Of the total number of respondents, only 3 (8%) indicated no response.

Column 2: showed that majority 194 (53.6%) of the respondents are females. This may be because female parents seem to be more concerned and in-charge of the sex education of their children especially female children. However, 165 (45.6%) of the respondents are males, while only 3 (8%) indicated no response.

Column 3: contained data on marital status of the respondents, 197 (54.4%) are married, 64 (17.4%) are divorced while 39 (10.8%) are widow/widower, 2 (0.6%) are single and 61 (16.95%) are separated.

Column 4: showed that most of the respondents 183 (50.6%) were from the urban areas. This may be due to the level of awareness in such centres as there are more enlightened people in the urban areas than in the rural areas. However, 179 (49.4%) of the respondents were from the rural areas. This may be due to public awareness on the subject matter. Such awareness could be provided by the electronic media such as radio which can be found virtually every where no matter how remote the area.

Column 5: showed that most of the respondents, 141 (39.0%) have between 3 and 4 children. This may be because many people in the country have realized the socio-economic benefit of having a sizeable number of children. However, 89 (24.6%) of the respondents indicated that they have between 5 and 6 children while 45 (12.4%) indicated that they have 7 and above.

Table 4.2: **Frequencies and percentages of responses on assessment of parental attitude towards the teaching of sex education**

S/NO	ITEM/STATEMENT	SA		A		U		D		SD	
		F	%	F	%	F	%	F	%	F	%
1 (Var.6)	Teaching of sex education is something I always want to en courage	95	26.2	75	20.7	30	8.3	77	21.3	85	23.5
2 (Var.7)	Teaching of sex education is an important form of social service	70	19.3	100	27.6	40	11.0	70	19.3	82	22.7
3 (Var.8)	Teaching of sex education is interesting because it deals with reality of life	50	13.8	80	22.1	60	16.6	80	22.1	92	25.4
4 (Var.9)	Teaching of sex education is good because it enlightens children about facts of life	60	16.6	70	19.3	20	5.5	152	42.0	60	16.6
5 (Var.10)	It encourages exploring the body	80	22.1	70	19.3	50	13.8	72	19.9	90	24.9

S/NO	ITEM/STATEMENT	SA		A		U		D		SD	
		F	%	F	%	F	%	F	%	F	%
6 (Var.11)	Teaching of sex education is dull	112	30.9	40	11.0	75	20.7	60	16.6	75	20.7
7 (Var.12)	It promotes immoral behaviour	120	33.1	103	28.5	15	4.1	52	14.4	72	19.9
8 (Var.13)	Teaching of sex education is good because it gives a person the opportunity to correct misconception about the subject matter.	125	34.5	140	38.7	10	2.8	50	13.8	37	10.2

In table 4.2, majority, 95 (26.2%) of the respondents were of the opinion that teaching of sex education is something they always wanted to encourage. Although 85 (23.5%) of the respondents strongly disagreed, only 30 (8.3%) remained undecided.

Results of this study have shown that 100 (27.6%) of the respondents agreed that teaching of sex education is an important form of social service. 85 (22.7%) of them strongly disagreed while only 40 (11.0%) were undecided.

Most of the respondents, that is 92 (25.4%) strongly disagreed that teaching of sex education is interesting because it deals with the reality of life. However, 80 (22.1%) agreed while 60 (10.6%) were undecided.

It is shown on this table that most of the respondents 70 (19.3%) agreed that teaching of sex education is good because it enlightens children about facts of life. 60 (16.6%) strongly disagreed which only 20 (5.5%) remained undecided.

A total of 90 (24.9%) of the respondents strongly disagreed that sex education encourages exploring the body but 80 (22.1%) strongly agreed. However 50 (13.8%) of the respondents remained undecided.

The findings also revealed that 112 (30.9%) of the respondents strongly agreed that teaching of sex education is dull. However 75 (20.7%) of them strongly disagreed. Others 75 (20.7%) remained undecided.

A total of about 120 (33.1%) of the respondents strongly agreed that teaching of sex education promotes immoral behaviour. Although 72 (19.9%) of them strongly disagreed, only 15 (4.1%) remained undecided.

A total of 140 (38.7%) out of the total number of respondents were of the opinion that teaching of sex education is good because it gives a person the opportunity to correct the misconception about the subject matter. Although 50 (13.8%) of them disagreed, only 10 (2.8%) were undecided.

Table 4.3: **Frequencies and percentages of responses on teaching of sex education in secondary schools**.

S/NO	ITEM/STATEMENT	SA		A		U		D		SD	
		F	%	F	%	F	%	F	%	F	%
9 (Var.14)	Teaching of sex education provides opportunity for proper counseling	120	33.1	88	24.3	30	8.3	74	20.4	50	13.8
10 (Var.15)	The teaching of sex education exposes students to immorality	200	55.2	90	24.9	13	3.6	45	12.4	14	3.9
11 (Var.16)	It allows students to understand their body better	90	24.9	111	30.7	11	3.0	80	22.1	70	19.3
12 (Var.17)	Exposure of students to sex education will lead to experimentation	180	49.7	100	27.6	5	1.4	10	2.8	67	18.5
13 (Var.18)	Teaching of sex education may encourage spread of HIV/AIDS	180	49.7	80	22.1	14	3.9	57	15.7	31	8.6
14 (Var.19)	Teaching of sex education may promote waywardness	210	58.0	100	27.6	3	0.8	33	9.1	16	4.4
15 (Var.20)	I am indifferent to the teaching of sex education to secondary school students.	200	55.2	50	13.8	30	8.3	42	11.6	40	11.0

S/NO	ITEM/STATEMENT	SA		A		U		D		SD	
		F	%	F	%	F	%	F	%	F	%
16 (Var.21)	Teaching of sex education to secondary school students should be discouraged	150	41.4	119	32.9	19	5.2	45	12.4	29	8.0
17 (Var.22)	My negative attitude to the teaching of sex education is because it is left in the hands of young teachers.	250	69.1	72	19.9	7	1.9	13	3.6	20	5.5
18 (Var.23)	I will appreciate if its teaching is handled by professionals.	190	52.5	112	30.9	15	4.1	20	5.5	25	6.9
19 (Var.24)	My attitude to its teaching is because of my own experience	180	49.7	100	27.6	10	2.8	32	8.8	40	11.0

In table 4.3 above, an indication was made that majority of the respondents, 120 (33.1%) strongly agreed that the teaching of sex education provides opportunity for proper counseling. However 74 (20.4%) of them disagreed while only 30 (8.3%) were undecided.

A total 200 (55.2%) of the respondents strongly agreed on the opinion that the teaching of sex education exposes students to immorality. A total of 45 (12.4%) respondent 45 (12.4%) disagreed while 13 (3.6%) remained undecided.

Similarly, 111 (30.7%) of the respondents agreed that sex education allows students to understand their bodies better. However, 80 (22.1%) disagreed while only 11 (3.0%) were undecided.

The results on the table indicated that most respondents, 180 (49.7%) strongly agreed that exposure to sex education leads students to experimentation. However 67 (18.5%) strongly disagreed while only 5 (1.5%) were undecided.

Similarly, 180 (49.7%) of the respondents strongly agreed that teaching of sex education may encourage the spread of HIV/AIDS. Although 57 (15.7%) of them disagreed, only 14 (3.9%) remained undecided.

A total of 210 (58.9%) respondents strongly agreed that the teaching of sex education may promote waywardness. While 33 (9.1%) disagreed, only 3 (0.8%) remained undecided.

Similarly 200 (55.2%) which constitute majority of the respondents were indifferent to the teaching of sex education to secondary school students. 45 (11.6%) of the respondents disagreed while 30 (8.3%) were undecided.

It is indicated in the table that 150 (41.4%) that is majority of the subjects who responded strongly agreed that teaching of sex education to

secondary school students should be discouraged. However 45 (12.4%) disagreed while only 19 (5.2%) did not take any stand as they indicated undecided.

The findings also revealed that majority, that is 250 (69.1%) of the respondents strongly agreed that their negative attitude to the teaching of sex education is because the issue is left in the hands of young teachers. But 20 (5.5%) of the respondents strongly disagreed while only 7 (1.9%) of the respondents remained undecided.

The table also shows that 190 (52.5%) of respondents appreciated the teaching of sex education if it is handled by professionals. However, 25 (6.9%) of them strongly disagreed while only 15 (4.1%) indicated that they were undecided.

Most, 180 (49.7%) of the respondents observed that their attitude towards the teaching of sex education was because of their own experiences. While 40 (11.0%) of the respondent submitted that their attitude to sex education was not based on personal experiences, only 10 (2.8%) were undecided.

Table 4.4: **Frequencies and percentages of responses on parental opinions about sex education**

	ITEM/STATEMENT	SA		A		U		D		SD	
		F	%	F	%	F	%	F	%	F	%
20 (Var.25)	Teaching of sex education will be acceptable to me if female teachers can teach female students.	160	44.2	182	50.3	5	1.4	-	-	15	4.1
21 (Var.26)	My attitude is a dictate of my belief.	210	58.0	90	24.9	4	1.1	38	10.5	20	5.5
22 (Var.27)	Sex education should focus on safe sex.	100	27.6	120	33.1	40	11.0	62	17.1	40	11.0
23 (Var.28)	Sex education should focus on abstinence education	200	55.2	100	27.6	2	0.6	30	8.3	30	8.3
24 (Var.29)	Sex education if handled taught by experts will produce the desired purposes.	150	41.4	100	27.6	3	0.8	59	16.3	50	13.8
25 (Var.30)	Sex education will serve as a tool which provides guidelines for the planning implementation and evaluation of HIV/AIDS prevention in schools.	180	49.7	120	33.1	2	0.6	25	6.9	35	9.7

In table 4.4 above, a total 160 (44.2%) of the respondents strongly agreed that the teaching of sex education would be acceptable to them if female teachers could teach female students. However 182 (50.3%) of the respondents agreed while only 5 (1.4%) remained undecided.

Majority of the respondents 210 (58.0%) strongly agreed that their attitude towards the teaching of sex education were the dictates of their beliefs. 38 (10.5%) of them disagreed while only 4 (1.1%) were undecided.

The findings also reveal that while most, 120 (33,1%) of the respondents were of the view that sex education should focus on safe sex, 62 (17.1%) disagreed and 40 (11.0%) were undecided.

It is also indicated in the table that majority, 200 (55.2%) of the respondents strongly agreed that sex education should focus on abstinence. However 30 (8.3%) strongly disagreed, while only 2 (0.6%) remained undecided.

The table also shows hat 150 (41.4%) were of the opinion that sex education if handled/taught by experts would produce the desired purposes but 50 (13.8%) strongly disagreed while only 30 (8%) were undecided.

Majority of the respondents that is 180 (49.7%) strongly agreed that sex education will serve as a tool which provides guidelines for the planning, implementation and evaluation of HIV/AIDS prevention in schools. Although 35 (9.7%) of the respondents strongly disagreed, only 2 (0..6%) were undecided.

4.3 Test of Hypothesis

Hypothesis I:

There is no significant difference between male and female parents in their attitude towards the teaching of sex education in secondary schools. To test this hypothesis, t-test was used and below are the results as shown in the table.

Table 4.5: **t-test for difference between male and female parents in their attitude toward teaching of sex education in secondary schools.**

Gender	N	Mean	Std. Dev.	Std. Error	Df	t	P
Male	165	1.5387	.51017	.02681	357	8.126	.000
Female	194	7.5663	2.49040	1.70766			

t = 1.96, df 357 < 0.05

The above table 4.5 shows that the calculated t value of 8.126 which is greater than the table value of 1.96 at the df of 357. The P at .000 is lower than the 0.05 level of significance set for the study. There is therefore no significant difference between the attitude of male and female towards the teaching of sex education in secondary schools. The null hypothesis is therefore rejected.

Hypothesis II:

There is no significant difference in attitude of parents of different age groups. To test this hypothesis one way analysis of variance (ANOVA) was used and the results as stated in the table below.

Table 4.6: **Summary of ANOVA for differences between the attitude of parents of different age groups.**

Source	**Df**	**Ss**	**Ms**	**F**	**P**
Between age groups	4	3620.99	405.248	. 16.891	.000
Within age groups	356	1907.92	53.592		
Total	**360**	**22699.91**			

F4, 356 = 2.37 < 0.05

It is indicated in table 4.6 above that P.000 is lower than 0.05 level of significance set for the study. The null hypothesis is therefore rejected. A look at the table above shows, that the calculated F value is 16.891 which are higher than the table value of 2.37at df 4,356. This is so because of the 0.05 level of tolerance set for the study.

Hypothesis III:

There is no significant difference between parents in urban and rural area in their attitude to the teaching of sex education in secondary

schools. To test this hypothesis t-test was used and the results are shown in the table below:

Table 4.7 **t-test for difference between parents in their attitude in teaching of sex education in secondary schools in urban and rural areas**

Location	N	Mean	SD	Se	Df	t	P
Rural	179	1.5055	.50056	.02631	360	7.213	.000
Urban	183	4.5663	1.04140	1.70766			

t = 1.96 df 360 < 0.05.

The results in table 4.7 above revealed that the calculated t value at 7.213 is greater than the table value of 1.96 at 360 degree of freedom. The P is .000 which is lower than the 0.05 level of significance set for this study. The null hypothesis which states that there is no significant difference between parents in the urban and rural areas in their attitude to the teaching of sex education in secondary schools is therefore rejected.

Hypothesis IV:

There is no significant difference in the attitude of parents to the teaching of sex education in secondary schools based on marital status. To test this hypothesis, one way analysis of variance (ANOVA) was used in order to ascertain the difference between various groups based on marital status. The parameters used were married, divorced,

widow/widower, single and separated. The results are shown in the table below.

Table 4.8: **Summary of ANOVA for difference between the attitude of parent in teaching of sex education in secondary schools based on marital status**

Source	Df	Ss	Ms	F	P
Between Groups	4	3395.92	848.981	72.728	.000
Within Groups	356	41550.986	116.722		
Total	**360**	**44946.906**			

F4, 356 = 2.37 < 0.05

The data in table 4.8 above indicate that P.000 is less than the 0.05 level of significance set for this study. The null hypothesis is therefore rejected. The reason for this result may be that people irrespective of their marital status have the same notion about the teaching of the subject matter. Considering the data on the above table the calculated F value of 72.728 is greater than the table value of 2.37 at df 4,356. It therefore suggests that parent's attitudes to the teaching of sex education in secondary school change base on their marital status.

4.4 **Discussion**

Hypothesis I:

There is no significant difference between male and female parent in their attitude towards the teaching of sex education in secondary schools. The findings reveals no significant difference. The reason for this may be because the issue of sex education calls for the involvement of both parents. However, mothers appeared to be more concern about the sexual life of their children because they don't want them to make mistakes. Whereas fathers concern though noticeable is a passing one. This is in line with the observation of Sheriff and Hovland (1961) in what is called "latitude of acceptance model" according to which they argue that an individual is also prepared to slightly alter his position either side of his maintained position either positively or negatively. The range within which the individual oscillates exhibits his latitude of acceptance.

It also implies that the level of understanding of the subject matter is not the same for both parents. To support this, Microsoft Corporation (1993), 2003) broadly defines sex education as any instruction in the processes and consequences of sexual activity ordinarily given to children and adolescents. Today the term refers to classroom lessons

about sex taught in primary and secondary schools usually as part of biology/health science class.

Based on some of the reasons mentioned above the null hypothesis is therefore rejected.

Hypothesis II:

There is no significant difference in the attitude of parents on account of their age groups. The outcome of the test on this hypothesis reveals no significance difference in the attitude of parents on account of their ages groups. This may also be attributed the level of education and awareness among various age groups to support this statement, Shoop and Hayhow, (1994) and Stinger (1997) point out that all education about harassment need to be age and grade related. It should describe what type of conduct constitutes, but, to reduce the possibility of establishing a climate of fear, the curriculum should help the students distinguished between contact perceived as menacing (and violation of the target privacy) and flirting which can be desired, feels good, makes the recipient happy and increase self esteem

Stein and Sjostrom (1994) suggest that a curriculum on human sexuality can easily cover harassment, but the problem can also be discussed in courses such as history, social studies contemporary issue,

English and health education. Co-teaching by males and females sends "a powerful message about the relevance of sexual harassment to both sexes"

In line with this Brandenburg (1997) also suggest that classes should include both male and female students so that they can gain an understanding of each other's perceptions. It is critical not to make the male feel threatened. The null hypothesis is rejected.

Hypothesis III:

There is no significant difference between parents in the urban and rural areas in their attitude towards the teaching of sex education in secondary schools on accounts of their locations. The results of the test of this hypothesis show no significant difference between the parents that come from the rural areas and those who come from the urban centres in their attitudes towards the teaching of sex education in secondary schools. This may be due to the assumption that individuals irrespective of where they come from or where they are can learn and become enlightened through diverse ways as there are indications that attitude are learned and if learned can be unlearned. However, attitude remains relatively stable and calm but changes in several ways such as through an accumulation of experiences, age, poverty, education, environment etc.

Some psychologists and social scientists in recent time have concerned themselves with critical questions in the dynamics of personality development which seek to know how an individual develops an attitude towards himself, objects, issues and situations. The developed attitude could be classified as either positive or negative in orientation. In relation to this, Krency (1962) states the major determinants of attitude formation as the individual wants, information, group affiliation and personality. An individual develops a favourable attitude towards people who satisfy his wants. Tyler (1949) asserts that one importance of attitude is that it arises from the fact that it has strong influences upon behaviour and also strongly influences the kinds of satisfaction and values the individual chooses. The null hypothesis is therefore rejected.

Hypothesis IV:

There is no significant difference in the attitude of parents to teaching of sex education in secondary school base on marital status. The results of the test on this hypothesis show that there is no significant difference in the attitude of parents whether married, single, divorced, widowed etc toward the teaching of sex education. This may be attributed to the assumed multidimensional aspect of attitude formation among individuals irrespective of their marital status. To support this,

Streufart (1978) stresses that the cognitive component of attitude involves the trait perception of the observed object, event, issue or person in relation to how one can view it and what stereotypes, one has towards it emotions are not likely to interplay in this dimension. On the affective dimension, the responses is primarily emotional one, when ones feelings toward as object event, issue or person is manifested play as to weather the cognitive or affective measure of an object is baked up by actions the are positive of negative. The findings signify that every individual maintain his/her relative position along a dimension of his/her attitude toward a particular object or issue.

According to interviews conducted for Kaiser Family Foundation (2000), most parents (65%) believe that sex education should encourage young people to delay sexual activity but also prepare them to use birth control and practice safe sex once they do become sexually active. In fact public opinion is overwhelmingly supportive of sexuality education that goes beyond abstinence. Similarly, Darroch, Landry and Singh (2000) state that moreover, public opinion polls over the years have routinely shown that majority of Americans favour broader sex education programs over those that teach. Only abstinence. The null hypothesis is rejected.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The study was aimed at assessing parental attitude toward the teaching of sex education in secondary schools in Kaduna State. This chapter therefore contains the summary of findings, conclusion and recommendations by the researcher.

5.2 Summary

The attitude of parents towards the teaching of sex education in school has been a matter of serious concern and this is affecting the dissemination of vital information the absence of which has led to the spread of sexually transmitted infections, unwanted pregnancy as well as the spread of HIV and AIDS. It is against this background that the study was set out to assess the attitude of parents towards the teaching of sex education in secondary schools in Kaduna State.

To achieve this, four hypotheses were formulated to determine whether there are differences between male and female parents in their attitude towards the teaching of sex education in secondary schools; The different attitude of parents on account of age groups to the teaching of sex education; parents in urban and rural areas in their attitude to the

teaching of sex education. Also one of the four hypotheses wanted to find out whether relationship exists between parental attitude on account of marital status. In addition, 460 subjects who were selected as samples out of a population of about 100,000 and above were served with copies of questionnaire. The subjects are parents of students from the selected schools and cluster sampling technique was used.

The data collected was analyzed using the statistical package for social science (SPSS). The data was tabulated into frequency distribution tables and percentages. The scores were then subjected to a t-test and ANOVA analysis in order to test the hypotheses of the study to find differences between the variables respectively. The probability level was taken at 0.05.

The study revealed that:

1. Majority of the respondents agreed to the teaching of sex education in secondary schools in Kaduna State.
2. There is no significant difference between parents in urban and rural area to the teaching of sex education in secondary schools in Kaduna State.
3. Gender did not significantly affect the attitude of parent towards the teaching of sex education in secondary school in Kaduna State.

4. Age did not significantly affect the attitude of parent towards the teaching of sex education in secondary school in Kaduna State.

5.3 Conclusion

On the basis of the result and in view of the limitation of the study, the following conclusions are drawn.

1. The attitude of parent towards teaching of sex education in secondary schools were positive.
2. Gender does not influence parents' attitude towards the teaching of sex education in secondary schools in Kaduna State.
3. Irrespective of location parents in urban and rural area had similar attitude towards teaching of sex education in secondary schools.
4. Age difference did not influence parents attitude towards teaching of sex education in secondary schools in Kaduna State.
5. Marital difference did not influence the teaching of sex education in secondary schools in Kaduna State.

5.4 Recommendations

Based on the findings of this study the following are hereby recommended:

1. The teaching of sex education should be encouraged at all levels of education especially at the secondary school level.

2. The teaching of sex education should be regarded as an important form of social service in the community or society at large.
3. Sex education should be used as a means or opportunity for proper counseling in secondary schools.
4. The government or any authority concerned should intensify enlightenment campaigns so as to make people aware that teaching of sex education does not expose students to promiscuity nor does it promote immoral behaviour or waywardness.

5.5 Suggestion for further research

The following suggestions are offered for future research:

1. Research on the relationship between parents and staff of secondary schools could be conducted to ascertain the influence of such relationship on the teaching of sex education.
2. Studies could also focus on the role of the State Ministry of Education in the teaching of sex education in schools.

REFERENCES

Action Health incorporated (1995). *Vol. 4 Number 1 & 2.*

Adebajo, T.A. (1997). Approach to Health Instruction. *Journal of Nigeria School Health Association* 6 (1 & 2).

Adeyemo, J.B. (1995). Family Life and Sex Education, *Nigeria School Health Journal* Page 10 – 15

Afolabi, M.L. (1993). *Introduction to Research Methods for Writing Project and Thesis*, Alpha Publishers Pp. 53 – 58.

Albert Ellis & Albert Abarbanal (1973). *Encyclopedia of sexual behaviour* Jason Aionson inc. New York.

Akinboye, A.O. (1987). Key Notes Address in National Seminar on Healthful School Environment Nigeria School Health. *Journal* Vol. 2 No. 1.

Anasa-Kolo, S. (1996). *Sexual behaviour and consequences amongst unmarried advancement Areas of Kaduna State.* Study on the community of medicine, A.B.U. Zaria. Nigeria.

Ariba, T. (2000). Promoting Mental Health of Nigerian School Health *Journal Vol. 1 No*. 1 Page 30 – 34.

Ariba, T. (2002). Health Education for Elementary, *Schools Health Review* 23 – 26.

Ariya, I. & Bennet, R. (1998). *Mode of Transmission*. The Basis for prevention strategies, Department of Health and Social Services, UK of Great Britain and Northern Ireland page 16 – 20.

Berkowit, Z. L. (1980). *A Survey of Social Psychology*. Holt, Reinhart and Winston, Chicago, Dallas Toronto London, Sydney.

Bobak, F.T. & Jensons, W. (1989). Attitudes and Job Performance *Journal of Vocational Behaviour* 340 – 350.

Brandenburg, J.B. (1997). *Confronting Sexual Harassment: what schools and colleges do*. New York: Teachers College Press.

Bromleu, P.& Britten, L. (1938). *America care system*: Issues and problems. Mosby Company.

Caldwell, P.L. (1989). Knowledge in adults and investigation of age and intelligence and Non, ability determinates. *Psychology and ageing* 615 – 628.

Cambell (1993). *Communication and Persuasion* Yale University Press.

Ciray, G. (1993). *Recreation and attitude of mind school practice* St. Louis times Musby Company Nigeria.

Collins J. (2002). *A guide to effective programmes that reduce health risk behaviour of Youths* Journal of school health 73:3-9.

Comprehensive Sexuality Education in Nigeria (1995). Human Right *Summary Cases Center for the eight to Health* Publication September. Page 9 -12.

Cosin, J.W. (1991). Attitude in Murchison, C. (ed). *A hand book of social psychology Worcester Clark University Press.*

Cozby.R. (1983). *Social Psychology*, Holt New York, Reinhart and Winston.

Curan, J. (1984). *Hope rises for People living with HIV/AIDS* Vol. 1 No. 3.

Darroach J.E, & Landry, H. (1998-1999). *Changing emphasis in sexuality education in U. S. Public Secondary school, family planning,* perspectives, Page 204 – 211 and 265.

Deschamps, B.P. (1974). *Stressful life events Nature and effects* New York, John Wiley Com.

Dicenso A (2002). *Interventions to reduced unintended pregnancies Among Adolescents:* Systematic Review of Randomized controlled trails. British medical journal. 324: 1426.

Domokes, A. (1971). Key notes address 1st National Work/Seminar on Healthful School Environment Nigeria *Health Journal* 1 (1)

Dubos .R. (1968). *Care concept in Health Lee and fabiger Philadelphia*

Eduvie, B. (1999). Health: Man in a changing Environment. *The Guidance News Paper November 1*6.

Emenike, O. (1981). Health and Diseases. *The Guidance News Paper* 12, November 8.

Enerst, M. (1995). Refinery Health. *A multiple demission model America School Health Journal Vol*. Pg. 54 – 79.

Federal Government Plan of Action for the protection of youths (FGN 2003). Vol. (1) Page 3 – 9.

Feming, R. Colleagues (1970). *Blood products and HIV Chapman and Hall medical 2nd edition* London Glasgow. New York, Tokyo, Melbounne. Mandras.

Fishbein M.T Triandis, A.C & Kanfer, F.H (1983). *Factors Influencing Behaviour and behaviour change* in Perlman hand book of health psychology.

Frost R.B. (1975). *Physical Education foundation, practice and principles*, Sydney addleson, Wesy Publishers company.

Geer, P. (1991). *A handbook of social psychology*, Clark University Press.

George, H. & Willad. W. (1978). Locus of Control and Health. *A review of the literature Health Education.*

Hayhow, A. (1994). *An Ecology view of Health and Education Journal for Schools* Vol. 2 Page 100 – 103.

HIV/AIDS, what is means for Nigeria Background, Projections, Impact Interventions and Policy. The National AIDS and STIs control Programme F.M.O.H. (1992). Abuja – Nigeria P. 2 and 42 December.

Ibrahim, M. & Ogunsanwo, Y. (2005). *Health Education for teachers*. A critical study of the preservice preparation of classroom teachers for school Health Programmes.

International Planned Parenthood Federation (1997). *Aids preemption through health promotion Global programmes on Aids WHO Geneva.*

Jackson P.W. (1968). *Life in classroom* New holt Reinhart and Winston Inc.

Jordan D. (1941). *Attitude of central school pupils to certain subjects and the correlation between Attitude and attainments*. British Journal of Education Psychology.

Karjicek, M. (1983). *The essential of contraceptives technology*. A handbook for clinic staff, Johns Hopkins population information public production report.

Kendler H.A (1963). *Basic Psychology century Craft* WMC Brown Company Low A

Ketting E. (1997). *A Contraception in the Netherlands the law abortion rate explained patient Education and counseling* 23.

Keyon G. S. (1968). *Six scales for assessing attitude towards physical activity.* Research Quarterly.

Krency D., Crucified, R.A. & Ballachy, E (1962). *Individual in society* McGraw Hill Book Company, New York.

Krency, D., (1962). *A text book of social psychology*, New York McGraw Hill Book Company.

LA Pierre, R.T. (1934). *Attitude versus action Social forces* 13.

Maclver, C. (2003). *Messages address to women as Target Audience Aids programme Training*, New York City Pg. 5.

Masters W. & John, V. (1966). *Human Sexual responses* Boston: Little, brown and company.

Michael (1981). *Aids Prevention and control World Summit of Ministers of Health on programmes for Aids prevention jointly organized by WHO and the UK Govern Northern Ireland* P. XIX - XXII

Microsoft Cooperation (1993 – 2003). *All right reserved*.

Money, J. & Ehrhardi, A. (1973). *A man and woman. Boy and Girl*, Baltimore: Johns Hopkins University Press.

Morgan, D.W. & Kreycie, C. (1970). *Education and psychological measurement*. Autumn.

Mukher, Jee, A. (1978). *Educational Psychology for students and parents,* India, K.P. Bas Publishing Company Calculta.

Nass, S.A. & Fisher, G. (1988). *The foundation of Health* New York Apletion Century Cretts.

National AIDS/STIs Control Programme (1992). *Nigerian Medical Association*. Handbook on HIV Infection and Aids for health workers. Lagos: FMH/NMA.

National Guidelines Task Force (1996). *Guidelines for comprehension sexuality.*

Neil Warren, R. A. (1996). *Public Health Awareness* Longman Green and Co. London.

Netting, N.S. (1997). *Exploring commitment love and sex among college students.* Unpublished manuscripts, Okagan University College, Kelown British Columbia.

Netting, N.S. & Burnett, ML. (2004). *Twenty years of student sexual behaviour of sub-cultural adoptions to a changing health environment.* Adolescence, vol. 39, No. 153 spring, Libra publishers. Inc. 3089 – Clairemonth, P.M.B. 383 San.

Nicholls, U. (1975). *Use of vital and Health records in Epidemiology research* 145 USA.

Nigeria School Health Journal (1981). Vol 4 Page 10 – 17.

Obinu, N.C. (2001). *Primary health care for developing countries,* Department of Community Medicine, College of Medicine, University of Nigeria Enugu.

Oladapo, M.M. & Brieger, W.R. (1997). *Reproductive knowledge, attitude and behaviour of secondary school students in Akure,* Nigeria a international quarterly of community health education 16, (4) P. 341 – 358.

Panos Institute (1988). *Aids and the third world panos publications*, London.

Patners for Development (2001). P. 24 – 25, 90 and 112.

Peters, H. (2002). *Theories Related to teaching*, Nigeria Schools Journals Vol. 1 Page 10 – 15.

Prine, L. & Osoba, C. (1984). The Structure of coping Journal of Health and Social Behaviour. *Journal of Health* Vol. 3 Page 16 – 18.

Perlman, D. (1983). *Social psychology*. New York Reinhart and Wiston

Planning Perspectives (2007) Vol. 3 Pg. 6 – 10.

Primary Health Care Developing Countries (2001). *Moving on The Bamako initiatives Nigeria NPHCA Lagos. Nigeria.*

Ransome-Kuti, O. (1996). *National Policy on health Federal Ministry of Health,* Lagos Nigeria.

Rein, D. & Muller, J. (1984). *Comprehensive School Health Programme in Fexas Schools Journal of Health* Vol. 6 Page 7 – 10.

Robin, L.C. (2002). *Research findings on programmes to reduce teen pregnancy*. Journal of Health 72:3.

Rokeach, M. (1998). *Attitude organization and change* Yale University press: P.3.

Roseberg, M.J. 1990). *Attitude organization and change* Yale University Press.

Sartin, D.C. (1973). *Introduction to psychology*. Health and Company Toronto.

Seidenberg, B. & Sandosvshy, A. (1997). *Social Psychology an Introduction.* New York the free press Macmillan Publishing Co.

Sheriff, D.F. & Hovland C.J. (1961). *Experiments on mass communication Princeton*, J.J. Princeton University Press..

Shoop, R.J. & Hayhow, A. (1994). *Sexual Harassment in our schools*. What parents and teachers need to know to spot it and stop it. Boston: Allyn and bacon (ED 386 – 794).

Shyler, J.B. (1976). *Sex education*. The leader may 1 – 5.

Sparling, P.F. (1994). "*Biology of Neisseria gonorrhea*" In Holmes, K.K. Sparling P.F. Mardh, P.A; Lemon, S.M.; Stamm, W.E., Piot P. and Wasserhit, J.N. (Eds) McGraw Hill New York Pp. 433 – 449.

Stein, N. & Sjostrom, L. (1994). *Flirghting or hunting*? A teachers guide to students-to-sexual harassment in schools (grades 6 through 12) Washinton, D.C. National Education Association. (ED 380 415).

Steineger, M. (1997). *Preventing and countering school based harassment*: A resource guide for K-12 educators. Port Land OR Northwest Regional Educational Laboratory. ED420 113).

Stigma, H. (1985). *Impact of sexuality transmitted infection spread of increased condom use by young females*, 1987 – 1982. Journal of Epidemiologists Vol. 4 (4): 813 – 20.

Streufart, S. (1978). *Behaviour in the Complex environment*. New York, A. Halated Press Book, John Wiley & Sons.

Suleiman, M. A. & Dominic, B. (2006). *Research concepts for behavioural researchers publish by Raspavicko Consultancy Services.*

Suleiman, M.A. & Venkateswarlu, K. (2002). A blueprint of effective programmes to reduced health risk behaviour of adolescence *journal of Nigeria association of women in sports (Journal vol. 2, No. 1).*

Suleiman, M. A. & Venkateswarlu (2006). Ten years of students sexual behaviour sub-cultural responses to a changing Health environment in Nigeria. *A paper presented at the 3rd International council, For Health, Physical Education, Recreation, Sport and Dance (ICHPER-SD) African scientific Congress,* Winneba GHANA AUGUST 7th – 12th.

Susana Chavez (2001). *Making women controlled method a priority women health journal* Vol. 3:345 – 38.

Taver, L. (1983). *Theory into Practice Health Promotion Programmes for specific groups Lintas World Wide* (Educational Programme) Ghana.

The encyclopedia of patient with sexually transmitted infection report on WHO study group page 2 – 16. World Health organization (*WHO technical report series* No. 810).

The World youth (2000). Management of patient with sexually transmitted infection report on WHO study group *(WHO technical report series* No. 810).

Tyler, R.N. (1949). *Basic Principles of Curriculum and Instruction*. University of Chicago Press.

UNDP (2001). *Human Resources Development for Primary Health Care Revolution study No.* 9 in the UNDP Thematic Evaluation Programme New York UNDP Information Division.

UNDP & Choices Magazine (2001). Vol. 6 Page 3 – 7.

Uwakwa, C.B.U.; Moronkola, O.A & Ogundiran, A. (2001). Awareness prevalence of sexually Transmitted Disease and Health Care seeking behaviour. *Nigerian School Health Journa*l Vol. 13 (2): 147 – 160.

Venkateswarlu, K. (2000). *Sexual behaviour patterns of students of tertiary institutions in Zaria* unpublished research paper Department of Physical and Health Education Ahmadu Bello University, Zaria.

W.H.O. (1975). *Scientific Report group on research in Health Education WHO Technical Report Series* No. 432 (Geneva).

W.H.O. (1991). *Management of patient with sexually transmitted disease reports of WHO Study group (WHO Technical Report* Series No. 810) Geneva Author.

W.H.O. EPI (1992). *HIV/AIDS Does Not Stop the Global Effort to Immunize Against EPI Target Diseases, HIV Infection and Immunization of Women and Children: EPI update Newsletter,* 112 (1) Geneva 27 Switzerland.

W.H.O. & USAID (2001). *Our Planet, our Health, Reprot of WHO on Health and Environment.* Geneva.

William, H. Masters & Virginia, E. John Son (1974). *The role of relilgion in Sexual Dysfunction*. Chapter in sexuality and Human values. Mary S. Calderone, ed (New York; Association Press, P. 86).

Womens Health Journal (2000). Vol. 2 Page 4 – 8.

Worlds Youth (2000). *The World Health situation*; Third Report of the World Health Situation 493, Geneva.

APPENDIX (A)

DEPARTMENT OF PHSICAL AND HEALTH EDUCATION
FACULTY OF EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA
KADUNA STATE, NIGERIA

QUESTIONNAIRE ON ASSESSMENT OF PARENTAL ATTITUDE TOWARDS THE TEACHING OF SEX EDUCATION IN SECONDARY SCHOOLS IN KADUNA STATE

This questionnaire is meant to collect data on "assessment of Parental attitude to the teaching of sex education in secondary schools in Kaduna". Respondents' opinion is sought by the tick (√) of on the appropriate boxes in the statement outlined below. Respondent's name is not required, and information given will be treated as confidence.

Section (A): Biodata

Tick (√) in the appropriate box indicating choice of options below.

1. Age:

20	-	30	years	( )
31	-	40	years	( )
41	-	50	years	( )
51	-	60	years	( )
61 years and above				( )

2. Gender:

Male	( )
Female	( )

3. Marital Status:

Married	( )
Divorce	( )
Single	( )
Widow/Widower	( )
Separated	( )

4. Location:

Rural	( )
Urban	( )

5. No. of Children:

1 - 2	( )
3 - 4	( )
5 - 6	( )
7 and above	( )

Section (B): Assessment of Parental Attitude

General Instruction:

Please read each of the following statements carefully. Then tick (√) for each, whether you **Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D),** or **Strongly Disagree (SD).**

S/NO	STATEMENTS	SA	A	U	D	SD
6.	Teaching of sex education is something I always wanted to en courage.					
7.	Teaching of sex education is an important form of social service.					
8.	Teaching of sex education is interesting because it deals with reality of life.					
9.	Teaching of sex education is good because it enlightens children about facts of life.					
10.	It encourages exploring the body.					
11.	Teaching of sex education is dull.					
12.	It promotes immoral behaviour.					
13.	Teaching of sex education is good because it gives a person the opportunity to correct misconception about the subject matter.					

Section (C): Assessment of Parental Attitude

S/NO	STATEMENTS	SA	A	U	D	SD
14.	Teaching of sex education provides opportunity for proper counseling.					
15.	The teaching of sex education exposes student to immorality.					
16.	It allows student to understand their body better.					
17	Exposure of student to sex education will lead to experimentation.					
18	Teaching of sex education may encourage spread of HIV/ AIDS.					
19	Teaching of sex education may not promote waywardness.					
20	I am indifferent to the teaching of sex education to secondary school students.					
21	Teaching of sex education to secondary school student should be discouraged.					

S/NO	STATEMENTS	SA	A	U	D	SD
22.	My negative attitude to the teaching of sex education is because it is left in the hands of young teachers.					
23.	I will appreciate its teaching if handled by professionals.					
24.	My attitude to its teaching is because of my own experience.					
	Section (D): **Parental Opinions about Sex Education**	**SA**	**A**	**U**	**D**	**SD**
25.	Teaching of sex education will be acceptable to me if female teachers can teach female students.					
26.	My attitude is a dictate of my belief.					
27.	Sex education should focus on safe sex.					
28.	Sex education should teach abstinence from sex.					
29.	Sex education if handled/taught by experts will produce the desired purposes.					
30.	Sex education will serve as a tool which provides guidelines for the planning, implementation and evaluation of HIV/AIDS prevention in schools.					

APPENDIX (B)

Southern Senatorial Zone

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
1.	Jaba Local government Area	1.	G.S.S. Kuryas
		2.	G.S.S. Bello Fushi Chori
		3.	G.S.S. Ramidop
		4.	G.S.S. Kwoi
		5.	G.S.S.Fai
2.	Jema'a Local Government Area.	1.	G.S.S. Zapak
		2.	G.S.S. Kafanchan
		3.	G.S.S. Takau
		4.	G.S.S. Ungwar Fari
		5.	G.S.S. Gidan Waya
3.	Jema'a Local Government Area.	1.	G.S.S. Ancha
		2.	G.S.S. Ramda
		3.	G.S.S. Fada Ayu
		4.	G.S.S. ABU
		5.	G.S.S. Mayir
4.	Kaura Local Government Area	1.	G.S. Bondon
		2.	G.S.S. Manchok
		3.	G.S.S. Kadarko
		4.	G.S.S. Kagoro
		5.	G.S.S. Kukum Daji

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
5.	Kauru Local Government Area	1.	G.S.S. Damakasuwa
		2.	G.S.S. Kono
		3.	G.S.S. Geshere
		4.	G.S.S. Kizakoro
		5.	G.S.S.Fadam Chawai
6.	Zango Kataf Local Government Area	1.	G.S.S. Samaru Kataf
		2.	G.S.S. Madakiya
		3.	G.S.S. Wadom
		4.	G.S.S. Marsa
		5.	G.S.S. Ungwar Rimi Kaje
7.	Kachia Local Government Area	1.	G.S.S. Kachia
		2.	G.S.S. Katari
		3.	G.S.S. Antong
		4.	G.S.S. Yarbung
		5.	G.S.S. Bishini
8.	Kagarko Local Government Area	1.	G.S. S. Kagarko
		2.	G.S.S. Idah
		3.	G.S.S. Kenyi
		4.	G.S.S. Dongon Kumi
		5.	G.S.S. Jere

Central Senatorial Zone

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
1.	Chukun Local Government Area	1.	G.S.S. Kuriga
		2.	G.S.S. Sabon
		3.	G.S.S. Kujama
		4.	G.S.S. Nassarawa
		5.	G.S.S. Gaiya
2.	Kajuru Local Government Area	1.	G.S.S. Kufana
		2.	G.S.S. Kasuwan Magani
		3.	G.S.S. Tudun Mare
		4.	G.S.S. Kallah
		5.	G.S.S. Idon
3.	Igabi Local Government Area	1.	G.S.S. Rigasa
		2.	G.S.S. Afaka Sabuna
		3.	G.S.S. Birin Yero
		4.	G.S.S. Air Force Base
		5.	G.S.S. Jaji
4.	Giwa Local Government Area	1.	G.S. S. Shika
		2.	G.S.S. Giwa
		3.	G.S.S. Fatika
		4.	Dr. Shehu Lawal (G.S.S) Giwa
		5.	G.S.S. Galadima

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
5.	Birin Gawari Local Government Area	1.	G.S.S. Birom Gwari
		2.	G.S.S. Dongon Dawa
		3.	G.S.S. Randagi
		4.	G.S.S. Kankangi
		5.	G.S.S. Bagoma
6	Kajuru Local Government Area	1.	G.S.S. Amina College (QAC)
		2.	G.S.S. Kakuri
		3.	G.S.S. Television
		4.	G.S.S. Tudun Wada
		5.	G.S.S. Kargi
7.	Kaduna North Local Government Area	1.	G.S.S. Kawo
		2.	G.S.S. Hayin Banki
		3.	G.S.S. Ungwar Sarki
		4.	G.S.S. Doka
		5.	G.S.S. Saraduna Memorial College Kaduna (SMC)

Northern Senatorial Zone

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
1.	Lere Local Government Area	1.	G.S.S. Rami Ramin Kura
		2.	G.S.S. Gure
		3.	G.S.S. Saminaka
		4.	G.S.S. Yarlasiwa
		5.	G.S.S. Garun Krma
2.	Kubau Local Government Area	1.	G.S.S. Damau
		2.	G.S.S. Pambegua
		3.	G.S.S. Zunbau
		4.	G.S.S. Kubau
		5.	G.S.S. Dutsen Wai
3.	Ikara Local Government Area	1.	G.S.S. Run
		2.	G.S.S. Ikara
		3.	G.S.S. Paki
		4.	G.S.S. Auchan
		5.	G.S.S. Pala
4.	Soba Local Government Area	1.	G.S. S. Gamargira
		2.	G.S.S. Kabomo
		3.	G.S.S. Soba
		4.	G.S.S. Dirya
		5.	G.S.S. Syakasai

S/NO	LOCAL GOVERNMENT AREAS	S/NO	NAMES OF SELECTED SCHOOLS AND NUMBERS
5.	Makarifi Local Government	1.	G.S.S. Makarfi
		2.	G.S.S. Mayere
		3.	G.S.S. Kubuchi
		4.	G.S.S. Mafida
		5.	G.S.S. Nassarawa Doya
6.	Sabon Gari Local Government Area	1.	G.S.S. Kwangila
		2.	G.S.S. Bomo
		3.	G.S.S. Samaru
		4.	G.S.S. Basawa
		5.	G.S.S. Chindit
7.	Kudan Local Government Area	1.	G.S.S. Hunkuyi
		2.	G.S.S. Kudan
		3.	G.S.S. Likoro
		4.	G.S.S. Dusten Kudan
		5.	G.S.S. Khuranwale
8.	Zaria Local Government Area	1.	G.S. S. Kaura
		2.	G.S.S. Dakachi
		3.	G.S.S. Zaria
		4.	G.S.S. Mangi
		5.	G.S.S. Ungwar Kaya