PATTERNS OF SEXUAL BEHAVIOUR AMONG OUT-OF-SCHOOL ADOLESCENTS IN EGBEDA LOCAL GOVERNMENT AREA, OYO STATE

BY

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ABSTRACT

Adolescents are important group of the population. The process of adolescents' maturation is influenced by recognised risk and protective factors that are present during adolescence, their families and the environment. Many people initiate sexual intercourse during their adolescent years and being out of school has been found to be a risk factor for initiation of health risk behaviours including high-risk sexual behaviours. The study was aimed at assessing the patterns of sexual behaviour among out-of-school adolescents in Egbeda local government area, Oyo State.

The study was carried out using a cross-sectional study design. A three-stage sampling technique was adopted to select 400 out-of-school adolescents within the age of 15-19years. The study employed quantitative method of data collection using interviewer-administered semi-structured questionnaire. Collected data were sorted and analysed using statistical package for social sciences (SPSS) software version 21 and analysis of data was carried out using descriptive and inferential statistics. Safe sexual practices were assessed on a 30-point scale, score <20 and ≥20 were considered to be unsafe and safe sexual practice respectively. The level of significance (α) was set at 95% confidence level.

The mean age of respondents was 17.5 ± 0.1 years, more than half were females (55.5%) and most (97.8%) of them were single.Majority (75.0%) of the respondents discussedsexual matters with friends and 72.3% had friends who were sexually active. Majority (82.8%) of respondents had a boy/girlfriend and many (64.8%) of the respondents had sexual intercourse. The lowest age at sexual debut was 13 years. Some (45.5%) of respondents used contraceptive the last time they had sexual intercourse and condom was used more (31.8%) than other contraceptive methods. Some (47.3%) of respondents have not used contraceptives in the past 12months. Less than a third (30.3%) of respondents had been forced by someone to engage in sexual intercourse. Few (32.6%) did engage in oral sex and 26.3% engaged in anal sex. Many (67.8%) of respondents are exposed to movies and musicals that teach and promote sexual activities. Few (15.5%) of respondents engaged in sexual activities in order to get money to take care of themselves. Some (46.3%) of respondents were encouraged by friends to engage in sexual activities.

Majority (94.8%) of the respondents engaged in unsafe sexual practice while few (5.3%) engaged in safe sexual practices. There was a significant association between age (p = 0.00), sex (p = 0.04), occupation (p = 0.01) and experience of sexual intercourse. Older respondents (OR= 8.29) and males (R= 0.68) are more likely to have sexual intercourse.

Findings reveal that most out-of-school adolescents were sexually active and a substantial majority of them engaged in unsafe sexual practices. Environmental factors and the people adolescents see as models especially their friends influenced their decisions concerning the kind of sexual behaviours to adopt. The need for further expansion and strengthening of information and services to adolescents, particularly for the less accessible out-of-school ones should be encouraged.

Key words: Out-of-school adolescents, sexual debut, sexual activities, sexual intercourse, safe sexual practices.

Word count: 483

DEDICATION

I dedicate this work to the Almighty God who has taken me one step at a time all the way, my caring Parents Prophet (Dr) and Deaconess Okunola, and my loving siblings Elijah, Deborah and Dorcas.

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CERTIFICATION

I certify that this work was carried out by Okunola Esther Inioluwa in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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GLOSSARYOF ABBREVIATIONS

- **STI** - Sexually Transmitted Infection
- **STD** - Sexually Transmitted Disease
- **NDHS** - Nigeria Demographic and Health Survey
- **WHO** - World Health Organisation
- **AAP** - American Academy of Paediatrics
- **USDHHS** - United States Department of Health and Human Services
- **CDC** - Centre for Disease Control
- **NARHS** - National HIV/AIDS and Reproductive Health Survey
- **SPSS** - Statistical Package for Social Science
- **OR** - Odds Ratio
- **CI** - Confidence Interval

OPERATIONAL DEFINITION OF TERMS

- **Adolescent:** An adolescent is a young person developing into an adult. The World Health Organisation defines adolescent as a young person usually between the ages of 10-19 developing into adult (WHO, 2015). For the purpose of this study, adolescents will be regarded as young people within the ages of 15-19 years. This is because previous surveys show that majority of adolescents are sexually active between the ages of 15-19 years (Slap *et al.,* 2003; Orji *et al.,* 2005; Dixon-Mueller, 2009; NDHS, 2013).

- **Out-of-school adolescents:** The term 'out-of-school adolescents' does not refer only to adolescents who are outside of the age-appropriate level of education (i.e. secondary level). Rather, the term denotes adolescents who are definitively not presently enrolled in secondary or any other level of education.

- **Pattern:** Patternin the context of this study refers to the sexual behaviours, safe sexual practices, risky sexual practices and factors influencing risky sexual practices among out-of-school adolescents.

- **Sexual behaviour:** Sexual behaviour refers to the manner in which humans express and experience their sexuality. It is a complex private activity, being subject to social, cultural, and moral issues. It is any activity (solitary, between two persons, or in a group) that induces sexual arousal.In the context of this study by sexual behaviour; sexual debut, use of protection, use of contraception, number of lifetime partners, type of sexual intercourse etc. were considered.

- **Sexually transmitted infection:** An infection transmitted through unprotected sex or genital contact, caused by bacteria, viruses or parasites such as HIV/AIDS, syphilis, gonorrhoea, genital herpes, chlamydia etc.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Knowing a regular way in which young adults and adolescents practice sexual behaviour is vital because it affects having good sexual health in adulthood, the likelihood of having sexually transmitted infections (STIs) and undeliberate pregnancy (Tolman & McClelland, 2011). There are so many wrong beliefs about discussing issues concerning sexuality with adolescents in such a way that a lot of them get information from sources that are wrong and this has dangerous effect on the health of the nation (Famutimi & Oyetunde, 2014).

Although young people aged fifteen to twenty-four years amount to only 19.61% of the population of Nigeria (CIA, 2018), estimates of prevalence and incidence suggest that youths within age fifteen to twenty-four years constitute half of the number of people that acquire all new sexually transmitted diseases. In comparison with people of middle age, adolescents aged 15-19 years and youths aged 20-24 years that have had sexual experience have increased threat to obtain STIs because of the way in which they act or conduct themselves, cultural as well as biological reasons (CDC, 2017). As sexual behaviour goes along with threat for unpleasant consequences such as STIs and unplanned pregnancy, it is also one of the process of healthy growth of young persons to maturity (Sujitar, Ananya and Abhishek, 2015). Late adolescence (15-19 years) especially deserves special attention as sexual debut and a process of testing usually happen during this teenage period (Dixon-Mueller, 2009).

From preceding investigations it has been revealed that disparities are in sexual behaviour by ethnic groups and sex (Fergus, Zimmerman and Caldwell, 2007; Mojola & Everett, 2012). Factors influencing adolescent sexual behaviour include: socio-economic factors, peer pressure and influence, gender norms and values, female genital cutting, influence of parents, influence of religion, media, uncontrolled curiosity, coercion, pornography, unrestrained natural urge, dependence on alcohol and drugs (Aji, Aji, Ifeadike, Emelumadu, Ubajaka, Nwabueze, Ebenebe and Azuike, 2013).

Almost all states in Nigeria have Non-Governmental Organisations conducting researches and interventions amidst out-of-school adolescents, even though the coverage extent geographically vary from state to state. This implies that sexuality programmes among out-of-school adolescents are unattainable equally in every state in Nigeria. Obviously, the programmes may not reach many adolescents in larger percentage of the states (Uche, Isiugo-Abanihe, Olajide, Nwokocha, Fayehun, Okunola and Akingbade, 2015).

Additionally, previous researches has shown that out-of-school adolescents have poor knowledge on sexual health matters (Adogu, Udigwe, Nwabueze, Adinma, Udigwe and Onwasigwe, 2014; Aji *et al.,* 2013; Abubakar, 2011; Odeyemi, Onajole and Ogunnowo, 2009). A research among female adolescents who are out-of-school in Lagos reported that some of participants are unaware that they could get pregnant at their first sexual intercourse, many of them thought no threat was related to sexual intercourse and a good number had wrong idea about abstaining from sex subsequent to the beginning of menstruation, they believed it was dangerous. Many of the respondents also believed that in relationships, having sex is required to express love (Odeyemi *et al.,* 2009).

Researches have revealed that some out-of-school adolescents in Nigeria do not reside with their parents, they live with their boss or sexual partners and are found most of the times in motor parks or market places hawking or assisting others in their shops (Sallah, 2009; Kipp, Diesfeld and Ndyanabangi, 2004; Batwala, Nuwaha, Nulogo, Bagende, Bajunirwe and Mirembe 2006; Adebiyi & Asuzu, 2009). This is the reason most are prone to risky sex and have poor knowledge of sexual health in comparison to their counterparts in school. Adolescents get facts about reproductive and sexual health from a collection of informal origins including peers, magazines and pornography. The unmonitored youths often test the information derived and usually become vulnerable to unwanted pregnancies and STIs, to mention a few (Adogu *et al.,* 2014).

Unlike in-school adolescents, out-of-school adolescents make up an audience not easy to deal with and engage for strategic projects, because of their outspread and occupied schedules. They are always on the move as they struggle to continue to be alive and keep up themselves (Uche *et al.,* 2015). The out-of-school adolescents are not easily reachable, since they are very mobile and not available for follow-up activities (Kipp *et al.,* 2004).

1.2 Statement of the problem

Adolescents usually start having sex prematurely, and they engage in unsafe sex most of the times (Envuladu, Kwaak, Zwanikken and Zoakah, 2017). Most youths in Nigeria begin sexual activities when they are within the school age (Hallett, Lewis and Lopman, 2007) and adolescents girls in Nigeria have great weight of reproductive and sexual health disparities that affects their wellbeing (Iwelunmor, Blackstone, Nwaozuru, Conserve, Iwelunmor and Ehiri, 2017). The ones of 15 to 19 years carry more negative health consequences from sexual behaviour in comparison to the other age groups (Bearinger, Sieving, Ferhuson and Sharma, 2007). From the Nigeria Demographic and Health Survey (NDHS), twenty-three percent of girls age 15-19 have begun childbearing. Adolescents with no education represent about half of those who have begun childbearing, while only two percent of adolescents with more than a Secondary education have begun childbearing. Also, proportion of females age 15-19years who are not educated were 27.8% and that of boys were 16.6% (NDHS, 2013). In 2016, there were 20.3 births for every 1000 adolescent female age 15-19. Worldwide, the rate of adolescent birth in 2018 was 44 per 1000 adolescent females aged 15-19years (WHO, 2018).

A postulate by Ahonsi (2013) that in Nigeria adolescents have reproductive health challenges is buttressed by earlier researches carried out on adolescents' sexual acts in Nigeria (NDHS, 2008; NARHS, 2012; IBBS, 2010) which show that among Nigerian adolescents age 15-19years, about a quarter of males (22.1%) and almost half of the females (46.2%) have engaged in sexual intercourse. There are variations in this figure from state to state, it can be as early as 7 years for some states like Cross River (Diala, Olujimi, Harris and Feyisetan, 2011). Data from a survey conducted by the Federal Ministry of Education (2009) showed that less than a third (21%) of late primary school children have had sex, but only less than half (40.6%) of those who possess multiple sexual mates 12 months before the survey disclosed that condom was used for the rearmost sexual intercourse they had (NDHS, 2008). Without doubts, young people are in disproportionate degree affected by HIV epidemic, although, there is decline in general prevalence of HIV from 5.8% in 2001 to 3.4% in 2012, study showed that 2.9 percent of those infected are adolescents aged 15-19 years (NARHS, 2012).

A study conducted by Fagbamigbe, Adebowale and Olaniyan, 2011, revealed that prevalence of sexual activities increases with age. One hundred and nine of the sexually

involved out-of- school adolescents engaged in this study could remember having sexual experience with one lifetime partner. Data from the 2013 Nigeria Demographic and Health Survey (NDHS) showed that the proportion of females age fifteen to nineteen years who have had coitus within the one year preceding the investigation were 18%. Also, among adolescents of 15-19 years, 4.5% of males and 15.6% of females had their first sex at 15years, also, 21% of males and 53% of females had their first sex prior to age 18 (NDHS, 2013). Although the survey was done for both out-of-school and in-school adolescents, comparing the data above, the patterns of sexual behaviour vary among males and females.

Social and economic factors such as earnings, nature of job, type of accommodation and environment, family size, societal values, influence adolescents' sexual behaviour. The survey among out-of-school girls in Nigeria revealed that most of them were found to be sexually active because they were assumed to look for the ways to add to the sum of money given to them in order to meet up with their fundamental needs (NPC, 2009; Udigwe, Adogu, Nwabueze, Adinma, Ubajaka and Onwasigwe, 2014). The real or perceived rewards from sexual activities, both material and financial, are major attractions to involve in early sex (Ankomah, Mamman-Daura, Omoregie and Anyanti, 2011).

The danger of unsafe sex, having several sexual partners, and STIs, as well as HIV and AIDS is increased by early sexual debut. Engaging in sexual activities early is a potential risk factor for unfavourable health outcome particularly if the age at sexual introduction is very early for the adolescent to have gained the required sexuality education to find a way around relationships (Okonofua, 2011; Erinosho**,** Isiugo-Abanihe, Joseph and Dike, 2012). Early sexual debut is heavily influenced by sexual norms and that have been found to be associated with unintended pregnancy. Pregnancy in a female adolescent is ill timed as their reproductive organs are not matured to cope with the rigors of delivery. Overall, 23% of youths are pregnant with their first child or already mothers (NPC, 2009). The life-threatening complications which young pregnant adolescents who engage in risky sexual behaviours face is numerous and they include pregnancy induced hypertension, anaemia, haemorrhage and vesico-vaginal fistula. Some youths have sexual intercourse infrequently which makes planning for contraceptive use difficult, others experience contraceptive failure and the rate of failure may be higher than in adults due to their lack of experience (Babalola, Tambashe and Vondrasek, 2005). Young people who begin sexual intercourse

early are of greater likelihood to have sex with multiple or high-risk partners and have lesser likelihood to use condoms (WHO, 2000).

Out-of-school adolescents are exposed to an increased risk of sexually transmitted infections due to the reports of their risky sexual behaviour and sexual acts with high-risk groups. These risky sexual behaviours of young people include unprotected sexual activities and having multiple sexual partners (Ajuwon, 2001). The commonest consequences of adolescent sexual behaviours include - unintended adolescent pregnancy, unsafe abortion, risky childbirth from sexual adventures, sexually transmitted infections and HIV/AIDs, premature death from accidents, suicide, dangerous aftermath of alcoholism, drug use, violence, etc. (Famutimi & Oyetunde, 2014).

Sexual behaviour in adolescent is a significant public health issue since it is associated with various health risks. Therefore, this study seeks to explore the patterns of sexual behaviour among out-of-school adolescents, the sexual behaviours they engage in, their risky sexual practices, their protective sexual practices and the factors that promote risky sexual practices among out-of-school adolescents.

1.3 Justification

Given a high prevalence of unintended pregnancies, STIs, increased morbidity and mortality among adolescents, reinvestigating patterns of sexual behaviour and developing interventions aimed at reducing risky sexual behaviours has the potential to have a major impact on public health. A lot of studies on sexual behaviour of adolescents in sub-Saharan Africa including Nigeria target in-school adolescents since they are easier to reach, less stressful to assemble and observe compared to those who are out-of-school. However, most adolescents of the secondary school age in Nigeria are out-of-school (79% of girls and 63% of boys) (NPC, 2008).

Nigerian studies investigating sexual behaviours conducted among in-school adolescents measured method of sex, early sexual intercourse, sexual initiating and experiencing behaviours, factors influencing sexual intercourse, number of sexual partners, oral sex, drug use or alcohol intake prior to sex, contraceptive behaviour, fertility experiences, experience of coerced sex, record of STI and unplanned pregnancy (Okpani & Okpani, 2000; Kabir, Lliyasu, Abubakar and Kabir, 2004; Salako, Iyaniwura, Jeminusi and Sofowora, 2006;

Morhason-Bello, Oladokun, Enakpene, Fabamwo, Obisesan and Ojengbede, 2008; Doyle, Mavedzenge, Plummer and Ross, 2012; Madan, 2013; Badaki, 2014; Famutimi & Oyetunde, 2014; Ayodele & Akindele-Oscar, 2015).

Also, among out-of-school adolescents, few studies conducted assessed sexual debut, multiple sexual partnership, sexual abuse, condom and other contraceptive use, STDs including HIV, pregnancy, pattern of communication, knowledge, perception and prevalence of high-risk sexual behaviour (Bo, Xiaoming, Bonita, Vafa, Sylvie, Igbal and Ronald, 2007; Idache, 2008; Adebiyi & Asuzu, 2009; Owoaje & Uchendu, 2009, Adesola & Akindele, 2013; Envuladu, Agbo, Ohize and Zoakah, 2013; Kannuji, 2014). Data about out-of-school adolescents are still insufficient apart from studies comparing in-school and out-of-school adolescents measuring variables such as: where and who they live with, knowledge of sexual health, sexual debut, sexual activity, number of sexual partners, method of utilisation of contraception, khat & alcohol use, environmental factors affecting sexual behaviour, peer involvement, family situation, knowledge of STI, sources of information and method of prevention (Kipp et al., 2004; Yordanos, 2004; Derege, Atalay, Getnet, Fikre, Frehiwot, Yigeremu, Reta, Wuleta, Tamrat and Tewodros, 2005; Batwala *et al.,* 2006; Sallah, 2009; Abubakar, 2011; Adogu *et al.,* 2014; Ugal & Floral, 2015).

Hence, this study was carried out among out-of-school adolescents in Ibadan reconsidering some of the variables earlier studied among adolescents in-school in other parts of the world but focusing on sexual behaviours, risky sexual practices, protective sexual practices and factors promoting risky sexual practices to determine the patterns of sexual behaviour among this often neglected population. The purpose of this study is to add to existing knowledge and intensify the development of approaches that will positively affect the attitudes of adolescents concerning sex related matters. This study aim to determine the pattern of sexual behaviour including protective and risky sexual practices which will help to design an effective training curriculum for organising an intervention which would assist in empowering out-of-school adolescents on sexual matters and decrease their risk taking behaviours.

1.4 Research questions

- What are the sexual behaviours of out-of-school adolescents in Egbeda Local Government Area?
- What are the risky sexual practices among out-of-school adolescents in Egbeda Local Government Area?
- What are the safe sexual practices among out-of-school adolescents in Egbeda Local Government Area?
- What are the factors influencing risky sexual practices among out-of-school adolescents in Egbeda Local Government Area?

1.5 Objectives of the study

1.5.1 Broad objective

The broad objective of this study is to investigate the patterns of sexual behaviour among out-of-school adolescents in Egbeda Local Government Area.

1.5.2 Specific objectives

- To determine the sexual behaviours of out-of-school adolescents in Egbeda Local Government Area
- To identify the risky sexual practices among out-of-school adolescents in Egbeda Local Government Area
- To determine the safe sexual practices among out-of-school adolescents in Egbeda Local Government Area
- To identify the factors influencing risky sexual practices among out-of-school adolescents in Egbeda Local Government Area

1.6 Study variables

The study variables include independent and dependent variables.

- Independent variable: Socio-demographic characteristics such as age, sex, marital status, occupation, religion, and state of origin.
- Dependent variable: Patterns of sexual behaviour among out-of-school adolescents.

1.7 Hypothesis (Ho):

i. There is no significant association between age of respondents and experience of sexual intercourse.

ii. There is no significant association between sex of respondents and experience of sexual intercourse.

iii. There is no significant association between occupation of respondents and experience of sexual intercourse.

iv. There is no significant association between age of respondents and safe sexual practice.

v. There is no significant association between sex of respondents and safe sexual practice.

vi. There is no significant association between occupation of respondents and safe sexual practice.

vii. There is no significant association between age of respondents and risky sexual practice.

viii. There is no significant association between sex of respondents and risky sexual practice.

ix. There is no significant association between occupation of respondents and risky sexual practice.

CHAPTER TWO

LITERATURE REVIEW

2.1 Adolescence

Adolescence is a suitable time to build healthy lifestyles and habits pertaining to sexual and reproductive health, since it is a stage of current physical, social and emotional change, also the time of life when many persons start developing relationships with others and trying out their sexuality. Adolescence is a crucial time of growth which is generally interpreted as the years between the beginning of puberty and the demonstration of self-reliance (Steinberg, 2014). The age of adolescence is a stage in life when young people are especially exposed to a lot of risks, particularly in reference to their sexuality; they are often deprived of access to counselling, sufficient information, and services concerning matters vital to the needs of their growth (Isiugo, 2011).

The World Health Organization (WHO) defines "adolescents" as persons between 10 and 19 years, "youths" between 15 and 24 years, and "young people" between 10 and 24 years (WHO, 2015). In 2015, the U.S. Department of Health and Human Services defines adolescents as ages 10-19 and young adults as ages 20-24 (USDHHS, 2015). Also, the American Academy of Pediatrics recommendations for pediatric preventive services highlights adolescence as the ages of 11- 21 years (AAP, 2015). The Centre for Disease Control and Prevention's Youth Risk Behaviour Surveillance System is constructed using a high school sample, grades 9-12, rather than age (CDC, 2015). Some researchers separated young people into early adolescence (10 to 14 years), late adolescence (15 to 19 years), and young adulthood (20 to 24 years) (Irwin, Burg and Cart, 2002). The U.S. Census Bureau used various constructs for the adolescent population dependent on the specific topic including 12-17 and 15-19 (U.S. Census Bureau, 2015).

From Nigeria Demographics profile, 2018 young people age 15-24 years make up 19.61% of the population. There is enough evidence that adolescents are exposed to unacceptable social behaviours particularly drug abuse and unsafe sexual practices (Isiugo, 2011; Fawole, 2011). Adolescent sexual behaviour has been of public concern, in Nigeria like other parts of the world because of increased physiological changes that occur in adolescents.

2.2 Out-of-school adolescents

Approximately, 61 million adolescents of lower secondary school age and 138 million of higher secondary age are out-of-school and exempted from any level of education (UNESCO, 2018). From the Institute for Statistics database of United Nations Educational Scientific and Cultural Organisation, majority of the adolescents out-of-school are found in South and West Asia (40%), and sub-Saharan Africa (30%). A total of 70% of all out-of-school adolescents are accounted for in these two regions. Notable numbers also exist in East Asia and the Pacific (15%) and lesser in the Arab States (6%). Variably, number of out-of-school adolescents contributes 3% or less to the global total in Latin America, Central and Eastern Europe, Central Asia, as well as North America and Western Europe

Globally, about 120 million children of school-age are out-of-school and over 50% of these are girls; a third of these children are in Sub-Saharan Africa and 10% in Nigeria (Egbochukwu and Ekanem, 2008). Previous researches in Nigeria revealed that in-school adolescents are sexually active (Adegbenga, 2002; Oladepo, 2000). Study has shown that out of every four in-school adolescents in Ibadan at least one is sexually active and most of the sexually active ones involve in risky sexual practises. Besides, research also showed that male students are more sexually active than their female counterparts. Also, it is distressing that anal sex is discovered among these students at high rate. This makes them vulnerable to various medical complications including genital cancers, STIs and HIV/AIDs (Morhason-Bello *et al.,* 2008).

The proportion of out-of-school adolescent is high for many developing countries. In Nigeria, for example, out-of-school youth (15–24 years) make up 54.2 percent of the total youth population (Fawcett *et al.,* 2010). This suggests that a substantial percentage of the youths are either not educated or their knowledge is inadequate. But, this does not mean that series of services and activities are not drawn out to some group of out-of-school adolescents in some states in the country. Hence, there is need to consider the quality of sexuality and life skills education presented to out- of-school adolescents, extent of coverage of sexual educational services, the methods of delivery of such services and organizations involved, and the results and oppositions facing sexuality and life skills education among out-of- school adolescents (Uche *et al.,* 2015). A study found that age is one of the characteristics of adolescents that is associated with their sexual behaviour, the

older adolescents were found to be sexually active more than the younger ones and those out-of-school were also more sexually active than those in school (Envuladu *et al.,* 2013).

The economic situation in a lot of developing countries like Nigeria have caused the development of adolescents into healthy adults to be very hard and this may describe the reason why sex with negotiation in terms of money or gifts is rampant among female adolescents (NPC, 2009). A study conducted in Iwaya community (Lagos, South-West Nigeria) among 480 out-of-school girls aged 10–19 years examined the relationship between forms of basic need (food, shelter, and clothing) and sexual outcomes (timing of onset of penetrative sex and involvement in multiple sexual partnerships). Analysis of the timing of onset of sex and a regression analysis for involvement in multiple sexual partnerships revealed that among the forms of lack of basic necessities explored, need of food is the only one that significantly predicts the timing of sexual debut and participation in multiple sexual relationships (Kannuji, 2014).

The sources of life skills and sexuality education among out-of-school adolescents are church, relatives, the media, internet, films/movies, friends, hospitals/clinics/health centres, and patent medicine dealers. Facts on the content of the sexuality and life skill education programme that out-of-school adolescents were engaged in shows that issues relating to HIV/AIDS and prevention of other STIs filled the list. Prevention of unplanned pregnancies ranked second among issues out-of-school adolescents were exposed to. This pattern is exceptional to Lagos and Oyo (south-west), Imo (south-east), Akwa Ibom (south-south) and Niger, Plateau and FCT in the north-central region of Nigeria. (Uche *et al.,* 2015).

An intervention study was carried out in two markets within Lagos, Nigeria to determine the effect of a community-based sexuality education programme on the sexual health knowledge and practices of out-of-school female adolescents. Respondents were interviewed on their sexual health knowledge and practices. A sexuality education-entertainment programme was presented to adolescents in the Mushin market only (intervention group), followed by post intervention study conducted after six months in the Mushin market and Sangrouse market (control group). The pre and post intervention surveys were juxtaposed to examine if there is any change. Sexual health behaviour and knowledge was indistinguishable among participants in both markets pre-intervention. After intervention, the sexual health knowledge of the participants in the intervention site

became better significantly ($p < 0.05$). Although amidst the sexually active, there was no significant improvement in their condom use and number of sexual partners, there were lesser adolescents who started engaging in sexual activities in the intervention site than in the control site and there was increase in contraceptive use (Odeyemi, Onajole, Ogunowo, Olufunlayo, and Segun, 2014).

A study conducted to determine the impact of internet exposure on sexual behaviour of young persons in an urban district of Southwest Nigeria inferred that about half (49%) of the respondents had their first use of internet between the ages of 15-19 years. Source of information about the internet was friends (63.3%) and majority (99.3%) accessed the internet from cybercafé. Many of the respondents (seventy-two percent) had tripped on pornographic sites while making use of the internet. Reactions to this included taking a brief or hurried look before closing (45.2%), discontinuance of the sites (38.5%), and minimizing page to view later (12.5%). Influence on behaviour of young persons after exposure included participating in oral sex (48.3%), having multiple sexual partners (11.6%), body tattoo (18.3%), and homosexuality (5.0%) (Arulogun, Ogbu and Dipeolu, 2016).

2.3 Sexual behaviours among adolescents

Some researches carried out among adolescents in the age group of 10 to 19 years in different countries showed that the frequency of sexual activity was 48.7% in America (Eaton, Kann, Kinchen, Shanklin, Ross, Hawkins, Harris, Lowry, McManus, Chyen, Lim, Brener and Wechsler, 2007), 38% in Italy (Giannotta, Ciairano, Spruijt, and Spruijt-Metz, 2009) 46% in South Africa (Palen, 2009), 11% in Burkina Faso (Guiella, 2007), 22% in Nigeria (Fatusi and Blum, 2008), and 56.6% in Turkey (Aras, 2007). The variations may be as a result of dissimilar features of respondents per country, different cultural background, and different socioeconomic environment.

In the United States, 5.6% of high school pupils disclosed that they had their first sex before age thirteen, fifteen percent reported that they had four or more sexual partners so far in life, and more than half 59% of sexually active high school pupils used a condom during their last sexual intercourse (CDC, 2014). According to National Demographic Health Survey, 15.6% of females' age at sexual debut was within age 15-19 years, also 2.9% of males' age at sexual debut was within age 15-19 years, 29.1% of 15-19 years females had

coitus within the four weeks prior to the interview and 4.5% of 15-19 years males had sexual intercourse within the four weeks prior to the investigation (NDHS, 2013). Engaging in sex early is an indicator for more risky sexual behaviour, and is related to greater probability of sexually transmitted infections (Kirby and Lepore, 2007).

It is generally known to everyone that coital occurrence is mutually related with exposure to unplanned pregnancy and spread of sexually transmitted diseases. Individuals who expose these young persons to sexual initiation also play a very important part in the perception of the young persons in relation to whether they liked the experience or not. Forced sexual initiation is known to have negative scars on the psychic composition of adolescent and early initiation has always left them with problems that often show in later life (Ugal and Flora, 2015).

Sexuality of adolescents is usually considered from a pessimistic aspect that focuses specifically on sexual behaviour and its relationship with other risky behaviours. Sometimes, there are bad opinions about youths as individuals unhealthily obsessed with sexual activity, extremely interested in sex, desire sexual intercourse uncontrollably and hormone-driven who have assume independence of adulthood without the demands of adulthood (Adejumo, 2011). Sexual activities involving sexual attractions to people of the opposite sex are included among forms of behavioural challenges common among Nigerian adolescents. These are given several names in the previous studies as sexual immorality, sex abuse, sexual misconduct, sex crimes, sexual promiscuity, and sexual maladjustment (Ndu, 2000; Nnachi, 2003).

Although global fertility rates have dropped to a great extent years back, many adolescent females between the ages of 15 and 19 have already started child bearing, with variations existing between geographic regions. The 2014 World Health Statistics shows that the average global birth rate among 15 to 19 year old adolescents is 49 per 1000 girls, with country rates ranging from 1 to 299 births per 1000 girls (WHO, 2014). Getting pregnant and giving birth early can have serious social and health aftermath and is the second cause of death among girls below 19 years old. A leading cause of death among adolescent females is complications during pregnancy or childbirth (WHO, 2011). Adolescent females who are carrying a baby are more likely to drop out-of-school and stop education, which limits their future life opportunities and employment (UNESCO, 2017).

Seven hundred and sixty-eight senior secondary school girls from Port Harcourt were randomly selected and surveyed to determine their contraceptive use and sexual activity. Six hundred and five (78.8%) of the girls are sexually exposed and one hundred and forty two among these have had two hundred and ten pregnancies (24 deliveries and 186 induced abortions) altogether. The mean age of onset of sexual activities was 15.04 and youngest ages of initiation into sexual activity was 12 years. During the time of the research, one hundred and ninety girls (24.7%) were sexually active and 74.2% of their male partners were older men. Awareness of the connection between sexual activities and sexually transmitted infections was high (72.4%), knowledge of effective contraceptive methods was low (56%), and most of the sexually active girls limit their use of contraceptive method to the withdrawal method. Respondents were exposed to more than one sexual partners and a high level of parental support to their use of birth control methods was discovered (Okpani & Okpani, 2000).

Also, in a study conducted among in-school adolescents in Owerri, Nigeria, a substantial amount of respondents have sexual experience. Among those who have had sex, a greater number have had it more than four times in the six months before the study. Majority have had more than one sexual partner. While many have had sex with an unascertained partner, many of the respondents used condom occasionally, majority were uncertain about future plan to use any form of protection. All the participants affirmed that they know the aftermath of risky sexual behaviour, such as STD/ HIV / AIDS, unplanned pregnancy resulting to parents abandoning them, dropping out from school, and aborting pregnancies which may lead to death. Association between adolescents' risky sexual behaviours and the age at onset of sexual intercourse was found to be significant (Nwankwo and Nwoke, 2009).

A study was carried out among female adolescents in a rural community in Plateau state Nigeria, Most of the participants who have engaged in sexual activities were within the ages of 16-19years. Many (67.7%) disclosed that they had heterosexual relationship and about half of them agreed that they engage in sexual intercourse with the opposite sex. Most of the respondents that have had sexual intercourse were those that are not living with their parents, not presently enrolled in school, of parent not living with a spouse and those that are from families with more than one spouse. Among those who have had sexual

intercourse, many (67.7%) have ever used condom and only half (50.5%) of them used condom for their last sex. The main basis they gave for unprotected sex was that their partners refused and they lack knowledge of the need to use any method of protection (Envuladu *et al.,* 2013).

Before now sex in Southwest Nigeria was regarded as worthy of high value and restricted to older men and women that are married but now it is common among adolescents (Alo, 2008). Information derived from public opinions have indicated that premarital sex is not morally correct and harmful to health, leading to adolescent mothers, abortions and STIs (Finer, 2007). The knowledge of premarital sex significantly influence sexual behaviour of adolescents (Badaki, 2014).

A study was conducted in six secondary schools in Ikenne Local Government, South West, Nigeria among in-school adolescents to determine the sexual behaviour, use of contraceptives and incidence of fertility of the adolescents. The study showed that sexual intercourse had been experienced by 28.5% of the respondents, significantly more males have experienced sexual intercourse than females, out of these, 26males and 23 females were married. Respectively, the mean ages at onset of sex were 13.9 +/- 2.8 years and 14.8 +/- 2.4years for boys and girls. Knowledge of birth control was 36.9% for males and 22.1% for females, which may be ascribed to expansion in consciousness of the condom among males. There was low present use of any form of birth control and it was found to be 10.9% for males and 6.0% for females. The main basis for non-usage were cost, negative attitude towards contraception due to societal believe that it is bad, non-availability and poor knowledge of contraceptive practice. 26.8 percent of the respondents had ever experienced symptoms related to sexually transmitted infections (Salako *et al*., 2006).

An investigation was conducted in tertiary institutions within Ilorin, Kwara State, Nigeria which examined the patterns of sexual behaviour and contraceptive practices among young students between the ages of 15 and 24 years; 98.6% of the respondents were not married, percentage of those that have had sexual intercourse is 77.6% and many (67.8%) of these have had an unplanned pregnancy, while 63.5% have had a deliberate termination of pregnancy. Almost all the participants knew about contraceptive methods, but less than a third (25.4%) have ever used any birth control method. The most occurring origin of information about contraception among the participants were peers and relatives, the most

rampant cause of non-usage was fear that modern contraceptives have side effects (Abiodun and Balogun, 2009).

A community-based study to determine the age of sexual debut and patterns of sexual behaviour conducted among young people in two Local Government Areas in southern Nigeria found that the mean age of sexual debut among unmarried boys and girls were 17 years and 18 years respectively, many of the respondents have had sex before age 16. Unmarried girls and boys started sex faster than the married older participants. 14% of the wedded males have other sexual partners apart from their wives, also 12 percent of unmarried masculine respondents with consistent sex partners have other casual sexual partners. In sexual relations involving casual sexual partners, use of condom is fairly high. There is higher probability of alcohol use when engaging in sexual intercourse with casual sexual partners. This indicates high frequency of spontaneous or unplanned sex and transactional sex and under the effect of alcohol, which has indications on the spread of HIV and AIDS (Isiugo-Abanihe, Erinosho, Ushie, Aderinto, Sunmola and Joseph, 2012).

A survey which aim to determine the sexual behaviours and danger of HIV among public secondary school students in Nigeria was conducted in eight public secondary schools in Osogbo, Osun State, South-Western, Nigeria. Five hundred and twenty-one students with the aged 10-19 years participated in the study. Data relating to their sexual behaviours and influencing factors were obtained. Many of the participants (74.3%) were late adolescence (15–19 years) and many of them knew the results of sex before marriage as feeling of guilt, unwanted pregnancy, STI/HIV/AIDS, and uncompleted education. Less than half (40 percent) of the participants had engaged in sexual activities with their classmates, teachers, neighbours, older men, strangers at parties or sex workers. Age at onset of sex was 15.2 +/- 1.62 years. Among respondents who were sexually active, 78.1 percent practiced heterosexual intercourse, 11 percent practiced oral sex, 12.4 percent practiced anal sex and 13.3 percent practiced homosexuality. More than a third (36%) of those who were sexually active had multiple partners, and few (14.8%) know that their partners had other sexual partners elsewhere. 41.9 percent had never used a condom at all and only 8.6 percent used condom consistently. More than half of the sexual practices engaged in by these adolescents were unplanned. The major causes given for participating in such acts were impact of peers, effect of drugs, financial reward and experimentation or fun (Bamidele, Abodunrin and Adebimpe, 2009).

Of the 19.7 million incidence of STIs in 2008, young people ages fifteen to twenty-four constitute almost half (9.8 million) (Satterwhite, Torrone, Meites, Dunne, Mahajan, Ocfemia and Weinstock, 2013). In a study carried out in Ibadan, Nigeria, findings showed that adolescents make-up between 3.3% and 4.8% of the amount of clients attended to in the STI clinic yearly, 133 (94.3%) were single, 54 (38.3%) were aged 19 years and 79 (53.2%) were females (Fawole, Ajaiyi, Babalola, Oni and Asuzu 1999).

2.4 Risky sexual practices among adolescents

The centre for disease control (CDC) described risky sexual behaviour as the way sexual activities are expressed which expands an individual's possibility of acquiring sexually transmitted infections and experiencing unwanted pregnancies. Risky sexual practices involve engaging in sexual intercourse at a tender age, exposed sexual behaviours, having diverse sexual partners and engaging in sex under the effect of drugs and alcohol (CDC, 2010). A research conducted among in-school and out-of-school adolescent girls showed that about 21% of the respondents were involved in risky sexual behaviour and this was greater among the out-of-school adolescents than their counterparts in-school (Adogu *et al.,* 2014). Previous WHO report revealed that many adolescents involve in unsafe sexual activity without protection and majority had their first sexual intercourse by a deceptive compulsion by their partner (WHO, 2001). Studies establishes that many young people engage in risky sexual activities including early initiation of sexual activities, inconsistent and low use of condoms and sex with many partners, (Ajuwon, 2005).

In a study conducted in Mombasa among youths in colleges and youth centres, majority (70%) of the youth reported being involved in sexual activities. The mean age of sexual debut of youth in colleges was 19yrs and for youth in youth centres it was 17yrs. The findings revealed that the youth were involved in diverse and highly risky sexual practices both at onset of sexual activities and subsequently. Unusual routes of penetration were reported, and oral and anal penetration accounted for 10.4% and 4.4% of the penetrations at sexual debut. Rape and sex for financial reasons each accounted for 8.4% of the sexual debuts. The study reflected subsequent high risk sexual behaviours in the youth; 20.7% of the youth report alcohol intake at last sexual contact and 11.8% of the youth revealed that they had transactional sex in the past year. Only half the youth reported using condoms at sexual debut and at the last sex. Of the female who had sexual penetration about one third had had a pregnancy and one fifth of those had procured an abortion. Study participants

especially the younger generation reported oral sex as being a stepping stone to vaginal penetration and half of those who had oral sex were less than 15 years of age at debut. These young persons reported oral sex as being safe, in avoiding unwanted pregnancies and maintenance of virginity (Hafsa, 2012).

A significant number of out-of-school adolescents engage in unsafe sex. Among Ethiopian in-school and out-of school adolescents who participated in a study, the intake of alcohol and khat has a significant relationship with risky sexual behaviour. More than 20% of out-of-school adolescents had unprotected sexual intercourse within 12-months before the study in contrast to 1.4% of the in-school adolescents. Intake of khat daily has a relationship with unsafe sex and there was a significant and linear association between alcohol intake and unsafe sex. There was no association between use of other substances apart from khat and unsafe sex, but with beginning of sexual activities (Derege *et al.,* 2005). Also, among the 628 study participants enrolled in a descriptive study to examine the factors that make out-of-school youths prone to HIV/AIDS-related risk behaviours conducted in Northwest Ethiopia, many (64.8%) had been involved in sexual intercourse before the period of the study and the average age at sexual debut was 17.7 $\pm$2 years. Among those that are sexually active, a third (33%) had sexual intercourse with casual partners and there was low (36%) consistent condom-use among those who engaged in transactional sex. Intake of alcohol, khat, poor educational background, and male gender had significant relationship with having sex with either a non-regular or a commercial sexual partner (Hibret, Damen, Kassahun and Gail, 2007).

In a study conducted in Addis Ababa, Ethiopia to describe sexuality patterns and assess socio-economic and cultural correlates of high-risk sexual behaviour. Over 60% of the respondents were in school and nearly one third (28.1%) were sexually active, 66.2% of these are males. Close to half (46.5% percent) of the sexually experienced adolescents had multiple sexual partners and 2.3% had history of sexually transmitted diseases. More than a third (36.5%) of respondents used condom at first sex and 30.8% use it regularly, 20.3% of the sexually active males have had sexual intercourse with commercial sex workers and the same proportion of girls had been pregnant (Yordanos, 2004).

Reports from a survey conducted among in-school and out-of-school adolescents aged 10 to 19 in five sites in Tanzania revealed that about one third (32percent) of adolescents are

sexually active and a larger percentage of these are boys. The sexual practices investigated and reported include masturbation, oral, vaginal and anal sex. Among the sexually active adolescents, about 15% disclosed that they have more than one sexual partners and notably, more males have many partners than females. About 42percent of sexually active adolescents disclosed that they used condom during the last sexual act and females dislosed having sex with partners whose age are higher than theirs at sexual debut (Method and Melkiory, 2009). Also, a study conducted in Tanzania among adolescent students to describe the patterns of sexual behaviour shows that 40.7% of the participants had experienced sexual intercourse, 17.6% have had multiple sexual partners, 53.8%, 52.5% and 42.5% of the respondents engaged in necking, French kissing, and breast fondling respectively and most of the participants had used contraceptives. The mean age was significantly lower for kissing, hugging and breast fondling when compared to the sexual intercourse. The main reasons participants gave for sexual debut were peer pressure and just for fun (Madan, 2013).

Doyle *et al.,* 2012 carried out a study to describe the sexual and reproductive behaviour of adolescents 15-19 years in sub-Saharan Africa, and inferred that about 25% of the respondents have had sex before age 15 and this percentage becomes smaller overtime in a number countries. In some countries, 5% of females said that they are married and more than 20% had commenced childbearing before age 15. Among the least educated females or those in the rural areas, early sexual initiation and childbirth were more rampant. Having many sexual partners was more rampant among boys compared with girls. Males and females in the urban areas, and females with more schooling, have more probability to disclose having many partners and condom use.

The findings of a research conducted to determine some psychological inclinations associated with adolescents' sexual behaviour among Nigerian adolescents revealed that 78.8% (1159) males have girlfriends and 75.5% (1111) have once had sexual intercourse while 66.8% (987) females have boyfriends and 64.7% (956) have once had sexual intercourse. Out of the 75.5% male and 64.7 percent female that has once had sexual intercourse, all the 75.5% male and 62.9% female has had coitus in the past six month. The participants' sexual life revealed that 7.2% males had experienced forced sex while 33.9% of female experienced same. It was revealed further that male adolescents (61.7%) are more protruding in sexual initiating behaviour such as wooing, touching compared to their female

counterpart (29.6%), while both male (68.5%) and female (64.3%) adolescents are sexually active. The average age of sexual initiation for male was 15.5 years and 13.5 years for girls; while the average number of sexual partners for male was 3.5 and 1.5 for female. This study implied that psychological inclinations to a great extent influence adolescents' sexual behaviour. Specifically, gender effect on the psychological inclinations associated with adolescents' sexual behaviour indicated that male reported significantly higher quality of internal control, relational self-esteem, motivation and satisfaction. The female on the other hand have higher quality of relational obsession, consciousness, anxiety, self-assertiveness, depression, monitoring and fear. The only assumption that can be deduced from these findings is that both male and female adolescents of today cannot distinguish between love, infatuation, and sex. To them sex is love (Ayodele & Akindele-Oscar, 2015).

An investigation carried out among students in tertiary institutions in Kano Nigeria shows that more than half of the participants (53%) had sexual intercourse at least once, more males had three or more sexual partners compared to females and anal sex has been experienced by only 12% of the respondents while 32% admitted to engaging in oral sex. About 30% of the respondents admitted to ever having STI, while 19% admitted to ever involved with a sexual partner who had STI. Of those who use condoms among the sexually active respondents, only 24.5% use it always, 18.2% use it regularly, 28.9% use it sometimes while 28.3% never used it. Only 19% of the respondents perceived themselves as being at high risk even though above half of the sexually active participants have many sex partners and only about a quarter of them use condom always. Majority of the respondents (56%) had poor knowledge of what acts constitute high-risk sexual behaviour and the implications of such acts (Kabir *et al.,* 2004).

Results of another study conducted among in-school and out-of-school adolescents in Kano State, Nigeria to determine the sexual behaviour and knowledge of sexually transmitted disease (HIV/AIDS included) among adolescents showed that respondents' attitude toward sexuality was positive. The greater the degree of knowledge of HIV/AIDS of the teenage respondents the more positive attitude to premarital sex, prostitution and engaging multiple sexual partnership and sex education. The out-of-school respondents were discovered to be more sexually active, are earlier sexually exposed and there is low and infrequent use of condom among sexually active ones. Their general knowledge of STD/HIV/AIDS is not only uncertain and inadequate but also hidden in misconceptions and strong emotion. 6.2%

of the entire student have sexual experience 8.9% of in school and 17.4% of out-of-school respondents have had six sexual experiences. Among the sexually active respondents 31% of them have multiple sexual partners while only 2.2% of the overall sexually active boys and girls uses condom (Abubakar, 2011).

A study conducted among in and out-of-school adolescents in Cross River State, Nigeria depicted that adolescent sexual debut is relatively young. Majority (80%) of participants had sexual intercourse before 18 years, only fifteen percent of the respondents had their sexual initiation at about nineteen years and above, almost forty percent of respondents accepted to have had their first sex with a regular partner. This response does not only capture the status of their sexual activity, it also assesses the age at which adolescents enter into relationships that lead to sex. The data showed that they begin relationship quite young and this leads to having sexual debut. Data portrayed that only about thirteen percent of respondents were forced into sexual initiation while almost ninety percent claimed that they were not forced. About sixty percent of respondents also said they did not like the experience of their sexual initiation. It is quite clear that young people enter into sexual relationship consciously and willingly. From the responses presented in this study, there has been no indication that adolescents have remorse on their sexual escapes (Ugal and Flora, 2015).

A research carried out in Anambra state of south eastern Nigeria to examine the pattern of risk-behaviour among students of tertiary institutions inferred that the patterns of sexuality amongst students in the higher educational institutions may be indifferent or even worse than what is obtained among out-of-school adolescents. Unprotected sexual intercourse with more than one partner is indeed a risky sexual behaviour that puts the individual involved at higher risk of sexually transmitted infections and unplanned pregnancy. It is discomforting to note that majority (63.2 percent) of the sexually active participants were having sex with multiple partners and 27.4percent are engaging in sex with as much as six or more partners while only 36.8% had a single sexual partner in one year before the study. Adolescents usually participate in sexual testing and are unknowledgeable about the related negative outcomes. This reason may be connected to their multiple sexual partnership (Adinma, Osita and Adinma, 2016).

Unsafe sexual behaviour is one of the health risks assessed in a study conducted in Kogi State, Nigeria to examine the frequency and demographic pattern of health risk behaviours among out-of-school adolescents. It was discovered that 1411 adolescents (78.2%) have engaged in heterosexual intercourse, 519 adolescents (28.7%) used condom as a form of protection the first time they had sexual intercourse, 363 adolescents (20.1%) had sexual intercourse with strangers, 362 adolescents (20.1%) have been sexually abused by somebody in the past 12 months, 279 adolescents (15.5%) have terminated or assisted in termination of pregnancy in the past 12 months while 211 (11.7%) have become pregnant or impregnated someone in the past 12 months. Except for non-utilization of condom at first sexual intercourse (71.3%), on the average, adolescents' responses indicated that unsafe sexual behaviours were prevalent (29.1%) among adolescent (Idache, 2008).

A study conducted in a sexually transmitted disease (STD) clinic, Ile- Ife Nigeria to determine the sexual behaviour in adolescents and young people attending the clinic showed that adolescents and young people are sexually active and their sexual behavioural patterns are risky. They constitute 30percent of the population of clients patronizing the STD clinic within the time of study. All the sexually active youths reported vaginal sexual intercourse and the age at which they started engaging in sexual activities was between 10-20 years in 80% of respondents. Sexual debut was rapid among females than males, 23.6percent of females have started sexual intercourse earlier than 18 years in contrast to 12.9percent among the males. The mean figure of sexual partners was greater among the males. 85% of participants practiced risky sexual behaviour, there was frequent patronage of casual partners especially after alcohol intake, 10% have had sex with commercial sex workers, there was poor use of condom and number of sexual partners ranged between one and five (Olasode, 2007).

Owoaje and Uchendu conducted a study in 2009 among youth aged 15–24 years in the major markets, motor parks, and commercial areas in two local government areas in Ibadan to determine the sexual risk behaviours of young people on the streets of Ibadan, South-west, Nigeria. Information was obtained on sexual behaviours, condom use, and history of sexually transmitted infections. Most of the participants (68.8 percent) were males, and 79 percent have sexual experience. More females (53.9%) disclosed that their initial sexual partners were older than them for five years or more compared to males (34.5%), condom was used for the first sex by only 32.2 percent of respondents and 18.2 percent reported

having sex with someone who collects money in exchange for sexual activities or engaging in transactional sex.

The findings of a research conducted among secondary school adolescents in Ibadan revealed that most of the participants were engaged in unsafe sexual behaviour, masturbation, early age of sexual initiation, and oral sex. Socio demographic characteristics such primary care giver and tribe had notable effect on adolescents' risky sexual behaviour. The research revealed that students whose ages fall within 10-14 years have more probability to practice risky sexual behaviour than those whose ages fall within 15-19 years. Female pupils were discovered to less likely involve in risky sexual behaviour than their male counterparts (Famutimi and Oyetunde, 2014).

A study assessed the connection between early sexual debut, risky sexual behaviours and sexually transmitted infections (STIs) among young males in Nigeria. The research made use of the representative of sexually active unmarried young males aged 15–24 years from the 2003 and 2005 National HIV/AIDS and Reproductive Health Surveys (NARHS) and engaged 1,278 Nigerian males. Logistic regression was used to assess the statistical association between early age at sexual initiation (<16 years) and self-announced STIs within one year before the study. The demographic characteristics, sexual behaviours, and psychosocial measures were controlled for. The findings showed that 6.8% of respondents had features of STI. At bivariate analysis, early age at sexual initiation, having several partners, coexisting partners, and sex with irregular/commercial partners were related with STIs and at multivariate analysis, early sexual debut remained significantly associated with STIs. Multiple sexual partnerships were also notably connected with STIs, and is an intermediary of the relationship between early age at sexual initiation and STIs (Fatusi and Wang, 2009).

2.5 Safe sexual practices among adolescents

The solution to elimination of unpleasant reproductive health results is the use of medical contraceptive methods (Bearinger *et al.,* 2007). A research juxtaposing the usage of such methods in national representatives of sexually active female adolescents revealed that adolescents in the United States of America reported less (42percent) use of contraceptive pills, implants, injectables and intrauterine devices at last sexual intercourse than girls from France (50percent), Canada (64percent) and the UK (69percent). In the developing

countries, there is lower use of medical birth control methods among female adolescents other than in fully grown women (Darroch, Singh and Frost, 2001). In sub-Saharan Africa, extremely little percentage of sexually active females aged 15–19 years that are not married, used medical birth control methods at last sexual intercourse (for instance, 4percent in Benin, 5·2percent in Zimbabwe, 8percent in Uganda, 10·7percent in Kenya and 12·4percent in Mali) (INSAE, 2001; CBS, 2003; UBOS, 2001). Young females often go through difficulties when trying to look for medical birth control methods, including inadequate understanding of current methods, restricted access to services, also health-care givers who effectually prevent the use of these methods by adolescents (Glasier, Gulmezoglu, Schmid, Moreno and Van, 2006).

A research carried out on adolescents in Greece showed that although use of condom is generally accepted among the adolescents, only half (50%) of adolescents used condoms regularly during sexual intercourse, while only 32% used condoms throughout sexual intercourse (Tsitsika, Greydanus, Konstantoulaki, Bountziouka, Deligiannis, Dimitrakopoulou, Critselis, Tounissidou, Tsolia, Papaevagelou, Constantopoulos and Kafetzis, 2010).

Bo *et al.,* 2007 conducted a study in China among out-of-school youths and found that, among youth who disclosed that they have had sexual intercourse, prevalence of contraceptive use was similar among boys and girls. Less than half (40percent) of the respondents used a contraceptive method most of the time while less than a third (32percent) used it sometimes and 29percent have never used a contraceptive method. The most common method of contraception used by the respondents was condom (73percent), followed by oral contraceptive pills (38percent) or withdrawal method (36percent). About one quarter of the respondents disclosed that they used menstrual timing (safe period) and 7percent used emergency contraceptive pills.

A research in Nigeria showed that only 54 (29.8%) in-school adolescents and 80 (40.8percent) of the out-of- school adolescents said that either themselves or their partners ever used condom when engaging in sexual intercourse. Altogether, more than a third (35.5percent) of the sexually active respondents ever used condom. Nevertheless, more investigation of those who said they have used condom revealed that only 6 (10.7%) of the in-school adolescents or their partners make use of condom frequently while larger number,

50 (89.3%) utilized it periodically. However, among the out-of-school adolescents, a larger proportion, 14 (20.6percent) made use of condom frequently and 54 (79.4percent) utilized it periodically. Comparison across groups revealed that higher number of out-of-school adolescents used condoms regularly than the in-school adolescents (Fagbamigbe *et al.,* 2011).

2.6 Factors influencing risky sexual practices among adolescents

Adolescents with home environments that are not emotionally or mentally healthy (new demise, divorce, not residing with parents), peers that are sexually active, and those that obtain information about sex from siblings or friends have greater likelihood of being sexually active (Tsitsika *et al.,* 2010). In the case of sexual debut, strong associations have been found between adolescent sexual behaviour and factors such as living with both biological parents, having a high level of religiosity, interpersonal relationship between members of the family, education, connectedness of the adolescents to parents and school, having a higher socioeconomic status, confidence that parents or other adults feel concern and have great belief in adolescents and higher achievement in school (Ekundayo, Dodson-Stallworth, Roofe, Aban, Bachmann, Kempf and Jolly, 2007; Fatusi & Blum, 2008).

In a study conducted in Addis Ababa, Ethiopia to describe sexuality patterns and assess socio-economic and cultural correlates of high-risk sexual behaviour. Youths with strong parental monitoring and who discuss sexual matter with parents demonstrated less indulgence in sexual activity. Living in the inner city, and having sexually active friends and involvement with immoral peers were correlates of sexual risk taking within the extra-familial system. The focused group discussion and the cases also confirmed the survey findings and further revealed that socially disadvantaged youth such as commercial sex workers and street youth were more at risk than others whereby the influence of familial and extra familial systems predominate (Yordanos, 2004).

According to a study conducted in China among out-of-school youths targeting sexual inclinations, mode of communication and sexual behaviour, male or female youths who do speak to their fathers about sex are very few, a comparatively large proportion of female youths do speak to their mothers about sex (33–38%). Both boys and girls preferred to discuss sexual matters with their friends. Age, parent's training and disposition concerning prenuptial sex, family structure, educational level, dating as well as communication

between parents and youths on issues about sex were notably connected with youth premarital sex (Bo *et al.,* 2007).

A study targeting unsafe sexual behaviours conducted among adolescents in Cameroon found that, the mean age at sexual debut was 15.6 for boys and 15.8 for girls. Curiosity was the disclosed basis for beginning sexual activities. More than a third 37percent of girls and 30percent of boys, stated that their initial sexual involvement was permissive. There are vital circumstances influencing beginning of sex prior to 16 years of age which include father's nationality and schooling. The factors that are most consistently associated with sexual risk behaviours include family composition and household standard of living. Youths residing in an impoverished house are 1.4 times probably to be sexually active and 1.3 times probably to have had sex with an irregular partner in twelve months before the study compared with youths residing in a house with a good quality of living during the period of the study. In comparison to those in two-parent households, young people residing with a single parent were 1.6 times probably to be sexually active, 1.7 times probably to have had sex with an irregular partner in twelve months before the study, 2.8 times probably to have many coexisting partners and 1.1 times probably not to be using condoms. Staying with parents of father or mother in a general way is effective in protecting adolescents, while staying alone, with a family member, or with an outsider in a general way raised the possibility of participating in sexual risk behaviours (Mburano, 2000).

In a study conducted by Nwankwo and Nwoke, 2009, majority of the respondents mentioned peer group as an important factor which is probably liable for opening the adolescents' eyes to risky sexual behaviours. In-school adolescents attributed premarital sex to influence of erotic movies from television, video and cinemas, while majority of their out-of-school counterparts attributed it to peer group influence (Abubakar, 2011). What adolescents see, pay attention to and the origins of their facts determines their sexual behaviour. It is evident that adolescents from homes devoted to sexual pleasure have a tendency to attempt sexual acts as they observe their parents displaying sexual activities publicly (Envuladu *et al.,* 2017).

An investigation carried out to determine factors associated with sexual abstinence among 143 out-of-school girls in Oyo State revealed that 42 of them had no sexual experience. Factors identified were residing with parents or relations, getting remunerations weekly

and monthly in contrast with getting remunerations per day, big self-worth, and studying books during time of relaxation. Points discovered to be notably connected with abstaining from sexual activities includes living arrangement, self-esteem, type of occupation, source of income, alcohol intake, and some recreations done at free time ($p < .05$) (Adesola and Akindele, 2013).

A study conducted among unmarried, out-of-school female adolescents examined their sexual behaviour and identified factors that influences it. The study shows that about half of the respondents (43.7%) had experienced coitus. The average age at sexual debut was 16 years. Curiosity was the major basis for debut. Unsafe sexual behaviour and sex in exchange of money was rampant, sex with coercion was also disclosed. Respondents had poor understanding of sexual health, and peers are their major origin of facts on sexual health matters. Friends' sexual behaviour, parents' marital status, the individuals adolescents live with, watching pornography and presence of finance to cater for their fundamental requirements were elements connected with the onset of sexual activities (Odeyemi *et al.,* 2009).

A research carried out in south west Nigeria shows that factors significantly associated with past record of sex in exchange for money are being a boy, being a youth (20–24 years), being out-of-school, and frequent alcohol intake. Although, 58.2 percent engage in multiple sexual partnership, notable factors were being a boy, initiation of sexual activities at early age, history of transactional sex and regular alcohol use. 44.8 percent of the respondents reported inconsistent condom use, the factors were being a girl, frequent alcohol intake, and past record of sex in exchange for money within twelve months before the study (Owoaje and Uchendu, 2009).

2.7 Theoretical framework

Social learning theory

The social learning theory was used to facilitate the design of this study. According to Bandura (1977), behaviour is learned from the environment by way of observational learning and that learning is an intelligent series of actions that occurs in a social context and can take place purely through observation. The theory describes a dynamic, ongoing process in which personal factors, environmental factors, and human behavior exert influence upon each other. It gives special importance to observing and modeling the behaviours, attitudes and emotional reactions of others. This theory suggests that contributory factors for sexual behaviour exist not only within the individual level, it looks at the dynamic interaction of the person, behaviour and the environment in which the behaviour is performed. According to Bandura (1977) and Joan (1992), the social learning theory comprises the following key six concepts.

1. ***Observational Learning****:* Social learning theory explains human behaviour in terms of uninterrupted reciprocal interaction between cognitive, behavioural and environment influence (Bandura, 1977). Observational learning also called "modelling" therefore takes into consideration the ability of every individual to learn from the others through observation of the behaviour, attitudes and outcome of those behaviours. Some respondents in this study learn sexual behaviours from their friends, boy/girlfriend and family members.

2. ***Reciprocal Determinism****:* The environment is influenced by an individual's behaviour just as the individual's behaviour is influenced by the environment, thus cognition, environment and behaviour all mutually influence each other.

3. ***Environment:*** The environment is where every individual lives and work. The environment constitute factors that interplay to influence the possibility of carrying out a particular behaviour as well as opportunities for social support. Questions were asked about the exposure of out-of-school adolescents to books, movies and musicals that teach and promote sexual activities. Accessibility to these are some facilitating factors among respondents in this study.

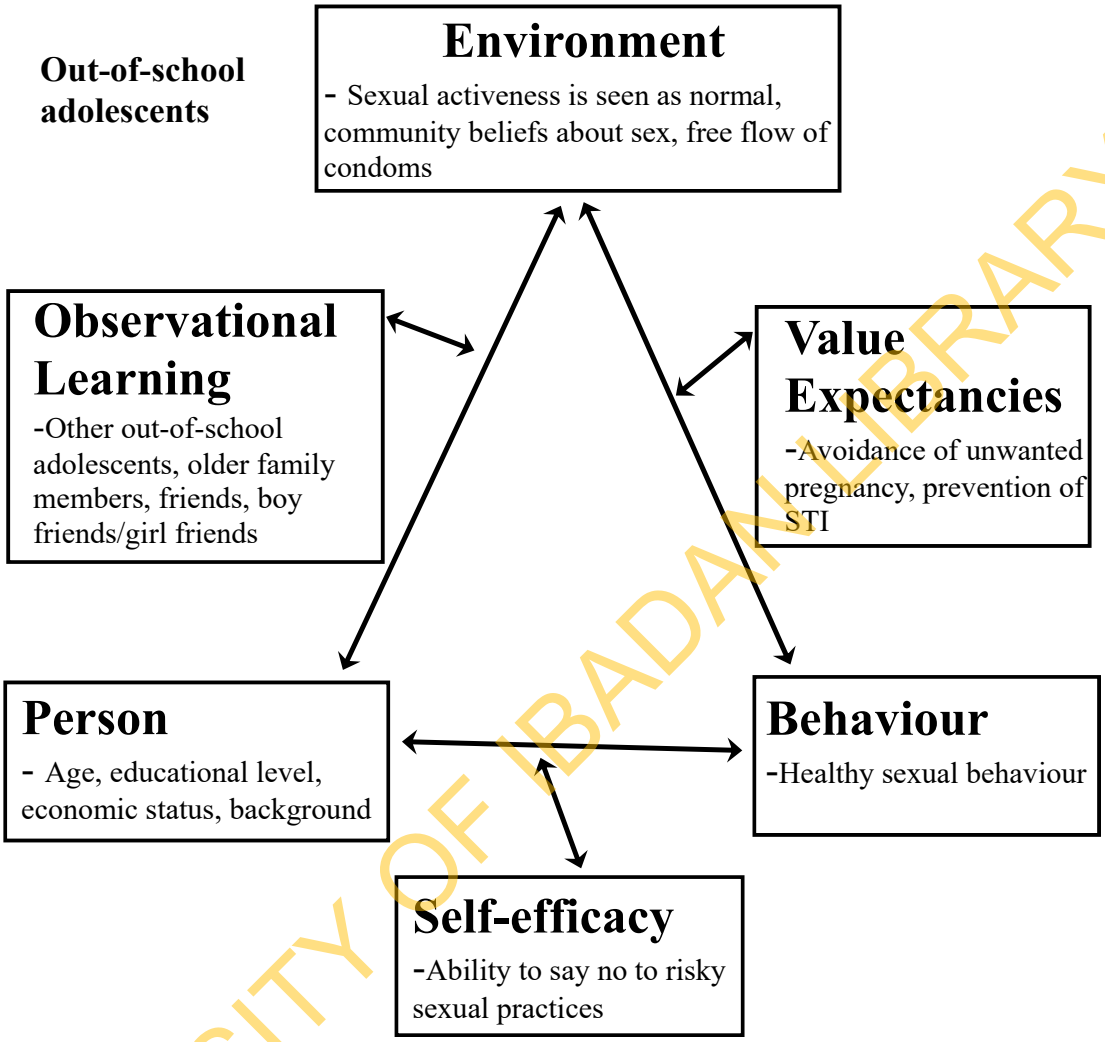
4. ***Expectations****:* Every action carries anticipatory outcomes or result which often serve as a motivation for behavioural intention. Those who engage in sexual activities have expected results in mind. In this study, questions were asked about safe sexual practices and risky sexual practices, respondents that engage in safe sexual practices do so in order to avoid unwanted pregnancy and prevent STI.

5. ***Self-Efficacy****:* Self-Efficacy is the self-assurance in carrying out a particular action and persisting therein. A greater self-efficacy therefore implies higher motivation in carrying out the practice despite existing obstacles or limitations and better perception of the practice being carried out. Through modelling, practice, information and social support, self-efficacy can be enhanced in an individual. In this study, some respondents lack self-efficacy to say no to risky sexual practices.

6. ***Reinforcement:*** This is one's response to a particular behaviour which often determines whether the behaviour is likely to be repeated or sustained. Reinforcements can either be positive or negative, the positive reinforcement is often called reward and the negative reinforcement often include punishment or no response.

   Applying this model to the study, out of school adolescents who live in an environment where sexual activities are rampant and acceptable with no regulations, have the opportunity to observe and learn from their sphere of influence (friends, peers, family etc.); their observations will increase their expectations by modifying their values and perception of the practice thereby motivating them to engage in the sexual behaviours. Their self-efficacy or feeling of capability in disengaging in the practice will be enhanced by social support. The key constructs of the model which include environment, observational learning, self-efficacy, value expectancies can be used to depict the patterns of sexual behaviour among out-of-school adolescents.

Figure 1: Application of social learning theory to patterns of sexual behaviour



2.7.1 Application of social learning theory to the questionnaire

- **Individual:** This refers to the personal characteristics of the respondents. These are presented in the questions 1, 2, 3, 4, 5, 6, 7 and 8 (Appendix 1).
- **Environment:** These are factors that are physically external to a man. These are presented in the questionnaire as environmental factors in questions 45, 46, 47, 48, 49 and 50 (Appendix 1).
- **Behaviour:** This is expressed in terms of ways by which out-of-school adolescents engage in sexual practices as presented in questions 15, 17, 20, 21, 25, 31, 39, 40, 41, 42, 43 and 44 (Appendix 1).
- **Value expectancy:** These are presented as safe sexual practices adolescents engage in with the mind-set of avoiding unwanted pregnancy and STI in the questions 22, 23, 25, 26, 28, 32, 33, 34, 35 and 36 (Appendix 1).
- **Observational learning:** This refers to behavioural acquisition that occurs by watching the actions of other's behaviour. This is presented in the questionnaire as observational learning in questions 51, 52, 53, 54 and 55 (Appendix 1).

CHAPTER THREE

METHODOLOGY

This chapter outlines the methodology that was used to obtain the research data. The study design, study setting, study population, sample and sampling procedure, data collection procedure, data analysis and ethical consideration are all described in the chapter.

3.1 Study design

The research was carried out using a descriptive cross-sectional survey where interviewer-administered questionnaires were used for out-of-school adolescents to ensure uniformity.

3.2 Study setting

Ibadan is the capital city of Oyo State and the third largest metropolitan area in Nigeria with a population of about 3.383 million according to the 2018 Central Intelligence Agency (CIA) World Fact book (CIA, 2018). It is located in the south eastern part of Oyo State which is situated in south-western Nigeria.

The study was carried out in Egbeda Local Government Area of Oyo State, one of the 33 Local Governments in Oyo State. Egbeda Local Government Area is one of the local government areas that makes up Ibadan metropolis with its headquarters at Egbeda. Egbeda local government was created in Egbeda Local Government was created in 1989 when it was carved out of Lagelu Local Government, a structure that has been in existence since 1961. The Local government currently has four urban political wards and seven rural wards covering a total of 136.83km^2. Egbeda local government area is subdivided into eleven wards: Erunmu, Ayede/Alugbo/Koloko, Owo Baale/Kasumu, Olodan/Ajiwogbo, Olodo/Kumapayi I, Olodo II, Olodo III, Osegere/Awaye, Egbeda, Olode/Alakia, and Olubadan Estate. The local government is headed by an elected chairman and eleven councillors elected from each ward. The current traditional ruler is the Baale of Egbeda High Chief Victor Olatunde Okunola who is also a member of the Oyo State of Council of Obas and Chiefs.

3.3 Study population

The study population consists of both male and female adolescents who are artisans and out-of-school within the age of 15-19years in Egbeda Local Government Area, Ibadan.

Inclusion criteria for out-of-school adolescents:

Male and female of age 15-19years that had never been to school, finished primary school but did not continue or had dropped out of secondary school and presently learning a trade. The type of trade included hairdresser, tailor, chemist, barber, shoemaker, mechanic, welder, aluminium fabricator, electrician, mobile phone repair and carpenter.

Exclusion criteria for out-of-school adolescents:

All adolescents age 15-19years employed or unemployed with mental, hearing or speech disabilities and those that did not consent.

3.4 Sample size determination

The sample size was determined based on past findings to deliberately obtain units of analysis in such a manner that the sample may be regarded has being representative of the relevant population. The prevalence 66.7% was used for this study based on the research work carried out on the Comparative Analysis of Sexual Practice and Contraceptive Use among Student and Non-student adolescent girls in Onitsha, Nigeria which stated that, 66.7% out-of-school girls reported that they are having sex regularly (Adogu *et al.,* 2014). The sample size, n, was determined using Leslie Kish formula:

$$N = \frac{z^2pq}{d^2}$$

Where p is the prevalence, q =1-p, z is confidence limit (95%) =1.96, d = 0.05 which is the level of precision.

p = 66.7% (0.667), z = 1.96, d = 0.05,

q = 1-0.667 = 0.333,

$$N = \frac{1.96 \times 1.96 \times 0.667 \times 0.333}{0.05 \times 0.05}$$

N = 341.2

Including a non-response rate of 10%, $\frac{1}{1-f} \times N = \frac{1}{1-0.1} \times 341.2 = 379$

The sample size was increased to 400.

3.5 Sampling procedure

In order to obtain participants for the study, a multi-stage sampling technique was adopted until a total of 400 respondents was reached.

- **Stage 1:** Simple random sampling was used to select 5 wards out of the 11 wards in the local government and two communities were randomly selected from each ward.
- **Stage 2:** Convenience sampling was used to select eleven major artisan association identified which include hairdresser, tailor, chemist, barber, shoemaker, mechanic, welder, aluminium fabricator, electrician, mobile phone repair and carpenter.
- **Stage 3:** From each selected artisan group in each ward, proportionate sampling was used to determine the number of respondents. Artisans who met the inclusion criteria and gave consent to participate in each shop visited were interviewed.

3.6 Instrument for data collection

Data was collected using quantitative method. Interviewer-administered semi-structured questionnaire was used to collect data, this contains seven sections. Section A focused on socio-demographic details of respondents with variables such as age of respondents, sex, marital status, occupation and so on. Section B described the relationship levels that affects sexual behaviour, section C focused on sexual activity of out-of-school adolescents, section D describes the safe sexual practices they engage in while section E described their risky sexual practices. Section F described the environmental factors that influence the sexual behaviours of respondents and section G is focused on observational learning. The questions in the instrument were obtained from literature and through professional views of the supervisor.

3.7 Methods of data collection

A letter of introduction was written to the artisan associations, the association leaders of the artisan groups were contacted through a member of the association that was sited in each of the selected communities to inform him or her ahead about what the research entails. The researcher attended one of the association meetings for each of the artisan groups for proper introduction of the research to members. The respondents were interviewed at their workplace and permission was gotten from their bosses before the data collection. During data collection, questions were asked in Yoruba language for adequate

comprehension. Verbal informed consent was obtained from the participants after explaining to them the purpose and ethical consideration guiding the study. Whenever the respondents need clarification about any question, the researcher explained to their understanding.

3.8 Recruitment of research assistants

Three research assistants were recruited and trained mainly to facilitate data collection. One of the criteria for selecting the research assistants was knowledge of sexual behaviour and the study population. The training covered data collection procedures, how to swiftly review questionnaires to ensure completeness, issues relating to privacy and good interpersonal relationship. The training took place for just one day.

3.9 Validity of the instrument

Extensive literature review was done which helped to develop variables for the questionnaire, experienced researchers in the field of public health were consulted and research assistants were adequately trained. The research instrument was subjected to critical review by the supervisor in charge, other experts in the department of Health Promotion and Education also contributed to the validation of the research instrument. Their suggestions and views were used to review the final copy of the research instrument. The instrument was translated to local language (Yoruba) by a language expert.

3.10 Reliability of the instrument

To ensure the reliability of the instrument, a pre-test of the research instrument was carried out on 10% of the sample size using of out-of school adolescents in Ibadan North LGA due to its similarities with Egbeda LGA and Cronchbar's Alpha statistical test was used to assess the questionnaire for reliability. A score of 0.7 determined the reliability of the instrument.

3.11 Data management and analysis

All data collected were reviewed by the researcher and the research assistants, sorted and kept in a safe place for confidentiality. They were checked for completeness and then serial numbers were given to each for easy identification. The researcher developed a coding guide after going through all the responses in each questionnaire. After coding, a template was designed on IBM SPSS Statistics 21.0 for entering of the coded data for analysis.

Copies of the questionnaire responses were entered into the computer. The results were presented as frequencies and percentages using tables. The demographic characteristics and objectives were analysed using frequencies and percentages. Inferential statistics such as correlational analysis, chi square and binary logistics regression were used to determine the statistical association and degree of relationship between variables. Safe sexual practices were assessed on a 30-point scale, a score of 2points was allotted to each correct response and a score <20 and ≥20 were considered to be unsafe and safe sexual practice respectively. Risky sexual practices were assessed 24-point scale, a maximum score of 3points and minimum score of 1point was allotted to each correct response depending on the frequency of practice and a score <8 and ≥8 were categorised as non-risky and risky sexual practice respectively. The level of significance (α) was set at 95% confidence level.

3.12 Ethical considerations

The ethical principles guiding the use of human participants in research was taken into consideration in the design and conduct of the study. Approval to carry out the study was obtained from the Oyo State Research Ethical Review Committee and permission was also obtained from the key stakeholders at the study site. Verbal informed consent was obtained from the participants and participation in the study was made voluntary. Each of the participants were provided with information about the focus of the study, objectives of the study, study methodology, inconveniences that might be experienced and the potential benefits of the study. No identifiers such as name of participants was required and all information provided were kept confidential.

3.13 Limitations of study

The study design presented some limitations, one of such is that, the issue of sexuality in the environment where the study was conducted is very sensitive and is considered private so there is possibility of concealment of vital information. Also, some questions require respondents to answer based on memory, which could increase the possibility of under or over- estimated reports and responses. To overcome these limitations, the researcher explained the importance of confidentiality to the respondents and assured them that confidentiality will be maintained. Also, it was emphasized that giving false information will have an effect on the data collected.

CHAPTER FOUR

RESULTS

This chapter presents the findings from this study which are organized into nine sections which includes: socio-demographic information, relationship levels that affects sexual behaviour, sexual activity, safe sexual practice, risky sexual practice, factors influencing patterns of sexual behaviour, correlation analysis, test of hypotheses and logistics regression analysis.

4.1 Respondents' Socio-Demographic Information

Table 4.1 summarizes the socio-demographic characteristics of the respondents. The ages of respondents ranged from 15-19 years with a mean age of 17.49 ± 0.066 years. The respondents were more of females (55.5%). Majority (97.8%) of the respondents were single. Many of the respondents are Christians (67.8%). Most (71.3%) of them stopped going to school at SS1-3. The respondents were all artisans, less than a third (32.3%) of them are tailors and very few (0.8%) are carpenters.

Table 4.1: Socio-demographic characteristics of the respondents (N= 400)

Socio-demographic variable	Frequency (N)	Percentage (%)
***Age at Last Birthday**		
15	36	9.0
16	71	17.8
17	73	18.3
18	101	25.3
19	119	29.8
Sex		
Male	178	44.5
Female	222	55.5
Highest Educational Level		
Primary 1-6	10	2.5
JSS 1-3	105	26.3
SS 1-3	285	71.3
Marital Status		
Single	391	97.8
Married	9	2.3
Religion		
Christianity	271	67.8
Islam	128	32.0
Traditional	1	.3
Ethnicity		
Yoruba	388	97.0
Igbo	10	2.5
Tiv	2	.5
Occupation		
Hairdresser	87	21.8
Tailor	129	32.3
Chemist	50	12.5
Barber	38	9.5
Shoemaker	19	4.8
Mechanic	29	7.3
Welder	7	1.8
Aluminium fabricator	15	3.8
Electrician	14	3.5
Mobile phone repair	9	2.3
Carpenter	3	.8

*Mean age of respondents = 17.5 ± 0.1

4.2 Relationship levels that affects sexual behaviour of out-of-school adolescents

Table 4.2 describes the relationship levels of respondents that could influence their patterns of sexual behaviour. Most (71.8%) of the parents of the respondents lived together and less than half (47.8%) of the respondents lived with their parents while few (2.0%) lived with their lovers. More than half (56.0%) of the respondents were not free to discuss sex with the person they lived with, the reason some of them gave for this was fear (46.9%). Instead of discussing sexual matters with the person they lived with, most (75.0%) of the respondents discussed with friends and most of them (72.3%) had friends who were sexually active. Majority (82.8%) of respondents had a boy/girlfriend.

Table 4.2: Relationship levels that affects sexual behaviour of out-of-school adolescents

Variable	Frequency (N)	Percentage (%)
Parents live together (N=400)		
Yes	287	71.8
No	113	28.3
Person living with most of the time (N=400)		
Parent/Guardian	191	47.8
Siblings/Relatives	113	28.3
Friends	65	16.3
Boss	23	5.8
Lover	8	2.0
Free to discuss sexual matters with the person living with (N=400)		
Yes	176	44.0
No	224	56.0
If no, reason for not discussing it (N=224)		
Fear	105	46.9
Not comfortable	75	33.4
Forbidden	13	5.8
Shame	31	13.8
Have a close friend you discuss sexual matters with (N=400)		
Yes	300	75.0
No	100	25.0
Friends sexually active (N=400)		
Yes	289	72.3
No	111	27.8
Have a boy/girlfriend (N=400)		
Yes	331	82.8
No	69	17.3

4.3 Sexual behaviours of out-of-school adolescents

Table 4.3 shows how sexually active the respondents are. Many (64.8%) of the respondents had sexual intercourse, they are more of females (58.3%) than males (41.7%). The lowest age of sexual debut was 13 years with more of females (55.6%) than males (44.4%) and the highest age of sexual debut was 19 years, all of them being females (100%). Less than a third (14.8%) of the respondents had their first sex at age 15 while very few (0.5%) had their first sex at age 19. Those that had their first sex at age 15 were more of females (59.3%) than males (40.7%). The mean age of sexual debut was 10.33 ± 0.386.

More than half (56.3%) of the respondents had been sexually active in the past year, more than half (51.1%) of these are females and more than a third (36.8%) had a single partner. More than a third (39.5%) of respondents had older partners, 49.4% of these are males and 50.6% are females. More than a third (35%) of those that had older partners had partners that are 1-5years older.

Less than a third (22.5%) of respondents had become pregnant or impregnated someone, 17.3% of these aborted the pregnancy. Majority (85.8%) of the respondents were sexually attracted to same sex, although few (4.8%) of them were attracted to the same sex, some (9.5%) of the respondents were also attracted to both opposite sex and same sex. Females (57.3%) were more attracted to opposite sex than males (32.7%) while males (57.9%) were more attracted to same sex than females (42.1%). One-third (33%) of the respondents had strong sexual urge, 42.4% of these were males and 57.6% were females.

Table 4.3a: Sexual behaviours of out-of-school adolescents

Sexual behaviour	(N)	(%)	Male (%)	Female (%)
Ever had sexual intercourse (N=400)				
Yes	259	64.8	108 (41.7)	151 (58.3)
No	141	35.3	44 (31.2)	97 (68.8)
***Age at first sexual intercourse (N=259)**				
13	9	3.5	4 (44.4)	5 (55.6)
14	36	13.9	19 (52.8)	17 (47.2)
15	59	22.8	24 (40.7)	35 (59.3)
16	56	21.6	21 (37.5)	35 (62.5)
17	54	20.8	22 (40.7)	32 (59.3)
18	43	16.6	19 (44.2)	24 (55.8)
19	2	0.8	0 (0)	2 (100)
Sexually active in the past year (N=400)				
Yes	225	56.3	110 (48.9)	115 (51.1)
No	175	43.8	79 (45.1)	96 (54.9)
If yes, number of current sexual partners (N=225)				
1	147	65.3	68 (46.2)	79 (53.7)
2-4	69	30.7	29 (42.0)	40 (58.0)
5-7	6	2.7	2 (33.3)	4 (66.7)
8-10	3	1.3	1 (33.3)	2 (66.6)
Partners older (N=331)				
Yes	158	47.7	78 (49.4)	80 (50.6)
No	173	52.3	82 (47.4)	91 (52.6)
If yes, number of years difference (N=158)				
1-5	140	88.6	71 (50.7)	69 (49.3)
6-10	18	11.4	7 (38.9)	11 (61.1)
You or one of your sexual partners ever become pregnant (N=400)				
Yes	90	22.5		
No	294	73.5		
I am not aware	16	4.0		

Table 4.3b: Sexual behaviours of out-of-school adolescents

Sexual activity	(N)	(%)	Male (%)	Female (%)
If yes, length of sexual activity at the time of conception (N=90)				
Less than a month	19	21.1		
2-3months	25	27.8		
4-6months	12	13.3		
6months to a year	11	12.2		
Longer than a year	6	6.7		
Don't know	17	18.9		
Decision made regarding the pregnancy (N=90)				
Kept the baby	21	23.3		
Abortion	69	76.7		
Sex sexually attracted to (N=400)				
Opposite sex	343	85.8	112 (32.7)	231 (67.3)
Same sex	19	4.8	11 (57.9)	8 (42.1)
Both opposite sex and same sex	38	9.5	17 (44.7)	21 (55.3)
Description of urge for sex (N=400)				
Very strong	62	15.5	29 (46.8)	33 (53.2)
Strong	132	33.0	56 (42.4)	76 (57.6)
Not strong	127	31.8	89 (70.1)	38 (30.0)
No sex drive	79	19.8	32 (40.5)	47 (59.5)

4.4 Safe Sexual practices among out-of-school adolescents

Table 4.4.1a describes the rate at which respondents use contraceptives as a safe sexual practice. Among respondents that have had sexual intercourse before, more than half (55.3%) use contraceptives methods which includes abstinence (1.3%), condom (39.3%), coitus interruptus (2%), oral pills (11.8%) and injectable (1%); more than a third (39.3%) of them use condom as a contraceptive method. For those that have had sexual intercourse and do not use contraceptives, 23% of them do not use it because they do not like it. Some (45.5%) of respondents used contraceptive the last time they had sexual intercourse and condom was used more (31.8%) than other contraceptive methods. Few (8%) of those that did not use contraceptive for their last sexual intercourse stated that they do not like it. Less than half (47.3%) of respondents have not used contraceptives in the past 12months. A correct response for safe sexual practice is indicated by a single asterisk (*) sign.

Table 4.4.1b explains other safe sexual practices respondents engage in and how frequently they engage in such practices. Less than a third (28.8%) of the respondents always abstain from sexual activities, 43.8% do abstain from sexual intercourse when they do not know their partners' sexual history and 49.5% abstain from sexual intercourse when they have sores or irritation in their genital area. Less than a third (23%) always insist on condom use, 47.3% stop foreplay long enough to put on a condom and 45.3% do carry condom with them when they know that they are likely to have sexual intercourse. More than half (55.6%) of respondents do ask potential sexual partners about their sexual histories, 28.8% always avoid direct contact with their sexual partner's semen or vaginal secretions and 43.3% usually insist on examining their sexual partners for sores, cuts or abrasions in the genital area. More than half (57.3%) of respondents do avoid direct contact with their sexual partner's blood, 33.8% always initiate the topic of safer sex with their potential sexual partners and only 24.6% of respondents usually get screened for STI. A correct response for safe sexual practice is indicated by a single asterisk (*) sign.

Table 4.4.2 describes the level of safe sexual practices among respondents. Majority (94.8%) of the respondents engage in unsafe sexual practice while few (5.3%) engage in safe sexual practices. The lowest and highest score are 0 and 28 respectively.

Table 4.4.1a: Safe sexual practices among out-of-school adolescents – use of contraceptives

Sexual Practices	Frequency (N)	Percentage (%)
Ever used contraceptives (N=400)		
Yes	221	55.3*
No	179	44.8
If yes, contraceptive method(s) used (N=221)		
Abstinence	5	2.3
Condom	157	71.0
Coitus interruptus	8	3.6
Oral pills	47	21.3
Injectable	4	1.8
If no, reasons for non-use (N=179)		
Partner refused	7	3.9
I do not like it	23	12.8
I am not aware	7	3.9
No reason	142	79.3
Used contraceptives at last intercourse (N=259)		
Yes	182	70.3*
No	77	29.7
If yes, type used (N=182)		
Condom	127	69.8
Coitus interruptus	9	4.9
Oral pills	42	23.1
Injectable	4	2.2
If no, reasons for non-use (N=77)		
Partner refused	20	25.9
I do not like it	32	41.6
I am not aware	2	2.6
No reason	23	29.9
In the past 12 months I have used contraceptive(s) (N=400)		
All the time	26	6.5*
Most of the time	111	27.8
Rarely	74	18.5
I have not used contraceptive	189	47.3

*Safe sexual practices

Table 4.4.1b: Safe sexual practices among out-of-school adolescents

(N = 400)

Sexual Practices	Always	Sometimes	Rarely	Never
	N (%)	N (%)	N (%)	N (%)
I abstain from sexual activities	115 (28.8)*	160 (40.0)	73 (18.3)	52 (13.0)
I insist on condom use when I have sexual intercourse	92 (23.0)*	97 (24.3)	51 (12.8)	160 (40.0)
I stop foreplay long enough to put on a condom or for my partner to put on a condom	70 (17.5)*	103 (25.8)	67 (16.8)	160 (40.0)
I ask potential sexual partners about their sexual histories	113 (28.3)*	109 (27.3)	58 (14.5)	120 (30)
I avoid direct contact with my sexual partner's semen or vaginal secretions	115 (28.8)*	97 (24.3)	57 (14.3)	131 (32.8)
I abstain from sexual intercourse when I do not know my partner's sexual history	82 (20.5)*	93 (23.3)	72 (18.0)	153 (38.3)
I do not abstain from sexual intercourse even if I have sores or irritation in my genital area	45 (11.3)	88 (22.0)	69 (17.3)	198 (49.5)*
If I know an encounter may lead to sexual intercourse, I carry a condom with me	73 (18.3)*	108 (27.0)	57 (14.3)	162 (40.5)
I insist on examining my sexual partner for sores, cuts, or abrasions in the genital area	108 (27.0)*	65 (16.3)	83 (20.8)	144 (36.0)
I avoid direct contact with my sexual partner's blood	144 (36)*	85 (21.3)	55 (13.8)	116 (29.0)
I initiate the topic of safer sex with my potential sexual partner	135 (33.8)*	84 (21.0)	59 (14.8)	122 (30.5)
I get screened for STI	47 (11.8)*	51 (12.8)	73 (18.3)	229 (57.3)

*Safe sexual practices

Table 4.4.2: Level of safe sexual practices among respondents

Safe Sexual Practice Score (SSPS)	N (%)
Unsafe practice (SSPS < 20)	379 (94.8)
Safe practice (SSPS ≥ 20)	21 (5.3)
Total	400 (100)

Minimum safe sexual practice score = 0

Maximum safe sexual practice score = 28

4.5 Risky sexual practice among out-of-school adolescents

Table 4.5.1 describes the risky sexual practices the respondents engage in. Less than a third (30.3%) of respondents had been forced by someone to engage in sexual intercourse while 23.3% have forced someone to engage in sexual intercourse with them. More than a third (37.1%) had sexual intercourse on a first outing and 49.1% had sexual intercourse without using condom. Less than a third (32.6%) did engage in oral sex without using condom or rubber dam and 26.3% engage in anal sex. Less than a third (21.8%) of respondents had sexual intercourse under the influence of drugs and 28.1% had sexual intercourse under the influence of alcohol. A correct response for risky sexual practice is indicated by a single asterisk (*) sign.

Table 4.5.2 shows the level of risky sexual practices among respondents. Majority (75.8%) of the respondents had low score on a 24-points risky sexual practice scale while 24.3% engage in risky sexual practices. The lowest and highest score are 0 and 24 respectively.

Table 4.5.1: Risky Sexual Practices among out-of-school adolescents (N = 400)

Risky Sexual Practices	Always	Sometimes	Rarely	Never
	N (%)	N (%)	N (%)	N (%)
I have been forced by someone to engage in sexual intercourse with me	16 (4.0)*	72 (18.0)*	33 (8.3)*	279 (69.8)
I have forced someone to engage in sexual intercourse with me	6 (1.5)*	52 (13.0)*	35 (8.8)*	307 (76.8)
I engage in sexual intercourse on a first outing	25 (6.3)*	50 (12.5)*	73 (18.3)*	252 (63.0)
I lick or suck my partners penis or vagina without using condom or rubber dam	29 (7.3)*	49 (12.3)*	52 (13.0)*	270 (67.5)
If swept away in the passion of the moment, I have sexual intercourse without using a condom	30 (7.5)*	103 (25.8)*	63 (15.8)*	204 (51.0)
I engage in anal intercourse without using a condom	12 (3.0)*	52 (13.0)*	41 (10.3)*	295 (73.8)
I have sexual intercourse while under the influence of drugs	10 (2.5)*	30 (7.5)*	47 (11.8)*	313 (78.3)
I have sexual intercourse while under the influence of alcohol	13 (3.3)*	50 (12.5)*	49 (12.3)*	288 (72.0)

*Risky sexual practices

Table 4.5.2: Level of risky sexual practices among respondents

Risky Sexual Practice Score (RSPS)	N (%)
Non-risky sexual practice (RSPS < 8)	303 (75.8)
Risky sexual practice (RSPS ≥ 8)	97 (24.3)
Total	400 (100)

Minimum risky sexual practice score = 0

Maximum risky sexual practice score = 24

4.6 Factors influencing patterns of sexual behaviour among out-of-school adolescents

Table 4.6 shows the environmental factors that influence patterns of sexual behaviour and people the respondents learn sexual behaviour from. Many (67.8%) of respondents were exposed to movies and musicals that teach and promote sexual activities, also, more than half (53.3%) of the respondents had access to books that promote sexual activities. More than a third (40.8%) of respondents said there are no laws that frown at adolescents engaging in sexual activities and 47.8% said their community do not care about their sexual activities. Few (15.5%) of the respondents engaged in sexual activities in order to get money to take care of themselves while 13.3% gave their sexual partners money in order to have sex with them.

Less than a third (29.8%) of respondents engaged in sexual activities because they see their friends do it and less than half (46.3%) of respondents said their friends encourage them to engage in sexual activities. Only 6.5% of respondents engaged in sexual activities because they see their parents do it, 8.5% engage in sexual activities because their siblings encouraged them to and majority (80.3%) of respondents said that their family will frown at it if they get to know that they are already engaged in sexual activities.

Table 4.6: Factors that influence patterns of sexual behaviour among out-of-school adolescents (N = 400)

Factors	Yes		No	
	(N)	(%)	(N)	(%)
Environmental factors				
I am exposed to films/movies and musicals that teach and promote sexual activities	271	67.8	129	32.3
I always have access to books that promote sexual activities	213	53.3	187	46.8
There are laws/regulations that frown at adolescents engaging in sexual activities	237	59.3	163	40.8
My community cares about my sexual activities	209	52.3	191	47.8
I engage in sexual activities to get money to take care of myself	62	15.5	338	84.5
I give my partner money to have sex with me	53	13.3	347	86.8
Observational learning				
I engage in sexual activities because I see my friends do it	119	29.8	281	70.3
I engage in sexual activities because I see my parents do it	26	6.5	374	93.5
My friends encourage me to engage in sexual activities	185	46.3	215	53.8
I engage in sexual activities because my siblings encourage me to	34	8.5	366	91.5
My family will frown at it if they get to find out that I am already engaged in sexual activities	321	80.3	79	19.8

4.7 Correlation analysis of factors influencing patterns of sexual behaviour among respondents

Correlation analysis was used to determine the influence of environmental factors and observational learning on risky and safe sexual behaviours. It was found that the environmental factors such as exposure to film/movies and musicals (-0.228), access to books that promote sexual activities (-0.238) and involving in sexual activities to get money (-0.225) had negative influence on risky sexual behaviour while availability of laws/regulations (0.184) and care from community members about respondents' sexual activities (0.160) had positive influence on risky sexual behaviour.

Observational learning such as engaging in sexual activities because friends are seen doing it (-0.391), engaging in sexual activities because parents are seen doing it (-0.231), encouragement from friends to engage in sexual activities (-0.370) and engaging in sexual activities due to encouragement from siblings (-0.205) had negative influence on risky sexual behaviour while family members frowning if they are aware that respondents engage in sexual activities (0.288) had a positive influence on risky sexual behaviour.

Table 4.7: Correlation analysis of factors influencing patterns of sexual behaviour among respondents

		Risky sexual practices	Safe sexual practices
Environmental Factors			
I am exposed to films/movies and musicals that teach and promote sexual activities	Pearson Correlation Sig. (2-tailed) N	-0.299 0.000 400	-0.037 0.464 400
I always have access to books that promote sexual activities	Pearson Correlation Sig. (2-tailed) N	-0.331 0.000 400	-0.058 0.247 400
There are laws/regulations that frown at adolescents engaging in sexual activities	Pearson Correlation Sig. (2-tailed) N	0.120 0.016 400	-0.12 0.011 400
My community cares about my sexual activities	Pearson Correlation Sig. (2-tailed) N	0.155 0.002 400	-0.193 0.000 400
I engage in sexual activities to get money to take care of myself	Pearson Correlation Sig. (2-tailed) N	-0.259 0.000 400	-0.060 0.229 400
I give my partner money to have sex with me	Pearson Correlation Sig. (2-tailed) N	-0.322 0.000 400	0.040 0.426 400
Observational Learning			
I engage in sexual activities because I see my friends do it	Pearson Correlation Sig. (2-tailed) N	-0.391 0.000 400	0.079 0.113 400
I engage in sexual activities because I see my parents do it	Pearson Correlation Sig. (2-tailed) N	-0.231 0.000 400	0.086 0.086 400
My friends encourage me to engage in sexual activities	Pearson Correlation Sig. (2-tailed) N	-0.370 0.000 400	0.111 0.026 400
I engage in sexual activities because my siblings encourage me to	Pearson Correlation Sig. (2-tailed) N	-0.205 0.000 400	-0.043 0.392 400
My family will frown at it if they get to find out that I am already engaged in sexual activities	Pearson Correlation Sig. (2-tailed) N	0.288 0.000 400	-0.128 0.010 400

4.8 Test of hypotheses

The following hypotheses were tested for the study:

4.8.1 Hypothesis I

The first hypothesis states that there is no significant association between age of respondents and experience of sexual intercourse. Chi square was used to test for the association. The result showed that, there was a significant association between age of respondents and experience of sexual intercourse $X^2 = 43.981$ ($p = 0.000$) (Table 4.8.1a). Binary logistics was used to test for the age that is more significant. The result showed that 19 year old are most likely to have had sexual intercourse (OR = 8.29, CI= 3.6-19.07) than any other group (Table 4.8.1b).

Table 4.8.1a: Chi-square test of association between age of respondents and experience of sexual intercourse

Variables	Ever had sex		Chi-square test		
	Yes	No	Value	Df	p-value
Age					
15 years old	14 (5.4%)	22 (15.6%)	43.981	5	0.000
16 years old	38 (14.7%)	33 (23.4%)			
17 years old	35 (13.5%)	37 (26.2%)			
18 years old	71 (27.4%)	30 (21.3%)			
19 years old	100 (38.6%)	19 (13.5%)			
Total	258	141			

Table 4.8.1b: Binary logistics test of association between age of respondents and experience of sexual intercourse

Age	Df	OR	CI	p-value
16 years old	1	2.31	1.20 – 4.45	0.012
17 years old	1	5.61	2.85 – 11.04	0.000
18 years old	1	4.35	2.30 – 8.6	0.000
19 years old	1	8.29	3.6 – 19.07	0.000

4.8.2 Hypothesis II

The second hypothesis states that there is no significant association between sex of respondents and experience of sexual intercourse. Chi square was used to test for the association. The results revealed that there was a significant association between sex of respondents and experience of sexual intercourse $X^2 = 4.212$ ($p = 0.040$) (Table 4.8.2a). Binary logistics was used to test for the sex that is more significant. The result showed that males are more likely to have had sexual intercourse (OR = 0.646, CI= 0.43-0.98) than females (Table 4.8.2b).

Table 4.8.2a: Chi-square test of association between sex of respondents and experience of sexual intercourse

Variables	Ever had sex		Chi-square test		
	Yes	No	Value	Df	p-value
Sex					
Male	125 (48.3%)	53 (37.6%)	4.212	1	0.040
Female	134 (51.7%)	88 (62.4%)			
Total	259	141			

Table 4.8.2b: Binary logistics test of association between sex of respondents and experience of sexual intercourse

Age	Df	OR	CI	p-value
Male	1	0.646	0.43 – 0.98	0.041

4.8.3 Hypothesis III

The third hypothesis states that there is no significant association between occupation of respondents and experience of sexual intercourse. Chi square was used to test for the association. The results showed that there was a significant association between occupation of respondents and experience of sexual intercourse $X^2 = 21.567$ ($p = 0.017$) (Table 4.8.3).

Table 4.8.3: Chi square test of association between occupation of respondents and experience of sexual intercourse

Variables	Ever had sex		Chi-square	P-value
	Yes	No		
Occupation				
Hairdresser	58 (22.4%)	29 (20.6%)	21.567	0.017
Tailor	87 (33.6%)	42 (29.8%)		
Chemist	20 (7.7%)	30 (21.3%)		
Barber	27 (10.4%)	11 (7.8%)		
Shoemaker	10 (3.9%)	9 (6.4%)		
Mechanic	23 (8.9%)	6 (4.3%)		
Welder	6 (2.3%)	1 (0.7%)		
Aluminium fabricator	10 (3.9%)	5 (3.5%)		
Electrician	9 (3.5%)	5 (3.5%)		
Mobile phone repair	6 (2.3%)	3 (2.1%)		
Carpenter	3 (1.2%)	0 (0.0%)		

4.8.4 Hypothesis IV

The fourth hypothesis states that there is no significant association between age of respondents and pattern of sexual behaviour (safe sexual practice). Chi square was used to test for the association. The results showed that there was no significant association between age of respondents and safe sexual practice $X^2 = 3.906$ ($p = 0.400$) (Table 4.8.4).

Table 4.8.4: Chi-square test of association between age of respondents and safe sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Unsafe	Safe	Value	Df	p-value
Age					
15 years old	34 (9.0%)	2 (9.5%)	3.906*	4	0.400
16 years old	68 (18.0%)	3 (14.3%)			
17 years old	71 (18.8%)	1 (4.8%)			
18 years old	93 (24.6%)	8 (38.1%)			
19 years old	112 (29.6%)	7 (33.3%)			

** Fisher's exact*

4.8.5 Hypothesis V

The fifth hypothesis states that there is no significant association between sex of respondents and pattern of sexual behaviour (safe sexual practice). Chi square was used to test for the association. The results showed that there was there was no significant association between sex of respondents and safe sexual practice $X^2 = 2.718$ ($p = 0.099$) (Table 4.8.5).

Table 4.8.5: Chi square test of association between sex of respondents and safe sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Unsafe	Safe	Value	Df	p-value
Sex					
Male	165 (43.5%)	13 (61.9%)	2.718	1	0.099
Female	214 (56.5%)	8 (38.1%)			

4.8.6 Hypothesis VI

The sixth hypothesis states that there is no significant association between occupation of respondents and pattern of sexual behaviour (safe sexual practice). Chi square was used to test for the association. The results showed that there was there was no significant association between occupation of respondents and safe sexual practice $X^2 = 5.729$ ($p = 0.771$) (Table 4.8.6).

Table 4.8.6: Chi square test of association between occupation of respondents and safe sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Unsafe	Safe	Value	Df	p-value
Occupation					
Hairdresser	84 (22.2%)	3 (14.3%)	5.729*	10	0.771
Tailor	122 (32.2%)	7 (33.3%)			
Chemist	46 (12.1%)	4 (19.0%)			
Barber	36 (9.5%)	2 (9.5%)			
Shoemaker	17 (4.5%)	2 (9.5%)			
Mechanic	28 (7.4%)	1 (4.8%)			
Welder	6 (1.6%)	1 (4.8%)			
Aluminium fabricator	14 (3.7%)	1 (4.8%)			
Electrician	14 (3.7%)	0 (0.0%)			
Mobile phone repair	9 (2.4%)	0 (0.0%)			
Carpenter	3 (0.8%)	0 (0.0%)			

* *Fisher's exact*

4.8.7 Hypothesis VII

The seventh hypothesis states that there is no significant association between age of respondents and pattern of sexual behaviour (risky sexual practice). Chi square was used to test for the association. The results showed that there was there was no significant association between age of respondents and risky sexual practice $X^2 = 4.012$ ($p = 0.560$) (Table 4.8.7).

Table 4.8.7: Chi-square test of association between age of respondents and risky sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Risky	Non-risky	Value	Df	p-value
Age					
15 years old	31 (10.2%)	6 (6.2%)	4.012*	5	0.560
16 years old	56 (18.5%)	15 (15.5%)			
17 years old	57 (18.8%)	15 (15.5%)			
18 years old	75 (24.8%)	26 (26.8%)			
19 years old	84 (27.7%)	35 (36.1%)			
Total	303	97			

* *Fisher's exact*

4.8.8 Hypothesis VIII

The eighth hypothesis states that there is no significant association between sex of respondents and pattern of sexual behaviour (risky sexual practice). Chi square was used to test for the association. The results showed that there was no significant association between sex of respondents and risky sexual practice $X^2 = 3.383$ ($p = 0.078$) (Table 4.8.8).

Table 4.8.8: Chi square test of association between sex of respondents and risky sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Risky	Non-risky	Value	Df	p-value
Sex					
Male	127 (41.9%)	51 (52.6%)	3.383	1	0.078
Female	176 (58.1%)	46 (47.4%)			
Total	303	97			

4.8.9 Hypothesis IX

The ninth hypothesis states that there is no significant association between occupation of respondents and pattern of sexual behaviour (risky sexual practice). Chi square was used to test for the association. There was a significant association between occupation of respondents and risky sexual practice $X^2 = 18.815$ ($p = 0.049$) (Table 4.8.9).

Table 4.8.9: Chi-square test of association between occupation of respondents and risky sexual practice

Variables	Pattern of sexual behaviour		Chi-square test		
	Risky	Non-risky	Value	Df	p-value
Occupation					
Hairdresser	65 (21.5%)	22 (22.7)	18.815*	10	0.049
Tailor	100 (33.0%)	29 (29.9%)			
Chemist	45 (14.9%)	5 (5.2%)			
Barber	31 (10.2%)	7 (7.2%)			
Shoemaker	15 (5.0%)	4 (4.1%)			
Mechanic	18 (5.9%)	11 (11%)			
Welder	5 (1.7%)	2 (2.1%)			
Aluminium fabricator	7 (2.3%)	8 (8.2%)			
Electrician	10 (3.3%)	4 (4.1%)			
Mobile phone repair	5 (1.7%)	4 (4.1%)			
Carpenter	2 (0.7%)	1 (1.0%)			
Total	303	97			

* *Fisher's exact*

4.9 Binary logistic regression analysis

Binary logistic regression analysis was used to determine the independent variable that has more significant influence on experience of sexual intercourse. The variables considered include age and sex. The result showed that older respondents (OR= 8.29, CI= 3.6-19.07) and males (OR= 0.684, CI= 0.44-1.07) have higher odds of ever having sex.

Table 4.9: Binary logistic regression analysis

	Df	OR	CI	p-value
Age				
16 years old	1	2.31	1.20 – 4.45	0.012
17 years old	1	5.61	2.85 – 11.04	0.000
18 years old	1	4.35	2.30 – 8.6	0.000
19 years old	1	8.29	3.6 – 19.07	0.000
Gender				
Male	1	0.684	0.44 – 1.07	0.097

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

This chapter discusses the socio-demographic characteristics of respondents, relationship levels that affects sexual behaviour, sexual activity, safe sexual practice, risky sexual practice, and factors influencing patterns of sexual behaviour. This chapter ends with the implication of findings for Health Promotion and Education, conclusion and recommendations.

5.1 Discussion

5.1.1 Socio-demographic characteristics of the respondents

From this study, the age range of the respondents fell between the ages of 15-19 years. Dixon-Mueller, 2009 reported that, late adolescence (15-19 years) especially deserves special attention as sexual debut and a process of testing often take place during this period. Also, the Nigeria Demographic and Health Survey (NDHS, 2013), reported that twenty-three percent of girls age 15-19 have begun childbearing and adolescents with no education represent about half of those who have begun childbearing. Christianity is predominant among the respondents, this can be attributed to the fact that the study was conducted in the South-western geographical region where Christianity is the most common religion practiced compared to the Northern part of the country where Islam is the predominant religion. The respondents were all artisans and majority of them were Yoruba by tribe. This could also be ascribed to the location of the study area which falls within the South-western region of the country where the Yoruba ethnic group constitute the majority.

5.1.2 Relationship levels that affect sexual behaviour of out-of-school adolescents

Most of the respondents' parents live together and less than half of the respondents live with their parents while few live with their lovers. This is in contrast to a study conducted in Anambra state which reported that more than half (57.9%) of the out-of-school girls lived most of their time with relatives, one of the two parents, friends and boyfriend (Adogu *et al.,* 2014). More than half of the respondents are not free to discuss sex with the person they live with, the reason most of them gave for this is fear, others said it is forbidden, they are not comfortable, or they are ashamed. This is similar to the findings of Envuladu, 2013 that about half of the teenagers 184(47.9%) reported that they were not free to discuss issue of sex with their parents due to fear, shyness and cultural acceptance among other reasons.

Instead of discussing sexual matters with the person they live with, most of the respondents in this study discuss with friends. This is similar to the findings of Bo *et al.,* 2007 that both male and female adolescents prefers their friends as the person with whom they talk to about sexual issues. Most of the respondents have friends that are sexually active and majority of them have a boy/girlfriend. This is supported by the report of a study conducted among Nigerian adolescents that 78.8% (1159) males have girlfriends while 66.8% (987) females have boyfriends (Ayodele & Akindele-Oscar, 2015).

5.1.3 Sexual behaviours among out-of-school adolescents

This study revealed that most of the respondents have had sexual intercourse. This is supported by earlier study among adolescents which discovered that 67.7% had a relationship with the opposite sex and 48.4% are having sexual intercourse with the opposite sex (Envuladu, 2013). The lowest age of sexual debut found in this study was 13 years and the highest age was 19 years. Less than a third of the respondents had their first sex at age 15 while very few had their first sex at age 19. This is supported by a study considering patterns and trends of adolescents sexual behaviour in sub-saharan africa which stated that up to 25% of 15-19 year-olds reported sex before age 15 (Doyle *et al.,* 2012). Also, findings of this study is similar to that of Hafsa, 2012 which shows that 70% of the participants had had their sexual debut, 55% of these were male and 45% were female; majority of the adolescents (33%) had their sexual debut between 16-18 yrs. Furthermore, it is supported by findings of a study conducted in Cross River state of Nigeria which indicated that adolescent sexual debut is relatively young because eighty percent of respondents had had sex before 18years of age and only fifteen percent of the respondents had their sexual initiation at about nineteen years and above (Ugal & Floral, 2015).

Most of the respondents in this study have been sexually active in the past year, more than a third of the respondents have a single partner and maximum number of partners reported was 8-10, this is supported by a studies conducted earlier. Abubakar, 2011 reported that within the last 12 Months 20% of the out of school adolescents were sexually active, 70% had single sexual partners and 10% of them had multiple partners. Hafsa, 2012 stated that 19.8% reported having had three or more lifetime partners and maximum numbers of partners reported by male were 15 and female were 10. Another study found that many 186 (69%) of the respondents have had sexual intercourse and 94 of them had only one sex partner while 92 had multiple sex partner Adejumo, 2011).

This study revealed that more than a third of respondents have older partners, few of respondents have become pregnant or impregnated someone and have aborted the pregnancy. This is similar to the result of Hafsa, 2012 where respondents reported having 45.8% of partners who were older by 1-4 years and 32.2% who were older by more than five years. Also, of the female youth who reported sexual penetration 33.8% reported ever being pregnant and 20% procured an abortion. From this study, most of the respondents have strong sexual urge and majority of the respondents are sexually attracted to opposite sex. Although few of them are attracted to the same sex, some of the respondents are also attracted to both opposite sex and same sex. Females are more attracted to opposite sex than males while males are more attracted to same sex than females. This is supported by a study conducted by Bamidele *et al.,* 2009 where heterosexual intercourse was practiced by 78.1 percent and homosexuality was practiced by 11 percent of adolescents who were sexually active.

The results of this study indicated that experience of sexual intercourse increases with age. This is supported by previous studies which revealed that prevalence of sexual activities increases with age (Fagbamigbe *et al.,* 2011; Envuladu *et al.,* 2013). This is very informative especially as it relates to the adolescent sexuality. Obviously, the age at sexual debut among adolescent boys and girls is very early, and this implies that there is a change in the moral structure of the society. It is a general believe that there has been a continuous moral decline in the society, which may be caused by changes in the value system, wrong use of modern technology and inadequate moral up-bringing.

5.1.4 Safe Sexual Practices among out-of-school adolescents

This study revealed that among respondents that have had sexual intercourse, more than half use contraceptives methods and condom use was higher. This is supported by studies conducted earlier that found that the commonest method of contraception known to out-of-school adolescents is condom (Adogu *et al.,* 2014; Ugal & floral, 2015). Also, the findings of Bo *et al.,* 2007 that condom was the most common birth control method of contraception used by the youth (73%), followed by oral contraceptive pills (38%) or withdrawal (36%) is similar to the results of this study.

For respondents that have had sexual intercourse and do not use contraceptives, higher proportion of them do not use it because they do not like it. Some of respondents used

contraceptive the last time they had sexual intercourse and condom was used more than other contraceptive methods. Most of those that did not use contraceptive for their last sexual intercourse stated that they do not like it, others said their partner refused, they are not aware and some said they have no reason. This report is similar to the result of a study conducted earlier which revealed that among the basis stated for not using condom was partner's refusal and poor knowledge about the need to use protective measures (Envuladu, 2013). Higher proportion of respondents have not used contraceptives in the past 12months. This is an indication that a majority of adolescents are prone to the danger of contracting sexually transmitted diseases because the high percentage of non-use is dangerous to the prevention of STDs including HIV/AIDS.

This study also revealed that less than a third of respondents always insist on condom use, few insist sometimes and less than half never insist. This is supported by a study conducted earlier which revealed that when respondents were asked about regularity of condom use, majority 370 (77.4%) of the respondents used it sometimes, some (12.6%) never used it while only few (10.0%) always use it thereby concluding that adolescents in this part of the world have engaged in premarital and unsafe sexual behaviours (Nwankwo & Nwoke, 2009). Also, this study revealed that less than half of respondents always initiate the topic of safer sex with their potential sexual partners. This is supported by an earlier study which reported that among the sexually active adolescents, 83percent said they had discussed sexual health topics with their dating partners. Consequentially, adolescents who discussed more sexual health topics with their partners significantly use condom more often (Widman, Choukas-Bradley, Helm, Golin and Prinstein, 2014).

5.1.5 Risky Sexual Practices among out-of-school adolescents

It has been reported that out-of-school adolescents engage in risky sexual behaviour compared to their in-school counterparts (Adogu *et al.,* 2014). This study revealed the risky sexual practices the respondents engage in. Some of the respondents have been forced by someone to engage in sexual intercourse and have had sexual intercourse without using condom. Less than a third do engage in oral sex without using condom or rubber dam and less than a third engage in anal sex. This is supported by earlier studies that revealed that the methods of sexual activity practised by the sexually experienced adolescents were vagina, oral and anal sex. Among the public health threats are some of the reported types of sexual practices that raises the likelihood for adverse health outcome, this includes

penetrative vaginal sex and anal sex (Morhason-Bello *et al.,* 2008; Hafsa, 2012). Also, few of respondents have sexual intercourse under the influence of drugs and alcohol. This is supported by a previous study that said alcohol intake is associated with casual sexual intercourse (Oyediran *et al.,* 2010). The higher likelihood of alcohol intake or use of drugs in sexual intercourse suggests sex in exchange for money and impulsive or unplanned sex under the effect of alcohol, with their implications for the spread of HIV and AIDS.

5.1.6 Factors influencing patterns of sexual behaviour among out-of-school adolescents

It is evident that not all adolescents go into sexual behaviours for the same reason, various factors influence their decisions and this depends on the circumstances surrounding them. This study identified some environmental factors that influence patterns of sexual behaviour. Most of the respondents have access to books and musicals that promote sexual activities, higher proportion of respondents are exposed to movies and musicals that teach and promote sexual activities. This is supported by a study conducted by Fatusi & Blum, 2008 which reported that exposure to television have a mutual relationship with early beginning of sex. Also, foreign films and locally produced movies have been identified as a causal agent for involvement in first sex, particularly for males (Ankomah *et al.,* 2011). Some of the respondents involved in sexual activities in order to get money to take care of themselves while some give their sexual partners money in order to have sex with them. This is supported by a study conducted by Hafsa, 2012 where both males and females reported having had sex for favours, the females at a higher frequency (7%) than the male (4.2%).

This study revealed the people out-of-school adolescents learn sexual behaviour from through modelling. Among respondents of this study, very few engage in sexual activities because they see their parents do it or their siblings encourage them to, majority of respondents said that their family will frown at it if they get to know that they are already engaged in sexual activities. But, less than a third of respondents engage in sexual activities because they see their friends do it and about half of respondents reported that their friends encourage them to engage in sexual activities. This is supported by the findings of Morhason-Bello *et al.,* 2008 that most adolescents first learnt about sex from their friends.

The findings from the chi-square test revealed that there was a significant association between age, sex, occupation and experience of sexual intercourse, binary logistics regression analysis further showed that the older the age, the higher the tendency of engaging in sexual intercourse and males are more likely to have had sexual intercourse than females. This is supported by a study conducted by Envuladu *et al.,* 2013 which revealed that age is significantly associated with sexual behaviour, the older adolescents were found to be sexually active more than the younger ones. The result is also supported by Salako *et al.,* 2006 which found that significantly more males have experienced sexual intercourse than females. Furthermore, previous researches revealed that gender had significant relationship with having sex (Hibret *et al.,* 2007; Ayodele & Akindele-Oscar, 2015). The result is in contrast with that of Madan, 2013 which found that the relationship between gender and sexual intercourse was insignificant.

5.2 Implications of findings for Health Promotion and Education

Health Promotion is a process of enabling people to have full control over their health and its determinants. Health promotion and education basically involves the collaboration of families, communities, regional and national authorities and stakeholders so that necessary resources and support are available to enable individuals live a healthy life. Health education is thus concerned with helping people change from their high-risk health behaviours to safe ones through a combination of learning experiences. The results of this study suggests that although some of the respondents engage in safe sexual behaviours a substantial part of them engage in unsafe sexual behaviours detrimental to their health. Health Education strategies such as Public enlightenment, peer education, counselling, training can be used to influence positive patterns of sexual behavior.

Public enlightenment campaign can be used as a strategy to create awareness on the health and social consequences of risky sexual behaviours. This has the potential of reaching to a very large number of people including artisans. This should involve the use of leaflets, posters, bill boards, flyers and jingles. The behavioural change communication materials can be provided by government agencies and non-governmental organisations committed to the health and wellbeing of adolescents and young people.

Peer education could also be used to promote respondents' understanding of the health consequences of unsafe sexual behaviours. Peers are models and they have great influence

on behavior of individuals, so educational and behavioural change activities provided by peers have great potentials of yielding positive results. Some out-of-school adolescents in each artisan group should be trained by health professionals on the health consequences of risky sexual behaviours, how to engage in safe sexual practices and its importance. These set of people will in turn educate other out-of-school adolescents in their various artisan groups.

Counselling as a health education strategy can be very useful. Sexual health professionals from relevant government sectors and non-governmental organisations where counsellors can be linked to artisan groups, can partner with various artisan associations to provide adequate counselling services to out-of-school adolescents on safe sexual behaviours.

Training of out-of-school adolescents on risky sexual behaviours and its associated dangers could be an effective strategy for addressing this health menace among respondents. Sexual and reproductive health experts can go through the artisan association leaders to train the out-of-school adolescents under their tutelage about health effects of unsafe sexual behaviours, importance of the use of contraceptives and correct usage, avoidance of models that can effect negative behaviours such as sexually active friends, in order to effect positive patterns of sexual behaviour.

5.3 Conclusion

This study has demonstrated that most out-of-school adolescents are sexually active, and a substantial majority of them engage in unsafe sexual practices. Environmental factors and the people adolescents see as models especially their friends influenced their decisions concerning the kind of sexual behaviours to adopt. The need for further expansion and strengthening of information and services to adolescents, particularly for the less accessible out-of-school ones should be encouraged. All sectors, including parents, media, religious organisations, health-care providers, community establishments and policy makers, have roles to play in promoting healthy sexuality. Risky sexual behavioural patterns can be reduced among out-of school adolescents and safe-sexual practices can be promoted if the recommendations are implemented.

5.4 Recommendations

The problems of out-of-school adolescents' unsafe sexual practices as observed in this study can be addressed by implementing the following recommendations:

- Out-of-school adolescents should be targeted for intervention through behavioural change communication (BCC) on sexual and reproductive health issues in the workplace settings.
- Using the results of the study as a baseline data, the Ministry of Health and Education, faith based organizations, international and non-governmental bodies and all adolescent stakeholders should collaborate with opinion leaders to improve the reproductive and sexual health knowledge of out-of-school adolescents. All stake holders such as educators, curriculum planners, counsellors etc. involved in the design of curriculum or policy formulation for this vulnerable group (the adolescents), are challenged to provide suitable, timely, scientifically sound and evidence-based sexuality information to the adolescents through the curriculum.
- Parents and guardians should be educated in order to have control over the cultural barriers that prevents giving adolescents early sexuality education at home. They should be enlightened on the importance of providing a supportive home environment, maintaining strong connection with their children and giving suitable information on sexual issues according to their ages. This will bring about a level of family interconnection that will effect positive changes in the sexual behaviour of the adolescents. The responsibility of sensitizing parents can be taken up by the Ministry of Women Affairs with cooperation from faith-based organisations, non-governmental organisations, parents, teachers association, representatives of market women and other related bodies.
- Erotic films shows on television should be banned and indiscriminate film shows in cinema and other private satellite film show centres should be banned by government. Governments both at the Federal and state levels should place sanctions on media messages, which have the capability of misguiding the adolescents by giving false sexual information.
- Efforts should be made by government to provide qualitative accessible and affordable reproductive health services to young people at community level. The services should be more adolescent friendly and more responsive to their needs.

- In view of the overwhelming influence of peer group as a major source of adolescent's sexuality information and a major factor promoting adolescents unsafe sexual behaviours. Peer educators should be trained to transfer correct information to their peers.
- Effective health education programmes should be targeted at out-of-school adolescents to enhance their knowledge on sexual issues, encourage abstinence and motivate behaviours that reduce sexual risk. This should include education about all aspects of sexuality, relationships, decision-making, communication, contraceptive methods, STIs, and pregnancy prevention. This will encourage adolescents to develop healthy, sensible, and mutually safe relationships whenever they make a choice to become sexually active. Where sexual abstinence counselling may not be enough, contraceptive counselling should be enhanced so as to expand utilisation.

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APPENDIX 1

QUESTIONNAIRE

SERIAL NO:

PATTERNS OF SEXUAL BEHAVIOUR AMONG OUT-OF SCHOOL ADOLESCENTS IN EGBEDA LOCAL GOVERNMENT AREA, OYO STATE.

Dear Respondent,

I am a post graduate researcher/student at the department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. The purpose of this study is to gather information about the PATTERNS OF SEXUAL BEHAVIOUR AMONG OUT-OF SCHOOL ADOLESCENTS.

Please note that your participation in this study is entirely voluntary. As the main intention behind the survey is not to identify any individual's response, but group responses, YOUR NAME WILL NOT BE WRITTEN anywhere on the questionnaire. Each questionnaire has been given a CODE NUMBER to conceal your identity. We would like to ask you about your personal experiences. Please note that all information that would be collected during this study will be treated with utmost confidentiality.

Your participation in this study is very important as it would help to get adequate information about the research topic. Please also note that there are no right or wrong answers to the questions that would be asked or the statements made.

The time needed to complete the questionnaire is approximately 10-15 minutes. Your willingness to respond to the questions implies you have given consent to participate. Thank you for cooperating. ***Please answer all the questions as honestly and accurately as you can — this is very important***.

Section A: Demography

1. Age as at last birthday: _____ years old
2. Sex: Male ( ) Female ( )
3. Highest Educational level (*if was ever enrolled in school*):
   Primary 1-6 ( ) JSS 1-3 ( ) SS 1-3 ( )
4. Marital status:
   Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )
5. Religion: Christianity ( ) Islam ( ) Traditional ( ) Others *specify* _____
6. Ethnicity: Yoruba ( ) Igbo ( ) Hausa ( ) Others *specify* _____

7. State of origin: _____

8. Occupation: _____

Section B: Relationship levels that affects Sexual Behaviour

Instruction: *Kindly consider the following statements in this section carefully and answer by ticking [√] under the appropriate column to indicate how each statement corresponds to your opinion.*

9. Do your parents live together? Yes ( ) No ( )

10. Who do you live with most of the time?

Parent/Guardian ( ) Siblings/Relatives ( ) Friends ( ) Boss ( ) Lover ( )

11a. Are you free to discuss sex with the person you live with? Yes ( ) No ( )

11b. *If no,* what is your reason for not discussing it?

Fear ( ) Not comfortable ( ) Forbidden ( ) Shame ( )

Others: ……

12. Do you have a close friend you discuss sexual matters with? Yes ( ) No ( )

13. Are your friends sexually active? Yes ( ) No ( )

14. Do you have a boy/girl friend? Yes ( ) No ( )

Section C: Sexual Behaviour

Sexual activity refers to any type of genital contact or sexual stimulation between two persons including, but not limited to sexual intercourse.

Instruction: *Kindly consider the following statements in this section carefully and answer by ticking [√] under the appropriate column to indicate how each statement corresponds to your opinion.*

15. Have you ever had sexual intercourse? Yes ( ) No ( )

16. How old were you when you had sexual intercourse for the first time?

_____ years old

17a. Have you been sexually active in the past year? Yes ( ) No ( )

17b. *If yes*, how many sexual partners do you currently have?

1 ( ) 2-4 ( ) 5-7 ( ) 8-10 ( ) 11 and above ( )

18a. Are your partners older than you? Yes ( ) No ( )

18b. *If yes*, how many years difference? 1-5 ( ) 6-10 ( ) 11-15 ( ) 15-20 ( )

19a. Have you or one of your sexual partners ever become pregnant?

Yes ( ) No ( ) I am not aware ( )

19b. *If yes,* how long had you and your partner been sexually active at the time of conception? Less than a month ( ) 2-3 months ( ) 4-6 months ( ) 6 months to a year ( ) longer than a year ( ) Don't know ( )

19c. What decision did you and/or your partner make regarding the pregnancy? Kept the baby ( ) abortion ( )

20. Which sex are you sexually attracted to? Opposite sex ( ) Same sex ( ) Both opposite sex and same sex ( )

21. How would you describe your urge for sex? Very strong ( ) Strong ( ) Not strong ( ) No sex drive ( )

Section D: Safe Sexual Practice

Instruction: *Kindly consider the following statements in this section carefully and answer by ticking [√] under the appropriate column to indicate how each statement corresponds to your opinion.*

22a. Do you or your partner use contraceptives? Yes ( ) No ( )

22b. *If yes*, which contraceptive method(s) do you use? Abstinence ( ) Condom ( ) Withdrawal ( ) Oral Pills ( ) Injectable ( ) Others: ……

22c. *If no,* why no use of contraceptives? Partner refused ( ) I do not like it ( ) I am not aware ( ) No reason ( )

23a. The last time I had sexual intercourse I used a contraceptive: Yes ( ) No ( )

23b. *If yes,* what type? ……

23c. *If no*, why? ……

24. In the past 12 months I have used contraceptive(s): All the time ( ) Most of the time ( ) Rarely ( ) I have not used contraceptive ( )

S/N	Statements	Always	Sometimes	Rarely	Never
25.	I abstain from sexual activity				
26.	I insist on condom use when I have sexual intercourse				
27.	I stop foreplay long enough to put on a condom or for my partner to put on a condom				
28.	I ask potential sexual partners about their sexual histories				
29.	I avoid direct contact with my sexual partner's semen or vaginal secretions				
30.	I abstain from sexual intercourse when I do not know my partner's sexual history				
31.	I do not abstain from sexual intercourse even if I have sores or irritation in my genital area				
32.	If I know an encounter may lead to sexual intercourse, I carry a condom with me				
33.	I insist on examining my sexual partner for sores, cuts, or abrasions in the genital area				
34.	I avoid direct contact with my sexual partner's blood				
35.	I initiate the topic of safer sex with my potential sexual partner				
36.	I get screened for STI				

Section E: Risky Sexual Practice

Instruction: *Please kindly tick [√] appropriately and supply adequate responses to the questions provided.*

S/N	Statements	Always	Sometimes	Rarely	Never
37.	I have been forced by someone to engage in sexual intercourse with me				
38	I have forced someone to engage in sexual intercourse with me				
39.	I engage in sexual intercourse on a first outing				
40.	I lick or suck my partners penis or vagina without using condom or rubber dam				
41.	If swept away in the passion of the moment, I have sexual intercourse without using a condom				
42.	I engage in anal intercourse without using a condom				
43.	I have sexual intercourse while under the influence of drugs				
44.	I have sexual intercourse while under the influence of alcohol				

Section F: Environmental Factors

Instruction: *Kindly consider the following statements in this section carefully and answer by ticking [√] under the appropriate column to indicate how each statement corresponds to your opinion.*

45. I am exposed to films/movies and musicals that teach and promote sexual activities: Yes ( ) No ( )

46. I always have access to books that promote sexual activities: Yes ( ) No ( )

47. There are laws/regulations that frown at adolescents engaging in sexual activities: Yes ( ) No ( )
48. My community cares about my sexual activities: Yes ( ) No ( )
49. I engage in sexual activities to get money to take care of myself: Yes ( ) No ( )
50. I give my partner money to have sex with me: Yes ( ) No ( )

Section G: Observational Learning

Instruction: *Kindly consider the following statements in this section carefully and answer by ticking [√] under the appropriate column to indicate how each statement corresponds to your opinion.*

51. I engage in sexual activities because I see my friends do it: Yes ( ) No ( )
52. I engage in sexual activities because I see my parents do it: Yes ( ) No ( )
53. My friends encourage me to engage in sexual activities: Yes ( ) No ( )
54. I engage in sexual activities because my siblings encourage me to: Yes ( ) No ( )
55. My family will frown at it if they get to find out that I am already engaged in sexual activities: Yes ( ) No ( )

Thank you for your participation

APPENDIX 2

QUESTIONNAIRE (YORUBA TRANSLATION)

NOMBA:

ERI IWA IBALOPO LAARIN AWON ODO TI KO SI NI ILE-IWE NI IJOBA AGBEGBE EGBEDA NI IPINLE OYO

Eyin oludahun,

Mo je omo ile iwe giga onipele keji ni sakaani Igbelaruge Ilera ati Eko, eka eko eto ilera gbogbogbo ti yunifasiti Ibadan. Idi iwadi yii ni lati ko alaye jo nipa ERI IWA IBALOPO LAARIN AWON ODO TI KO SI NI ILE-IWE.

Jowo se akiyesi pe ikopa ninu iwadi yii je atinuwa. Ero ti o wa leyin iwadi yii kii se lati fi idahan eni kookan han bi ko se idahun akojopo, A O NI KO ORUKO YIN SI ORI IWE IWADI YII. A ti fun iwe kookan ni NOMBA IWADI lati fi idanimo yin pamo. A o fe lati beere nipa iriri yin. Jowo se akiyesi pe a o fi gbogbo alaye ti a ba gba pamo gidigidi.

Ikopa re ninu iwadi yii se pataki nitori yoo ran mi lowo lati gba alaye ti o dara nipa koko iwadi yii. Jowo se akiyesi pe ko si idahun ti ko to tabi idahun to peye si awon ibeere ti a o beere.

Akoko ti a nilo lati pari iwe iwadi yii o to iseju meje si mejila. Ninife lati dahun si awon ibeere wonyii tumosi pe o ti gba lati kopa. Mo dupe fun ifowosopo. ***Jowo dahun gbogbo ibeere ni otito – eleyii se pataki.***

Abala A: Igbe Aye Oludahun

1. Omo odun melo ni o: odun _____
2. Eda: Okunrin ( ) obinrin ( )
3. Ipele eko (ti o ba lo si ile iwe ri): Alakobere, ipele kini de ikefa ( ) Ile iwe girama akoko, ipele kini de iketa ( ) Ile iwe girama ikeji, ipele kini de iketa ( )
4. Se o ni iyawo tabi oko:
   da nikan wa ( ) ti gbeyawo ( ) ti pinya ( ) Ko sile ( ) Opo ( )
5. Esin: Kristeni ( ) Islam ( ) Elesin abalaye ( ) Omiran e salaye _____
6. Eya: Yoruba ( ) Igbo ( ) Hausa ( ) Omiran e salaye _____
7. Omo ipinle wo ni o: _____
8. Ise wo lo n se: _____

Abala B: Awon ipele ibasepo ti o le ni ipa lori ihuwasi ibalopo

9. Se awon obi re n gbe papo? Beeni ( ) Beeko ( )

10. Taani o n gbe pelu lopolopo igba?

Obi/Oluso ( ) Awon tegbontaburo/ awon ibatan ( ) Ore ( ) Oga ( ) Ololufe ( )

11a. Se o ni ominira lati so nipa ibalopo fun eni ti o gbe pelu? Beeni ( ) Beeko ( )

11b. *Bi beeko,* kini idi ti o fi le ba won soro?

Eru ( ) Okan re o ni bale ( ) Eewo ni ( ) Itiju ( )

Awon idi miran: ……

12. Se o ni ore timotimo ti o ma n ba so awon oro ibalopo? Beeni ( ) Beeko ( )

13. Se awon ore re ma n ni ibalopo? Beeni ( ) Beeko ( )

14. Se o ni orekunrin taki orebinrin? Beeni ( ) Beeko ( )

Abala D: Ise Ibalopo

Ise ibalopo tunmosi iru ibalopo ti o wa laarin eniyan meji.

15. Nje o ti ni ibalopo ri? Beeni ( ) Beeko ( )

16. Omo odun melo ni o ni igba akoko ti o ni ibalopo? Odun _____

17a. Nje o ni ibalopo ni odun to koja? Beeni ( ) Beeko ( )

17b. *Bi beeeni*, alabalopo meloo lo ni? Eyokan ( ) Meji si merin ( )

marun si meje ( ) mejo si mewa ( ) mokanla soke ( )

18a. Se awon alabalopo re ju o lo lojo ori? Beeni ( ) Beeko ( )

18b. *Bi beeni,* odun melo ni won fi ju o lo? Eyo si marun ( ) Mefa si mewa ( )

mokanla si meedoogun ( ) Meedogun si ogun ( )

19a. Nje iwo tabi okan lara awon alabalopo re ti ni oyun ri?

Beeni ( ) Beeko ( ) Miomo ( )

19b. Bi beeni, o to igba wo ti iwo ati alabalopo re yii ti n ni ibalopo ki o to loyun?

Ko to osu kan ( ) Osu meji si meta ( ) Osu merin si mefa ( ) Osu mefa si odun kan ( ) O ju odun kan lo ( )Mi o mo ( )

19d. Ipinu wo ni iwo ati alabalopo re se nipa oyun naa?

O bi omo naa ( ) O se oyun naa ( ) Awon nkan miran ……..……

20. Awon wo ni o ma n nipa ibalopo pelu?

Eda keji lokunrin/lobinrin ( ) Iru eda tire ( ) Iru eda mejeeji ( )

21. Bawo ni o se le salaye bi ara re se ma n beere fun ibalopo?

O lagbara gan ( ) O lagbara ( ) Ko lagbara ( ) Kosi ibeere fun ibalopo ( )

Abala E: Ise ibalopo ailewu

22a. Nje iwo tabi alabalopo re n lo ounkohun lati feto si omo bibi?

Beeni ( ) Beeko ( )

22b. *Bi beeni*, iru ifeto si omo bibi wo ni o ma n lo? Yiyera fun ibalopo ( ) Ora idaabobo ( ) Yiyo kuro ( ) Oogun lilo ( ) Alabere ( ) Awon miran:..……..

22d. *Bi beeko*, kilode ti o lo ifeto si omo bibi?

Alabalopo mi o gba ( ) Mi o feran re ( ) Mio mo nipa re ( ) Ko si idi ( )

23a. Mo lo ifeto si omo bibi fun ibalopo to kehin ti mo ni: Beeni ( ) Beeko ( )

23b. Bi beeni, iru ewo? ……..

23d. Bi beeko, kilode? ……

24. Ni osu mejila seyin, mo ti lo ifeto si omo bibi:

Ni gbogbo igba ( ) Ni opo igba ( ) Leekookan ( ) Mi o lo ifeto si omo bibi

Ilana: *Jowo mu idahun ti o ba o lara mu si awon ibeere wonyii.*

S/N	Oro	Gbogobo igba	Igba miran	Kowopo	Rara
25.	Mo ma n yera fun ise ibalopo				
26.	Mo ma n duro lori ipinu mi lati lo ora idabobo ti mo ba fe ni ibalopo				
27.	Mo ma n da ere ife duro lati wo roba idabobo tabi fun olubalopo mi lati wo ora idabobo				
28.	Mo ma n bi eniti mo ba fe ba lopo nipa itan ibalopo won				
29.	Mo ma nyera fun fifi ara kan ato okunrin ati nkan to n ti oju ara obinrin jare				
30.	Mo ma n yera fun ibalopo ti mi o ba mo itan ibalopo olubalopo mi				
31.	Mi o ki n yera fun ibalopo bi mo tile ni egbo ni oju ara mi				

32.	Ti mo ba mo tele wipe ipade emi ati ore okunrin/ore obinrin mi lee yori si ibalopo, mo ma nlo pelu ora idabobo				
33.	Mo ma n duro lori ipinu mi lati ye oju ara olubalopo mi wo fun egbo				
34.	Mo ma n yera fun fifi arakan eje olubalopo mi				
35.	Mo ma n bere akori oro ibalopo ailewu pelu eniti mo ba fe ba ni ibalopo				
36.	Mo ma n se ayewo fun arun ibalopo				

Abala E: Ise ibalopo to lewu

Ilana: *Jowo mu idahun ti o ba o lara mu si awon ibeere wonyii.*

S/N	**Oro**	**Gbogobo igba**	**Igba miran**	**Kowopo**	**Rara**
37.	Enikan ti fi ipa ba mi lo po ri				
38.	Mo ti fi ipa ba enikan lo po ri				
39.	Mo ni ibalopo ni ijade akoko				
40.	Mo ma n fi enu lai la oko tabi oju ara alabalopo mi lai lo ora idabobo				
41.	Ti adun ere ife ba ti wo mi lara, mo ma n ni ibalopo lai lo ora idabobo				
42.	Mo ma n ni ibasepo ni iho idi lai lo ora idabobo				
43.	Mo ma n ni ibalopo nigba ti mo ba lo ogun oloro				
44.	Mo ma n ni ibalopo nigba ti mo ba mu oti				

Abala F: Awon Okunfa Ayika

45. Oju mi la si wiwo fimu tabi orin ti o n gbe ise ibalopo ga: Beeni ( ) Beeko ( )
46. Mo ma n ni anfani si awon iwe to n gbe ise ibalopo ga: Beeni ( ) Beeko ( )
47. Ofin tabi ilana to lodi si ise ibalopo wa: Beeni ( ) Beeko ( )
48. Ise ibalopo mi kan awon ara agbegbe mi: Beeni ( ) Beeko ( )
49. Mo ma n kopa ninu ise ibalopo lati ri owo ti maa fi toju ara mi:
    Beeni ( ) Beeko ( )
50. Mo ma n fun alabalopo mi lowo lati bami lo po: Beeni ( ) Beeko ( )

Abala G: Kikeko Nipa Wiwo Awokose

51. Mo ma n kopa ninu awon ise ibalopo nitori mo ma n ri awon ore mi to n se bee:
    Beeni ( ) Beeko ( )
52. Mo ma n kopa ninu awon ise ibalopo nitori mo ma n ri awon obi mi to n se bee:
    Beeni ( ) Beeko ( )
53. Awon ore mi ma n gba mi niyanju lati kopa ninu ise ibalopo be:
    Beeni ( ) Beeko ( )
54. Mo ma n kopa ninu awon ise ibalopo nitori awon tegbontaburo mi ma n gba mi niyanju lati se be: Beeni ( ) Beeko ( )
55. Awon idile mi yoo lodi si ti won ba mo wipe mo n kopa ninu ise ibalopo:
    Beeni ( ) Beeko ( )

Ese fun ikopa yin.

APPENDIX 3

CODING GUIDE

Patterns of Sexual Behaviour among Out-of school Adolescents in Egbeda Local Government Area, Oyo State.

Question	Variable (Questionnaire/Statement)	Variable label	Code
Q1	Age as at last birthday		
Q2	Sex	Male	1
		Female	2
Q3	Highest Educational level (*if was ever enrolled in school*)	Primary 1-6	1
		JSS 1-3	2
		SS 1-3	3
Q4	Marital status	Single	1
		Married	2
		Separated	3
		Divorced	4
		Widowed	5
Q5	Religion	Christianity	1
		Islam	2
		Traditional	3
Q6	Ethnicity	Yoruba	1
		Igbo	2
		Hausa	3
		Tiv	4
Q7	State of origin	Oyo	1
		Osun	2
		Ogun	3
		Ondo	4
		Ekiti	5
		Lagos	6
		Kwara	7
		Kogi	8

		Edo	9
		Anambra	10
		Benue	11
		Rivers	12
		Delta	13
		Imo	14
		Enugu	15
Q8	Occupation	Hairdresser	1
		Tailor	2
		Chemist	3
		Barber	4
		Shoemaker	5
		Mechanic	6
		Welder	7
		Aluminium	8
		Electrician	9
		Phone repairer	10
		Carpenter	11

Q9	Do your parent live together?	Yes	1
		No	2
Q10	Who do you live with most of the time?	Parent/Guardian	1
		Siblings/Relatives	2
		Friends	3
		Boss	4
		Lover	5
Q11a	Are you free to discuss sex with the person you live with?	Yes	1
		No	2
Q11b	*If no*, what is your reason for not discussing it?	Not applicable	0
		Fear	1
		Not comfortable	2
		Forbidden	3

		Shame	4
Q12	Do you have a close friend you discuss sexual matters with?	Yes	1
		No	2
Q13	Are your friends sexually active?	Yes	1
		No	2
Q14	Do you have a boy/girl friend?	Yes	1
		No	2

Q15	Have you ever had sexual intercourse?	Yes	1
		No	2
Q16	How old were you when you had sexual intercourse for the first time?		
		Not applicable	0
Q17a	Have you been sexually active in the past year?	Yes	1
		No	2
Q17b	*If yes*, how many sexual partners do you currently have?	Not applicable	0
		1	1
		2-4	2
		5-7	3
		8-10	4
		11 and above	5
Q18a	Are your partners older than you?	Not applicable	0
		Yes	1
		No	2
Q18b	*If yes*, how many years difference?	Not applicable	0
		1-5	1
		6-10	2
		11-15	3
		15-20	4
Q19a	Have you or one of your sexual partners ever become pregnant?	Yes	1
		No	2
		I am not aware	3

Q19b	*If yes,* how long had you and your partner been sexually active at the time of conception?	Not applicable	0
		Less than a month	1
		2-3 months	2
		4-6 months	3
		6 months to a year	4
		Longer than a year	5
		Don't know	6
Q19c	What decision did you and/or your partner make regarding the pregnancy?	Not applicable	0
		Kept the baby	1
		Abortion	2
Q20	Which sex are you sexually attracted to?	Opposite sex	1
		Same sex	2
		Both opposite sex and same sex	3
Q21	How would you describe your urge for sexual intercourse?	Very strong	1
		Strong	2
		Not strong	3
		No sex drive	4

Q22a	Do you or your partner use contraceptives?	Yes	1
		No	2
Q22b	*If yes*, which contraceptive method(s) do you use?	Not applicable	0
		Abstinence	1
		Condom	2
		Withdrawal	3
		Oral pills	4
		Injectable	5
Q22c	*If no,* why no use of contraceptives?	Not applicable	0
		Partner refused	1
		I do not like it	2
		I am not aware	3
		No reason	4

Q23a	The last time I had sexual intercourse I used a contraceptive	Not applicable	0
		Yes	1
		No	2
Q23b	*If yes,* what type?	Not applicable	0
		Condom	1
		Withdrawal	2
		Oral pills	3
		Injectable	4
Q23c	*If no*, why?	Not applicable	0
		Partner refused	1
		I do not like it	2
		I am not aware	3
		No reason	4
Q24	In the past 12 months I have used contraceptive(s)	All the time	1
		Most of the time	2
		Rarely	3
		I have not used contraceptive	4
Q25	I abstain from sexual activity	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q26	I insist on condom use when I have sexual intercourse	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q27	I stop foreplay long enough to put on a condom or for my partner to put on a condom	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q28	I ask potential sexual partners about their sexual histories	Always	1
		Sometimes	2

		Rarely	3
		Never	4
Q29	I avoid direct contact with my sexual partner's semen or vaginal secretions	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q30	I abstain from sexual intercourse when I do not know my partner's sexual history	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q31	I do not abstain from sexual intercourse even if I have sores or irritation in my genital area	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q32	If I know an encounter may lead to sexual intercourse, I carry a condom with me	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q33	I insist on examining my sexual partner for sores, cuts, or abrasions in the genital area	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q34	I avoid direct contact with my sexual partner's blood	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q35	I initiate the topic of safer sex with my potential sexual partner	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q36	I get screened for STI	Always	1
		Sometimes	2

		Rarely	3
		Never	4

Q37	I have been forced by someone to engage in sexual intercourse with me	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q38	I have forced someone to engage in sexual intercourse with me	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q39	I engage in sexual intercourse on a first outing	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q40	I lick or suck my partners penis or vagina without using condom or rubber dam	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q41	If swept away in the passion of the moment, I have sexual intercourse without using a condom	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q42	I engage in anal intercourse without using a condom	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q43	I have sexual intercourse while under the influence of drugs	Always	1
		Sometimes	2
		Rarely	3
		Never	4
Q44		Always	1

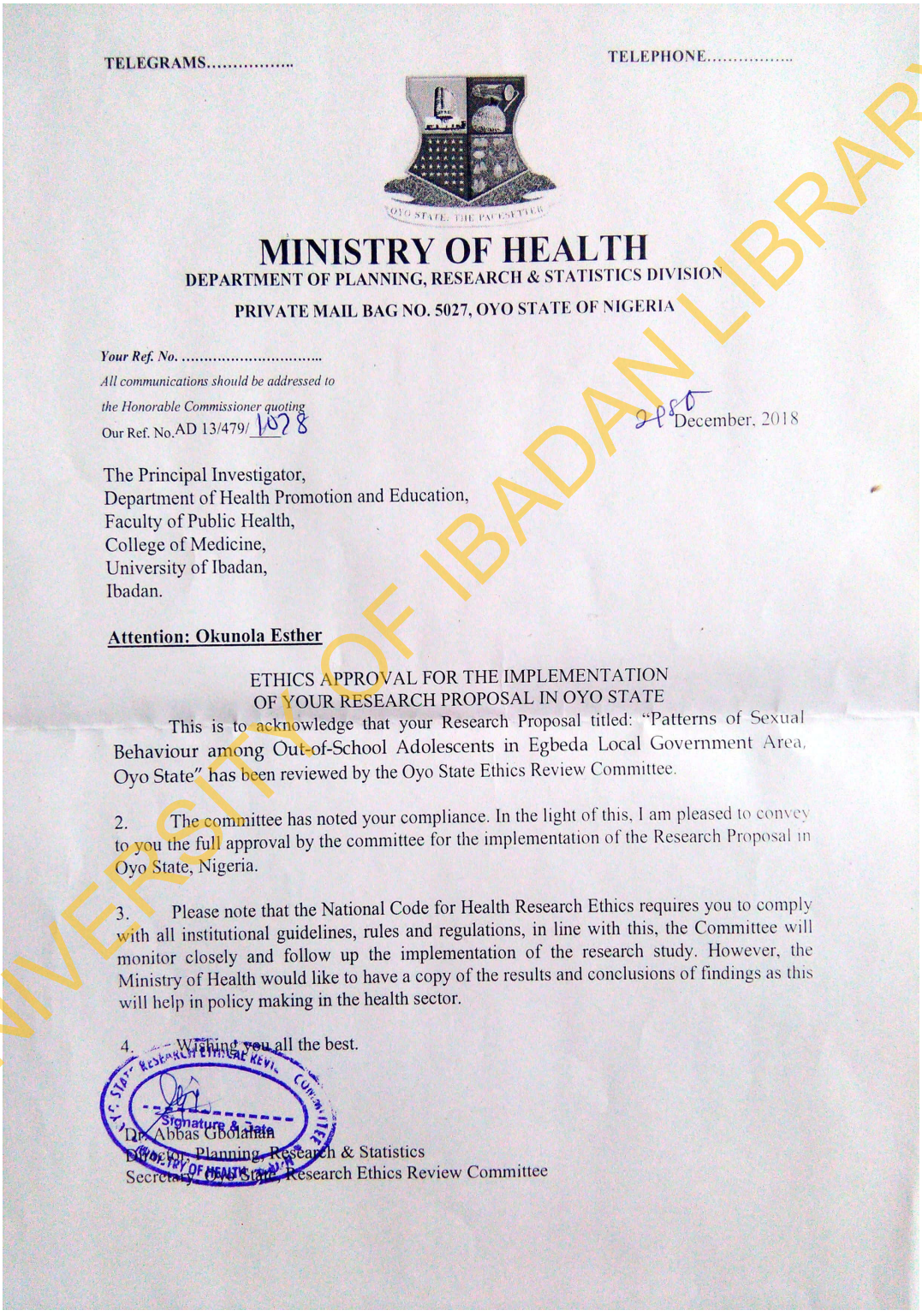
	I have sexual intercourse while under the influence of alcohol	Sometimes	2
		Rarely	3
		Never	4

Q45	I am exposed to films/movies and musicals that teach and promote sexual activities	Yes	1
Q46	I always have access to books that promote sexual activities		
Q47	There are laws/regulations that frown at adolescents engaging in sexual activities		
Q48	My community cares about my sexual activities	No	2
Q49	I engage in sexual activities to get money to take care of myself		
Q50	I give my partner money to have sex with me		

Q51	I engage in sexual activities because I see my friends do it	Yes	1
Q52	I engage in sexual activities because I see my parents do it		
Q53	My friends encourage me to engage in sexual activities		
Q54	I engage in sexual activities because my siblings encourage me to	No	2
Q55	My family will frown at it if they get to find out that I am already engaged in sexual activities		

APPENDIX 4

ETHICAL APPROVAL LETTER



TELEGRAMS..... TELEPHONE.....

OYO STATE: THE PACESETTER

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/479/1078

21st December, 2018

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Okunola Esther

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Patterns of Sexual Behaviour among Out-of-School Adolescents in Egbeda Local Government Area, Oyo State" has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE
Signature & Date
MINISTRY OF HEALTH

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethics Review Committee