EFFICACY OF SEXUALITY EDUCATION ON KNOWLEDGE, ATTITUDE AND SEXUAL RIGHTS PROTECTIVE BEHAVIOUR OF FEMALE STUDENTS IN THE COLLEGES OF EDUCATION, ANAMBRA STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This project is dedicated to my all sufficient God, the Alpha and Omega, the one that knows the end of all things from the beginning, who has proved over and over again that He is more than able in my life.

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ABSTRACT

Sexual rights of girls and women are often times violated with attendant health consequences, such as unwanted pregnancies, abortion, stigmatisation and sexually transmitted infections. Studies in sexuality education have focused largely on sexual coercion and sexually transmitted infections with little attention paid to sexual rights protective behaviour. This study was, therefore, conducted to examine the efficacy of sexuality education on knowledge, attitude and sexual right protective behaviour of female students in the Colleges of Education (CoEs), Anambra State, Nigeria. The moderating effects of age and level of study were also examined.

Bandura's Social Cognitive Theory provided the framework, while the pretest-posttest control group quasi experimental design of 2x2x3 factorial matrix was adopted. Multistage sampling procedure was used. The two public CoEs in Anambra State (Nwafor Orizu College of Education, Nsugbe (NOCEN) and Federal College of Education (Technical) Umunze (FCET) were enumerated. Simple random sampling technique was used to select 410 female students in NOCEN and 270 from FCET. The NOCEN and FCET were randomly assigned to experimental and control groups. Knowledge of Sexual Rights (r=0.71), Attitude Towards Sexual Right (r = 0.84) and Sexual Rights Protective Behaviour (r= 0.77) scales were used. Treatment lasted eight weeks. Data were analysed using descriptive statistics and Analysis of covariance at 0.05 level of significance.

Participants' age was 22.30±3.1 years. There were significant main effects of treatment on knowledge ($F_{(1; 665)} = 295.63$, partial $\eta^2 = .31$), attitude ($F_{(1; 665)} = 358.94$, partial $\eta^2 = .35$) and sexual rights protective behaviour ($F_{(1; 665)} = 249.63$, partial $\eta^2 = .27$). The participants in sexuality education group obtained higher mean score in knowledge - 27.14; attitude - 17.46; sexual right protective behaviours - 16.99 than those in the control group; knowledge - 21.24; attitude - 10.72; sexual right protective behaviours -14.66. There were no significant main effect of age and level of study on knowledge, attitude and sexual right protective behaviour. There was a significant interaction effect of age and level of study on sexual rights protective behaviour ($F_{(2; 665)} = 4.85$, partial $\eta^2 = 0.01$) in favour of adolescents in 100level from sexuality education group but not on knowledge and attitude. There was no significant interaction effect of treatment and level of study, as well as treatment and age on knowledge, attitude and sexual rights protective behaviour. The three-way interaction effect of treatment, age and level of study was also not significant.

Sexuality education had the greatest impact on the knowledge, followed by attitude and sexual rights protective behaviour of female students in colleges of education, Anambra State. Sexuality education with emphasis on issues of sexual rights protective behaviour should be effectively implemented in the curriculum of colleges of education.

Keywords: Sexuality education, Female students of colleges of education, Sexual assertiveness

Word count: 462

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CHAPTER ONE
INTRODUCTION

Background of the Study

Addressing young people's sexual rights and interests is of utmost importance in ensuring health and well-being of this vital segment of population. Many times, adults especially teachers, parents, child welfare bodies and policy-makers find it difficult to acknowledge, address and provide for the sexual interests and rights of the youths. Also, there may be practical difficulties of how sexual matters may be with young people,due to cultural norms and taboos relating to sexuality.Cultural and religious diversities in sexual norms within the adult population, which often encompass cultural practices concerned with when and how it is acceptable for young people to gain sexual knowledge and experience, compound the difficulty on a cultural (or national) level. Provision of information and guidance is difficult to deliver in a culturally nuanced manner, even if this were a consensually desired aim (Moronkola, Amosu and Okonkwo, 2006; James 2012).

A further challenge is that the very process of addressing an issue seems to impose normative pressures on a developing child. For example, to offer information about sexual development or health before a child who is sufficiently mature or ready to hear about it seems to set up the expectation that the child 'should' by now be interested, perhaps even to undermine, their present state of innocence of sexual matters. Yet to leave the provision of such information 'too late' is to risk their obtaining information from inappropriate or misleading or exploitative sources, or to lack the information or awareness vital to guide their legitimate sexual exploration and their sexual right.

There are more than one billion 15 - 24 years old, 70% of who live in developing nations (UNFPA, 2014; Udigwe, 2018). The young people are growing up in circumstances quite different from those of their parents with greater access to formal education, increasing the need for such technological skills as computer and internet literacy, different job opportunities, and better exposure to new ideas through the media, telecommunications and other avenues. The environment in which young people were making decisions related to sexual and reproductive health is also rapidly evolving. The rate of sexual initiation during young adulthood is rising or remaining unchanged in many developing countries (Aliand Cleland, 2015; Gupta and Mahy, 2013; Bilicon 2018),

childbearing and marriage are increasingly unlinked (Bearinger, 2017) and in many countries, high HIV prevalence adds to the risks associated with early sexual activity (Pettifor, 2004, Dixon-Mueller, 2009). For example, in all but a few countries in sub-Saharan Africa, AIDS is a generalized epidemic in which young people are disproportionately affected, accounting for almost two-thirds of the people living with HIV in the region. Hence, the need for sexuality education programme in order to reduce the scourge of sexuality related diseases through information dissemination.

Sexuality is a central aspect of being human throughout life, and it encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is experienced and expressed in thoughts, fantasies, desire, beliefs, attitudes, value, behaviour, practices, roles and relationships, (WHO, 2003 and Obiekea, Ovri and Chukwuma, 2018). Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethnical, legal, historical and religious and spiritual factors.Sexuality education is a planned process of education that fosters the acquisition of factual information, the formation of positive attitudes, beliefs and values as well as the development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human sexuality. The main goal of sexuality education is the promotion of sexual health by providing young people with opportunities to develop a positive and factual view of sexuality; acquiring the information and skills they need to take care of their sexual health, including preventing HIV/AIDS; respect and value themselves and others as well as acquire the skills needed to make healthy decisions about their sexual health and behaviour (Moronkola, Amosu and Okonkwo, 2006).

Sexuality education is most effective when it continues across the life cycle, and when other services are available to help young people make lasting social, educational, economic, and lifestyle choices. Reproductive health addresses the reproductive processes, functions and system at all stages of life. It therefore implies that people are able to have a responsible satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of aid to have access to safe, effective, affordable and acceptable methods of birth control of their choice, and the right of access to appropriate

health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chances of having a healthy infant.

Arising from papers presented and discussions at International Conference on Population and Development (ICPD) held in Cairo in 1994, experts are now of the opinion and documented that reproductive and sexual health, therefore, encompasses freedom from fear of unwanted pregnancy, diseases and abuse from the shame and guilt that surrounds sexuality in many cultures.Oladepo (2002) noted that the magnitude of young people's sexual problems in Nigeria is enormous and these include premarital sex, multiple sex partners, unintended pregnancy, sexually transmitted infection, including HIV/AIDS, abortion, coercion, sexual abuse and early child bearing. Moronkola, Amosu and Okonkwo (2006) in their study found out that university students have poor knowledge about conception but were very sexually active as 60.1% had procured abortion during their studentship in the university and 3.6% of these abortions was carried out in privately owned hospitals/clinics, through self medication with attendant dangers.

Mahini (2018) stated that there is inadequate knowledge related to reproductive health even among educated persons. The media and friends not health professionals are the major sources of health information for young men and women of all ages; hence inadequate information is expected in young stars. Iyanda and Moronkola (2017) found that adolescents had poor attitude towards seeking reproductive health information. They found that 66.0% had negative attitude towards seeking reproductive health information while 28.8% were indifferent. This is an indication of poor knowledge towards sexual rights which is observed by the researcher among the population.Okonkwo Fatusi and Illika (2015) in their study in Anambra state on sexual rights,found that girls and women had poor knowledge or demand for sexual rights due to diverse factors especially those that are socio-cultural in nature.

Attitude is formed from a collection of behavioural belief, it refers to the degree to which a person has a favourable or unfavourable evaluation or appraisal of the behaviour in question. Attitude means a predisposition to act in a certain way towards some aspect of one’s environment including other people. It serves as a primary function of bringing together the various experiences to which an individual is exposed and forming them into a cohesive, organized whole. Attitude can be positive or negative and can affect the

behaviour of an individual. Essentially, attitudes are formed through a learning process which can occur in a number of ways which include observational learning and imitation, workshops and seminars, health education intervention programme and group discussion. The strategies for reduction in the abuse of sexual rights of young people requires both knowledge gaining and attitudinal change.

Studies on reproductive health behaviour of young people in Nigeria indicate that many young people initiate sexual intercourse at an early age and engage in high-risk sexual behaviours (Okonkwo, Fatusi and Ilika, 2015). Concerns regarding the implications of this behaviour have led to increasing intervention for those in the early phase of adolescent life particularly in-school adolescents. However, very little attention has so far been given to young adults within the age range of late adolescents and youths.Indeed, the environment in higher institutions of learning in Nigeria like that in many other parts of the world, is characterized by high level of personal freedom and social interactions. Socially, the typical tertiary institution environment in Nigeria offers opportunities for high level of sexual networking and the "freedom" that characterizes the higher institutions permits permissive lifestyle (Fatusi, 2014).

Katjavivi (2003) was of the opinion that based on the picture of sexual behaviour within the campuses; African institutions of higher learning have been described as high-risk institutions for the transmission of HIV.According to the Federal Ministry of Health (FMOH) (2004), the National HIV/AIDS and Reproductive Health Survey (NARHS) showed that only 7% and 44% of 15-19 years old knew of sexuality transmitted infection symptoms in men and women respectively. Research also confirms that many young person’s participate in risky sexual activities including early sexual debut of sexual activities (Slap, Lot, Huang, Daniyan, Zink and Succop, 2003) multiple sexual partners, low and inconsistent use of condoms (Ajuwon, 2002; Olaseha, Ajuwon and Onyejekwe, 2004; Iwuagwu, Olaseha and Ajuwon, 2000).

According to WHO (2001), data on levels of induced abortion in developing countries are notoriously difficult to gather, either because abortion is restricted or because the issue is too sensitive. Most young female students who get pregnant in every region often opted for abortion. Even when the practice of abortion is restricted, large percentage of pregnant young females opted for abortion.

Sexual health rights of people imply the rights of all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health; be free of discrimination, coercion or violence in their sexual life and in all sexual decisions as well as expect and demand equality, full consent, mutual respect, and shared responsibility in sexual relationships. (Adinma, 2002, Akande, 2002). Many of sexual abuses against females and sexual behaviour of female students are due to cultural norms favouring male dominance over the female in all areas of life as well as lack of knowledge of personal skills among students. Personal skills (assertiveness, negotiation, values, self-esteem, goal setting, decision making and communication) are necessary for one to live a meaningful life.

Sexual Rights (SR) encompass the right of all individuals to make decisions about their sexual activity and reproduction free from discrimination, coercion and violence, and to achieve the highest attainable standard of sexual health. Sexual and reproductive ill health accounts for more than a third of the global burden of disease for women of childbearing age, and one-fifth of the burden for the whole population (WHO, 2014). When girls are healthy and their rights are fulfilled, they can go to school, learn and gain the skills and resources they need to be healthy, productive and empowered adults. Protecting sexual rights of all individuals not only saves lives and empowers people, but it can also lead to significant economic gains for individuals, families, and nations. It has been shown to reduce healthcare costs, improve productivity, and increase rates of education which lead to greater economic growth.

A significant proportion of girls become pregnant during the time that they should be in school: About 19% of girls in the developing world become pregnant before age 18, and about 3% become pregnant before age 15 (Bailey, 2011). Sexual and reproductive health and rights issues, especially gender-based violence and adolescent girls' vulnerability to child, early and forced marriage, unintended pregnancy, and HIV and other sexually transmitted infections impede girls' educational aspirations.

For some time now, the sexual rights of many female students in tertiary institutions in terms of coercion or violence in their sexual lives and in all sexual decision have been violated by male staff and students .Ajuwon, Owoaje, Falaye, Osinowo, Aimakhu and Adewole,(2007) noted that although among women of all ages, female youth

are disproportionately affected. Adolescents who experienced sexual violence suffer from unwanted touch of the breasts and buttocks, unwanted kissing, forceful exposure to pornographic materials, attempting to rape, and rape, and incest, verbal insistence on having sex, forced marriage and being forced to carryout sexual acts.

Ajuwon, Akin-Jimoh, Olley and Akintola (2001) in their review ofliterature documented that sexual coercion is the act of forcing or attempting to force a person to succumb to sexual activity against the person's will through violence, threats, verbal insistence, cultural expectations or economic circumstances and this may take the form of unwanted or unasked for touching, insistence and verbal intimidation. There are seven tertiary institutions in Anambra State (Nnamdi Azikwe University, Awka, Anambra State University Uli, Federal Polytechnic, Oko, Nwafor Orizu College of Education Nsugbe, Federal College of Education,Umunze, Tansian University Umunya and Madonna University, Okija).

Teachers and teacher trainees are expected to have knowledge, positive attitude and exhibit acceptable behaviour to the society to serve as role models to their students as well as being social agents in their various communities. This informed the researcher to decide to study the efficacy of sexuality education programme on knowledge, attitude towards sexual rights and behaviour among female College of Education Students in Anambra State.

Statement of Problem

Exploratory survey by the researcher revealed that female students in tertiary institutions in Nigeria are sexually active. They are also threatened by sexual coercion and they engage in risky sexual health behaviour with the attendant medical and socio-emotional health consequences.

There are external pressures on the youths like pornographic materials, wearing of highly seductive fashionable clothing by members of the opposite sex and peers and effects of films and video tapes that promote unsafe sexual behaviour among young persons in Nigeria. These pressures are intensified by the fact that many parents have found it difficult to perform effectively the role of sex guidance for the youths consequently failure to address the reproductive health needs of the youths predisposes them to the risk of

contracting HIV/AIDS and other Sexually Transmitted Infections as well as to unwanted pregnancy.

In a study carried out by Okonkwo Fatusi and Illika (2015) in Anambra state, girls and women were found to have poor knowledge or demand for sexual rights due to diverse factors especially those that are socio-cultural in nature. The researchers thereafter, recommended that there is a need for more detailed study that will involve the use of both quantitative as well as qualitative methods to facilitate a better understanding of the situation and uncover associated issues. The findings from this study, have implications for both programme and research activities. In terms of programme design and implementation, the findings indicate that in order to improve sexual behaviour among young people in Nigeria, tertiary education interventions must target the totality of their social environment.

It was based on this premise that the study sought to examine the efficacy of sexuality education on knowledge, attitude and sexual rights protective behaviour among female students in the College of Education, Anambra State.

General Objective of the Study

The main objective of the study was to determine the efficacy of sexuality education on knowledge, attitude and sexual rights protective behaviour among female students in the College of Education, Anambra State.

Specific Objectives

The following specific objectives were accomplished:

1. Determined the main effect of treatment on knowledge, attitude and sexual rightsprotective behaviour of female college of education students in Anambra State.
2. Evaluated the main effect of age on knowledge, attitude and sexual rightsprotective behaviour of female college of education students in Anambra State.
3. Determined the main effects of level of study on knowledge, attitude and sexual rightsprotective behaviour of female college of education students in Anambra state.

4. Ascertained the interaction effect of treatment and age on knowledge, attitude and sexual rightsprotective behaviour of female college of education students in Anambra state.
5. Establishedthe interaction effect of treatment and level of study on knowledge, attitude and sexual rightsprotective behaviour on female college of education students in Anambra state.
6. Determined the interaction effect of age and level of study on knowledge, attitude and sexual rightsprotective behaviour of female college of education students in Anambra state.
7. Examined the interaction effect of treatment, age and level of study on knowledge, attitude and sexual rights protective behaviour of female college of education students in Anambra state.

Research Questions

The study provided answers to the following research questions:

1) What is the level of knowledge of sexual rights of female students in Colleges of Education in Anambra State?
2) What is the attitude of female students in College of Education in Anambra State towards sexual rights?
3) What is the behaviour of female students in Colleges of Education in Anambra State towards sexual rights?

Hypotheses

The following hypotheses were tested:

1) There is no significantmain effect of treatment on
   (a) knowledge
   (b) attitude towards sexual rights
   (c) sexual rightsprotective behaviour of femalestudents in colleges of education in Anambra State.
2) There is no significant main effect of age on
   (a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female students in colleges of education in Anambra State.

3) There is no significant main effect of level of study on

(a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female students in colleges of education in Anambra state.

4) There is no significant interaction effect of treatment and age on

(a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female students in colleges of education in Anambra state.

5) There is no significant interaction effect of treatment and level of study on

(a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female colleges of education students in Anambra state.

6) There is no significant interaction effect of age and level of study on

(a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female students in colleges of education in Anambra state.

7) There is no significant interaction effect of treatment, age and level of study on

(a) knowledge

(b) attitude towards sexual rights

(c) sexual rights protective behaviour of female students in colleges of education in Anambra state.

Delimitation of the Study

The study was delimited to the following;

1. Quasi experimental research design of pretest- post test control method.
2. All female students in Colleges of Education in Anambra State as population of study.
3. Six hundred and eighty participants.
4. Independent variables of Sexuality Education Programme Package, moderating variables (Age and level of study) and dependent variables of knowledge of sexual rights, attitude toward sexual rights and sexual rightsprotectivebehaviours as variables of study.
5. Multistage sampling procedure.
6. Self-developed structured, validated and reliable questionnaire and focus group guide as instruments for data collection.
7. Descriptive statistics of frequency count and percentages for the demographic characteristics of the participants and to provide answers to the research questions while the inferential statistics of analysis of Multivariate Analysis of Covariance (MANCOVA) was used to test the hypotheses at 0.05 alpha level.

8.Ten trained research assistants.

Limitation of the Study

Based on the sensitive nature of the study, some of the participants may not be honest in their responses to the questionnaire items because of the sensitive nature of the study which may, despite all appeal against dishonesty and might, affect the quality of data collected and conclusion made at the end of the study. Also, since the participants were not camped, some extraneous variables such as viewing television on information relating to sexual rights may also affect the result of the study. However, the researcher tried as much as possible to control all extraneous variables to the minimum.

Significance of the Study

The empirical results of the study provided a basis for the establishment of the existence of inadequate knowledge of sexual rights among female students of Colleges of Education in Anambra State, Nigeria. It also provided empirical basis for evaluating the

efficacy of sexuality education on knowledge as well as attitude towards sexual rights among female students of Colleges of Education in Anambra State, Nigeria. The result of this study also provided information on the contribution of the intervention onbehaviour as far as sexual right is concerned among female students of Colleges of Education in Anambra State in Nigeria.

An intervention programme of this nature will equip the students with adequate knowledge about sexual rights which will assist in making informed decision about their sexual health and reproduction.

The outcome of this study shall be made available to the authority of each participating college of education so as to motivate them to concentrate on developing policies on health education and promotion, particularly targeting the sexual rights skills of female college of education students. If this is achieved, the unsafe sexual behaviour can be reduced among the students. The outcome of this study shall add to the body of knowledge on sexuality education in Nigeria.

Operational Definition of Terms

Attitude: Mental views, opinions, dispositions or how one feels about sexual rights particularly in a situation that is related to sexual rights.

Female Students: Female Colleges of Education students in Anambra State who are not more than 24 years of age at the time of the study.

Knowledge: The information, understanding and skills that one has about sexual rights especially among college of education students.

Sexual behaviour: Sexual activities among Colleges of Education students like premarital sex and extra-marital sex.

Sexual coercion: The use of force or the attempts to force another individual through threats, verbal insistence, deception, cultural expectations and economic circumstances to engage in any sexual activity with another person against his or her will.

Sexual rights: These are rights of all female students to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health.

Sexual rightsprotective behaviour: This implied that the rights of all students to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health; be free of discrimination, coercion or violence in their sexual life and in all sexual decisions as well as expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationship.

CHAPTER TWO

LITERATURE REVIEW

The related literature will be reviewed under the following sub-headings:

1. Conceptual framework
2. Theoretical framework
3. Conceptual review of literature
    a. Concept of sexuality education
    b. Concept of youth
    c. Concept of health seeking behaviour
    d. Overview of health seeking behaviour in Nigeria
    e. Overview of sexual health behaviour of youth in Anambra State
    f. Concept of sexual reproductive health
    g. Concept of sexual rights and sexual offence/right act
    h. Concepts of sexually transmitted infections
    i. Sexual health knowledge and attitude of young people
    j. Sexual rights bahaviour
    k. Overview of sexual behaviour of youths (World View)
    l. Overview of sexual behaviour of youths in Nigeria
2. Empirical review of literature
    a. Sexuality education in Nigeria
    b. Intervention on sexual rights knowledge
    c. Sexuality education and attitude towards sexual rights
    d. Sexual rights behaviour
    e. Intervention and sexual behaviour modification
3. Appraisal of literature.

Conceptual Framework

Conceptual framework is pertaining to the process of forming and interpreting a concept or idea. But conceptual application can vary. Meanwhile, in this context; it is the ways ideas are organised or structured so as to achieve the study objectives. It is also a set of coherent ideas or concept organised in a manner that makes it to be easily

communicated to others. Therefore, the conceptual framework for this study is operationalised in the figure below;

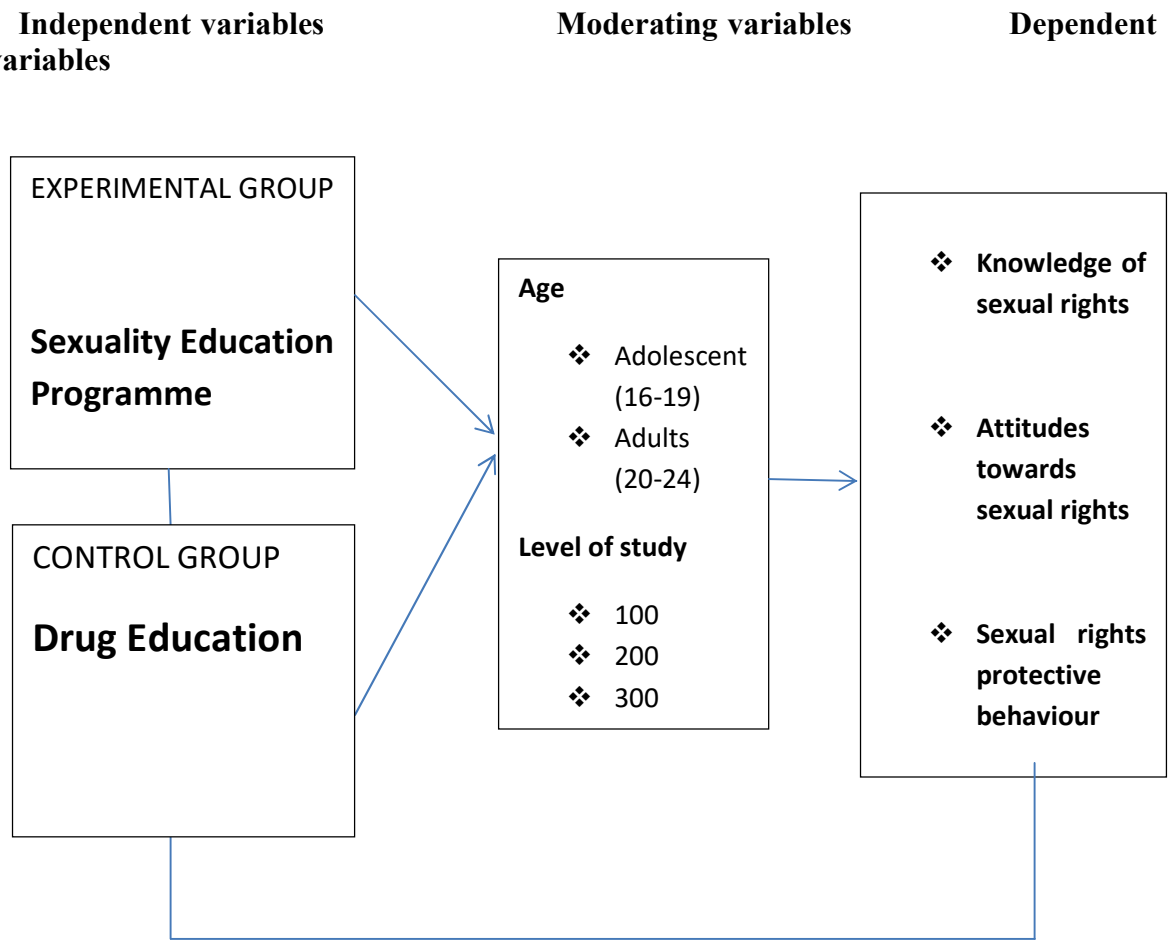

Fig 1: Self-developed Conceptual framework Showing the Effect of Sexuality Education Programme on Knowledge, Attitude andSexual Rights Protective Behaviour of Female Students

The figure above depicts and operationalised the variables that are involved in this study. As it is shown in the above fig 1, there are three key variables which are; independent; moderating and dependent variables. The independent variable represents sexuality education programmes, while the moderating variable represents the groups (experimented and control) that are exposed to the sexuality education programmmes. Meanwhile, the dependent variable represents the impact of sexuality education programmes.

The figure shows that, there is positive relationship between the three (independent; moderating and dependent variables) as dependent variable indices (sexuality knowledge; sexual attitude; sexual rights and sexual behaviour strongly depend on the extent and level of sexuality education programmme (independent variable)that was given to the students (experimental and control groups). Meanwhile, the moderating variable is the variable in between the dependent and independent variables which moderate the impact of sexuality education programme based on the adolescent age and the level of education of the female students.

Theoretical Framework

This study is based on the influence of sexuality education programme on sexual rights, behaviour and attitude of female students. As such, there is the need to strengthen it with a theory. Therefore, social learning and social cognitive theory were considered appropriate for this study. These theories were propounded by Albert Bandura. Social (or Observational) Learning Theory (SLT) which stipulates that people can learn new behaviours by observing others. Earlier learning theories emphasised how people behave in response to environmental stimuli, such as physical rewards or punishment. In contrast, social learning emphasises the reciprocal relationship between social characteristics of the environment, how they are perceived by individuals, and how motivated and able a person is to reproduce behaviours they see happening around them. People both influence and are influenced by the world around them. According to Social Learning Theory, people learn by:

- Observing what other people do
- Considering the apparent consequences experienced by those people
- Rehearsing (at first mentally) what might happen in their own lives if they followed the other peoples' behaviours
- Taking action by trying the behaviour themselves
- Comparing their experiences with what happened to the other people
- Confirming their belief in the new behaviour

Application of Social Learning Theory to Sexuality Education Programme

The principles of social learning can be applied to almost any social and behaviour change programme that aims to influence social behaviours, particularly behaviours that are complex or involve interactions with other people, for example sexual intercourse that involve having partner(s) which might be influenced or facilitated by many factors which include peer pressure. Social learning theory may be especially useful when a particular behaviour is difficult to describe, but can be explained through demonstration or modeling. Also, when adopting or practising a particular behaviour that requires overcoming barriers or challenges, social learning principles can be used to demonstrate how a person can overcome those challenges and succeed. Finally, because people tend to adopt and practice behaviours they see others doing, social learning principles can be used to change perceptions of the social environment, making behaviours seem more common and providing social support to people who are considering a behavioural and altitudinal change towards knowing their sexual rights .

The Social Cognitive Theory (SCT)

Also, Social Cognitive Theory was propounded in 1963 by Albert Bandura; the SCT which stemmed from the Social Learning Theory (SLT); The SCT has its origins in the discipline of psychology, with its early foundation which was laid by behavioural and social psychologists. The SLT evolved under the umbrella of behaviourism, which is a cluster of psychological theories intended to explain why people behave the way they do.

Social learning principles place an emphasis on cognitive variables. Whereas strict behaviourism supports a direct and unidirectional pathway between stimulus and response, representing human behaviour as a simple reaction to external stimuli. It(the SLT) asserts that there is a mediator (human cognition) between stimulus and response, placing individual control over behavioural responses to stimuli. While there are several versions of the SLT to which researchers currently subscribe, they all share the following three basic tenets.

Tenet 1: Response consequences (such as rewards or punishments) influence the likelihood that a person will perform a particular behaviour again in a given situation. Note that this principle is also shared by the classical behaviourists.

Tenet 2: Humans can learn by observing others, in addition to learning by participating in an act personally. Learning by observing others is called vicarious learning. The concept of vicarious learning is not one that would be subscribed to by classical behaviourists.

Tenet 3: Individuals are most likely to model behaviour observed by others they identify with. Identification with others is a function of the degree to which a person is perceived to be similar to one's self, in addition to the degree of emotional attachment that is felt toward an individual.

Albert Bandura has led the efforts on cognitive SLT as he places a heavy focus on cognitive concepts. His theory focuses on how children and adults operate cognitively on their social experiences and how these cognitions then influence behaviour and development. His theory was the first to incorporate the notion of modeling, or vicarious learning, as a form of social learning. In addition, Bandura also introduced several other important concepts, including reciprocal determinism, self-efficacy, and the idea that there can be a significant temporal variation in time lapse between cause and effect. In 1986, Bandura renamed his SLT, Social Cognitive Theory (SCT), as a better description of what he had been advocating since the 1960's. This name change was also likely the result of an effort to further distance himself and his theory from the behaviourist approach.

Bandura's work has stimulated an enormous amount of research on learning and behaviour, and has been extremely fruitful in developing techniques for promoting behaviour change. In addition, his more recent work has been redirected from developmental psychology to the field of health psychology.The SCT explains behaviour in terms of a triadic, dynamic and reciprocal interaction of the environment, personal factors, and behaviour. However, this reciprocal interaction does not imply that all sources of influence are of equal strength. The SCT recognizes that some sources of influence are stronger than others and that they do not all occur simultaneously. In fact, the interaction between the three factors will differ based on the individual, the particular behaviour being examined, and the specific situation in which the behaviour occurs.

The person-behaviour interaction involves the bi-directional influences of one's thoughts, emotions, and biological properties and one's actions. For example, a person's

expectations, beliefs, self-perceptions, goals, and intentions give shape and direction to his behaviour. However, the behaviour that is carried out will then affect one's thoughts and emotions. The SCT also accounts for biological personal factors, such as sex, ethnicity, temperament, and genetic predisposition and the influences they have on behaviour.

A bi-directional interaction also occurs between the environment and personal characteristics. In this process, human expectations, beliefs, and cognitive competencies are developed and modified by social influences and physical structures within the environment. These social influences can convey information and activate emotional reactions through such factors as modeling, instruction, and social persuasion. In addition, humans evoke different reactions from their social environment as a result of their physical characteristics, such as age, size, race, sex, physical attractiveness.

The final interaction occurs between behaviour and the environment. Bandura contends that people are both products and producers of their environment. A person's behaviour will determine the aspects of the environment to which he/she is exposed, and behaviour is, in turn, modified by that environment. A person's behaviour can affect the way in which he/she experiences the environment through selective attention. Based on learned human preferences and competencies, humans select whom they interact with and the activities they participate in from a vast range of possibilities. Human behaviour also influences their environment, such as when an aggressive person creates a hostile environment. Thus, behaviour determines which of the many potential environmental influences come into play and what forms they will take. In turn, the environment partly determines which forms of one's behaviour are developed and activated.

Inherent within the notion of reciprocal determinism is the concept that people have the ability to influence their own destiny, while at the same time recognizing that people are not free agents of their own will. Humans are neither driven by inner forces nor automatically shaped and controlled by the environment. Thus, humans function as contributors to their own motivation, behaviour, and development within a network of reciprocally interacting influences. Within this SCT perspective, humans are characterized in terms of five basic and unique capabilities: symbolizing, vicarious, forethought, self-

regulatory, self-reflective. It is these capabilities that provide humans with cognitive means by which to determine behaviour.

Symbolizing Capability: The SCT maintains that most external influences affect behaviour through cognitive processes. However, Bandura suggests that it is symbols that serve as the mechanism for thought. Through the formation of symbols, such as images (mental pictures) or words, humans are able to give meaning, form, and contiguity to their experiences. In addition, the capability to form symbols enables humans to store information in their memory that can be used to guide future behaviours. It is through this process that humans are able to model observed behaviour.

Symbols provide the mechanism that allows for cognitive problem solving and engaging in foresightful action. It is through foresight that one can think through the consequences of a behaviour without actually performing the behaviour. Research indicates that indeed much of human thought is linguistically based, and that there is a correlation between cognitive development and language acquisition (Bandura, cited in George, 2014).

Vicarious Capability: Vicarious processes refer to the human ability to learn not only from direct experience, but also from the observation of others. Observational learning allows one to develop an idea of how a new behaviour is formed without actually performing the behaviour oneself. This information can then be coded (into symbols) and used as a guide for future action. Vicarious learning is important in that it enables humans to form patterns of behaviour quickly, avoiding time-consuming trial and error, as well as avoiding costly and even fatal mistakes. In addition, a vicarious capability allows one to explore situations and activities for the attainment of new knowledge that would normally be out of reach due to constraints on time, resources, and mobility. TV for example, has vastly expanded the range of models and behaviours one is exposed to every day, allowing people to transcend the boundaries of their own environment.

Observational learning is governed by four processes: attentional span, retention processes, motor reproduction processes, and motivational processes. Attentional span refers to a person's ability to selectively observe actions and behaviours in his or her

environment. In addition, attentional span mediates the specific information that is extracted from each observation. There are specific observer characteristics as well as modeled activity characteristics that regulate the type and amount of observation that is experienced. For example, the complexity and salience of a modeled activity will influence the amount of attention a person gives to that activity. In addition, the observer is most likely to selectively attend to, and model, behaviours of people that are most like themselves and those that they associate with the most. Observed behaviour or activities can only be modeled if they are retained in one's memory. Retention processes are made possible by the human ability to form symbols from observed behaviour that are stored in one's memory. Once symbols are formed and stored in one's memory, they must be converted into appropriate action for modeling to occur. This process is referred to as motor reproduction processes. Lastly, the degree to which a behaviour is seen to result in a valued outcome (expectancies) will influence the likelihood that one will adopt a modeled behaviour (the motivational process).

Social and moral standards also regulate behaviour. The relationship between thought and conduct is mediated through the exercise of moral agency. Through evaluative self-reactions, such as self-approval or self-reprimand, internalized morals and standards can regulate conduct. For example, if a person internalizes the notion that stealing is bad, and then they will impose self-sanctions in order to keep their conduct in line with this internal standard. Therefore, if a person is faced with a decision of stealing or not stealing, he or she would anticipate that this action would violate their internal standards and result in self-criticism. As a result, they would self-regulate their own behaviour by deciding not to steal.

The development and nature of a moral agency has been the topic of much research. In general, it is thought that people develop moral standards from a variety of influences, such as direct instruction, feedback on behaviours from significant others, and modeling of moral standards by others. Standards are also developed from institutionally organized systems, such as education, the media, religion, political, and legal agencies. Bandura contends that observation of behaviour often outweighs verbal instruction as an influence on children's internalization of morals and standards. However, the fact that

people often differ in the standards that they model (such as changing standards in different social settings), the impact of modeling on the development of personal standards is reduced. People do not passively absorb all the standards of behaviour to which they are exposed. Instead, the standards that are internalized are dependent on the degree to which the model is like oneself, the value of an activity, and one's perception of their degree of personal control over the behaviour (locus of control). It is through the process of self-regulation that pro-social behaviour can be internally maintained.

Self-Reflective Capability: Self-refection enables people to analyze their experiences, think about their own thought processes, and alter their thinking accordingly. One of the most important types of self- reflection is self-efficacy. Self-efficacy has received an enormous amount of attention in health-related research in the last five years. In fact, self-efficacy has become a central focus of research, as researchers contend that self-efficacy is a major determinant of self-regulation. Self-efficacy is a type of self-reflective thought that effects one's behaviour. According to the SCT, people develop perceptions about their own abilities and characteristics that subsequently guide their behaviour by determining what a person tries to achieve and how much effort they will put into their performance.

Theoretical Review

Studies in sexual risk behaviour have identified three levels of theoretical influences; personal factors, the proximal context (interpersonal relationships, physical and organizational environment) and the distal context (culture and structural factors) (Easton, Flisher and Aaro, 2003). Among personal factors that may influence sexual risk behaviours are evaluations of vulnerability to a health risk perceived severity of health outcome, the costs versus benefits associated with risk behaviour, perceived emotional and social consequences of health-related behaviour and perceptions about social norms.

The influence of personal factors on sexual risk behaviour are the key focus of a whole range of social psychological theories collectively dubbed the "social cognitive theory". Notable among these theories are the Health Belief Model and the social cognitive learning theory. Despite the validity of individual cognition models in Western societies where they have been largely applied, their key limitation is the scent attention to broader

environmental and economic forces that may influence individual health-related behaviour particularly protective sexual behaviour (Mberu, 2005).

Moreover, evaluations of interventions based on the Health Belief Model for instance have shown consistent disappointing effects on risky behaviour, giving strength to the criticism that the individual is an inadequate unit of analysis.

The need to transcend individual subjective characteristics and focus on objective proximal and distal factors in sexual risk behaviour has been widely recognized in Africa. The proximal factors comprise interpersonal relationships, the physical and organizational environment. The distal factors are cultural and structural factors. While the cultural factors include traditions, the norms of the large society, shared beliefs and values, and variations in such factors across subgroups and segments of the population, the structural factors are legal, political, economical and organizational elements of a society (Eaton et al 2003).

Concept of Sexuality Education

According to Bello; Oladokun; Enakpene; Fabamwo; Obisesan; and Ojengbede (2008), sexuality education among adolescence in Nigeria schools had been a controversial issue that is begging for to be resolved. Sexuality is a fundamental concept in the understanding of sexuality education. Clear understanding of what sexuality and sexuality education mean is necessary because there seems to be widespread misconception that sexuality is all about issues related to sexual intercourse and on the basis misconception some programs of sexuality education in Nigeria havefaced steep opposition (James, 2012).

According toa report by WHO cited in James (2012), sexuality is a central aspect human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is often experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships but not all of them are experienced or expressed since it is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (James, 2012). It has been described to mean”the totality of whom you are, what you believe, what you feel and how

you respond" (Action Health Incorporated, 2003) cited in (James, 2012). Sexuality is often broadly defined as the social construction of a biological drive, which often deals with issues such as whom one has sex with, in what ways, why, under what circumstances and with what outcomes a person engages in sex National Aids Control Council (NACC, 2002). Thus, sexuality pertains to the totality of being human (a female or male) and this suggests a multidimensional perspective of the concept of sexuality which is shaped by biological, psychological, economic, political, social, cultural and religious factors operating within the particular context of young persons in each society. It also underscores the need to understand that sexuality education addresses a wide range of needs and is meant for all persons since its purpose is to achieve sexual health, which is not restricted to the act of having sex, but refers to "a state of physical, emotional, mental and social wellbeing in relation to sexuality and not merely the absence of disease, dysfunction or infirmity".

Sexual health requires a positive and respectable and safe sexual experience free from coercion, discrimination and violence. For sexual health to be attained and maintained in any social setting, the sexual rights of all persons must be respected, protected and fulfilled. Sexual rights necessities that all persons, irrespective of sex, are free from coercion, discrimination and violence.

Sexuality education, on the other hand, has been defined and approached differently by various schools of thoughts. James (2012) describes sexuality education as a planned process of education that fosters the acquisition of factual information, the formation of positive attitudes, beliefs and values as well as the development of skills to cope with the biological, psychological, socio-cultural and spiritual needs of human sexuality. This implies learning about the anatomy, physiology and bio-chemistry of the sexual response system which determines identify, orientations, thoughts and feelings as influenced by values, beliefs ethics and moral concerns. Evidently, sexuality education is a lifelong process of building a strong foundation for sexual health through acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. The education whose curricula encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles, takes place

on a daily basis in homes, schools, faith-based institutions and through the media. The curriculum emphasizes knowledge, behaviour, attitudes and skills that promote committed family and healthy relationships, good character, healthy sexual and reproductive health.

A comprehensive sexuality education program, therefore, teaches young people knowledge and skills of critical issues related to sexuality, including puberty and the reproductive anatomy, emotional aspects of maturation, value of abstinence among teens who are not sexually active, alternative methods of contraception and HIV/STD prevention, health consequences of avoiding contraceptives, preventive methods among sexually active youths. These recommendations are supported by Kirby (2001) who advises that effective sexuality programs:

- Include activities that address social pressures associated with sexual behaviour
- Provide modeling and the practice of communication, negotiation and refusal skills
- Incorporate behaviour goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of the students
- Last a sufficient length of time to adequately complete important activities adequately
- Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse

According to Dienye, 2011 cited in Obiekea, Ovri, & Chukwuma, (2013), sexuality education is a planned process of education that fosters the acquisition of factual information, the formation of positive attitudes, beliefs and values and the development of skills to cope with the biological, socio-cultural and spiritual aspects of human society. It is a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy (Dienye, 2011). In the view of Obiekea, Ovri, & Chukwuma, (2013) Sexuality education is one of the global emerging social issues which is fast becoming a major discourse for various stakeholders in the school system and public health throughout nations of the world. In Nigeria, this issue needs to be addressed not only among youths in tertiary education but likewise among youth/peers in secondary

education whom as a result of western civilization/culture and technological advancement, interact socially or engaged into early social relationships with their opposite sex within their immediate environment (school and home). Coupled with many cases of unsafe abortions, unwanted/unintended pregnancies, Sexually Transmitted Diseases (STDs), Sexually Transmitted Infections (STIs), early childbearing, drop-outs from school at early age, psychological defeats, deviant behaviours among peers as a result of peer influence, premarital sex, expulsion from school, etc, deemed it necessary for the study of sexuality education to be taught early among youths in secondary education. The youth are adolescents who are between the ages 11-17 years or below 18yrs and are exposed to peer pressures.influences, curiosity, adventurism and explorative in nature.

The introduction of sexuality education became one of the immediate efforts made to address and create awareness about the sexually based problems. The rationale was to acquaint the youth with factual and accurate sexual information about the dimensions of sexual knowledge that will enable them understand and clarify their personal values, improve their sexual knowledge and sexual decision-making and promote their knowledge and understanding about how all these interact with socio-cultural and religious factors to affect personal well-being (Adepoju, 2005 cited in Obiekea, Ovri, & Chukwuma, (2013).

Sexuality is the cultural way of living out our bodily pleasures. It has a lot to do with sex but is more than that as there are other processes and activities surrounding it. It contributes to human definition of the self and their relationship with other (Ikpe, 2004). Also sexuality and gender roles are intricately related so that it might be difficult to speak of one without the other. Adolescent sexuality refers to sexual feelings, behaviour and development in young people and is a stage of human sexuality. Sexuality and sexual desire usually begins to appear along with the onset of puberty. The expression of sexual desire among young people might be influenced by family values and influences, the culture and religion they have grown up in, social engineering, social control, taboos, and other kinds of social norms. The risk of adolescent sexual activity is sometimes associated with emotional distress, sexually transmitted diseases including HIV/AIDS and pregnancy through failure or nonuse of contraceptive.

In a survey of more than 5,500 urban youths aged 12-24years, 41% had experienced sexual intercourse. Of these, 82% of females and 72% of males had sexual relationships by age 19 (Makinwa and Adebusoye, 2000), they recommended that in Nigeria more researchesand evaluations are needed on adolescent reproductive health.Bilikis and Yusuf (2000) stated that because of the culture of silence on sexuality, there has been little or no structured way of teaching Nigerians about sexuality. The majority of Nigerians have the misconception that sexuality is equivalent to coitus. This has been a major obstacle to the integration of sexuality education into school curriculum and other youth related activities. Because of this equation of sexuality education with intercourse, the focus tends to be on biological components.

Therefore, the Action Health Incorporated (2003) viewed sexuality education as a planned process of education that fosters the acquisition of factual information, the information of positive attitude, beliefs and values as well as the development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human sexuality. It aims at developing a positive and factual view of sexuality, acquiring the information and skills they need to take care at their sexual health including preventing HIV/AIDS, respect and value themselves and others as well as acquiring the skills needed to make healthy decisions about their sexual health and behaviour.

Studies of the sexual and reproductive health behaviour of Nigerian youth confirms that they had not been taught about sexuality. Their information on this important subject come from peer, news magazines and biology classes. Though a high percentage expressed the view that they should not engage in premarital sexual activity, 25% to 50% disclosed that they were already sexually active. Almost 25% of young girls questioned stated that their first experience of sexual intercourse was through rape or one in which they were forced to have sexual intercourse (Association for Reproductive and Family Health, 2003). Rakiya and Booth cited in (Ikpe, 2004), they gave the following summary of the attitudes and practices regarding sexuality education and the discussion of sex of several ethic groups:

Yoruba sexual knowledge is acquired through story telling myths, peers, schools, apprenticeship centres, televisions, magazines, novels and overheard adult conversations.

There is a positive attitude regarding sexuality education. Educated adults see nothing bad in sexual education, but the uneducated say it is an abomination and such things should not be heard of when compelled to discuss sexuality issues.

In Delta region, children learn about sexuality from their peers and media in urban areas. Most adults view sexuality education negatively because they believe it initiates the young ones to sexual relationships. Therefore, discussion of sexual topics is a taboo. In Imo, Enugu and Anambra states collectively, knowledge about sexuality is picked up accidentally mostly from peers. There is no formal sexuality education, parents teach their children through their own attitudes and behaviour. They believe that talking about sexual matters is vulgar, sexual education should not exist, and sexuality should never be discussed.

Oladepo, (2202) stated that comprehensive sexuality education is not accessible to the majority of youths in Nigeria. The bulk of sexuality education programmes implemented in schools still use the extracurricular methods because sexuality education is not included in the curricular in many states of the country and this made the students to be less informed about reproductive health and participate more in risky sexual activity.

The Need for Sexuality Education Programme

The values and attitude of our youth toward sexuality are increasingly being shaped by their peers, exposure to the media, popular culture and the internet. Young people/ adolescence is a complex stage in life as the adolescent attempts to find his or her own identity and often struggles with new social relationships. Sexuality education aims to help our young people understand the physiological, social and emotional changes they experienced as they mature, develop healthy relationships with opposite sex and to teach them how to make responsible choices.

The aim of sexuality education is to:

- Provide accurate and adequate knowledge in human sexuality and the consequences of sexual activity so that young people are able to make informed decisions

- Impart intra-and interpersonal skills of problem solving decision making and effective communication so that youths are able to build responsible and rewarding relationships
- Inculcate positive values and attitude of sexuality so that pupils develop a respect for themselves and others as sexual begins in line with the national value of the family as the basic unit of society.

In many settings, high rates of HIV prevalence, along with early sexual debut and multiple partnerships, have led researchers to conclude that there is a need for sexual and reproductive health education comprising more than messages promoting abstinence (Bearinger, 2005; Bersamin, 2007 and Masatu, 2009). Well-designed impact evaluations are needed to provide evidence about the quality and content of interventions. Many of the adolescents at greater risks are missed by school based programmes because they are no longer in school (Bearinger, 2005). Gaps still exist within programmes that target both knowledge and behaviour change in the sexual activities of adolescents. Programs need to go beyond HIV and focus on broader topics in sexual activities and reproductive health currently in many programs, other STIs and pregnancy prevention are conspicuously absent. Given gender differences in bahaviour as well as in some of the consequences of sexual activity, communication from any reliable source on sexual and reproductive health needs not only to be gender sensitive but to empower adolescents, particularly young women to negotiate behaviour on the basis of accurate information (Glasier, 2006).

According to Action Health Incorporated (2003), young people need sexuality education programmes that model and teach positive self-worth, responsibility, understanding and acceptance of diversity and sexuality education would encourage "sexual experimentation" and several studies have been conducted to determine whether sexuality education programme actually increase young people's sexual involvement. Rather, sexuality education results in postponement or reduction in the frequency of sexual activity and more effective use of contraception and adoption of safer behaviour.

The Role of Schools in Sexuality Education

According to Jame, Rosen, Murray (2004), in Nigeria, as elsewhere in Africa and the developing world, schools play a key role in imparting important information on health

and human relations. Although too many Nigerian youth still lack access to secondary or even primary education , for those young people who do not attend school, the school setting provides an important venue to transmit information and skills that can protect youth against risky behaviours.

School-based sexuality and reproductive health education is one of the most important and widespread ways to help young people improve their reproductive health. Countries in every region have organized sexuality education programs of one type or another. Such programs, if thoughtfully designed and well implemented, can provide young people with a solid foundation of knowledge and skills. By providing students with information and skills, sexuality education complements other efforts to provide quality reproductive health information and services and to create an enabling context that allows young people to positive behaviours.

The objective of Sexuality Education Programs

According to Jame, Rosen, Murray (2004), like other YRH programs, sexuality education aims to achieve a range of outcomes, some of which apply to sexually active youth and some to those not yet having sex. These objectives include

- Reduced number of sexual partners
- Increased contraceptive use, especially use of condoms among youth who are sexually active for both pregnancy prevention and prevention of HIV/AIDS and other sexually transmitted infections(STIs);
- Lower rates of child marriage
- Lower rates of early, unwanted pregnancy and resulting abortions
- Lower rates of infection of HIV/AIDS and other STIs; and
- Improved nutritional status

Sexuality education program are part of a suite of proven interventions that include activities such as peer education, mass media, social marketing, youth-friendly services, and policy dialogue and advocacy. School and livelihood opportunities complement and reinforce these approaches.

The Policy Environment for Sexuality Education

According to Jame, Rosen, Murray (2004), advocates worldwide recognize the need to address the political and social context in which young people make decisions about sex and reproduction. Globally, commitment to meeting youth reproductive health (YRH) needs has never been higher. The U.N . World Program of Action for Youth of the Year 2000 and Beyond, and the 2001 U.N. General Assembly Special Session on HIV/AIDS have affirmed the needs of young people for information, counseling, and high-quality sexual and reproductive health services.

Against the background of these international agreements, to which Nigeria is a signatory, the government of Nigeria has recently taken a number of important policy steps to support YRH care, including the following:

- The government formulated and lunched a national YRH policy
- Reproductive health is on the concurrent legislative list in Nigeria, and therefore, the three independent policies to guide their programs and service delivery.
- In 2002, the Federal Ministry of Education approved the teaching of sexuality and life planning education in the secondary schools. This policy directive paved the way for development of a national curriculum, recently approved after extensive stakeholder review and debate.

The Widespread of School-based Sexuality Education

According to Obiekea, Ovri, & Chukwuma, (2013), sexuality education is of great importance for all young people, especially young people, especially those at highest risk of unhealthy behaviours. The origin of sexuality education came into being in different countries at various times. The sexual revolution of 1800's contributed immensely to the debate of sexual pleasure as an ethical substance which continued to be governed by relations of force, struggle and establishment of dominion. During this period, women started agitating for more debates concerning their sexuality. With all the controversies on the issue of sexuality that lingered for about six to seven decades, in 1897, a fermale Swedish doctor, Karolina Widerstorm saw the need to educate the young especially girls about sexual hygiene as a way of informing and protecting them from STDs such as

Gonorrhea and Syphilis which found very common as at that time (Obiekea, Ovri, & Chukwuma, 2013). To her, the idea was that "if girls got to know in good time how pregnancy came about and how STDs were spread, they would be better able to protect themselves. In this way, girls were considered to be able to take responsibility for the sexual health of boys as well as themselves (Adepoju, 2005 cited in Obiekea, Ovri, & Chukwuma, 2013). That has given sexuality education recognition and by 1900s, several vents had occurred which changed the way people perceive sexuality, hence sexuality education was introduced in Swedish schools.

In Nigeria, efforts have been made to introduce sexuality education. Adepoju, 2005 cited in Obiekea, Ovri, & Chukwuma, (2013) identified that the initial efforts to introduce sexuality education in Nigerian educational system was done through the introduction of population and education which considered as potential way of tackling the problems of rapid population growth and its consequence for socio-economic development in the country. This has led to the introduction of school-based population and family life programmes especially at the tertiary institutions because this burgeoning adolescent group that constitute more than 12 percent of the Nigerian population are prone to health risk because they are uninformed or poorly informed under-age sexual practices and other anti-social practices (Obiekea, Ovri, & Chukwuma, 2013). However, the evolution of sexuality education and its introduction in Nigeria schools came about when it became apparent that there was, as there is an urgent need to address adolescents reproductive health, reproductive rights and sexuality issues. For instance, the International Planned Parenthood Federation (IPPF) highlighted that "it is an education process designed to assist young people in their physical, social, emotional and moral development as they prepare for adulthood, marriage, parenthood and ageing as well as their social relationship in the socio-cultural context of family and society (Adepoju, 2005 cited in Obiekea, Ovri, & Chukwuma, 2013).

School based sexuality education was first established on a national scale in Europe in the 1960s, while developing countries introduced school-based sexuality education in the 1980s (Jame, Rosen, Murray, 2004). Similarly, Smith, Kippax, and Aggleton, (2000); also affirmed that the emergency of HIV/AIDS gave many governments the impetus to

strengthen nd expand sexuality education efforts and, currently, more than 100 countries have such programs, including almost every country in sub-Saharan Africa. United Nations organizations such as UNFPA, UNESCO, and UNICEF have traditionally been the leading international supporters of sexuality education. The World Bank, through its intensified efforts to help countries fight HIV/AIDS, has also become a major funder (World Bank, 2002 cited in Jame, Rosen, and Murray 2004). Many other bilateral donors and private foundations and organizations support and promote sexuality education worldwide (Jame, Rosen, Murray, 2004).

Importance of Sexuality Education Programme

Dienye, 2011 cited in Obiekea, Ovri, & Chukwuma, (2013), highlighted the importance of sexuality education as it ensures better understanding of the influence of society on everyday interactions it prevents diseases and promotes abstinence which are programmes designed with the purpose of teaching the social, psychological and health gains to be realized by abstaining from sexual activity. Abstinence education is a proposed standard for every young Nigerian school age child. It is the only way to avoid out of wedlock pregnancies, STDs/STIs and other health associated problems. Sexuality education preaches abstinence which indicates that sexual activities outside the context of marriage have harmful psychological, social and physical effect that damages one personality.

Therefore, sexuality education as pointed out by writers constitutes the following programmes: human growth and development, relationships, life skills, sexual attitude and behaviour, sexual health, society and culture, alcohol and drug use/abuse vulnerability to sexual advances, premarital sex problems, personal hygiene, puberty, sports, reproductive system education, aging, sex education, menopause, abstinence education, and issues of STDs/STIs, HIV/AIDS and other diseases, among others. However, there are many challenges towards effective implementation of sexuality education in the secondary education curriculum. Ideally, sexuality education should start at home but there are impeding factors such as: socio-cultural beliefs of parents, customs, culture and backgrounds, religion and lack of professional teachers/ guidance and counselors that will

handle or teach such subject. Most school see it as not necessary to teach students on such issues because of their curiosity and explorative nature, might want to practice such.

Nakpodia (2012) believed that a well developed and implemented school-based sex education programme can effective help young people reduce their risk of STI/HIV infection and unwanted pregnancy. He further stressed that important goal of sexuality education is to provide insights into broader aspects of sexuality, including sexual well-being and rewarding interpersonal relationships (Oganwu, 2003 cited in Nakpodia, 2012). It will also help to provide young people with information on a wide range of sexual health topics including puberty, reproduction, healthy relationships, STI/AIDs prevention, birth control, abstinence, sexual orientation, and sexual abuse/coercion (Rueben, cited in Nakpodia, 2012).

Effective sex education will also support informed decision-making by providing individuals with the opportunity to develop the knowledge, personal insight, motivation and behavioural skills that are consistent with each individual's personal values and choices. For many young people, these personal values choices will lead to the decision to abstain from sexual intercourse and other sexual activities (Nakpodia, 2012).

In addition, particularly for young teens that have not yet become sexually active, delaying first intercourse can also be an effective way for adolescents to avoid unwanted pregnancy and STI/HIV infection. Sexuality education programmes which focus on delaying first intercourse as part of a broadly based curriculum that also focuses on contraceptive/safer sex practices can help some adolescents who have been sexually active to have a re-think and also see the need to quit until they are physically and emotionally ready for it. It is a fact that more and more teens these days are engaging into pregnancy sex. This further underscores the need for sex education to students. This will help them to make better informed decision about their personal sexual activities. Sex education imparted through school can also prove to be a significance and effective method of bettering the youngster's sex-related knowledge, attitude and behaviour. Sex education is also importance because many parents (especially in African) are shy about talking/teaching their children on this subject.

The provision of information about sexual orientation also helps to fulfill the sexual health education needs of gay, lesbian, and bisexual students such as homophobia and discrimination based on sexual orientation can be addresses. Through sex education children will be able to establish and accept the role and responsibility of their own gender by acquiring the knowledge of sex. It also enables young ones understand the body structures of men and women and acquire the knowledge about birth. Through sex education, young people will be able to develop a positive sense of their own sexuality by creating opportunities for them to consider all aspects of sexuality, ask questions and also understand that there are an adult who supports them as they learn about this part of themselves.

The Effectiveness of Sexuality Education Programme

One of the many fears of parents and other adults is that giving adolescents' information about sex will cause them to become sexually active. The evidence from two recent reviews shows this not to be the case. In one exhaustive study, the World Health Organization reviewed 47 sexuality education programmes in both developed and developing countries. In another study, the U.S. National Campaign to Prevent Teen Pregnancy reviewed over 250 programmes in the United States and Canada. Both found that, in almost all the programmes, sexuality education did not lead to either the initiation of sexual activity or an increase in the frequency of sex among youth (Katz and Finger, 2002 cited in Jame, Rosen, and Murray, 2004).

According to YWCA (2013), more and more, adolescents and young people face increasing pressure about sex and sexuality, including conflicting messages and norms due to lack of adequate information, skills and awareness on their rights, especially around sex, sexuality and gender expectations. Comprehensive Sexuality Education programmes is effective to delay the initiation of sex, reduce the number of sexual partners, and increase the use of condoms and other forms of contraception. Some programmes also seeks to increase testing and treatment for HIV and other STIs. The sexuality education programme can be implemented both in schools and in other community settings for the out-of-school adolescents. The High Level Taskforce for ICPD recommended in its recent report that all young people shouldhave access to comprehensive sexuality education and related services

in order to enable them to exercise their rights, understand their bodies, make informed decisions about their sexuality and better plans their lives. This recommendation encapsulates the reality of youth and underscores the need to heighten the focus on CSE for young people. Access to comprehensive sexuality education, including family planning, is an essential element of youth sexual and reproductive health and rights programming in Africa, as seen in major frameworks such as the Maputo Plan of Action (Maputo PoA) for the operationalisation of the continental policy framework for sexual and reproductive health and rights, the African Youth Charter and the ICPD Programme of Action, 2007.

Similarly, Jame, Rosen, Murray (2004), virtually all comprehensive sexuality education programmes promote abstinence from sexual activity as part of the curriculum, and try to teach young people how to resist pressure for unwanted sex. One type of programme known as "abstinence-only-untilmarriage" approach teaches young people the social, psychological, and health gains to be realized by abstaining from sexual activity. Such abstinence-only programs do not offer students other strategies, for example, quality information for youth who already are or may become sexually active. How effective are abstinence-only programs in achieving important YRH outcomes such as delaying sexual activity? Only three such programmes that was carried out state wide in California for students ages 12-13. None of the programmes report any significant impact on the initiation of sexual activity, frequency of sexual activity, number of sexual partners, use of condoms, or use of contraception (Kirby, 20021).

By contrast, programmes that provide comprehensive information and include abstinence promotion as an important message have been shown to delay sexual debut, decrease the number of sexual partners, and increase condom use among youth who are sexually active (FOCUS, 2001 cited in Jame, Rosen, Murray, 2004).

Concept of Youth

According to Bearinger; Sieving; Ferguson; and Sharman (2007), today's generation of adolescents is the largest in history. Nearly half of the global population is less than 25 years old. UN cited in Bearinger et al, (2007), used the term adolescents for the people aged 10 – 19 years, young people for those aged 10-24years, and youth for

those aged 15-24years. Similarly, Bello; Oladokun; Enakpene; Fabamwo; Obisesan; and Ojengbede (2008), believed that, adolescence represents a transition to adulthood with features including secondary sexual growth, changes in hormonal milieu, emotional, cognitive and psychological development.

Action Health Incorporated Journal (2003) defined adolescent as a period of transition from childhood to adulthood. It further stated that adolescence as a physiological state is a universal experience. Even though the age range and the duration of adolescence may vary from society to society, the transition from childhood to adulthood is phase of life that is common to culture. Adolescence as atransition between childhood and adulthood is best viewed as a time of evaluation, decision making and commitment rather than as a time of rebellion and crisis. He further explained that puberty is a rapid change for maturation occurring mainly in early adolescence. Puberty occurs roughly 2 years earlier in girls (10-12years) than for boys (12 ½ years).

Adolescent is a transitional stage of physical and mental development that occurs between childhood and adulthood. This transition involves biological (i.e puberty)/ social and psychological changes, though the biological or physiological ones are the easiest to measure objectively. (Penner, 2008, Chisties, 2007 and Hill, 2008). Young people identify a particular mindset of attitude. The National Adolescent Health Policy considers ages 10-24years as a more appropriate range for young people in Nigeria the age boundaries of youths may vary, the experience is similar across societies. Young people everywhere experience a complex psychosexual development involving the formulation of a sexual identity, management of emerging sexual feelings and accommodation to cultural expectations. About a third of global population today is aged 10-24 years. This proportion varies for developed and developing countries. Young people make up only 21% of the developed countries but 29% in less developed countries (UN, 2008). Currently, there are more than 1.5 billion people between the age of 10-24 year, largest number ever and 85% of them live in developing countries.

Sociologically, adolescence is seen as a cultural phenomenon for the working world and therefore its ends points are not easily tied to physical milestones. It should also be noted that adolescence/young people is the stage of a psychological breakthrough in a

person's life when the cognitive development is rapid (www.newcastle.n/m.nihqov/entrez/query.fegi?').

Youth Reproductive Health Challenge in Nigeria

According to Jame, Rosen, Murray (2004), the current cohort of Nigerian youth is the largest ever. To contribute their full social and economic potential, young people need the knowledge and skills to make the right choices about when to have sex and how to protect themselves from infection and unintended pregnancies. The reproductive health challenges Nigerian youth face are similar to those of young people in many other African countries with high rates of teen pregnancy, high and arising rates of HIV infection, early marriage for young girls, malnutrition, and harmful traditional practices such as female genital cutting. Increasingly, policy makers are acknowledging the link between better youth reproductive health (YRH) and other aspects of healthy youth development including livelihoods, mental health, and road safety.

There are various types of risks that young people are exposed to which sexuality education can target and bring about redress. These include early sexual activity and its consequences such as unwanted pregnancy, induced abortion and pregnancy complications as well as Sexually Transmitted Infections (STI).

Poor knowledge: The National HIV/AIDS and Reproductive Health Survey (NARHS) (FMOH, 2003) reported poor knowledge of sexuality and reproductive health issues, especially among young persons of 15 to 19 year old. Knowledge of condom among 15 to 19 year olds was found to be 59.4%; whereas knowledge of symptoms of different types of STIs in men and women by 15 to 19 year olds ranges from 6.8 to 44.1%. In respect of knowledge of rights of People Living with HIV/AIDS PLWA), 30.6% of the respondents aged 15 to 19 years believed that the rights of the PLWA are protected in Nigeria. This is evidence of gross lack of knowledge about sexuality and reproductive health issues among young people across the country.

Poor access/unmet need: Among the 15 to 19 year olds, accessibility/ unmet needs of different family planning methods was found to vary from 6 to 19%; and use of condoms was found to be practiced by a mere 34.4% (FMOH, 2003). According to Alan Guttmacher Institute (2004), only 4% of married adolescent women used a modern contraceptive

method, compared with 24% of unmarried sexually active women of this age. Overall, 17% of adolescent women in Nigeria, about one-half of whom are unmarried, have an unmet need for effective contraception; that is, they are sexually active, are capable of becoming pregnant and do not want a child soon, but they are not using an effective contraceptive method.

Early sexual debut/high sexual activity: As in most parts of the world where premarital sex is rising (PRB, 2000), in Nigeria, by the age of 19 years, 70% of all Nigerian adolescents have become sexually active and they often do not employ any means of protection (Nigeria Demographic and Health Survey, 1999); no wonder, Nigerian adolescents of ages 15 to 19 years rank among the highest in level of fertility, with 112 births/ 1000 females.

The 2008 NDHS shows that over 15% of women age 15-19 had first sexual intercourse by age 15 and more than half (56%) of women age 15-49 were sexually active during the 4 weeks preceding the survey. Similarly, over 12% of women age 15-19 married by age 15. Overall, 23% of women age 15-19 have begun childbearing in Nigeria; 18% have had a child and 5% are pregnant with their first child (NPC and ICF Macro, 2009). Although there was a 27% decline in the birth rate among women age 15-19 between 1980 and 2003, 46% of women nationally and about 70% of those in some geo-political zones still give birth before their 20th birthday (Alan Guttmacher Institute, 2004; NPC and ORC Macro, 2004).

Unwanted/unintended pregnancy: There is ample evidence that much of this early childbearing, whether within or outside marriage is unwanted. In Nigeria as a whole, 18% of recent births to adolescent women (married and unmarried) are unplanned, that is, the mother would have preferred the birth later or not at all (Alan Guttmacher Institute, 2004). However, this proportion reportedly ranges widely by region, from a low of 3% among women in the North-West region to a high of 69% among those in the South-West region. The proportion unplanned is also above average in the case of births to more educated adolescent women in both urban and rural areas (31 and 44%, respectively).

Unsafe abortion: High rates of unsafe abortion among female adolescents also attest to the issue of unwanted pregnancies. Abortion is illegal in Nigeria, but roughly 610,000 abortions are performed in the country each year (Henshaw, 1998) under unsafe conditions

and by untrained persons, with potentially harmful consequences for women. In a similar report which was compiled by International Planned Parenthood Federation (IPPF), Airiohuodion (1997) cited that abortion complications accounted for 72% of all deaths of young women under 19 years of age in Nigeria.

Some hospital-based studies conducted in Nigeria, particularly Adewole (1992), Okonofua (1996) and Adetori (1999), showed that adolescents make up a disproportionately high proportion of females treated for abortion complications-between 61- 75%. This over-representation is likely due to the fact that compared with their adult counterparts, female adolescent are less likely to use contraceptives and more likely to resort to an unsafe abortion. In fact, adolescents are more likely to turn to traditional healers, chemists, shopkeepers or other non-medical personnel for abortion, or selfinduce abortion using a variety of unsafe methods, including drinking quinine, alcohol, detergent or toxic teas, or swallowing large doses of over-the-counter substances, such as prostaglandin (Mohamud, 1996). They are also more likely to seek an abortion later in their pregnancy and are slower to seek medical help once complications develop.

Adolescents' vulnerability: Apart from sexual activity, among boys and girls, gender issues in sexuality and reproductive health is a major concern for sexuality education. There is need to highlight the issue of double vulnerability of girls as they are more exposed to risky sexual encounters. These include young girls' exposure to rape and other forms of sexual violence, which often lead to sexual dysfunction and involvement in sex with multiple partners and sex for exchange of money.

Sexuality education on gender issues is far from optional as the incidence of gender-based violence often associated with sex seems to be on the increase. Young people often know little or have incorrect information about sexuality, fertility and contraception. Young men are more likely than women to mention lack of knowledge and are much more likely to say that it is their partner's responsibility to avoid pregnancy (Berganza *et al*., 1989; Baker and Rich, 1992; Morris, 1992). Even when young people can name contraceptives, they often do not know where to get them or how to use them (Agyei and Epema, 1992).

Contraceptive methods are not often used at the first intercourse mainly because of the belief that a girl cannot become pregnant the first time she had sex. For instance,

Makinwa-Adebusoye (1991) reported that 30% of male and female adolescents sampled in five major urban centers in Nigeria did not realize that the first intercourse could result in pregnancy, thus they do not use contraceptive methods to prevent unwanted pregnancy. The high rate of unprotected sexual networking among adolescents in Nigeria increases their risk of contracting STDs/HIV/AIDS. Since most adolescents are active sexually but lack adequate knowledge of the risks involved, they constitute the group that is highly vulnerable to unwanted pregnancy and HIV/AIDS pandemic.

It should be noted also that STDs including HIV are rampant in the developing nations including Nigeria due to lack of education. Most of the adolescents do not receive family life education and hence, they are not aware of precautionary measures to adopt in order to prevent and protect themselves at sexual relationship/intercourse. Even in the event of getting in contact with any of these diseases, most adolescents do not know their symptoms, what to do next, or where else to go. Instead, they prefer to conceal it until it almost gets out of hands, or ask for advice from their peers who are just ignorant as them.

Concept of Health Seeking Behaviour

Health-seeking is an activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. In exploring the databases to inform this discussion, the terms health-seeking and help-seeking were found to be used interchangeably. Health-seeking behaviour taken in its literal sense means to seek health. The Nursing Outcomes Classification defines health-seeking behaviour as "personal actions to promote optimum wellness, recovery and rehabilitation." This definition appears to propose that health-seeking behaviour can occur with or without a health problem and covers the spectrum from potential to actual health problem. Therefore, contained within the concept of health-seeking behaviour is the aspect of health promotion that might be aimed at preventing a disease and includes behaviour such as lifestyle changes. Students constitute a population subgroup with lower rates of mortality, morbidity and medical use, nevertheless, they tend to have significant health concerns that are often hidden and/ or underdiagnosed.

Being at a transition stage between puberty and young adulthood; college students must cope with certain problems brought by college life as well as trying to accomplish

their developmental tasks. When we think of the developmental stage college students are in, it is normal that they experience sexual, familial, personality problems as well as problems related to romantic relationships. They will further face difficulties related to their academic life brought about by education. The type of health-seeking behaviour of students most frequently reported by the research explored for this discussion could be divided into five categories, physical issues (acute or chronic), psychological issues, social and relational issues, sexual issues and drug, alcohol and smoking issues.

Research explored defines health-seeking behaviour as formal, when professional help was sought from health care services and/or health care providers (physicians, psychologists); informal relational, when help was sought from members of the student's social network (parents, friends, teachers, trusted persons); informal personal, when young persons resorted to self-medication or browsed the Internet or used social media. Cornally & McCarthy (2011) reviewed the literature and concluded there is no disparity among researchers of health-seeking behaviour that problem recognition and definition must transpire before health-seeking behaviour can be executed. Perception is the most intrinsic factor in the process of health-seeking behaviour whereby the person themselves identifies the problem for which help is being sought. Evidence confirms that individuals differ in their choice of treatment sources depending on the type and perceived intensity of sickness. For example, students perceive alcohol problems as significantly less serious than drug problems and are significantly less willing to seek help for alcohol problems (Lowinger, 2012).

Traditionally, college students tend to define illness in terms of limitations it places on their daily activities and desire or demand the "quick fix" (Haltiwanger, Hayden, Weber, Evans & Possner, 2001). The student's main considerations are how many class assignments are due, the scheduling of examinations, and when they are most available to seek health. Students expect care when needed but also based on when they themselves are available. Nicoteri & Arnold (2005) gathered qualitative data to illuminate the process of the development of health-seeking behaviour in traditional age undergraduate students (18-23 years). It is the opinion of these researchers that the behaviours of accessing health care in what may be considered an inappropriate or less economically responsible manner often extend beyond the college years into adulthood and family life if the issue has not been

addressed earlier. Until this time in their lives, generally family is the initiator of health care for the student whether the need for health care is preventive or illness related.

In a setting away from home, when to seek health care and how to access the healthcare system are two areas of healthcare decision making in which this population has difficulty. Nicoteri & Arnold (2005), concludes that health-seeking behaviour amongst students can be more 'adolescent-like'. Students perceive they are making their own decisions about health care yet seek advice and help from their families when they are ill. If family are intensely involved, autonomous decision making and responsible self-care may not be developed. Dickey and Deatrick (2000) state that autonomy in decision making regarding health issues is a set of skills that develops as part of self-care. Deciding to seek health will very much be based on self –efficacy. College therefore, is a very important time to foster development of autonomy.

One variable that may play a role in the decision to pursue health-seeking is the perception of stigma. Stigma is the fear of being negatively evaluated upon obtaining health care. Much of the research relating to the effect of stigma on health-seeking behaviour relates to psychological and sexual disorders. The public tends to have a negative conceptualization of individuals who suffer from psychological difficulties. Stigma plays a role in individual's decisions to seek, or not to seek treatment. For example, Gott and Hinchliff (2003) interviewed older British adults, aged 50-92, regarding sexual health and attitudes toward treatment for sexual difficulties. Only 24% of participants who had experienced sexual problems had sought treatment. Personal embarrassment/shame was one of the six barriers to treatment described by participants, a response suggestive of self-stigma. It is encouraging however that more recent literature reviewed by the author found that stigma no longer influenced actual use of services among college students (Bilican, 2013). Stigma tolerance and interpersonal openness can significantly influence health-seeking behaviour amongst students.

Attitudes towards health-seeking are largely influenced by socio-demographic variables, including gender, religion and cultural background. Although findings vary across studies, one of the most consistent findings in the research is that women have generally been found to have more positive attitudes to health-seeking than men, particularly in the college samples. Young women, naturally preoccupied with

reproductive health issues such as contraception and menstruation, tend to seek professional help more frequently than men for whom these issues tend to be of lower importance. Men's health-seeking behaviours vary considerably depending on the context. The current empirical literature on the influence of masculinity on health-related help-seeking confirm gender constraints to be predominant with student males denying weakness and limiting self-disclosure. Males avoided completely and/or concealed health-seeking efforts in order to pass as being free of psychological issues. Many males tend to endure pain without complaining, and view exhibiting signs of, or expressing emotional distress as contravening. By understanding how masculinities work for and against college men's health-seeking we can provide explicit permission for men to talk about their health concerns and tailor gender-specific health promotion to engage more men.

Spirituality has been found to play a critical role in mitigating the pains and sufferings of ill-health because the relationship with a transcendent being or concept can give meaning and purpose to people's lives and sufferings. Several studies demonstrated the relevance of spirituality in health-seeking behaviour of students. While, the impact of religious faith on health-seeking behaviour is unclear, religiosity is associated with stronger preferences for help-seeking from a religious advisor among college students. Religiosity may negatively influence the likelihood of seeking treatment if individuals experience greater personal stigma.

Several studies have pointed to the importance of background, ethnicity, or nationality on seeking help for psychological problems. In some cultures, individuals adopt a fatalistic approach and believe if you face difficulties in accessing care then you are not meant to obtain same. Many may feel more comfortable with health care professionals from the same ethnic/cultural group. Many use traditional medicine or home remedies influenced by their culture. Cultural considerations must be given to issues of abortion, suicide and homosexuality. Geographical differences and feeling unwelcome can play an important role in attitude and in turn health-seeking. Nam et at. (2010) found that among US college students, white students held more positive attitudes toward seeking help for psychological problems than Asian or Asian-American students. Within Western cultures, variability in attitudes is evident. No research was found which reviews health-seeking behaviour among international students in the UK or Ireland. In addition to difficulties

faced by domestic students, international students, experience unique problems stress from negotiating cultural differences. It has been observed in the author's own practice that Chinese-speaking international students which make up the largest percentage of international students attending U.K. institutions encounter more adjustment difficulties than their European counterparts. It may be the case that health-seeking amongst this cohort is informal and traditional such as Chinese medicine. Lu et al (2013) concluded that education about the effectiveness of face to face and online treatments may increase treatment seeking by this population.

Research by Shankar et al. (2017) recently carried out a cultural beliefs project to study medical student's opinions regarding possible influences of culture and social issues on health-seeking behaviour. Language difficulties, perceived discrimination, low treatment credibility, difficulties and shortage of culturally appropriate services were identified as cultural barriers affecting health-seeking behaviour of students. Ensuring linguistic competency and developing cultural competence action plans are strategies which could reduce these barriers.

An additional issue which affects health-seeking is knowledge about, and access to appropriate professional services. Students need to have the right information and knowledge about the professionals available, as well as about the types of treatment. Eisenberg et al. (2007) found that many students were unaware of or unfamiliar with the service options. Yorgason et al. (2008) similarly concluded that some students in need of mental health services may not receive them because they do not have sufficient knowledge of the services available to them. Students who lived off campus were less likely to know about and use the services. There may be genuine confusion about appropriate sources for the treatment of various conditions. The type of problem perceived by the student will certainly influence the type of health seeking behaviour.

Bergvall and Himelein (2013) concluded from a study of Swedish and US college students attitudes towards seeking help for sexual dysfunctions that while primary care professionals would seem an obvious source of help, students may be reluctant to raise the topics of sexual concerns and resource this help on their own. Students learn about health services available to them from friends or fellow students, the Internet, student orientation programmes and faculty sources. Although students' internet use has increased

substantially in the past decade and although campus services are typically on the institution websites, having this information available on the internet may not be sufficient for informing students. Educational and awareness campaigns may be especially effective for reducing unmet needs. Such campaigns could address the facts that many students do not know about the availability of health services and their potential effectiveness.

Issues with accessibility such as inadequate means of transportation, difficulties in making contact and cost can further influence the type of health-seeking behaviour of students. As well as considering the personal cost of health-seeking, it is important to mention that financial cost can be an issue for some students. Although financial constraints have been cited as prominent barriers to health care in general populations, the student population in Ireland and the U.K. can access free or low cost primary healthcare on site. It is the author's own experience that even low-cost services can pose as a significant barrier to students affected by current socioeconomic pressures. Research explored did not illuminate the impact of financial cost on health-seeking behaviour.

Erkan et al. (2012) conducted a study which found that the most significant predictor of college student's willingness to seek psychological help is positive attitudes towards seeking help. A negative attitude towards campus services may stem from already existing stigmas about the services. The importance of the approproachability of professionals in influencing the decision about and type of health-seeking behaviour in this regard should be highlighted. When asked about using campus health services 36% of respondents in Yorgason et al. (2008) study reported they did not want to talk to a stranger and did not believe the services could help them. Literature also illustrates student's low confidence in the ability of services to help with their problems. The type of helper and the characteristics of the helper are all aspects considered by the health-seeker before contact is initiated.

Gulliver et al. (2010) work pointed to the important facilitator of health-seeking behaviour, perceived past positive experiences. Responses such as invalidation of symptoms, reactions to unsuccessful health-seeking and negative experiences with healthcare professionals impact on health-seeking behaviour. It is the author's experience that trustful relationships, and the provision of support and encouragement foster formal health-seeking behaviour amongst students. There can be a belief that issues are normal for

this stage of life. Students can have a preference for self-reliance which coincides with the increased need for autonomy during this developmental phase.

Preference for solving one's own problems is a commonly endorsed reason for not seeking health services in college students. Self-investigation and self-treatment is prevalent among this population. (Vaz et al. 2012). Students see this behaviour as acceptable. Some 75-80% of adolescents with mental-health related problems, including dating, peer pressure, depression, fatigue, trouble with parents, suicidal thoughts, feeling overweight, drug use and alcohol use, report they can handle their problems on their own (Dubow et al. 1990). Essentially, the research suggests that students attempt to solve problems independently before they involve progressively more complex systems in their environments. Issues over confidentiality and fear of academic reprisal are common concerns which can influence health-seeking behaviour and lead further to this preference for self -management. Students fear that the student health professionals will share the student's situation with the student's department, other students and authorities.

Students frequently report that they do not have enough time to seek health professionally on campus. In the author's experience students have an already loaded timetable throughout the day which leaves little or no 'free time'. Student health service operating times on the campus where the author practices are restricted to 'office hours' which presents as a significant barrier in terms of time constraints and accessibility to students who may wish to seek help. Students at the author's institute are more likely to be working part-time jobs which restrict schedules furthermore. Students often report that excessive waiting time at service delivery points radically influence their decision to attend and perception of a service. Students resort to seeking help informally via social media or attending alternative services such as out of hour's emergency care which may be wholly inappropriate.

Health-seeking behaviour is viewed as the varied response of individuals to states of ill-health, depending on their knowledge and perceptions of health, personal attitudes, socioeconomic constraints, adequacy of available health services, and attitude of healthcare providers. This discussion has shown how these and additional factors discussed can influence the decision to seek help. Examining student's health-seeking behaviour ultimately helps in the design of ways to ensure better access to health and the quality of

that care. Effective mechanisms to identify students with the most serious needs are essential, so that with the removal of the barriers to care, systems can optimise the match between the services and those who are likely to benefit most.

Despite the availability of services, students tend to rely on informal services, such as reliance on friends and family as a primary source of help. It is important to acknowledge that although students are more likely to seek help from informal sources they may not receive the type of help that is needed from these sources. Avoidance of appropriate health-seeking behaviour starts early and is linked to perceived norms which dictate that experiencing a problem may be viewed as a form of weakness that has implications for subsequent successful career progression. Efforts must aim to increase health-seeking and lower student's threshold for seeing formal help.

Health Seeking Behaviour in Nigeria

Health is the main aspect of human life. Although a healthy life is the desire of everyone, the reality is that everyone is not healthy. An essential aspect of preserving health is to identify the factors that enable or prevent people from making healthy choices in either their life-style or their use of medical care and treatment, the underlying assumption being that behavior is best understood in terms of an individual's perception of their social environment (Tipping and Segall, 1995). Sheeram and Abraham (1996) categorised the range of behaviors that has been examined using health belief model into three broad areas: preventive health behavior, sick role behavior and clinic use. In this type of model, individual beliefs offer the link between socialization and behaviour.

When individuals make decisions in relation to their health, they weigh up the potential risks or benefits of a particular behavior. They do so in a way that is influenced by their immediate physical environment, social rootedness, life-style, religious belief and their whole outlook on life generally (Norman and Bennet, 1996; WHO, 2002; Orubuloye, 2003). Thus various authors (Fabrega, 1973; Tanahashi, 1978; Egunjobi, 1983; Aregbeyen 1992; Orubuloye 1992; Ademuwagun, 1998) have noted that in a pluralistic medical milieu in which the rural dwellers find themselves, the decision to seek care, where to do this and the form of care perceived as appropriate are all influenced by a multiplicity of factors relating to the person, the facility and the socio-cultural environment.

According to Tanahashi (1978), the level of functionality of a health facility or service may be measured by the degree to which it is accessible, affordable, acceptable and available to its potential users. Other relevant socio-cultural factors which affect the perception of health and wellbeing include religion, availability of relatives in the hospital or connection with hospital staff, family decision, marital status, position in the family, educational status and also very importantly the nature of the illness (Omotosho, 2010). The polarisation of Nigerian society into a large rural sector and a small urban component provides a basis for the inadequate provision of infrastructure.

For instance, over 65% of Nigerian population who live in the rural areas are most neglected and deprived of modern healthcare services as well as other modern infrastructural necessities that are essential to the maintenance and promotion of good health (Olujimi, 2006; Ewhrudjakpor, 2008; Omotosho, 2010). This situation is unfortunate as the majority of the nation's population who produce the nation's food needs including valuable export crops reside in the infrastructurally underserved area. In some areas where medical facilities exist, they are not sufficiently patronised to promote the sustenance of the healthcare services because of the undesirable health-seeking behaviour of rural dwellers (Olujimi, 2006). It is in this unhealthy state of affairs that the present review is designed to enhance the health status of rural dwellers by improving the knowledge of healthcare professionals with respect to the peculiar health-seeking behavior of this category of people. This understanding will assist the healthcare providers during consultation, in therapeutics; in handling complications of TAM and evolving ethical dilemmas as well as provide empirical basis for proper and rational health policy formulation for rural dwellers, particularly in Nigeria.

Community ideas and attitudes toward health and illness affect the way they utilise health services. This is because these ideas and attitudes provide ideological basis for the healthcare system (WHO, 2002; Omotosho, 2010). In Nigeria, and in many developing countries, the factors that commonly affect the way rural dwellers shop for health include.

i. Religious Beliefs

Everywhere, the quest for health easily shades into issues of morality and religion because the latter plays a significant aspect of social life. The rural populace has cosmological and nosological notions which ascribe etiology of diseases and ill-health to entities far beyond

the realm of the stethoscope. They believe that the doctor knows all and can cure all provided the right conditions are fulfilled. Hence, treatment of diseases classified as "common" or "ordinary" is diffused using either traditional or allopathic medicines while those classified as "severe" or "extraordinary" usually require special (traditional) attention (Olujimi, 2006; Ewhrudjakpor, 2007; Omotosho, 2010).

The basic explanatory theory is that in serious illness, there is an underpinning of the supernatural. The most frequently evoked agency is ancestor spirit anger. Ancestor spirits constitute part of the ordered structure of the African cosmology. Upsetting the ancestors produces a disturbance of this order and hence disharmony and illness. In African thought, all living things including man are linked in harmonious relationships with the gods and the spirits, so that reality consists in the relation not of man with things but of man with man and of all with the spirits. Such relationship is ascribed to vital forces which each entity generates. A state of health exists when there is perfect harmony between man and his environment.

This belief is inherent in those who practice African Traditional Religion as well as in many Christians and Moslems (Mbiti, 1987; Ewhrudjakpor, 2008). On the other hand, ill health and other misfortunes can result from a disturbance in the relationship between man and his social cum spiritual environment, or from forces directed by witches, wizards, sorcerers, evil spirits or angered ancestors because of infraction of totemic principles (Mbiti, 1987). The popular notion is that "people do not just suffer illness by chance" therefore, serious illness is believed to have its origin in a primary supernatural cause. There is no difficulty, however, in accepting biomedical explanations based on the presence of viruses, bacteria, parasites, cancer or high blood pressure; these are simply seen as secondary causes. The idea of primary causation provides an explanation as to why a particular individual, and not others in the group, is afflicted by these infectious agents (Kroeger, 1983; Twumasi, 1988).

ii) Traditional African Medicine (TAM)

Since TAM has been with the rural dwellers for generations and also for the fact that orthodox medicine is often in short supply, their approach in times of ill health is first towards TAM. It is when this fails that they result to chemist shops or medicine vendors and then the hospital as a last resort (Katung, 2001). In TAM, divination (consulting the

oracles), confession, ritual sacrifices, incantations and potions made from plant and animal parts are essential components of illness management (Sallah, 2007). These are aimed at restoring the patient to a harmonious relationship with his environment and/or counteract the effect of evil forces. In every instance where an illness is diagnosed to be due to ancestor spirit anger, there is usually an antisocial act of commission or omission by the person who must usually confess the misdemeanor, followed by ritual sacrifices to appease the offended supernatural agency before he can be expected to recover (Badru, 2001). Confession, that is, admission of guilt, is crucial for therapeutic success. In other words, although the illness is attributed to ancestor spirit anger, the trigger for this is the sin against moral laws committed by the afflicted person. It can, therefore, be said that ancestor spirit anger in TAM is a metaphor for emotional upheaval arising from guilt, anxiety and fear of ancestor spirit intervention in the minds of culturally socialized individuals. Such emotional torture can initiate a stress syndrome which may depress the immune system of the culprit making him more susceptible to serious illness than a devout member of the community (Okpako, 1991; Calhoun, 1992; Jegede and Onoja, 1994; Raikkonem et al., 1996; Sallah, 2007).

Since rural patients tend to shop around for healthcare depending on how they perceive ailments, their gender and position in the family, and their socioeconomic status (Kroeger, 1983; Olujimi, 2006), it is not uncommon nowadays to find that at the primary, secondary, and tertiary levels of healthcare, they secretly or openly combine traditional and allopathic medicines either sequentially or concurrently (Aregbeyen, 1992; Ewhrudjakpor, 2008; Iyalomhe, 2009a). Anecdotal reports abound about medical doctors who combine orthodox drugs with traditional remedies in collaboration with the traditional healers. This amounts to association with unqualified people which is a serious professional misconduct (Medical and Dental Council of Nigeria, 2004). TAM practitioners claim they can successfully handle all manners of health problems. From febrile illness and infections such as malaria, tuberculosis, Sexually Transmitted Infections including HIV/AIDS; pains, aches and arthritis; convulsive disorders like febrile convulsions and epilepsy; hypertension, congestive heart failure and stroke; cough and asthma; diabetes mellitus and cancer; obstetric and gynecological problems including infertility; orthopedic problems like fractures to minor/major psychiatric disorders as well as various skin diseases.

Other traditional healers specialize in medicines that empower one to commit crimes and escape safely, vanish in time of danger, assault or accident and to remedy witchraft effects as well as bad luck. Other specialists undertake traditional surgical procedures such as male and female circumcision, ethnic or cultural body markings for identification or beautification purposes, tattooing, herbal skin incisions, bloodletting, uvulectomy and keratectomy.

Hysterotomy is usually done to remove a fetus from a dead pregnant woman because many Nigerian traditions forbid the burial of the woman with the fetus (Tanahashi, 1978; Erinosho, 1989; Aregbeyen, 1992; Sallah, 2007; Iyalomhe, 2009a; Omotosho, 2010). The roles of the Traditional Birth Attendants (TBAs) and Traditional Bone Setters (TBSs) in TAM are noteworthy. Between 60-80% of deliveries particularly in rural areas are taken by TBAs (frequently elderly women with no formal or medical education but whose forbears have coaxed the birth of generations of children) for reasons such as the good reputation of the TBA, personalized care, cheap fees and accessibility (Abioye-Kuteyi et al., 2001; Iyalomhe, 2009a). In the same vein, despite criticisms and supposed antagonism from orthodox medical practitioners, over 70% of Nigerians mainly in the rural areas, still rely on the TBS for primary fracture care because of the widespread belief that the TBS uses a traditional remote control means to hasten the reduction and healing of fractures (Onuminya, 2004). For example, he may deliberately fracture a fowl limb for sequential reduction and manipulation claiming that when the fowl's limb is set, the patient's fracture will be set as well (Iyalomhe, 2009a).

The health-seeking behaviour of theNigerian citizens especially the rural dwellers reveals the level of health/disease awareness in the rural community. Healthcare providers must pay more attention when dealing with this category of people. In particular, the following aspects must be emphasized. Since the rural patient has been used to being told his/her problems by the traditional healers before complaining, he/she gets surprised, if not disappointed, when on getting to the clinic the doctor who is supposed to know all diseases asks for presenting complaints. To obviate this, we have learnt to start by saying to the rural patient "You have a fever" when the temperature is obviously high; or "You are sick!" Then, of course, he/she volunteers all the necessary information in the history taking. In taking drug history, you must assume that he/she may have taken many drugs by

asking “Which drugs have you been taking?” You may be surprised that he/she may narrate a litany of drugs. If you ask “Have you been taking any drugs?”, the obvious answer you may get is most likely to be “No, doctor”, because he/she feels you may be offended that some native or other medicines have been used prior to clinic attendance (Iyalomhe, 2009a; Iyalomhe and Iyalomhe, 2010).

In order to get greater effect, the rural patient increases dosage or frequency of usage of native medicines. Also, serious side effects like profuse diarrhea, dizziness or sudden collapse from orthostatic hypotension are interpreted to mean that the medicine is “powerful and efficacious” particularly when the patient survives the illness. Also one native medicine may be used to treat many disparate diseases quite unlike modern medicine (Okpako, 1991; Atemie and Okaba, 1997). Indeed, any medicament that has multiple efficacies has the potential for equally producing multiple adverse effects. This is all the more likely when in the case of herbal medication adherence to strict dosage regimen is not the common practice (Omogbai, 2009). Monitoring and documentation of the adverse effects of herbal medicines is not a routine practice. The healthcare professional should therefore take note of presenting symptoms of rural dwellers as these may be adverse effects of traditional medicines (Okpako, 1991). Patients should be advised to restrict themselves to either orthodox or traditional medicine at particular times.

Concept of Sexual Reproductive Health

A working definition for sexual health is that it is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of diseases, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurably and safe sexual experiences, free of coercion, discrimination and violence. According to WHO (2004) for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. It asserted further that, reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men.

Sexual health therefore implies that people are able to have a responsible, satisfying and safer sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be

informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choices as well as other methods of birth control which are not against the law, and the right access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chances of having a health infant.

Sexual health is influenced by a complex web of factors ranging from a sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and STIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs and sexual dysfunction. It can also be influenced by mental health, acute and chronic illnesses, and violence. Addressing sexual health also requires understanding and appreciation of sexuality gender roles and power in designing and providing services.

Nakajima (2009) asserted that more than half of world's population is under the age of 25 and a significant number of adolescents are sexually active. From birth through childhood and adulthood, girls and women need effective services and information to enable them to lead healthy productive lives. Boys and men also need information and services that contribute to responsible behaviour and equal treatment of women and girls. He further noted that, it is estimated that about 15 million young women give birth each year, accounting for up to one-fifth of all births worldwide. And every year, 1 out of 20 youths contract sexually transmitted infections.

Concepts of Sexual Rights

Addressing sexual health at the individual family and community or health system level requires integrated interventions by trained health providers and a functioning referral system. Is also requires a legal policy and regulatory environment where the sexual rights of people are upheld. Sexual health also requires understanding and appreciation of sexuality, gender roles and power in designing and providing services. Understanding sexuality and its impact on practices, partners, reproduction and pleasure presents a number of challenges as well as opportunities for improving sexual and reproduction health care services and intervention.

WHO (2005) stated that sexual rights embraces human rights that are already recognized in national laws, international human right documents and other consensus statements. They also include the rights of all persons, free of coercion, discrimination and violence:

- The highest attainable standard of health in relation to sexuality including access to sexual and reproductive health care services
- Sexual education
- Seek, receive and impart information in relation to sexuality
- Respect for bodily integrity
- Choice of partner, decide to be sexually active or not, consensual sexual relations
- Consensual marriage
- Decide hwre or not and when to have children
- Purdue of satisfying pleasurable sexual life

The responsible exercise of human rights requires that all persons respect the rights of each other. On the whole, it has been observed that Africa, especially the Sub-Saharan Africa has the worst indicators of women's health especially with regards to reproductive health. This is an indication thatthere is still pervasive violation of women's right especially their sexual rights, due to prevailing cultural practices in this part of the world. According to Nnaemego (2005), overemphasis on traditional values and lack of respect of women's consent in marital union has impeded marital relations in many parts of Africa. Furthermore, failure to define discrimination of women as an issue of women and led to the violation of women's rights as espoused by the declaration of sexual rights as stated above.

Sexuality education should not only be geared towards the acquisition of skills in sexual act but should promote the scientific, physiological, social and psychological aspect of humanity. Sexuality education is a s a life-long health education on sexuality focusing on the sharing of information, experiences, skills and resources about sexuality through different sources, media. This is the type that will produce positive effects on the sexual attitude and behaviour of individual.

Concept of Sexual Transmitted Infections

Sexually transmitted Infection as a concept has been defined from the many perspectives of authors, but all definitions still tilt towards the same goal. According to Longman (2003), Sexually Transmitted Infection (STI) are diseases that is passed on through sexual intercourse via bacteria and viruses. These infections can be passed from one persons to another during intimate physical contact. They are so common and can affect the person whether the person is a gay or engages bisexual relationship. You don't need to have sex with lots of people to be at risk of catching an STI - just one brief encounter with an STD carrier may be enough. Sexually Transmitted Infections (STI) including HIV (Human Immunodeficiency Virus) mainly affects sexually active young people. (Young adults aged 15-29 years,) (Mukherjee, K.2007).

AIDS (Acquired Immunodeficiency Syndrome). Sexually Transmitted Infections (STI) also known as sexually Transmitted Infections (STI) or Venereal disease (VD), is an illness that has a significant probability of transmission between humans or animals by means of sexual contact, including vaginal intercourse, oral sex, and anal sex. While in the past, these illnesses have mostly been referred to as STI or VD, in recent years the term sexually transmitted infection (STI) has been preferred, as it has a wider range of meaning, a person may be infected, and may potentially infect others without showing signs of disease. Sexually Transmitted Infectionss have been well known for hundreds of years. Morton, R.1999).

Causes of STI

According to Onoyima (1998), one of the causes of STI is unfaithfulness among couples. Once a married person starts to sleep outside, committing adultery, he or she is likely to contract AIDS or any other Sexually Transmitted Infections. Hence, one of the reasons why STD has refused to disappear in our universe is the unfaithfulness among some married couples.

Osgood (2000) believes that one of the causes of STI is unprotected sex with a strange partner. When people start having sex with strange partners without being protected, the tendency is that they would obtain a Sexually Transmitted Infections, such as syphilis, Gonorrhea and AIDS.

In her own contribution, Amanda (2003) believes that one of the causes of STD is unfaithfulness. This implies that one party may have multiple partners. Boys and girls these days are not faithful on each other and always see sex as something one can engage in when one feels like such attitude exhibited by both males and females often results in getting infected. Majority of them do not stick to a particular partner in their sexual relationships. Another cause of STD is heterosexual intercourse. The HIV which eventually developed to AIDS can be contracted from either semen or blood the later due to minor abrasions that often occur during lovemaking or to cuts or lesions in the vagina or on the penis. Kalichmen (1995) believes that transmission have also been documented.

Carlin and Boag, (1998) believes that STI can also be contracted through oral sex. Oral sex can transmit the virus when there is a tiny cut or sore in the mouth. In essence, this may even be more dangerous than sexual intercourse. Anal intercourse, whether with a man or woman is particularly a dangerous practice that appears more likely than vaginal intercourse to result in infection.

Boardman (1998) believes that one of the causes of STI is when partners do not have the partner's sexual history. On many occasions, people fall in love with partners whom they cannot prove their sexual history - like how many boys or girls they have slept with, the chances are that they would carry STD with out their unknowing .

Omolade (2001) is of the opinion that one of the causes of STI is when one trades sex for money. Once money is involved in love making, there is the tendency that those involved in such act will contract STD in the sense that they can sleep with anybody provided the person pays the amount requested. Another cause of STI as mentioned by Owen (1996) is that partners involved in sexual intercourse fail to go for medical test before they start dating. Once partners are in love for a long period and start making love without going for test to verify whether any of them is with any disease or not, the possibility of contracting STD is there.

Billing (1998) believes that one of the factors that causes STI in every individual is the poor attitude given to the disease from the general public. People generally believe that once they have gone for STD test, they are free from the disease for their entire lifetime. Billing (1998) believes that for one to be free from STI, everybody should always go for a

test every two years until a period of ten years before he or she can stop. Going for test from time is the only measure that can keep one free from STI.

In his own contribution, Martins (1993) states that one of the factors that causes STI in individuals is their eagerness to have sex with a beautiful partner without any form of protection. Immediately a boy sees a beautiful girl, he will be eager to have sex with the person. As they continue in that practice, they will tend to stop using condom, believing that they two are meant for each other.

According to Miram and Morgan (2004) one possible way of getting STI is not only through sex but also through using unsterilize needles which other people have used for injection and for other ceremonies. Continuing, Miriam and Morgan asserted that as a result of ignorance especially in the rural areas of various communities in Indonesia, China and deeply in part of Africa like Somalia, Ethopia, Kenya, and even Nigeria but to mention a few, a great number of people have come to use unsterilize needle for activities ranging from tattoo, to circumcision without knowing the implication of what they are doing to themselves and others.

Signs and Symptoms of STI

Among other researchers who have written about STI and general symptoms is Volker (1997). In his own contribution about the signs and symptoms of STI, he described one of the symptoms of STI as rash in the body, once an individual witness unusual rash with constant fever, there is the tendency one is infected with AIDS.

In his own contribution, Kehinde, (2007) indicated that the following symptoms could indicate Sexually Transmitted Infections: an unusual discharge in both men and women, in women- bleeding after intercourse or between periods, sores, blisters warts, rashes, irritation or itching near the genital or anus, pain on intercourse, pelvic or lower abdominal pain, and inflammation of testicles. Richmen and Havlin (1995) believes that one of the signs and symptoms of one of the STI (AIDS) is cough coupled with diahorrhea. When one is infected with AIDS, there is the tendency that there would be persistent cough and diahorrhea. The victim may cough from morning till night with little or no strength to hold herself together. Apart from cough, there is also diahorrea which makes the person to visit the toilet often.

Hoffins (1998) also believes that one of the major symptoms of AIDS is excessive fatigue and shortness of breath. Patients infected with AIDS often exhibit fatigue and shortness of breathe at interval. On many occasions most of them do not have enough strength to even stand up. Apart from fatigue, most victims witness shortness of breath which often lasts for about 10 seconds before they recover. Such shortness of breath often makes people believe that the victim will die very soon.

Frank (1999) in his own contribution sees weight loss as one symptom of HIV/AIDS. This constant weight loss is caused by the destruction of the white blood cells which helps to fight the germs and defend the body against external forces.

Kelvin (1999) believes that skin discoloration is one of the sgns and symptoms associated with HIV/AIDS. When HIV/AIDS becomes severe in a victim, there tends to be skin discoloration which makes the person look light yellowish in colour. Hence when one notices an unusual colour that manifest in the body coupled with headache, cough rash and constant fever, the person should visit a clinic to know whether he or she is infected with HIV/AIDS. Hoover, McArthur, Bacellar, and Miller,(1993), believe that one of the general signs and symptoms of HIV/AIDS disease is thrush. Thrush is a fungal infection that produces white spots in the mouth, making the mouth not to receive any taste of food. Hence, when this thrush is produced in the mouth, the victim will have no appetite for food, and even if he or she should eat the food, it is likely to be vomited by the victim.

In his own contribution, Omolade (2005) believes that of the greatest symptoms of AIDS is weaken of the body from time to time thereby making the victim to loose weight and in the process loose appetite. Once the AIDS virus destroy ones immune system, the person or victim tends to decline in weight and in the process feel weak for no just reason. Under such condition, the AIDS virus must have eaten deep into his/her immune system and leave the body in a condition where any disease can attack and in the process kill the person.

Why STI is on the Increase

According to Madubuko (2001), STI is on the increase simply because the awareness associated with the disease is confusing. Most people who have heard about HIV/AIDS and other STI are confused on how the disease spread. Most people do believe that HIV/AIDS only spreads through sexual contact. Such poor awareness often makes them fall victim of disease by not engaging in proper healthcare practice that would help them to control the disease. In his own contribution, Wenger (1995) believes that HIV/AIDS disease is on the increase because only few people have comprehensive knowledge about the disease. As far as AIDS is concerned world wide, only few people have the full knowledge of the signs, symptoms and how to avoid being victim to the deadly disease. Hence, it is only when majority of people in the world have knowledge of the signs, symptoms and how to avoid and how it operated that the disease will disappear from the universe.

In their own contribution, Micah and Jekings (1992) believe that AIDS is on the increase because only few people stick to their partners when it comes to sexual relations. People these days are no longer faithful to their partners in the sense that only one partner cannot satisfy their sexual needs. As a result of unfaithfulness associated with sexual relationship AIDS continues to be on the increase world wide.

Yemann and young (1999) believe that AIDS is on the increase because most people world wide are ignorant of the disease. On many occasions people do not believe that disease called AIDS exists and even if it exists, it cannot kill humans. This particular attitude exhibited by man concerning the disease has allowed HIV/AIDS to be on the increase especially in certain localities like South Africa, Uganda and Kenya. Lufthman and Kongberg (2001) believe that the disease called AIDS on the increase because the seminars and workshops organized for such programmes are still very poor. On many occasions, seminars and workshops concerning AIDS are organized with pamphlets being distributed, but there is no empirical evidence like Cinema to show the audience how the disease operates on the human body.

Concept of Knowledge

The word knowledge according to American Heritage in his dictionary of English Language (2000) is defined as the state of fact of knowing, familiarity, awareness, or understanding gained through experience or study, it is synonymous with information, learning, erudition, lore, scholarship. However, knowledge is the broadest.

Mercer in his dictionary of languages and liquistics (1999) defined knowledge as that which is known, the sum of what has been perceived, discovered inferred; that which is known about a specific subject or situation e.g. data.

Oxford, in his advanced learners dictionary of current English (2005) also defined knowledge as an English word, which usually implies an erudition open to those who seek it, the theoretical or practical understanding of a subject. It could also be used to mean the confident understanding of a subject.

Longman, in his dictionary of contemporary English (2003) also defined knowledge as the facts, skills and understanding that you have gained through learning or experienced. In continuation; knowing that something has happened or is true: spoken used to say that something is not true, based on what you know: information that you have about a particular situation and event among others; It is a state of having information. Knowledge acquisition involves complex cognitive process: perception, learning, communication, association and reasoning.

Knowledge of Students towards STI;

Knowledge of student refers to all information the students has acquired in relation to STI. Generally, adolescents seem to have some knowledge about STI, although there was disagreement about the medical parallels to local names and about the symptoms and causes of the STI discussed. Gonorrhea and AIDS were identified as STI in all of the groups and syphilis was mentioned in many of them. A few participants described scabies, chancroid, pubic lice, candidiasis and trichomoniasis. The students mentioned a variety of local names for STI, including "*korokoro" or "Akpikpa"* (generally referring to scabies) *Chop garri* (usually referring to syphilis) "toilet disease," *gonococci* (generally referring to gonorrhea) and *oyanminwu* or *mbirina aja ocha* (generally referring to AIDS). A few individuals talked about other conditions they considered STI. For example, one said "you

can hardly cure some gonorrhea, and the very strong gonorrhea is called gono- AIDS". According to Bamidele; (1998), he reported that experiencing pain in the genital area during urination was the most frequently mentioned sign of STI, mostly related to gonorrhea. Most groups mentioned pussy or milk-like discharge, swollen organs, boils, itching and rashes. Males were more likely to mention swelling, and females were more likely to mention discharge, itching and rashes. Males also discussed bloody urine, while females mentioned fever.

Medical research (NEAC Report.1998), reports that some of the students know that STI manifest themselves differently in males and females. Students in half of the groups understood that STI are often asymptomatic or slower to appear in females than in males. Not surprisingly, females were more likely than males to be aware of this difference. One explained. "For the boys, they easily know because of the symptoms, but for the females they don't show symptoms and may have it for long time."

Onwudinjo's study (1996), revealed more knowledge about HIV and AIDS than other STI. From his study the students did not mention the link between AIDS and other STI. A few students gave clear descriptions of AIDS. One said. "AIDS has a very long incubation period; it stays in the human body for about two or five years or so before you start getting symptoms of the syndrome, "Long incubation period, destroys the blood cells, constant fever, cold, malaria. Loss of strength, frequent stooling, loss of appetite, weight loss, looking dull and fatigued," some students demonstrated knowledge about the causes and impact of AIDS; one gave the acronym an alternate definition- after iniquity, destruction is sure. In a similar submission, Nwankwo and Unachukwu (2003) opined that only a few knew that AIDS is transmissible through blood - to - blood contact, such as sharing razor blades. Some reported that AIDS can be transmitted through sex and injections, but others incorrectly stated that infections can occur through mosquito bites and from toilets(Nwankwo and Unachukwu 2003).

The Concepts of Attitude

Attitude has been explained, described and defined by many authors in different ways. Even though it has no single universally accepted dentition, all the definitions still convey the same meaning. Longman dictionary (2000), defined attitudes as opinions and

feelings which a person has about something and Arken (1999) sees it as learned predispositions to respond positively or negatively to certain objects,, situations, concepts or other persons. Arken felt that attitudes are not in - born in man but are learned through life. Nixon, Koy and Fredrickson in Onwudinjo (1996), agreed with Arken when they said that Attitudes are learned through orientation, Arken further stated that attitudes can be either positive or negative. Pisbern and Ajzen, also in Onwedinjor (1996) re- echoed that attitudes are learned and predisposes action which could be favorable or unfavorable. They however added that such actions must be consistent. The idea of consistency tallies with the views of Britannica (1997 vol.1), which described attitude as a predisposition to classify objects or events and to react to them with some degree of evaluative consistency. Smith (1998), also agreed with this view when he stated that attitude is a relatively enduring predisposition to respond in a reasonably consistent manner toward a person, object, situation, or idea. By enduring, Smith meant that attitudes held by an individual can persist for a long time.

Furthermore, Britannica (1997) opined that attitudes are not objectively observable but inferred from behavior and manifest in conscious experience, verbal reports, gross behavior and the like. Schaller (1994), had earlier stated that attitudes are important determinants of behaviors.

The above definitions show that attitudes determine the way individuals behave towards issues, situations events, objects and other person. They also show that attitudes meted out to objects or other persons as the case may be, do not necessarily depend on their real situations but rather, on the way they are perceived. The definitions also reveal the consistency and enduring nature of attitudes which therefore suggests that, to make people change their attitudes would require a good programme on “attitudes change” especially where such attitudes affect others negatively.

Attitude of Students toward STI

Almost every student in the school system has a particular attitude towards the STD especially Acquired Immune Deficiency Syndrome (AIDS). Though, most of the students tend to be positive, some are also negative.

Malcolm (1996) indicate that attitudes of people towards STI these days is improving especially when it comes to students opinion in secondary school. Unlike before when students are not anxious of HIV virus, most students tend to avoid anything that would make them to be infected with the disease. That is properly why students tend to use condom regularly for sex and other protective measures to make sure that they do not contract the STI including HIV/AIDS virus. (Arms,1992)

In their own contribution, Micah and Jekings (1992) believe that girls have more positive attitudes towards STI, unlike men. This is because most women or girls who are students in secondary school tend to be more when it comes to sex, unlike their male counterparts who are mostly randy set of people. Moreover, girls tend to avoid sex if a boy is not with condom, unlike boys who tend to go wild on sex without much protection (Wenger 1993).

In his own contribution, Elmana (2001) stated that stigma attached to STI HIV/AIDS in particular by the society at large has made people most especially students to have negative attitude towards the disease. For example, if students find out that their colleague is infected with HIV/AIDS, there is the tendency that they would avoid the person totally despite the fact that they know the disease cannot spread by being close to the victim.

Hayduk (1993) believes that students' attitudes to STI differ with individual differences. In an experiment to this effect, 10 students were meant to interview on AIDS patient in hospital where they are admitted, in the process of conducting the interview, it was observed that some students show some kind of affection to the AIDS patient by sharing sympathy and jokes with them, while some students keep certain kilometers in the process of conduction of the interview in order not to have body contact with the victims.

Borellen (1998) believes that student attitudes to STI depends on the education and awareness he or she has received about the disease and also the environment where he or she received the education and awareness. Hence, students who have received good education and awareness about STD tends to tolerate people with the disease, unlike students who has little information about STD disease.

Karlinger (2001) believes that students attitudes to STI/ HIV/AIDS in particular these days has increased tremendously with each student being careful on how he or she uses objects especially the piercing ones. Hence, students these days tend to be very careful

on whom they choose as girl friend or boy friend, the saloon they barb their hairs and whom they share their belongings with.

Empirical Review

Impact of Sexual Education on Knowledge and Behaviour

Sexuality education is defined by SEICUS as a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, body image, and gender roles. Sexuality education addresses biological, sociocultural, psychological and spiritual dimensions of sexuality from a cognitive, affective (emotional), and behavioral domain including skills to communicate effectively and make responsible decisions. (National Guidelines Taskforce, 1991) This definition means sexuality education is comprehensive, and includes a gamut of social science perspectives and learning material, that is supposed to help our youth develop to become responsible adults that can process learned information in order to make conscious, positive decisions. The argument has been made over and over that sexual education promotes high risk sexual behavior and has been the rationale for abstinence-only educational approaches, coupled with cultural aspects as the proper way to instruct our youth about sex. This approach has also become highly politicized and no longer addresses the real issue – increased rates of STDs and pregnancy (Braeken & Cardinal, 2008).

Prior research has supported the fact that abstinence-only sexual education fails to reduce the age of sexual debut and has even less of a positive effect on high risk sexual behavior. Kirby (2008) reviewed 56 studies that evaluated the impact of abstinence-only versus comprehensive sexual education programs on sexual behavior and found evidence supporting the lack of positive influence on high risk behavior among abstinence-only education. Conversely, Kirby found that almost two-thirds of comprehensive programs positively affected sexual debut and the use of protection, both condoms and contraception. School plays a major role in affecting the lives of youth given that school is the one place in our society that is most attended. Nearly all of our youth aged 5 to 17 are enrolled in school and attend school before they initiate sexual behavior as well as during

the time they initiate sexual behavior. Research supports the fact that when a young individual drops out of school, they are more likely to initiate sex and participate in high risk behavior, or become pregnant. Some of this risk is also associated with the environmental and socio-demographic differences between youth who remain in school and those who drop out which cannot be ignored. Despite these differences, it cannot be ignored that dropping out of school continues to impact sexual behavior negatively (Kirby, 2002).

The question remains whether sexual education matters, and whether it has an impact on STDs. Again, research supports the ineffectiveness of abstinence-only education on decreasing sexual behavior, but there is a gap in the literature regarding the age at which sexual education should be implemented, and what level of education it should entail. Ott and Pfeiffer (2009) believed that sexual education should include age appropriate models that are culturally sensitive. At the same time, the researchers believe that the level of a youth's own understanding of the meaning of abstinence and the premise of no sex until marriage lead to its ineffectiveness. They conducted a study among 11 to 14 year olds to assess their view of abstinence and found that among this group of participants, effective programs must examine an individual's sense of how they view sex. Some participants viewed sex as "nasty" and embraced abstinence, while others were curious, and in a transition between sex as a rite of passage to adulthood, were undecided if they were ready or not to engage. The last group identified themselves as "normative" and assessed their own level of readiness and the readiness of others as well as the influence of adult responsibility required by engaging in sexual behavior. The researchers argued that sexual education programs would require an approach that especially serves those adolescents that see themselves as "curious" or "ready" (Ott & Pfeiffer, 2009).

DeRosa et al. (2010) examined the prevalence and correlation of sexual behavior among adolescents as a guide for interventions with regard to intercourse and oral sex, and believe that such interventions should be implemented before sixth grade and continue throughout middle school. The researchers also stressed the importance of targeting high risk groups such as African American males and teens who know someone that has become pregnant. The researchers administered a survey to sixth, seventh, and eighth graders attending one of 14 middle schools in Los Angeles, California. The survey

consisted of demographic, sexual behavior, and risk and protective factor questions adapted from existing questionnaires, including the Youth Risk Behavior Surveillance System (YRBS), facilitated by the CDC. DeRosa et al. found that the difference between youth in eighth grade versus younger grades was significant with regard to sexual behavior, especially among African-American males, who reported higher rates of sexual intercourse. The researchers concluded that interventions that target elementary school students are necessary with a focus on interpersonal relationships and expand to sexual activity throughout middle school. These formative years are highly influenced by peer relationships and should include educational information of sexuality and negotiation of protective measures to help reduce the prevalence and incidence of STDs and pregnancy (DeRosa et al., 2010). In support of this argument, Downs, Bruine de Bruin, Murray, and Fischhoff, (2006) examined 300 sexually active females aged 14 to 18, with the majority (75%) of them African American, with regard to STD knowledge after administration of an interactive STD DVD and questionnaire. Downs et al. found that despite the intervention, the participants learned about STDs other than HIV/AIDS only after being diagnosed with an STD. The researchers concluded that adolescents need an introduction to STD information earlier, and not only an intervention that focuses on HIV/AIDS, but on the more prevalent STDs such as Chlamydia, gonorrhea, and herpes.

In addition, Tortolero et al. (2010) examined the effects of a theory-basedintervention called “It’s Your Game: Keep it Real” (IYG) on delaying sexual behavior among minority middle school students in Southeast Texas. IYG consisted of 24 grade appropriate lessons administered by trained facilitators that utilize classroom-based activity coupled with journaling and individual computer based lessons. Some of the topics included healthy friendships, setting limits, refusing negative behaviors, and STDs/STD testing. Parents were also involved in the program through the use of parent child homework assignments that promoted dialogue and communication. The researchers demonstrated that sexuality and STD-prevention based interventions can delay the onset of sexual intercourse and specifically impact the onset of anal and oral sex behavior, especially among females. IYG also reduced the number of sexually active students having sexual intercourse three months after the introduction of the intervention. The researchers also believed that middle school programs do not adequately address oral and anal sex and

must implement these factors into sexual education programs, given the increasing tendency of teens and young adults to engage in such behaviors. Some students who have already initiated sexual behavior prior to the seventh grade may require more intense intervention as they are considered a high risk group, at higher risk of developing STDs and becoming pregnant (Tortolero et al., 2010). One study in Washington, D.C. that evaluated an intervention intended to delay sexual debut among fifth graders considered high risk found that interventions must seek to be culturally and environmentally sensitive given the population's circumstances. High risk youth are not only battling peer influences, but they also have the additional economic and environmental obstacles that often outweigh positive influences, and have a greater impact on poor choices. For example, nationally, almost five percent of adolescents younger than age 12 have initiated sex, whereas in Washington, D.C., over 11% initiated sex prior to age 13 (Koo et al., 2011).

Despite the above-mentioned findings, additional research has indicated that although adolescents have received STI education, their knowledge still remains low with regard to current prevalent infections, and different approaches are required to improve such knowledge including earlier implementation of knowledge coupled with other riskprevention programs (Kurkowski et al., 2012). In support of Kurkowski et al., Agius, Pitts, Smith, & Mitchell (2010) conducted a study of secondary school students in Australia and found that HIV knowledge is high and STI knowledge does increase with age; however, younger adolescents were having the same level of sexual partnering as their older counterparts. The researchers also supported previous findings that conclude that higher knowledge levels do not necessarily cease high risk behavior, but it does improve an adolescent's ability to make informed, positive decisions regarding their health and sexual behavior. With regard to research among females and the impact of education on sexual behavior, Annang, Walsemann, Maitra, and Kerr (2010) found that education inversely affected the acquisition of STDs among females, with the exception that the relationship was stronger for Caucasian females compared to African-American females. The researchers found that African-American female college students reported higher incidence of STDs than their Caucasian female counterparts, and that the impact of education and reduced sexual risk behavior strongly varies by ethnicity. On the other hand, the researchers also concluded that education had a positive influence on sexual debut,

partnering with an IV drug user, prostitution, and condom use between both African-American and Caucasian females. This research supports the positive influence of education on sexual behaviors; however, supports the need for culturally appropriate curricula with regard to interventions and the need for more research into the underlying causes of ethnic differences in high risk behavior (Annang et al., 2010).

Sexual Health Knowledge and Attitude of Young People

Kasier Family Foundation (2003) observed that many young people are misinformed about the health risk associated with unprotected sexual activity. While three-fourths engaged in oral sex, one-fifth are unaware of STIs can be transmitted through this activity. They further asserted that one-third of respondents surveyed are unaware that young people account for 50 percent of all new HIV infections. And while most of the young people are aware that STIs can cause serious health problems, between one-fifth and three-fifth do not know the specific complication of certain diseases.

More than three-quarters of adolescents and young adults express a need for more information about sexual topics. They are especially concerned with hoe to recognize STIs and HIV/AIDS infection, what STI and HIV testing involves and where they can go to get tested. According to Esere (2008) the level of young people understands of human sexuality limits their ability to make informed decisions. For instance, almost half of the menstrual cycle equated with the 'safe period'. In Nigeria today, many reluctant to discuss sexuality and sexual health openly in most African countries. Nigeria in particular matters relating to sex and sexuality are usually shrouded in secrecy (Esere, 2006). Neither the adolescent boy nor girl has free access ro information he or she needs on sexuality questions bordering on sexuality and girl-boy relationship are usually hisses-up and regarded as taboo.

According to Ogulayi (2005) majority of the young people were aware of sexual and reproductive health rights (60.3% in Ikeja LGA and 62.3& in Ikorodu LGA) but lacked knowledge of contexts of the rights. Majority of them in various categories were not aware of sexual and reproductive programmes being implemented for young people. In addition, those who were aware of such programmes could not access or use the services due to certain sociocultural barriers. In a study carried out by Zhang, Bi, Maddock and Li

(2011) fermale college students lack knowledge of sexual and reproductive health, and their knowledge was influenced by numerous socio demographic factors (age, grade, menarche age, mothers occupation). Studies in Nepal have documented that knowledge about sexual and reproductive health, particularly about STIs and condom is inadequate and that knowledge among female and urban young people was generally better than females and rural young people (Jha, Chaurasia and Jha, 2010). Poor knowledge about many aspects of sexual health is unlikely to encourage the use of sexual and reproductive health services (Stone, Ingham and Simkhada, 2009; Upreti, Regmi, Pant and Simkhada, 2009).

Adolescent sexuality is a highly charged moral issue. There are core health care providers of adolescent sexual and reproductive health services but public health facilities are under-utilized by adolescents. Adolescent students imbibed these differences and started to propagate them. It was difficult to have heterosexual friendships and such friendship connotes sexual relationships. Girls suffer more restriction as faced by both and were controlled in their mobility and relationships. This affected their personality and their freedom. Over-consciousness about marriage virginity and chastity made girls lives miserable. The gendered conditioning the adolescents received at home continued in their schools, society, in religious forums, wherever as part of their self-formation. It shaped their relationships, their understanding of the body. Sexuality acceptable behaviour, the kind of work they could do, the amount of freedom they could possess.

Warenius, Faxelid, Chishimba, Musandu, Ong'any and Nissen (2006) in their observed that nurse-midwives disapproved of adolescent sexual activity, including masturbation, contraceptive use and abortion but also had a pragmatic attitude to handling these issues. Those with more education and those who had received continuing education on adolescent sexual and reproduction showed a tendency towards more youth-friendly attitudes.

Sexual Behaviour of Young People

Young men and women is Sub-Saharan Africa often exhibit different patterns of sexual behaviour. Most estimates suggest that prevalence of sexual debut, marriage and

child bearing among young people is highest in sub-Saharan Africa. By the age of 20, 80% of women are sexually active compared to about 75% in some developed countries approximately half of all teenagers in Latin America and even lower percentage in Asia (IPPF, 2000, Defo, 2003).

Aderibigbe and Araoye (2008) in the study observed that more than 20% of the sexuality active respondent and 16.4% of the sexually active control respondents engage in sexual intercourse at least once a week, compared to 35% and 47.8% of the sexually active study and control respondents who have sexual relations at least once in a month. More than half of the sexually active respondents 58.7% in the study group have had between 2-4 sexual partners since sexual initiation compared to 31.3% of sexually active control respondents.

Premarital Sexual Behaviour

According to Garcia-Moreno (2003), data on sexual abuse are scarce and commodity incomplete. Much of the information comes from police and health services and figure from such sources are underestimates since only a small fraction of those experiencing sexual abuse reach the services. More reliable estimates have been obtained from specific surveys, particularly on sexual abuse in the context of intimate partner violence and on the first sexual experience of young adults.

Sexual abuse occurs when an adult forces another adult or child to have sexual intercourse or perform other sexual acts against their will. It is also defined as unwanted sexual contact with a person for the purpose of one's sexual excitement and satisfaction or gratification. It includes sexual intercourse against ones will fondling or looking at people in an unapproved sexual way or as a way of intimidating or humiliating another person (Action Health Incorporated, 2003).

Ikechebelu, Udigwe, Ezechukwu, Ndinechi and Joe-Ikechebelu (2008) in their study observed that out of 186 respondents, 130 (69.9%) has been sexually abused with 32 (17.2%) having had penetrative sexual intercourse (28.1%) were forced and 56.3% submitted willing. It was also observed that other sexual abuse experienced by the female street hawkers include inappropriate touches (106 cases; 81.5%) and verbal abuses (121

cases; 93.1%). There was low awareness of the twin risks of pregnancy (43.1%) and sexually transmitted infections (54.3%) following sexual abuse among respondents.

Studies around the world indicate that the first sexual experience is commonly forced or unwanted especially in females. For instance, in South Africa, 28% of women reported that their first sex had been forced, compared with 5% of men, and among 10-18years in nine Caribbean countries nearly half the females who had intercourse, compared with one-third of the males, said that their first experience had been forced (Jewkes and Abrahams, 2002). In New Zealand, the figures were 7% of females and 0.2% of males (Halcon, Beuhring and Blum, 2004).

Like other forms of abuse, sexual abuse involves complex interactions between the individual, family, community and the society. Factors that increase a woman's vulnearability to sexual violence include their being young, consuming alcohol or drugs, having been abused sexually before, involvement in sex work, high number of sexual partners and poverty. (Jewkes, Sen and Garcia-Moreno, 2002).

Concept of Abortion

Abortion is the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or in a place that does not meet minimal medical standards or both. Action Health Incorporated (2003) views abortion as the removal by mechanical or chemical means of a fertilized egg from the uterus for the purpose of terminating the pregnancy before the 28^{th} week. One of the consequences of an unwanted pregnancy is abortion. Abortion under the law is illegal in Nigeria unless it is performed to save the life of the mother. Unsafe abortion is a major cause of maternal mortality. It refers to the termination of pregnancy carried out by the persons not trained in the procedure or non-medical personnel. Unsafe abortions are mostly of the induced type. It also refers to any abortion performed under conditions hazardous to the patient. Some of the consequences of unsafe abortion are:incomplete abortion (hemorrhage, serious cramps, protracted bleeding); infection, perforation of the uterus, secondary sterility, miscarriage or premature births. Other consequences include feelings of guilt and shame or physical trauma before and after the abortion.

WHO cited in Ore (2006) asserted that twenty million unsafe abortions take place each year, 95% of them in the developing world. Complications of unsafe abortion kill at least 78,000 women every year. Hundreds of thousands of other women experience short or long term disabilities including severe bleeding, injury to internal organs and infertility. Nigerian youths generally have low level of contraceptive use but their reliance on unsafe abortion is high and results in many abortions-related complications. Unsafe abortion which causes as many as 200,000 deaths and many more injuries each year is a problem which only gets worse as the number of women with unwanted pregnancies increase (Ore, 2006).

Estimates range from 30 – 55 million a year or about 40 – 70 per 1000 women of reproductive age with an abortion ratio of 260 – 450 per 1000 live births. Studies indicate globally that abortions, whether spontaneous or induced whether in hands or skilled or unskilled (quack) persons are almost ratio ranges from 1.3.5 per 100, 000 abortions in developed countries (Araoye and Fakeye, cited in Oladeji, 2013).

Over the last decades, several researchers have identified unsafe abortion as an important challenges associated with women's reproductive health in Nigeria. Indeed abortion currently accounts for 20, 000 of the estimated 50, 000 maternal deaths that occurs in Nigeria each year. It is thus single largest contributor to maternal mortality (Otoide, Orosaye and Okonofua, 2001).

The performance of an abortion is illegal under Nigeria criminal law, unless the woman's life is threatened by the pregnancy. As a result, induced that more than 60,000 Nigerian women obtain abortion each year. According to advocates for Youth, (2006) One third of women obtaining abortions were adolescents, hospital-based studies showed that up to 80% of Nigerian Patients with abortion-related complication were adolescent.

Ihejiamaizu and Etuk (2001) cited in preliminary results of a study on "induced abortion among secondary school girls in Calabar" observed that out of 946 respondents aged 10-16 years, 93.2% had begun to menstruate. The early intercourse and attendant unwanted pregnancies of which 60% of such pregnancies were terminated through induced abortion. Reasons given for termination include not married 40%, not ready for parenthood

40% and social stigma and shame 20%. They also observed that the pattern of sexual behaviour among their study group in induced abortion has concomitant risks not only of pregnancy and complications of abortions, but of the adolescents-contracting sexually transmitted infections especially HIV/AIDS.

Many sexually active unmarried young women in the Latin American region become pregnant, data suggest that 12 to 25% of adolescents who gave birth are unmarried (Blum and Nelson-Nmari, 2004). Combined data on unwanted pregnancies and abortions suggest that in Brazil, Peru and Columbia approximately 30 to 40% of adolescent pregnancies are unwanted (Guzman, 2000). Unsafe abortion is an important contributor is material mortality in Latin American region and maternal mortality is among the causes of death for adolescents (Schuff-Ainer and Maddaleno, 2003). Also complicating matter is the fact that youths tend to delay seeking abortion services leading to later term abortions with increased risk of complications.

According to Park (2003) contraceptives are preventive methods to help women avoid unwanted pregnancies. They include all temporary and permanent measure to prevent pregnancy resulting from coitus. He further stressed that there can never be an ideal contraceptive that is safe, effective, acceptable, inexpensive simple to administer, independent of coitus, long lasting enough to obviate frequent administration and requiring little or no medical supervision. Every contraceptives method has its unique advantages and disadvantages.

Use of modern contraceptives, particularly among married youth in Sub-Saharan Africa is very low-women who are married even as adolescents are expected to have children right away. In many developing country settings, particularly Sub-Saharan Africa, women's gender identities and social status are tied to motherhood (Cooper, 2007) and childlessness is highly stigmatized (Dodoo and Frost, 2006; Dyer, 2007). Among unmarried sexually active adolescents in Sub-Saharan Africa, contraceptive use ranges from a low of 3% in Rwanda to a high of 56% in Burkina Faso (Khan and Mishra, 2008). Unmet need for contraception, or nonuse of methods despite the desire to limit births or delay them for at least two years, is high among unmarried adolescents in Sub-Saharan Africa (more than 40% in most countries)..

As expected, unmet need among married adolescents is lower but still substantial (Paul-Ebhohimhen, 2008; Poobalan and Van-Teijilingen, 2008). Adolescents have unprotected sex for a multitude or reasons. Within or outside of marriage, young women may feel pressure to prove their fertility. Other young people may engage in unprotected sex because they have not considered contraception (Gomes, 2008) fear possible side effects (Abiodun and Balogun, 2009) are misinformed about the risk or pregnancy or STIs posted by unprotected or are more concerned with the safety of condoms than the safety of an unintended pregnancy (Warenius, 2007).

Ajuwon, Olaleye, Faromoju and Ladipo (2006) reiterated that there is concern that only about 4% of the sexually active students used a condom during their most recent sexual activities. Male condoms have been widely promoted in Nigeria as an efficient means of preventing the sexual transmission of HIV; condoms are relatively cheap, readily available and do not require medical supervision. Yet they remain under-utilized by many adolescents in Nigeria (Ajuwon, Mcfarland, Hudes, Adedapo, Okikwilu and Lurie, 2002).

Sexual coercion like any other form of violence is a complex phenomenon resulting from the interplay of multiple factors. In this respect an ecological framework has been used increasingly to organize and explain findings about various types of violence. Sexual coercion lies on the continuum of sexually aggressive behaviour. This continuum includes many harmful and aggressive acts we bear frequently, such as rape, sexual and sexual assault.

Sexual coercion is a serious public health problem that affects adolescents in many countries, including Nigeria. Sexual coercion is the use of force or the attempt to force another individual through violence, threats, verbal insistence, deception, cultural expectations and economic circumstances to engage in any sexual activity against his or her will. Examples of sexually coercive behaviours include unwanted touch of breast and backside deception, intimidation, rape and the attempt to rape. Sexual coercion causes serious physical and mental problems, including bodily injury, depression, suicide and death (Ellsberg, Heise, Pena, Agurto and Winkvist, 2001). Female victims of coercion also suffer serious reproductive problems, namely chronic pelvic pain, sexually transmitted infections (STIs) unwanted pregnancy and adverse pregnancy outcomes including

miscarriage and low birth weight. Unfortunately, in Nigeria, many victims of sexual coercion suffer in silence because of the stigma associated with this behaviour. Coercive sexual behaviour exists at alarming rates on college campuses. Researches attempting to identify factors related to sexual coercion have primarily investigated either the coercing college male or the coerced college female, independent of relationship factors.

The review of sexual coercion literature shows that great part of this studies are quantitative that analyze the prevalence of sexual coercion experimented for women and or men mainly among young and adolescents high school ages (Halpen, 2001) or in some cases these studies look for identifying variables that predict the fact of being victim or perpetrator of sexual coercion (Forbes and Adams-Curtis, 2001).

According to Awuno, Obuehi and Nwankwo (2006), the prevalence of sexual coercion is not known with certainty due to gross underreporting in Nigeria; it is not seen as an issue of concern for this reason. Addressing this in the education sector hits at the intersection of human rights, public health and educational agenda. Sexual coercion prevents students from achieving their intellectual, emotional and educational potential. There is need to prevent sexual coercion and its attendant integral part of such a programme would be efforts to encourage victims to seek medical care.

Age and educational level on knowledge, attitude and sexual rights

Udigwe, Adogu, Nwabueze, Adinma, Ubajaka, &Onwasigwe, (2014) conducted a study on the Factors that influence sexual behavior among Female Adolescents in Onitsha, Nigeria with sample size of 400 respondents comprises of unmarried female secondary school student adolescents and non-student adolescents aged 10 - 19 years. As such, their result revealed that, the common reasons for first sexual intercourse for both groups (unmarried female secondary school student adolescents and non-student adolescents) was pressure from partner or boyfriend. However, more of the student adolescents (29.3%) were engaged in transactional sex, while more of their non-student counterparts were forced or coerced into sex (19.2%). According to the, sexual practice among the girls was statistically significantly associated with age. More so, the result revealed that the likelihood to have ever engaged in sex is significantly increased with wrong knowledge of fertile period ($x2 = 15.23$, $p = 0.009$), knowledge of STIs ($x2 = 21.46$, $p = 0.0001$) and

knowledge of HIV transmission (x2 = 3.83, p = 0.050) and prevention (x2 = 38.08, p = 0.0001) (Udigwe, et al. 2014).

Nakpodia (2012) also conducted a study on the relevance of sex education in secondary school curricula in Abraka metropolis, Delta state, Nigeria. The target population consists of public senior secondary school teachers in Delta State, Nigeria. Therefore, the findings revealed that there is significant difference in the attitude of teachers towards the relevance of sex education due to gender. Also, there is significant difference in the attitude of teachers towards the relevance of sex education due to their educational status or attainment.

In the same vein Obiekea, Ovri, &Chukwuma, (2013) conducted a study on Sexual Education as an intervention and Social Adjustment Programme for Youths in Secondary Education in Anambra state, Nigeria. The descriptive survey research design was used to unravel the importance of sexuality education for youth in secondary education in the State. Their study population was 5,926 in the 261 government owned secondary schools within the six education zones in Anambra State. They drew sample size of 593 respondents from 26 public secondary schools through a multiple statistical sampling technique. As such, the grand mean of 3.51 indicated a strong positive reaction from the respondents on the need/importance for sexuality education to be taught in secondary education. Results from the table using the grand mean of 3.14 reveal that sexuality education served as an intervention and social adjustment programme for youth in secondary education in the state. More so, their findings revealed that sex education programme increased students' ideas, knowledge and understanding about their reproductive and other related health issues and exposed them to varying health problems in the society.

A recent review of school-based programs in developing countries conducted by FOCUS in 2001 cited in Jame, Rosen, Murray (2004), found strong evidence of the effectiveness of such programs in improving youth reproductive health (YRH) outcomes. Seventeen of 19 school programs that had undergone relatively rigorous evaluation were effective in improving young people's knowledge of sexual and reproductive health, including contraception and HIV/AIDS prevention. Nine of 14 school programs were

effective in improving YRH behaviors such as delaying sexual debut, decreasing the number of sexual partners, and increasing condom use

among youth who are sexually active.

Impacts of intervention on sexual rights

In a study conducted by Oshi; Nakalema and Oshi cited in Obiekea, Ovri, &Chukwuma, (2013), in South Eastern Nigeria on sex education, the findings revealed that teachers are not passing on this knowledge because of cultural and social inhibitions. In addition, teachers have not been receiving adequate training and motivation on information, education and communication for sex education. The findings of the study also show a high level of knowledge of HIV/AIDs preventive measures among teachers (Oshi; Nakalema and Oshi, 2005 cited in Obiekea, Ovri, &Chukwuma, (2013). Thus, the task of all education stakeholders, administrators and teachers is to ensure the sexuality education is filly taught in schools.

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among youth who are sexually active.

The FOCUS evidence reviewed include& a description of three Nigerian programs. Although different in their approach, all three show a significant impact on reproductive

health knowledge and behaviors. Program 1: HIV/AIDS education for secondary school students. A new HIV/AIDS curriculum was developed and carried out during six weekly sessions lasting 2—6 hours in Ibadan, Nigeria. The educational sessions used a variety of techniques, including lectures, films, and role plays, debates, stories, songs, and essays. A physician carried out the curriculum with the assistance of two trained teachers. Key findings are as follows:

- The sessions improved knowledge and attitudes: Six months after completion of the intervention, the intervention group had improved knowledge about AIDS and improved attitudes toward people with AIDS. • The sessions reduced the number of sexual partners: Youth who participated in the intervention had fewer partners after the intervention (FOCUS in 2001 cited in Jame, Rosen, Murray 2004).

Program 2: Linking schools with private physicians. An integrated school and clinic program in Benin City, Nigeria, was carried out in 1998 to teach students about STIs and encourage them to receive treatment for STIs from trained, private medical doctors. Adolescents in four schools received both formal and peer education on STIs. Eight schools served as a control group. Adolescents in the intervention schools learned about the symptoms and ways to recognize various STIs; the complications arising from nontreatment or delayed treatment; the need for early and effective treatment; the need to inform sexual partners and to treat them for STIs; and the effective methods for preventing STIs, especially correct use of condoms. Additionally, private doctors, pharmacists, and patent medicine distributors in the neighborhood of the intervention schools received training in youth-friendly services and in the World Health Organization (WHO) approach to syndromic management of STIs. 2 Peer educators received a list of trained providers to whom they could refer their peers for appropriate services. An evaluation after one year yielded the following findings:

• The intervention improved knowledge: Students in intervention schools had significant increases in knowledge of STIs, use of condoms, and knowledge of the correct treatment-seeking behavior for STIs compared with students in the control schools.

• The program appeared to lower STls: The self-reported symptoms of STIs in the six months after the intervention were lower in the intervention group as compared with the control schools.

• The program improved health-seeking behavior: The in-school activities and the physician training significantly increased students' use of private physicians, where they received more effective and comprehensive treatment of their STIs compared with the care received through patent medicine providers and pharmacies (FOCUS in 2001 cited in Jame, Rosen, and Murray 2004).

Program 3: The West African Youth Initiative. This peer program took place in Nigeria and Ghana. The project worked with organizations serving youth to develop peer programs in three types of sites: secondary schools, postsecondary schools, and out-of-school settings. Each community selected a site for the project and then chose a comparison site. The baseline and follow-up studies (two cross-sectional samples) included 100 youth from each site (100 interventions and 100 comparison). Key findings are as follows:

• The program had the greatest impacts on secondary school and postsecondary school students:

Specifically, among secondary and postsecondary school women, greater awareness of youth programs was reported among the intervention group at follow-up.

• The program increased knowledge and self-efficacy:3 In-school males (secondary and postsecondary) from intervention schools reported greater knowledge and self-efficacy than students from comparison schools (controlling for age, living arrangement, etc.).

• The program reduced risky behaviors: Among in-school males and secondary-school females, youth from intervention schools reported greater recent use of protective methods against STIs (that is, using condoms, staying with one sexual partner, or abstaining) than comparable youth from nonintervention schools.

• The program did not affect behaviors of out-of-school youth: This finding may be a consequence of the fact that out-of-school youth are a heterogeneous group that does not necessarily congregate in specific, fixed locations like schools (FOCUS in 2001 cited in Jame, Rosen, Murray 2004).

Based on the above findings, the FOCUS cited in Jame, Rosen, Murray (2004), strongly endorses school-based sexuality and reproductive health education as a means to improve YRH. Specifically, the review recommends the following:

Where school enrollment is fairly high, a comprehensive approach should include school-wide reproductive health education to reach large numbers of young people. Ideally, governments should scale up these efforts to be national in scope; should begin them, with age-appropriate information, in primary school; and should adequately train and support teachers to impart reproductive health education. Further research is needed to determine how to strengthen connections among school programs and commercial sources as well as among other nonclinical sources of reproductive health care. (FOCUS in 2001 cited in fame, Rosen, and Murray 2004).

On the aspect of funding Sexuality education programs which is relatively low-cost in African countries. A review of youth reproductive health programs in African countries evidence revealed that such programs cost between US$0.30 and US$71 per year per person, with a median cost of about US$9 per person per year (World Bank, 2003). Moreover, according to Jame, Rosen, Murray (2004), recent studies have found that sexuality education programs offer a good return on investment, for example, a study in Honduras found that for each $1.00 invested in sexuality education to prevent HIV infection among youth, the program would generate up to $4.59 in benefits from improved health and reduced medical care costs. This estimate only includes the economic benefits of averted HIV infection and does not include the benefits of other potential program outcomes such as increased education, reduced STIs, and reduced teen pregnancies and abortions (K and Behrman, 2003). Confronting AIDS, the World Bank's cited in Jame, Rosen, Murray (2004), uses a similar public investment rationale to recommend that every countries should carry out sexuality education programs.

Angela; Weaver; Sandra Byers Heather; Sears;. Cohen; Randall (2002) conducted a study on Sexual Health Education at School and at Home with the Attitudes and Experiences of New Brunswick Parents in Canada. The researchers sampled Over 4200 parents with children in grades K-8 in 30 New Brunswick schools completed surveys. Their findings revealed that, the vast majority of parents were in support of school- based

sexuality education programme, with 94% of parents either agreeing (40%) or strongly agreeing (54%) that Sexual Health Education (SHE) should be provided in school. Almost all parents (95%) felt that both the school and parents have a role to play in Sexual Health Education, with 33% agreeing and 62% strongly agreeing that the school and parents should share this responsibility. More so, approximately equal numbers of parents reported that Sexual Health Education should begin in grades K-3, 4-5, and 6-8 (33%, 32%, and 32% respectively). Thus, 65% of parents felt that Sexual Health Education should begin in elementary school and 97% felt that it should begin in elementary or middle school. Only 1% of parents reported that SHE should not be provided in school. In order to determine whether parental characteristics were associated with attitudes towards Sexual Health Education, parents' age, level of education, community type (rural versus urban), and age of their oldest child were correlated with these three items. Because of the large sample size, only correlations accounting for more than 4% of the variance were interpreted. None of these characteristics significantly predicted parental attitudes towards Sexual Health Education.

The median of parents' responses shows that parents rated each of the 10 listed topics as important to include in a sexual health curriculum. Parents rated personal safety, abstinence, puberty, sexual decision-making, and reproduction as extremely important. They rated sexually transmitted diseases, sexual coercion/assault, birth control methods and safer sex practices, and correct names for genitals as very important to the curriculum. Although parents felt that sexual pleasure/enjoyment was less important than the other nine topics, they still rated it as important overall (Angela; Weaver; Sandra Byers Heather; Sears;.Cohen; Randall 2002).

Appraisal of Literature Review

The literature reviewed under this chapter discussed the following areas, background of the study, key facts about sexuality education, sexual health rights, sexual health knowledge and attitude of young people, sexual behaviour of young people (abortion, sexual abuse, contraception and unwanted pregnancy and sexual coercion), and the need for intervention programme.

It was discovered that young people constitute about 20% of the world's population and that 85% of these young people live in developing countries. Most estimates suggest that prevalence of sexual abuse, marriage and childbearing among young people is highest in sub-Saharan Africa. It was also discovered that by age 20, 80% of women are sexually active. The young people engage in risky sexual behaviour due to their poor knowledge and attitude of sexual health rights which could lead to serious health implications.

The sexuality education programme according to literature review depends on the outcome of the teaching imbibed into the young people in terms of treatment. The study focus on the influence of sexuality education programme on the sexual behavior, altitude and sexual rights of female students of Anambra state college of education. Meanwhile there are large extant of literatures on the subject matter but a gap exist as majority of the literatures and empirical evidence reviewed on sexuality education studies were conducted outside Anambra state, while few of these studies conducted in Anambra state sampled respondents from secondary schools in the state. As such, the researcher identifies this gap since there is no documented evidence on sexuality education among the female students in Anambra state college of education, thus, the researcher is determined to fill this gap at the completion of this study.

CHAPTER THREE

METHODOLOGY

The focus of this study is on the efficacyof Sexuality Education on Knowledge, Attitude and BehaviourTowards Sexual Health Rights among Female Colleges of Education Students in Anambra State. This chapter was discussed under the following headings:

1. Research Design
2. Population of the Study
3. Sample and sampling techniques
4. Research Instrument
   - Validity of the instrument
   - Reliability of the instrument
5. Field-testing of Research Instrument
6. Procedure for Data Collection
7. Procedure for Data Analysis

Research Design

Quasi-experimental design of pretest-post test control method was adopted for this study. This design was chosen because it allows the researcher to match the participants in the experimental and control groups in similar variables (Frankel and Walken, 2000). This design also enabled the researcher to introduce a new intervention to the experiment group and take measurement both before and after the intervention to be able to establish effect observed between the experimental and control group (Townsend, 2004, Kerlinger and Lee, 2000).

Population

The population of the study comprised all the three thousand four hundred (3,400) female students in the two Colleges of Education in Anambra State in the 2009/2010 academic session.

Sample and Sampling Technique

The sample for the study were 680 participants. The multistage sampling procedure was used to select the sample for the study. At the first stage, purposive sampling technique was used to select the two (2) Colleges of Education in Anambra State. At the second stage through randomization students of Nwafor Orizu College of Education, Nsugbe was used as experimental group while students of Federal College of Education (Technical) Umunze will serve as the control group. Thirdly, the fish bowl method of simple random sampling technique was used to select 50% of the six schools in each of the colleges of education. Thereafter, the proportionate random sampling technique of twenty percent of students in the 200 level NCE in each college of the departments in each selected school were sampled.Finally, the systematic sampling technique was used to select the participants for the study.

Distribution of respondents for the study

Selected schools	**No of Depts**	**Sampled Depts**	**Population**		**No of Selected participants**	
			Nsugbe	**Umunze**	**Nsugbe**	**Umunze**
Science	7	4	600	200	120	40
Vocational & Technical Edu.	4	2	800	750	160	150
Social Sciences	4	2	650	400	130	80
Total			2050	1350	410	270

Research Instrument

i. Modules of Sexuality Education on knowledge, attitude towards sexual rights and behaviour. These served as a guide for educating the participants who were students of Nwafor Orizu College of Education, Nsugbe, and a placebo for students at Federal College of Education (Technical), Umunze.

ii. Self developed questionnaire on knowledge and attitude towards sexual rights and behaviour. The questionnaire was four sections:

Section A - Demographic data of the participants

Section B - Knowledge of Sexual Rights Questionnaire (KSRQ) with True and False options.

Section C - Attitude towards Sexual Rights Questionnaire (ATSRQ) with modified likert scale options.

Section D - Adolescents Sexual Behaviour Questionnaire (ASBQ) with True and False options.

Focus group discussion (FGD) was used to collect baseline information which revealed areas needing special attention during the intervention, this which was qualitatively analysed. The focus group discussion preceded the real intervention programme. Thereafter, the eight weeks consecutively. Participant from Nwafor Orizu College of Education received treatment while participants from Federal College of Education (Technical) Umunze received placebo training, but both groups were exposed to pre-test and post test. At the eight week, a post test was administered on the participants exactly as the pre-test was given and collected on the spot.

Validity of Instrument

In order to ensure that the instrument measures what they are meant to measure, the structured questionnaire was subjected to content validation. The instruments were submitted to the researcher's supervisor and other lecturers in and outside the Department of Human Kinetics and Health Education, University of Ibadan for modification. All corrections were carefully looked into and made use as appropriate.

Reliability of the Instrument

Corrected version of the instrument was administered to 20 students of the college of education who were not part of the sampled participants using a test-retest method. The data collected was used to estimate the reliability of the instrument using Pearson Product Moment Correlation. The instrument yielded a reliability co-efficient of 0.78

Field Testing of the Instrument

Prior to the commencement of the actual study, a field test of the research instruments was concluded. This was done in order to familiarise the researcher with the problems that may arise during the course of answering the pre and post test and to ascertain the average time that will be required to answer them.

Ethical Issue: Study participants' rights were respected. They were given informed Consent Form for Participation in Research, developed by University of Ibadan Ethics Committee (2010) see Appendix 1.

Procedure for Data Collection

The researcher collected a letter of introduction from the Head of Department of Human Kinetics and Health Education, University of Ibadan to the Provost of each College of Education in Anambra State in order to gain access and co-operation of the respondents. The researcher held discussions with the research assistants (10) in the experimental and control groups on the procedure for the programme, the venue and the time on different days. Pre-test wasadministered first and collected followed by the intervention programme (sexuality education package). The post test was given after the completion of the intervention and questionnaire was -collected. Which was the same as the pre-test.

Sexuality Education Intervention Package

Week I: Pretest Administration

Time: 1hr

Objective: The purpose of this session was to administer the questionnaire on the participants so as to determine the ability of the students that will benefit from the training.

The participants were warmly welcomed into the programme. They were informed that the training would be run once a week for eight weeks consecutively.

- The researcher explained to the participants the reasons for the programme and what they stand to benefit at the end of the programme.
- The researcher explained the rules guiding the conduct of the programme and what was expected of the participants
- The researcher and her assistants administered the pre-test instruments to the participants

Week 2

Step I

Time: 15 minutes

Participants were welcomed and allowed to take their seats in readiness for the training package.

Step 2

Objective (i) To explain the concept of sexuality health

(ii) To identify factors that influence sexual health

Time: 1hr

Sexual health is a state of physical, emotional, mental and social well being in relation to sexuality; it requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence.

This therefore implies that people are able to have a responsible, satisfying and safer sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so.

Factors that influence Sexual health

(i) It could be influenced by factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition

(ii) Problems of HIV and STIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs and sexual dysfunction

(iii) Influenced by mental health, acute and chronic illnesses, and violence

Step 3

Objectives:

(i) To explain the concept of sexuality rights

(ii) To identify the personal skills adopted for sexual rights.

Time: 30 minutes

Sexual rights implies the rights of all people to decide freely and responsibly on all aspects of their sexuality, including protecting and promoting their sexual and reproductive health, be free from the discrimination, coercion or violence in their sexual life and in all sexual decisions as well as expect and demand equality, full consent, mutual respect and share responsibility in sexual relationship, pursue of satisfying, safe and pleasurable sexual

life, respect for bodily integrity as well as seek, receive and impart information in relation to sexuality.

Personal Skills in Sexual Rights

Owing to the fact that sexual abuses against and sexual behaviour of female students are due to cultural norms favouring male dominance over the female in all areas of life, there are personal skills that could be adopted which are necessary for one to live a meaningful life.

These include:

- Assertiveness
- Negotiation
- Self esteem
- Goal setting
- Values
- Decisions making and
- Communication

Step 4

Time: 15minutes

The participants are allowed to ask questions from the topics discussed after which they share their snack.

Week 3

Step I:

Time: 15 minutes

Participants were welcomed and allowed to take their seats for the days' training package.

Step 2

Time: 25minutes

Objectives

(i) To explain the concept of sexuality transmitted infection (STIs)

(ii) Identify the causes of birth while breastfeeding.

Sexually transmitted infections cannot only be prevented, but in most cases can also be treated.

There are many different types of STL. Some are caused by bacteria, viruses and still others by fungi and parasites. The sexually transmitted infections include:

- Gonorrhea
- Syphilis
- Cancroids
- HIV/AIDS
- Candidiasis/Monila
- Genital Herpes

Step 3

Objective: i) to identify behavioural risk factors of STIs

ii) to identify consequences of STIs

iii) to outline the symptoms and complications of STIs.

Time: 1hr I5 minutes

Behaviours predisposing people at risk of STIs

- Having many sexual partners
- Having unprotected sexual intercourse with either male or female who is infected
- Get high or drunk before sexual intercourse Do not know the symptom of an STI

Symptoms of STIS in Men and Women

- Sores, rashes, bumps or blisters on the vagina, penis, mouth
- Burning or painful urination or bowel movements
- Frequent urination, itching or swelling of the genitals
- Swelling or redness in the throat (for people engaging in oral sexual activity).

Consequences of sexually transmitted infections

- Damage to the reproductive organs, resulting infertility
- Bladder infections
- Bladder infections

- Cervical cancer (vaginal warts)
- Breakdown of the immune system or death (HIV)
- Premature labour or still birth (gonorrhea)
- Blindness and birth defects in new babies (syphilis and gonorrhea)
- Pelvic inflammatory disease (PID) in women can result in infertility, entopic pregnancy, and chronic pains.

Disease (causative Organism)	**Incubation Period**	**Sign/symptoms**	**Complications**
GONORRHEA (Netsseria gonorrhea bacteria)	2-14 days; usually 3 days following exposure	Frequently slight, especially in females, painful urination. Pus discharge from infected site. Abdominal pains. Painful swelling of glands in genital area.	Severe infections of fallopian tubes, ovaries, lower abdomen. Chronic inflammation of ducts and glands in reproductive system. Sterility, Arthritis, Tubal pregnancy. Infection of baby's eyes at childbirth. Spread to sex partners
Syphilis (Traponema pallidum: spirochete)	10-90 days usually 3 weeks following exposure	Frequently slight. Hidden, or absent, first-primary: hard, painless sore at point where germs entered the body. Swollen lymph nodes. Second-secondary: rashes, white mucous patches, parch hair loss, malaise. Latest: no symptoms	Insanity, blindness, heart damage, paralysis, death. Transmission to unborn baby by infected female. Spread to sex partners
Herpes Genitals 'Genital Herpes, (Herpes-virus hominus Type II: virus	2-20 days; usually 6 days following exposure	Single or multiple raised, painful lesions. Fever, headache, malaise. Tender, swollen lymph nodes. Duration 2-3 weeks, often recur	Infection of child at birth, may be fatal. Apparent relationship to cervical cancer. Recurrence of painful symptoms. Secondary infections. Highly

			contagious, spread to sex partner. No know cure
NON-SPECIFIC OR NON GONOCCOCAL URETHRITIS. VAGINITIS "NSU, NGU NSV, NGV" Many possible causes actual not always determined	Uncertain; 8-14 days	Pus discharge from sex organ, painful or frequent urination inflammation of vaginal wall	Chronic inflammation of carious glands and tubes in reproductive or urinary systems. Infection of infants at childbirth. Possible spread to sex partners
MONILIA (Candida albacans: yeast fungs	Organization commonly present, disease state may triggered by pregnancy, diabetes birth-control pills, antibiotic treatment, lowered resistance	Intense genital itching, Thick, curd-like, white discharge, odorous, inflamed, dry vagina	Frequent recurrence possible spread to partners
CHANCROID 'Soft Chancre" (Hemophilus ducrey" bacillus	1-5 days	One of several small. Raised, painful sires with ragged, irregular edges Hard, painful swelling of lymph glands in groin (bubo)	Secondary infection spread to sex partners

Step 4

The participants are allowed to ask questions from the past and present subtopic discussed after which they share their snack.

Week 4 Step1

Time: 15minutes

Participants were welcomed and allowed to ask questions from previous subtopics. The new subtopic will be introduced.

Step 2

Objectives: i) to explain the concept of abortion.

ii) identify the various types of abortion

Time: 25minutes

Abortion is defined as the removal, by mechanical or chemical means, of a fertilized egg from the uterus or womb for the purpose of terminating the pregnancy before the 28th week.

Unsafe abortion is the major course of material mortality. It is a serious medical procedure requiring the assistance of a trained and exported health provides.

TYPES OF ABORTION

i. Induced Abortion: This is the type of abortion that is done intentionally. Many girls and women opt for it as a last resort to control their fertility (is when they have an unwanted pregnancy).

ii. Spontaneous Abortion: This is the form of abortion that is not intentional. Spontaneous abortions are usually caused by faulty development of the embryo, abnormalities of the placenta, endocrine disturbance, acute infections, severe trauma, or shock. They are often referred to as "miscarriages" to differentiate them from abortions that are induced.

Step 3

Objectives: i) to state reasons for abortion by young people.

ii) to discuss the medical techniques for abortion.

Time: 45minutes

The reasons for intentional termination of pregnancy

- The pregnancy is unwanted
- The pregnancy will cause shame to the girl and members of her
- Poverty (no means of caring for the child)
- Pregnancy resulting from exploitative sexual relationship eg rape, incest
- Fear of expulsion from school
- Humiliation by members of the community
- Too many children already
- To please ones partner or person responsible for the pregnancy

- Mother sick from HIV/AIDs or other terminal disease. Medical Techniques for abortion

Abortions are generally performed within the first trimester of an unwanted pregnancy. The procedure includes

- Suction: drawing out the contents of the citrus through a narrow tube attached to a gentle vacuum source
- Dilation: enlarging the cervical opening by stretching it with tapered instruments called dilators.
- Curettage: scraping the inside of the citrus with a metal loop called a corvette, to loosen and remove tissue

Step 4

Objective: to understand the consequences of unsafe abortion

Time: 20minutes

Consequences of unsafe abortion

- Incomplete abortion which leads to hemorrhage, serious cramps and pains in the pelvis, protracted bleeding for more than 3 weeks.
- Infection from unspecialized instruments
- Perforation of the uterus which may necessitate a surgical procedure called hysterectomy which is the removal of the uterus to save the life of the girl
- Secondary sterility: This refers to inability of the women to conceive as a result of damage done to the uterus. It causes serious emotional problems.
- Miscarriage or premature birth: Owing to cervical incompetence caused by the frequent opening of the cervix the chances of future miscarriage and premature birth are increased
- Feelings of guilt and shame or physical trauma before and after the abortion.

Step 5

Time: 15minutes

The participants shared refreshments and they disperse

Weeks

Step 1

Time 15 minutes

The researcher welcomes the participants, appreciate their cooperation and encouraged them further.

Step 2

Objectives: to explain the concept sexual violence

Time: 25minutes

The researcher will introduce the topic sexual violence.

Concept of sexual violence

Sexual violence is a hidden issue to many women attending health care.

Sexual violence encompasses wide range of aids including forced / coerced sex in marriage and dating relationships, rape by stranger, sexual harassment, sexual abuse of children, and forced prostitution and sexual trafficking.

Sexual violence often affects women and girls rape and sexual abuse are also increasingly common in situations of armed conflict.

Step 3

Objectives: i) to identify various types of rape.

ii) to differentiate between sexual abuse and sexualharassment.

Time: 1hr Sexual Abuse

This occurs when one adult forces another adult or a child to have sexual intercourse or perform other sexual acts against their will. It is also an unwanted sexual contact with a person for the purpose of one's sexual excitement and satisfaction or gratification.

Types of sexual abuse

Incest: sexual activity between close child, sibling, cousins, uncle and niece etc.

Rape: Is sexual intercourse that takes place as a result of force rather than consent. Is the subjugation of women by men by force or threats of force. Most common types of rape are

i. Stranger rape
ii. Acquaintance rape
iii. Date rape

iv. Statutory rape

v. Child sexual abuse

Sexual harassment: Is the deliberate or repeated unsolicited verbal comments, gestures, or physical contact of a sexual nature. It includes touching against a person's wish, verbal pressure or sexual activity, or even physical assault. It is sometimes confused with flirting

Step 4

Time: 20minutes

The participants are given opportunity to ask questions, thereafter they take their snacks.

Week 6

Step 1

Time: 15minutes

The researcher will welcome the participants as they take their seats.

Step 2

Time: 25minutes

The researcher will introduce the topic: concept of sexual coercion

Sexual coercion is the use of physical force threats of physical or psychological harm, economic or evaluative pressure to force one or to attempt to force one into engaging in sexual intercourse (oral, anal and other forms). It is an unwanted verbal or physical behaviour of a sexual nature that occurs in places such as the workplace or in an educational setting under certain conditions. Such behaviour is illegal if it creates an environment that is hostile or intimidating, if they interfere with a person's work or school performance, or if the coercer's behaviour is made a condition for employment or academic reward of performances.

Step 3

Objectives: i) to itemize sexual coercive behaviour

ii) to identify the effects of sexual coercion on young people

Time: 1hr

Typical examples of sexual coercion

These include sexually oriented gestures, jokes or remarks that are unwelcome, repeated and unwanted sexual advances, touching or other unwelcome bodily contact and physical intimidation.

The categories of sexual coercion includes

- pressure sexual coercion: this is a situation where the sex partner continues to trouble or stress the other party for sexual intercourse
- Manipulation sexual coercion: this involves verbal persuasion and persistent forceful anti-social acts which include, using or threating force, expressing anger at the partner, and verbally insulting the partner.

Three types of dating coercion which include beginning dating coercion, early dating coercion and rational dating coercion.

- Effects of sexual coercions
- Makes quantity and quality of work to suffer
- Affects the victim's psychological and physical well-being.
- Victims suffer emotional distress
- Loss of trust
- Contact sexually transmitted infections

Step 4

Time: 20minutes

The researcher will allow the participants to ask questions from the past subtopics, discusses and then shares their snacks.

Week 7

Step 1

Time: 15minutes

The research will welcome the participants as they take their seats

Step 2

Objective: to develop the need for sexuality education on young people

Time: lhr

The researcher will introduce the subtopic for the day. The need for sexuality education

Need for sexuality education

Young people need sexuality education as they nurture and develop health relationships with the opposite sex, as well as how to make responsible choices.

The goals include:

- Provide accurate and adequate knowledge in human sexuality and the consequences of sexual activity so as to make informed decisions
- Impart intra and interpersonal skills of problem solving decision making and effective communication so that youths are able to build responsible and rewinding relationships
- Inculcate positive value attitude of sexuality so that they develop a respect for themselves and others as sexual beings in order to live with national values of the family as the basic unit of society.

Step 3

Time: 25minutes

The research will allow the participants to ask questions.

Step 4

Time: 20minutes

The researcher will congratulate the participants for staying through the period of the health education, she will remind the participants about the posttest the following day.

They share their snacks.

Week 8

Step 1

Objective: to sensitize the students in preparation for the posttest.

Time: 20minutes

The researcher will welcome the participants and remind them to retain their seats as was done during the pretest.

Step 2

Objective: to administer the questionnaire

Time: 50minutes

The researcher will administer the questionnaire (posttest) and collect after encouraging the participants to fully complete the questionnaire

Step 3

Time: 15 minutes

The researcher will congratulate the participants and wish them success in their academic endeavour

Step 4

Time: 35minutes

They all share the refreshment including the researcher and her assistants

Overall review, Post-test Experiment Test Administration and Conclusion

Post test

This will be an interactive session between the researcher and the participants to ascertain the effect of the therapeutic programme. Activities of the previous session will be role played to be sure they have attained positive experience via the intervention. The participants will be administered posttest instrument.

The researcher will then thank the participants for their cooperation while a token gift will be given to each one of them in appreciation of their participation in the training programme.

Closing Remarks

The researchers will commend the participants for the unrelenting cooperation

The participants will be encouraged to utilize effectively the skills they have acquired via the intervention programme.

Control Group

Session 1:

Topic Administration of Pretest Instrument

Objective: To administer pretest instrument to the participants

Activity: The researcher will formularise that the member of the group. The researcher will also explain to the that the programme is mainly for research purpose only and that

their support and cooperation is highly needed. The pretest instruments will be administered on them.

Closing Remarks: The researcher will commend the participants for their time and effort. The participants will be reminded of the time and venue of the next session.

Procedure for Data Analysis

All data collected were coded and analyzed with the computer using the SPSS programme package. Descriptive statistics of frequencies and percentage were used to analyze the demographic data and provided answers to the research questions while Multivariate Analysis of Covariance (MANCOVA) was used to test all the hypotheses at 0.05 level of significance.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

This chapter focuses on the analysis of data with respect to research questions and hypotheses earlier stated. This chapter is divided into two (2) sections. Section A provided answers tothe research questions while section B provided the result of the tested hypotheses.

Section A: Socio-Demographic Information of the participants

TABLE 1: Distribution of participants according to selected demographic characteristics

Marital status	**Frequency**	**Percentage**
Single	532	78.2
Married	108	15.9
Separated	24	3.5
Divorced	16	2.4
Total	**680**	**100.0**
Age		
16-19years	107	15.7
20-24years	214	31.5
25-29years	241	35.4
30-34years	102	15.0
35years and above	16	2.4
Total	**680**	**100.0**
Ethnicity		
Igbo	551	81.1
Yoruba	107	15.7
Hausa	22	3.2
Total	**680**	**100.0**
Religion		
Christianity	477	70.1
Islam	199	29.3
Traditional	4	0.6
Total	**680**	**100.0**

Table 1 above shows that 532 (78.2%) of the respondents were single, 108 (15.9%) were married, 24 (3.5%) were separated while 16 (2.4%) were divorced, showing that majority of the respondents were single. The table also revealed that 107 (15.7%) were between the ages of 16 and 19years, 214 (31.5%) were between the ages of 20 and 24years, 241 (35.4%) were between the ages of 25 and 29years, 102 (15.0%) were between 30 and

34years while 16 (2.4%) were 35years and above, showing that majority of the respondents were between the ages of 25 and 29years. Out of the 680 respondents, 551 (81.1%) were Igbo, 107 (15.7%) were Yoruba, while 22(3.2%) were Hausa showing that majority of the respondents wereIgbo. Concerning religion, 477 (70.1%) were Christians, 119 (29.3%) were Muslims while 4 (0.6%) were traditional worshippers, showing that majority of the respondents were Christian.

RESEARCH QUESTION 1: What is the level of knowledge of sexual rights of female students in Colleges of Education in Anambra State?

Table 2: Distribution of responses of the respondent knowledgeably of their sexual rights

S/N	Knowledge about sexual rights	True	False
1	Refuses to be discriminated against because she is a woman/girl	535 78.7%	145 21.3%
2	Resist unwanted touching by boy/man	583 85.7%	97 14.3%
3	Decide freely on when to use contraceptive	494 72.6%	186 27.4%
4	Resist being raped	544 80.0%	136 20.0%
5	Freely enter into sexual relationship without being threatened, forced, coerced	562 82.6%	118 17.4%
6	Decide freely when to get pregnant	540 79.4%	140 20.6%
7	Decide freely on any type of sexual activity regardless of partners wish	345 50.7%	335 49.3%
8	Demand for STIs, HIV, AIDS, sickle cell anaemia status before sex or marriage	598 87.9%	82 12.1%
9	Frowns at verbal sexual abuse against her	557 81.9%	123 18.1%
10	Discourage being asked sexy questions from an unwanted person	521 76.6%	159 23.4%
11	Resist being shown sexy objects against her wish	566 83.2%	111 16.3%
12	Resist hugging, kissing from an unwanted person	566 83.2%	114 16.8%
13	Demand mutual respects in all sexual relationship	593 87.2%	87 12.8%
14	Demand consent before any action relating to her sexuality can be taken	596 87.6%	84 12.4%

Note:

Very knowledgeable-	above 70% correct responses in all the items
Knowledgeable-	61-70% correct responses in all the items
Very fairly knowledgeable-	56-60% correct responses in all the items
Fairly knowledgeable-	50-55% correct responses in all the items
Poorly knowledgeable-	below 50% correct responses in all the items

The table 2 result revealed that the respondents were very fairly knowledgeable enough about their sexual rights, as above listed items. Thus 78.7% of the respondents affirmed that they refused tobe discriminated against because they are women or girl; also 583 respondents representing 85.7% of the respondents responded positively (YES) that they resisted unwanted touching by boy or man. Similarly, 72.6% of the respondents decided freely on when to use contraceptive while 80.0% of the girls resisted being rape. In the same vein, 562 respondents representing 82.6% affirmed to the fact that they entered into sexual relationship freely without being threatened, forced or coerced. The result in table 1 also shows that, the respondents are fully aware of their sexual rights as the evidence from the result table shows that they take sexual decisions independently. Some of the sexual decisions include, decide freely when to get pregnant (79.4%); decide freely on any type of sexual activity regardless of their partners wish (50.7%); demand for STIs, HIV, AIDs, Sickle cell status of their partner before sex or marriage (87.9%); they frowned at verbal sexual abuse (81.9%); they freely discouraged being asked sexy questions from unwanted persons (76.6%); they resist being shown sexy objects against their wish (83.7%); always resist hugging, kissing from unwanted person (83.2%); demand mutual respects in all sexual relationship they find themselves (87.2%) and lastly they demand consent from their partner before any action relating to their sexuality can be taken.

Based on the above evidences, female college of education students were veryknowledgeable about their sexual rights since they are exposed to sexuality education which is important to enhance and strengthen their self-confidence, self-esteem and self-responsibility.

Research Question 2: What is the attitude of female students in Colleges of Education in Anambra State towards sexual rights?

Table 3: Distribution of responses on the attitude of respondents towards sexual rights

S/N	Attitude towards sexual rights	SA	A	D	SD	Mean	S.D
1	Demanding for condom use before sexual intercourse shows one doubts the sincerity of the sex partner	(176) 25.9%	(149) 21.9%	(183) 26.9%	(172) 25.3%	2.48	1.13
2	Girls that are social have many dressing to show sensitive parts of one's body showing one is fashionable	(118) 17.4%	(116) 17.1%	(270) 39.7%	(176) 25.9%	2.26	1.03
3	Refusing hugging by anybody is unfashionable	(58) 8.5%	(174) 25.6%	(258) 37.9%	(190) 27.9%	2.15	.93
4	It is good to kiss or be kissed by a boy, man who says he loves me	(48) 7.1%	(129) 19.0%	(281) 41.3%	(222) 32.6%	2.00	.89
5	Men should decide on all matters relating to sexual activities	(76) 11.2%	(96) 14.1%	(256) 37.6%	(252) 37.1%	1.99	.98
6	Parents have right to circumcise their children	(61) 9.0%	(150) 22.1%	(147) 21.6%	(322) 47.7%	1.93	1.02
7	It is disrespect to demand for STIs, HIV, AIDS status and sickle cell anaemia status of would be sex marriage partner	(103) 15.1%	(103) 15.1%	(110) 16.2%	(364) 53.5%	1.92	1.13
8	It is not proper to refuse sex when a man says he loves me	(45) 6.6%	(103) 15.1%	(167) 24.6%	(365) 53.7%	1.75	.94
9	Girls that are social have many sex partners	(57) 8.4%	(47) 6.9%	(239) 35.1%	(337) 49.6%	1.74	.91

The result on table 2 was deduced from 4 point scale analysis with threshold of 2.5. That is, any variable (attitude towards sexual rights) that score above the standard mean of 2.5 was considered to be positive (Agree) while those that score below 2.5 was considered negative (Disagree). As such, evidence from the table revealed that none of the variable score above mean rating of 2.5. Meanwhile, demanding for the use of condom before sexual intercourse has the highest mean value (2.48). Therefore, the grand mean (x) is 2.024 which indicates that the majority of the respondents had negative (Disagree) attitude towards sexual rights. Thus, some of these negative attitude towards sexual rights include; social girls have many dresses to show sensitive parts of their body and this is considered

fashionable (2.26); refusing hugging by anybody is unfashionable (2.15), it is good to kiss or be kissed by a boy or man who says he loves you (2.00); the respondents also disagreed that men should decide on all matter relating to sexual activities (1.99); the respondent also shows negative attitude towards parents having rights to circumcise their female children (1.93); it is disrespect to demand for STIS, HIV, AIDSstatus and sickle cell status of marriage partner (1.92); also they show negative attitude towards not being proper to refuse sex when a man says he loves the respondents. (1.75). Finally, the respondents disagreed that girls that are social have many sex partners (1.74).

Research question 3: What is the behaviour of the participants towards sexual rights ?

Table 4: Distribution of responses on the behaviour of the participants towards sexual rights

S/N	**Behaviour Towards Sexual Rights**	**Yes**	**No**
1	I have many sex partners	86 12.6%	594 87.4%
2	I can demand for use of condom before sex	439 64.6%	241 35.4%
3	I demand for STIs, AIDS status of my sex partner	523 77.1%	156 22.6%
4	I resist verbal sexual abuse	523 76.9%	157 23.1%
5	I resist being discriminated against my gender	587 86.3%	93 13.1%
6	I resist non-consensual sexual relations	512 75.3%	168 24.7%
7	I refuse coercive behaviour from lecturers/male counterparts	594 87.4%	86 12.6%
8	I demand mutual respect from my partner	588 86.5%	92 13.5%
9	I pursue safe and satisfying sexual life	524 77.1%	156 22.9%

The table 4 revealed the behaviour of the respondents towards sexual rights. Evidence from the table shows that 87.4% of the respondents disagreed (No) that they have many sex partners, as 64.6% of them affirmed (yes) that they demand for the use of condom before having sex with their partner. Similarly, the majority of respondents affirmed (yes) that they demand for STIs and HIV status of their partners (77.1%); they

resist verbal sexual abuse (76.9%); resist discrimination (86.3%); as well as resisting non-consensual sexual relations (75.3%); refusing coercion behaviour from lecturers and male counterparts (87.4%), demand mutual respect from partner (86.5%) and pure safe and satisfying sexual life.

Therefore, the positive behaviour among the study participants about theirsexual rights will promote good health living among them and this eventuallywill discourage or reduce the rate in which they procure abortion due to unwanted pregnancy that result from poor sexual rights behaviours.

Hypotheses testing

This section presents the result of the tested hypotheses

Ho1a: There is no significant main effect of treatment on knowledge of sexual rightsof female college of education students in Anambra state.

Table 4.1: Summary of MANCOVA showing the pre-post effect of treatment on knowledge, attitude and sexual behaviour

Source	Dependent Variable	Type III Sum of Squares	DF	Mean Square	F	Sig.	Eta Squared
Corrected Model	Post-Knowledge	5555.980	14	396.856	56.719	.000	.544
	Post-Attitude	7437.718	14	531.266	62.409	.000	.568
	Post-Behaviour	903.983	14	64.570	43.942	.000	.481
Pretest Knowledge	Post-Knowledge	.157	1	.157	.022	.881	.000
	Post-Attitude	1.474	1	1.474	.173	.677	.000
	Post-Behaviour	2.303E-02	1	2.303E-02	.016	.900	.000
Pretest Attitude	Post-Knowledge	.135	1	.135	.019	.890	.000
	Post-Attitude	.110	.1	.110	.013	.909	.000
	Post-Behaviour	.215	.1	.215	.147	.702	.000
Pretest Behaviour	Post-Knowledge	1.142	1	1.412	.163	.686	.000
	Post-Attitude	4.135	1	4.135	.486	.486	.001
	Post-Behaviour	.676	.1	.676	.460	.498	.001
Treatment Groups	Post-Knowledge	2068.508	1	2068.508	295.634	.000	.308
	Post-Attitude	3055.533	1	3055.533	358.939	.000	.351
	Post-Behaviour	366.812	.1	366.812	249.629	.000	.273
Age	Post-Knowledge	25.116	1	25.116	3.590	.059	.005
	Post-Attitude	.456	1	.456	.054	.817	.000
	Post-Behaviour	4.307	1	4.307	2.931	.087	.004
Level	Post-Knowledge	2.159	2	1.079	.154	.857	.000
	Post-Attitude	2.930	2	1.465	.172	.842	.001
	Post-Behaviour	3.188	2	1.594	1.085	.339	.003
Treatment x Age	Post-Knowledge	14.818	1	14.818	2.118	.146	.003
	Post-Attitude	.207	1	.207	.024	.876	.000
	Post-Behaviour	1.981	1	1.981	1.348	.246	.002
Treatment x Level	Post-Knowledge	3.594	2	1.797	.257	.774	.001
	Post-Attitude	1.248	2	.624	.073	.629	.000
	Post-Behaviour	.849	2	.425	.289	.749	.001
Age x Level	Post-Knowledge	17.978	2	8.989	1.285	.277	.004
	Post-Attitude	13.002	2	6.501	.764	.466	.002
	Post-Behaviour	14.244	2	7.122	4.847	.008	.014
Treatment x Age x Level	Post-Knowledge	7.782	2	3.891	.556	.574	.002
	Post-Attitude	4.591	2	2.295	.270	.764	.001
	Post-Behaviour	7.966	2	3.983	2.710	.067	.008
Error	Post-Knowledge	4652.908	665	6.997			
	Post-Attitude	5660.935	665	8.513			
	Post-Behaviour	977.170	665	1.469			
Corrected Total	Post-Knowledge	10208.888	.679				
	Post-Attitude	13098.653	.679				
	Post-Behaviour	1881.153	.679				

a. R^2 for Knowledge about Sexual Rights = .544 (Adjusted R^2 =.535)

b. R^2 for Attitude about Sexual Rights = .568 (Adjusted R^2 =.559)

c. R^2 for Behaviour about Sexual Rights = .481 (Adjusted R^2 =.470)

The results from table 4.0 above shows that there was a significant main effect of treatment on the knowledge of sexual rights($F(1,678) = 295.634$, $P < .05$, $\eta^2 = .308$). Hence, the null hypothesis is rejected.

Table 4.1a: Estimated Marginal Mean Score showing the direction of differences in knowledge between the treatment groups

Knowledge	Mean	Std. Error
Experimental	27.139	.131
Control	21.239	.161

Table 4.1a above shows the Estimated Marginal Mean Score on knowledge based on treatment Groups. The table shows that the experimental group had a mean score of 27.139 while control group had a mean score of 21.239. This shows that the experimental group had a higher mean than the control group showing that the intervention was effective.

H_0 1b: There is no significant main effect of treatment on attitude toward sexual rights of female college of education students in Anambra state.

The results from table 4.0 shows that there was a significant main effect of treatment on attitude towards sexual right($F(1,678) = 358.939$, $P < .05$, $\eta^2 = .351$). Hence, the null hypothesis is rejected.

Table 4.1b. Estimated Marginal Mean Score showing the direction of differences in attitude between the treatment groups

Attitude	Mean	Std. Error
Experimental	17.461	.143
Control	10.722	.177

Table 4.1bshows the Estimated Marginal Mean Score on attitude based on treatment Groups. The table shows that the experimental group had a mean score of 17.461 while control group had a mean score of 10.722. This shows that the experimental group had a higher mean than the control group showing that the intervention was effective.

H0 1c: There is no significant main effect of treatment on sexual rights behaviour of female college of education students in Anambra state.

The results from table 4.0 above shows that there was a significant main effect of treatment on sexual rights behaviour ($F(1,678) = 249.629$, $P > .05$, $\eta^2 = .273$). Hence, the null hypothesis is rejected.

Table4.1c: Estimated Marginal Mean Score showing the direction of differences in behaviour between the treatment groups

Behaviour	Mean	Std. Error
Experimental	16.987	.060
Control	14.664	.074

Table 4.1c above shows the Estimated Marginal Mean Score on sexual behaviour based on treatment Groups.The table shows that the experimental group had a mean score of 16.987 while the control group had a mean score of 14.664. This shows that the experimental group had a higher mean than the control group showing that the intervention was effective on sexual rights behaviour.

Ho2a: There is no significant main effect of age on knowledge of sexual rights among female College of Education students in Anambra state.

The results from table 4.0 above shows that there was no significant main effect of age on the knowledge of sexual rights($F(1,678) = 3.590$, $P > .05$, $\eta^2 = .005$). Hence, the null hypothesis is accepted.

Table 4.2a: Estimated Marginal Mean Score showing the direction of differences in knowledge by age between the treatment groups

Knowledge	Mean	Std. Error
Adolescents	25.081	.374
Adults	24.785	.163

Table 4.2a: above shows the Estimated Marginal Mean Score on knowledge of sexual right based on Age. The result revealed that adolescents had a higher mean score of 25.081 than adults with a mean score of 24.785. This shows that the intervention was more effective on adolescents than in adults.

Ho 2b: There is no significant main effect of age on attitude towards sexual rights of female college of education students in Anambra state.

The results from table 4.0 above show that there was no significant main effect of age on the attitude towards sexual rights (F(1,678) = .054, P> .05, η^2 = .000). Hence, the null hypothesis is accepted.

Table 4.2b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by age between the treatment groups

Attitude	Mean	Std. Error
Adolescents	14.675	.424
Adults	14.806	.184

Table 4.2b above shows the Estimated Marginal Mean Score of attitude based on age. The result revealed that adolescents had a higher mean score of 14.675 than adults with a mean score of 14.806. This implies that the intervention was more effective on adolescents than in adults.

Ho 2c: There is no significant main effect of age on sexual rights behaviour of female college of education students in Anambra state.

The results from table 4.0above shows that there was no significant main effect of age onsexual right behaviour(F(1,678) = 2.931, P> .05, η^2 = .004). Hence, the null hypothesis is accepted.

Table 4.2c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by age between the treatment groups

Behaviour	Mean	Std. Error
Adolescents	16.149	.161
Adults	16.049	.070

Table 4.2cabove shows the Estimated Marginal Mean Score on sexual rights behaviour based on Age. The result shows that adolescents had a higher mean of 16.149 than adults with a mean score of 16.049. This implies that the intervention was more effective on adolescents than on adults.

Ho3a: There is no significant main effect of level of study on knowledge of sexual rights among female college of education students.

The results from table 4.0 above show that there was no significant main effect of level of study on knowledge of sexual rights ($F(2,677) = .154$, $P > .05$, $\eta^2 = .000$). Hence, the null hypothesis is accepted.

Table 4.3a: Estimated Marginal Mean Score showing the direction of differences in knowledge of sexual rights by level of study between the treatment groups

Knowledge	Mean	Std. Error
100 L	25.014	.448
200 L	24.700	.201
300 L	24.989	.259

Table 4.3aabove shows the Estimated Marginal Mean Score of knowledge of sexual rights based on level of study. The table showed that 100 Level had the highest mean score of 25.989 followed by 300Level with a mean score 24.989 and the least was 200 Level with a mean score of 24.700. This shows that the intervention was more effective on students in 100 Level.

Ho 3b: There is no significant main effect of level of study on attitude toward sexual rights of female college of education students.

The results from table 4.0above shows that there was no significant main effect of level of study on attitude towards sexual rights ($F(2,677) = .172$, $P > .05$, $\eta^2 = .001$). Hence, the null hypothesis is accepted.

Table 4.3b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by level of study between the treatment groups

Attitude	Mean	Std. Error
100 L	14.939	508
200 L	14.700	.227
300 L	14.875	.293

Table 4.3babove shows the Estimated Marginal Mean Score of attitude based on level of study. From the table presented 100 level had the highest mean score of 14.939, followed by 300level with a mean score of 14.875 and the least was 200level with a mean score of 14.700. This shows that the intervention was more effective on students in 100level.

Ho 3c: There is no significant main effect of level of study on sexual rights behaviour of female college of education students.

The results from table 4.0 above show that there was no significant main effect of level of study sexual rights behaviour ($F(2,677) = 1.085$, $P > .05$, $\eta^2 = .003$). Hence, the null hypothesis is accepted.

Table 4.3c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by level of study between the treatment groups

Behaviour	Mean	Std. Error
100 L	16.024	.193
200 L	16.055	.086
300 L	16.095	.111

Table 4.3cabove shows the Estimated Marginal Mean Score of sexual right behaviour based on level of study. From the table presented 300 level had the highest mean score of 16.095, followed by 200 level with a mean score of 16.055 and the least was 100 level with a mean score of 16.024. This shows that the intervention was more effective on the sexual rights behaviour of students in 300level.

Ho4a: There is no significant interaction effect of treatment and age on knowledge of sexual rights of female college of education students.

The results from table 4.0 above show that there was no significant interaction effect of treatment and age on knowledge of sexual rights ($F(1,678) = 2.118$, $P > .05$, $\eta^2 = .003$). Hence, the null hypothesis is accepted.

Table 4.4a: Estimated Marginal Mean Score showing the direction of differences in knowledge of sexual rights by interaction effect of treatment and age between the treatment groups

Dependent Variable	Treatment	Age	Mean	Std. Error
Knowledge of Sexual Rights	Experiment Group	Adolescents	27.227	.331
		Adults	27.123	.331
	Control Group	Adolescents	22.025	.394
		Adults	21.090	.176

Table 4.4aabove shows the Estimated Marginal Mean Score of knowledge based on interaction of treatment and age. This showed that adolescents obtained a higher mean score of 27.227 then the adults mean score of 27.123 in the experimental group while in the control group adolescents obtained a higher mean score of 22.025 than adults with a mean score of 21.090.This shows that the interaction effect of treatment was more on adolescents in the experimental group than adults.

Ho 4b: There is no significant interaction effect of treatment and age on attitude towards sexual rights of female college of education students.

The results from table 4.0 shows that there was no significant interaction effect of treatment and age on attitude towards sexual rights ($F(1,678) = .024$, $P > .05$, $\eta^2 = .000$). Hence, the null hypothesis is accepted.

Table 4.4b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by interaction effect of treatment and age between the treatment groups

Dependent Variable	Treatment	Age	Mean	Std. Error
Attitude towards Sexual Rights	Experiment Group	Adolescents	17.398	.364
		Adults	17.473	.156
	Control Group	Adolescents	10.799	.434
		Adults	10.707	.194

Table 4.4b shows the Estimated Marginal Mean Score of attitude based on interaction of treatment and age. The table shows that the adults in the experimental group obtained a higher means score of 17.473 and the adolescents had a mean score of 17.398 while the adolescents in the control group obtained a higher mean score of 10.799 than the adults that had a mean score of 10.707. This implies that the interaction effect of treatment was more effective on the adults than the adolescent.

Ho 4c: There is no significant interaction effect of treatment and age on sexual rights behaviour of female college of education students.

The results from table 4.0 above shows that there was a significant interaction effect of treatment and age on sexual rights behaviour ($F(1,678) = 1.348$, $P > .05$, $\eta^2 = .002$). Hence, the null hypothesis is accepted.

Table 4.4c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by interaction effect of treatment and age between the treatment groups

Dependent Variable	Treatment	Age	Mean	Std. Error
Sexual Right Behaviour	Experiment Group	Adolescents Adults	17.047 16.976	.153 .066
	Control Group	Adolescents Adults	14.870 14.623	.182 .081

Table 4.4c: Table of Estimated Marginal Mean Score of sexual rights behaviour based on interaction of treatment and age .The table shows that the adolescents in the experimental group obtained a higher mean score of 17.047 and the adults had a mean score of 16.976 while the adolescents in the control group had a mean score of 14.870 and the adults 14.623. This implies that the interaction effect on treatment was more effective on the adolescents than the adults.

Ho5a: There is no significant interaction effect of treatment and level of study on knowledge of sexual rights of female college of education students in Anambra State.

The results from table 4.0 above shows that there was no significant interaction effect of treatment and level of study on knowledge of sexual rights($F(2,677) = .257$, $P > .05$, $\eta^2 = .001$). Hence, the null hypothesis is accepted.

Table 4.5a: Estimated Marginal Mean Score showing the direction of differences in knowledge of sexual rights by interaction effect of treatment and level of study between the treatment groups

Dependent Variable	Treatment	Level of Study	Mean	Std. Error
Post-Knowledge about Sexual Rights	Experimental	100 L 200 L 300 L	27.059 27.141 27.165	.363 .178 .225
	Control	100 L 200 L 300 L	21.458 21.153 21.590	.502 .214 .261

Table 4.5a shows the Estimated Marginal Mean Score of knowledge of sexual rights based on interaction of treatment and level of study. This shows that the 300 level students in the experimental group obtained a higher mean of 27.165, followed by 200Level with the

mean 27.141 and the least 100l with the mean score of 27.059 while in the control group 300L had the highest mean score of 21.590, followed by 100 Level with the mean score of 21.458 and the least 200 level with the mean score of 21.153. This shows that the interaction effect on treatment was more effective on 300 level students.

Ho 5b: There is no significant interaction effect of treatment and level of study on attitude towards sexual rights of female college of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of treatment and level of study on attitude towards sexual rights($F(2,677) = ..073$, $P > .05$, $\eta^2 = .000$). Hence, the null hypothesis is accepted.

Table 4.5b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by interaction effect of treatment and level of study between the treatment groups

Dependent Variable	Treatment	Level of Study	Mean	Std. Error
Post-Attitude towards Sexual Rights	Experimental	100 L 200 L 300 L	17.372 17.441 17.524	.421 .491 .248
	Control	100 L 200 L 300 L	10.708 10.717 10.736	.552 .235 .309

Table 4.5b: shows theEstimated Marginal Mean Score of attitudetowards sexual rights based on interaction of treatment and level of study. This shows that the 300 Level in the experimental group obtained a higher mean score of 17.524, followed by 200 level with the mean score of 17.441 and the least 100 Level with the mean score of 17.372 while in the control group, 300 level had the highest mean score of 10.736, followed by 200 level with the mean score of 10.717 and the least 100 Level with the mean score of 10.708. This implies that the interaction effect in treatment was more effective for the 300 level students.

Ho 5c: There is no significant interaction effect of treatment and level of study on sexual rights behaviour of female college of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of treatment and level of studyon sexual rights behaviour ($F(1,678) = 1.348$, $P > .05$, $\eta^2 = .002$). Hence, the null hypothesis is accepted.

Table 4.5c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by interaction effect of treatment and level of study between the treatment groups

Dependent Variable	Treatment	Level of Study	Mean	Std. Error
Sexual Right Behaviour	Experimental	100 L	16.940	.177
		200 L	17.004	.082
		300 L	16.977	.104
	Control	100 L	14.433	.231
		200 L	14.675	.099
		300 L	14.718	.129

Table 4.5c shows the Estimated Marginal Mean Score of sexual rights behaviour based on interaction of treatment and Level of study. The result presented showed that in the treatment group 200 level obtained a higher mean score of 17.004 followed by 300 level with the mean score of 16.977 and the least 100 level with the mean score of 16.940. Also from the table, in the control group, 300 level obtained a higher mean score of 14.718 followed by 200 level with the mean score of 14.675 and the least 100 level with the mean score of 14.433. This shows that the interaction effect of treatment was more effective on 300 level students.

Ho6a: There is no significant interaction effect of age and level of study on knowledge of sexual rights of female colleges of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of age and level of study on knowledge of sexual rights($F(2,677) = 1.285$, $P > .05$, $\eta^2 = .004$). Hence, the null hypothesis is accepted.

Table 4.6a: Estimated Marginal Mean Score showing the direction of differences in knowledge of sexual rights by interaction effect of age and level of study between the treatment groups

Dependent Variable	Age	Level of Study	Mean	Std. Error
Post-Knowledge about Sexual Rights	Adolescents	100 L	25.629	.871
		200 L	24.921	.518
		300 L	25.025	.692
	Adults	100 L	24.789	.525
		200 L	24.661	.219
		300 L	24.984	.279

Table 4.6aabove shows the Estimated Marginal Mean Score of knowledge of sexual rights based on interaction of age and level of study.The result presented showed that adolescents in 100 level obtained a higher mean score of 25.629 followed by 300 level with mean score of 25.025 and the least 200 level with the mean score of 24.921, while the adults at 300 level obtained the highest mean score of 24.984 followed by 100 level with the mean score of 24.789 and the least 200 level with the mean score of 24.661 This overall comparison shows that adolescents in 100 level had the highest mean score than adults in 300 level. This implies that the interaction effect of age and level of study was more effective on the adolescents in 100 level.

Ho6b: There is no significant interaction effect of age and level of study on attitude towards sexual rights of female colleges of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of age and level of study on attitude towards sexual rights($F(2,677) = .764$, $P > .05$, $\eta^2 = .002$). Hence, the null hypothesis is accepted.

Table 4.6b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by interaction effect of age and level of study between the treatment groups

Dependent Variable	Age	Level of Study	Mean	Std. Error
Attitude towards Sexual Rights	Adolescents	100 L	15.176	.987
		200 L	14.622	.587
		300 L	14.456	.784
	Adults	100 L	14.855	.594
		200 L	14.715	.248
		300 L	14.941	.316

Table 4.6babove shows the Estimated Marginal Mean Score of attitude towards sexual rights based on interaction of age and level of study. This shows that adolescents in 100 level had the highest mean score of 15.176, followed by 200 level with the mean score of 14.622 and the least 300 level with the mean score of 14.456 while adults in 300 level obtained a higher mean score of 14.941, followed by 100 level with the mean score of 14.855 and the least 200 level with the mean score of 14.715. This comparison shows that adolescents in the 100 level had the highest mean score than the adults in 300 level.

Ho6c: There is no significant interaction effect of age and level of study on sexual rights behaviour of female colleges of education students in Anambra State.

The results from table 4.0 above show that there was a significant interaction effect of age and level of study on sexual rightsbehaviour ($F(2,677) = 4.847$, $P< .05$, $\eta^2 = .014$). Hence, the null hypothesis is rejected.

Table4.6c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by interaction effect of age and level of study between the treatment groups

Dependent Variable	Age	Level of Study	Mean	Std. Error
Sexual Rights Behaviour	Adolescents	100 L	16.442	.374
		200 L	16.201	.222
		300 L	15.875	.297
	Adults	100 L	15.872	.225
		200 L	16.029	.094
		300 L	16.131	.119

Table 4.6cabove shows the Estimated Marginal Mean Score of sexual rights behaviour based on interaction of age and level of study. This shows that adolescents in 100 level obtained the highest mean score of 16.424, followed by 200 level with the mean score of 16.202 and the least 300 level with the mean score of 15.875 while adults in 300 level had the highest mean score of 16.131, followed by 200 level with the mean score of 16.029 and the least 100 level with the mean score of 15.872. This comparison shows that adolescents in the 100 level obtained the highest mean score than the adults in 300 level. This implies that the interaction effect on age and level of study was more effective on the 100 level adolescent.

Ho7a: There is no significant interaction effect of treatment, age and level of study on Knowledgeof sexual rights among female college of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of treatment, age and level of study on knowledge of sexual rights($F(2,677) = .556$, $P>.05$, $\eta^2 = .002$). Hence, the null hypothesis is accepted.

Table 4.7a: Estimated Marginal Mean Score showing the direction of differences in knowledge of sexual rights by interaction effect of treatment, age and level of study between the treatment groups

Dependent Variable	Treatment Groups	Age	Level of Study	Mean	===Std. Error
Knowledge of Sexual Rights	Experimental Group	Adolescents	100 L	27.330	.764
			200 L	27.289	.469
			300 L	27.070	.594
		Adults	100 L	26.960	.442
			200 L	27.118	.192
			300 L	27.182	.243
	Control Group	Adolescents	100 L	23.123	.936
			200 L	21.880	.530
			300 L	21.600	.765
		Adults	100 L	20.780	.595
			200 L	21.012	.234
			300 L	21.589	.302

Table 4.7aabove shows the Estimated Marginal Mean Score of knowledge of sexual rights based on interaction of treatment, age and level of study. This shows that in the treatment group, adolescents at 100 level had the highest mean score of 27.330, followed by 200 level with the mean score of 27.289 and the least 300 level with the mean score of 27.070 while adults in 300 level obtained the higher mean score of 27.182 followed by 200 level with the mean score of 27.118 and the least 100 level with the mean score of 26.960. In the control group, adolescent in the 100 level had the highest mean score of 23.123, followed by 200 level with the mean score of 21.880 and the least 100 level with the mean score of 21.6000. While the adults at 300 level had the highest mean score of 21.589, followed by 200 level with the mean score of 21.012 and the least 100 level with the mean score of 20.780. The overall comparison shows that adolescents in the 100 level obtained the highest mean score than the adults. This means that the interaction effect on treatment, age and level of study was more effective on 100 level adolescents.

Ho7b: There is no significant interaction effect of treatment, age and level of study on attitude toward sexual rights of female college of education students in Anambra State.

The results from table 4.0 above show that there was no significant interaction effect of treatment, age and level of study on attitude towards sexual rights($F(2,677) = 270$, $P > .05$, $\eta^2 = .001$). Hence, the null hypothesis is accepted.

Table 4.7b: Estimated Marginal Mean Score showing the direction of differences in attitude towards sexual rights by interaction effect of treatment, age and level of study between the treatment groups

Dependent Variable	Treatment Groups	Age	Level of Study	Mean	===Std. Error
Attitude towards Sexual Rights	Experimental Group	Adolescents	100 L 200 L 300 L	17.997 17.588 16.732	.843 .517 .655
		Adults	100 L 200 L 300 L	17.163 17.418 17.655	.488 .212 .268
	Control Group	Adolescents	100 L 200 L 300 L	10.993 10.812 10.645	1.032 .585 .843
		Adults	100 L 200 L 300 L	10.592 10.699 10.749	.657 .258 .333

Table 4.7b above shows the Estimated Marginal Mean Score ofattitudetowards sexual rights based on interaction of treatment, age and level of study. The result presented shows that in treatment group, adolescents at 100 level obtained the highest mean score of 17.997, followed by 200 level with the mean score of 17.588 and the least 300 level with the mean score of 16.732 while adults at 300 level obtained the highest mean score of level obtained the highest mean score of 17.655, followed by 200 level with the mean score of 17.418 and the last 100 level with the mean score of 17.163. In the control group, 100 level adolescents had the highest mean score of 10.993, followed by 200 level with the mean score of 10.812 and the least 300 level with the mean score of 10.645 while adults at 300 level obtained the highest mean score of 10.749, followed by 200 level with the mean score of 10.699 and the least 100 level with the mean score of 10.592. The overall comparison shows that adolescents at 100 level obtained the highest mean score than the

adults. This means that the interaction effect on treatment on age and level of study was more effective on the 100 level adolescents.

Ho7c: There is no significant interaction effect of treatment, age and level of study on sexual rights behaviour of female college of education students in Anambra State.

The results from table 4.0 above show that there was a significant interaction effect of treatment, age and level of study on sexual rights behaviour ($F(2,677) = 2.710$, $P< .05$, $\eta^2 = .008$). Hence, the null hypothesis is rejected.

Table 4.7c: Estimated Marginal Mean Score showing the direction of differences in sexual rights behaviour by interaction effect of treatment, age and level of study between the treatment groups

Dependent Variable	Treatment Groups	Age	Level of Study	Mean	===Std. Error
Sexual Rights Behaviour	Experimental Group	Adolescents	100 L	17.080	.350
			200 L	17.129	.215
			300 L	16.899	.272
		Adults	100 L	16.889	.203
			200 L	16.984	.088
			300 L	16.990	.111
	Control Group	Adolescents	100 L	15.503	.426
			200 L	15.010	.243
			300 L	14.166	.350
		Adults	100 L	13.998	.273
			200 L	14.610	.107
			300 L	14.803	.138

Table 4.7cshows the Estimated Marginal Mean Score of sexual rights behaviour based on interaction of treatment, age and level of study. The result presented shows that in treatment group, adolescents at 200 level obtained the highest mean score of 17.129, followed by 100 level with the mean score of 17.080 and the least 300 level with the mean score of 16.899 while adults at 300 level obtained the highest mean score of 16.990, followed by 200 level with the mean score of 16.984 and the least 100 level with the mean score of 16.889. In the control group, the 100 level adolescent had the highest mean score of 15.503, followed by 200 level with the mean score of 15.010 and the least 300 level with the mean score of 14.166. While adults at 300 level obtained the highest mean score of 14.803, followed by 200 level with the mean score of 14.610 and the least 100 level with mean score of 13.998. The overall comparison shows that adolescents at 200 level

obtained the highest mean score than the adults. This implies that the interaction effect on treatment, age and level of study was more effective on the 200 level adolescents.

Discussion of findings

The result of the study revealed that the main effect of the treatment on knowledge, attitude and sexual rights behaviour were significant. This is in line with Esere (2008) who recorded a statistically significant difference between the intervention and control groups in relation to risky sexual behaviours after exposure to an 8week sexuality intervention. He stressed further that adolescents in the intervention group reported less at-risk sexual behaviours than their control group counterparts and knowledge of sexual and reproductive health, family planning and transmission and prevention of STIs and AIDS was found to be significantly higher in the intervention group than in the control group. The result also tallied with the view of Alan Guttmacher Institute (2004) who concluded that many young people do not even know that they have sexual rights, let alone know how to assert them. In their study they found that less than 30% of adolescents knows that it is their right to have access to sexual and reproductive health care services; 12% knows that it is their right to have access to sexuality education; 26.1% have knowledge about sexual right for respect for bodily integrity and choose their partner while 30.6% have knowledge about sexual right to decide to be sexually active or not and consensual sexual relations. This led to the conclusion that there is poor knowledge of sexual rights among adolescents.

The result of this study also corroborates the view of Ogunlayi (2005) who affirmed that the young female were aware of their sexual and reproductive health rights but they lacked knowledge of the contexts of the rights. A study in Lagos, Nigeria shows that adolescents educational level are crucial to their knowledge of preventive factors that can predispose them to sexual and reproductive ill health. The more educated an adolescent, the better his or her chances of taking precaution to prevent unwanted pregnancy and STIs and vice-versa. In the same vein, Esere (2008) study outcome was also in affirmation that, the level of young people understands of human sexuality limits their ability to make informed decisions. Similarly, Stone, Ingham and Sinikhada (2009)

concluded that poor knowledge about many aspects of sexual rights is unlikely to encourage the use of sexual and reproductive health services.

The result of hypothesis two is corroboratedby the findings of Nakpodia (2012) who conducted a study on the relevance of sex education in secondary school curricula in Abraka metropolis, Delta state, Nigeria. The target population were public senior secondary school teachers in Delta State, Nigeria and the findings revealed that there was significant difference in the attitude of teachers towards the relevance of sex education based on their educational status or attainment.

The result of hypothesis three is in line with Udigwe, Adogu, Nwabueze, Adinma, Ubajaka, andOnwasigwe (2014) study that result revealed that, the common reasons for first sexual intercourse for both groups (unmarried female secondary school student adolescents and non-student adolescents) was pressure from partner or boyfriend. However, more of the student adolescents (29.3%) engaged in transactional sex, while more of their non-student counterparts were forced or coerced into sex (19.2%). According to the finding, sexual practice among the girls was statistically significantly associated with age and educational status. This result is also in agreement with Warenius, Faxelid, Chislimbs, Musandu, Ong' any and Nissen (2006) affirmation that a pragmatic attitude was necessary in handling sexual rights attitudes. They observed that those people with more education and those who had receive continuing education, adolescent sexual and reproduction showed a tendency towards more youth-friendly attitude. In Nigeria today, people show negative attitude to sexual rights because they are reluctant to discuss sexuality and sex health/education openly as they are usually shrouded in secrecy.

The findings of this study in hypothesis four falls in line with Kirby, Obasi and Laris (2006) who stated that among the 66 studies that measured the impact of sex education programmes on condom use, 25 (38 per cent) found that the programmes they evaluated increased condom use, while 41 (62 per cent) concluded that the programmes evaluated had had no impact in changing condom use. In no case did the studies available indicate that sex education programmes reduced the level of condom use. Among the 36 studies referring to the United States, the proportion of programmes that increased condom use was also 38 per cent. The number of programmes in developing countries that were the object of evaluation was smaller (23) and a similar proportion increased condom use (35

per cent). Among the seven programmes in developed countries other than the United States, three (43 per cent) increased condom use.

The result of hypothesis five tallied with that of Kirby (2007), also in support of the finding stated that when the effect of his sexuality education meta-analysis was done on one or more sexual behaviours, 62 of the 97 studies available influenced at least one behaviour in a positive way either for the entire sample in the programme or for a relevant sub-group. In addition, 28 per cent of the 97 programmes improved at least two behaviours among young people. Also among the 18 studies that used biomarkers to measure the impact of sex education programmes on the incidence of pregnancy or sexually transmitted infections, five showed significant reductions while 13 did not. In line with the outcome of this study, Henderson (2007) study revealed that even effective sex education programmes reduced risky sexual behaviour only moderately across age group depending on their level of education. The most effective programmes tended to reduce risky sexual behaviour by one-fourth to one-third. Thus, if 30 per cent of the young people in the control group had unprotected sex during a given period, a successful programme might reduce the prevalence of that behaviour to 20 per cent among the group of young people participating in the programme. The overall reduction in risky behaviour amounted therefore to 10 percentage points or one third with respect to the prevalence of risky behaviour in the control group. A meta-analyses of studies carried out in the United States shows that behavioural change of this magnitude can lead to significant reductions in pregnancy rates and in the incidence of sexually transmitted infections.

The results of Ketting and Winkelmann, (2013) also agreed with this result when he found that participants demonstrated a very low level of knowledge about reproductive matter. In his study he found a poor knowledge of reproductive issues while Dienye (2011) found incomplete and inaccurate knowledge about sexual health issues.

The result of hypothesis six is in agreement withUdigwe, Adogu, Nwabueze, Adinma, Ubajaka, andOnwasigwe (2014) who conducted a study on the Factors that influence sexual behavior among Female Adolescents in Onitsha, Nigeria with sample size of 400 respondents comprises of unmarried female secondary school student adolescents and non-student adolescents aged 10 - 19 years. As such, their result revealed that the common reasons for first sexual intercourse for both groups (unmarried female secondary

school student adolescents and non-student adolescents) was pressure from a partner or from a boyfriend. However, more of the student adolescents (29.3%) were engaged in transactional sex, while more of their non-student counterparts were forced or coerced into sex (19.2%). According to the, sexual practice among the girls was statistically significantly associated with age and educational status

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary, conclusion and recommendations which were drawn based on the result of the findings. The contributions to knowledge as well as suggestions for further studies were based on the identified limitations of the study.

Summary

The study focused on the efficacy of sexuality education on knowledge, attitude and sexual rights protective behaviour of femalestudents in Colleges of Education, Anambra State.

The variables for the study were knowledge of sexual rights, attitude towards sexual rights and sexual rights protective behaviour as dependent variables, age and level of study as moderating variables. Relevant literature werereviewed in chapter two of the work.

The quasi-experimental research design of pretest, post-test was used for the study. The choice of this design becomes relevant because it allowed the researcher to introduce a new intervention to the experimental group and take measurement both before and after intervention to be able to establish effect observed between the experimental and control group. The multistage sampling procedure was adopted for the study.

The first stage involved the purposive sampling technique of selecting the two Colleges of Education in Anambra state. The second stage involved randomization whereby students of Nwafor Orizu College of Education were used as experimental group while students of Federal College of Education (Technical) Umunze served as the control group. The fish bowl method ofrandom sampling technique was used to select 50% of the six schools in each of the colleges of education. Thereafter, the proportionate random sampling techniques of the departments in each selected school were sampled. The systematic sampling technique was used to select 680 students who participated for the study.

Data collection for the study was carried out using modules of sexuality education on knowledge, attitude towards sexual rights and behaviour for the experimental group and a placebo for the control group and a self-developed and validated questionnaire on the

variables under study with a reliability coefficient of 0.86 and focus group discussion. Ten (10) research assistants were used during data collection.

The field testing of the instrument was carried out with 20 students of the Colleges of Education who were not part of the sampled participants for the study. The data was analysed using descriptive statistics of frequency counts and percentages for the demographic characteristics of respondents while the inferential statistics of MultivariateAnalysis of Covariance (MANCOVA) was used to determine the main as well as the interaction effects of the independent, dependents and moderating variables. The study provided answers to three research questions and tested seven hypotheses each with three sub-variables, making it twenty one sub-variables three of the sub-variables were rejected while the remaining eighteen were accepted. The result of the study shows that treatment was effective on knowledge, attitude towards sexual right and sexual behaviour while age and level of study had no significant effect on knowledge, attitude towards sexual right and sexual behaviour. The results also showed that the interaction effect of treatment, age and level of study were not significant.

Recommendations were made thus; the school curriculum should be reviewed so as to make sexuality education a compulsory course in Colleges of Education in Anambra State. This enable the young people to have a clear and sound knowledge of their sexual rights at their youthful age.

Conclusion

Based on the findings, the researcher concluded that sexuality education package was effective on knowledge, attitude towards sexual rights and sexual protective behaviour of female students in College of Education Anambra State. Age and level of study had no significant effect on knowledge, attitude towards sexual rights and sexual rights protective behaviour. The interaction effects of treatment, age and level of study were not significant on knowledge, attitude towards sexual rights and sexual rights protective behaviour.

Recommendations

In order to enhance sexuality education and strengthen sexual rights among the female students, the following recommendations are hereby made:

1. Family life and sexuality education should be given attention in the curriculum of Colleges of Education in Anambra State as general study by all students
2. Government and the educational institutions should embark on capacity building for the facilitators and the health instructors that handle sexuality education programmes. This will enhance their teaching skills.
3. Modern teaching aids and materials should be provided for teachers. This will facilitate effective learning among the students and also enrich their knowledge of sexual rights and protective behaviour.
4. The school curriculum should be reviewed so as to make sexuality education a compulsory course of study. This will enable the young people to have a clear and sound knowledge of their sexual rights at their youthful age.
5. Parents should be encouraged through rigorous awareness campaign programme on the need and importance of giving children a sound sexuality education at a tender age. This will boost the self-confidence and self-esteem of children essential to improve attitude towards sexual rights and protective behaviour.

Contribution to Knowledge

The study assessed the efficacy of sexuality education on knowledge, attitude and sexual rights protective behaviour of female students in colleges of education, Anambra state. This study has contributed to knowledge thus:

i. It added to the existing relevant literature on sexuality education in Nigeria.
ii. The result from the study will serve as empirical evidence for programme officers whose work include sexuality education to justify and strengthen their work.
iii. The study provided credible source of literature for researchers, students and other people who have interest in sexual rights education.
iv. The study will further change attitude and positive behaviour towards sexual rights which will enhance the quality of healthy life among study participants.
v. The study will also aid policy makers, health educator, donor agencies, government and international agencies who come in contact with this thesis to

formulate strategies and implement policies that will promote sexual rights among young people.

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Appendix I

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION, FACULTY OF EDUCATION, UNIVERSITY OF IBADAN.

QUESTIONNAIRE ON EFFICACYOF SEXUALITY EDUCATION PROGRAMME ON KNOWLEDGE, ATTITUDE AND SEXUAL HEALTH RIGHTS PROTECTIVE BEHAVIOUR OF FEMALE STUDENTS IN THE COLLEGES OF EDUCATION ANAMBRA STATE, NIGERIA

Dear Respondent,

I am a post-graduate student of the Department of Human Kinetics and Health Education, Faculty of Education in the University of Ibadan. I wish to solicit your utmost co-operation and honest response in completing the questionnaire which is purely for academic exercise and confidentiality of your responses is highly assured. Your participation is voluntary and your responses will be treated with strict confidentiality.

Thank you.

Yours sincerely,

Ibeagba, N.E.

SECTION A: DEMOGRAPHIC DATA

Instruction: Please tick the appropriate column that best represent your opinion.

1. Name of Institution: (1) Nwafor Orizu College of Education ( )
   (2) Federal College of Education (Technical) Umunze ( )

Age: (1) Less than 15 years (2) 16- 19 years ( ),
(3) 20-24years( ), (4) 25-29 years ( ),
(5) 30 - 34 years (6) 35 years and above ( )

3. Ethnicity: (1) Ibo ( ), (2) Yoruba ( ),
   (3) Hausa ( ) (4) Others ( )
4. Marital Status: (1) Married ( ) (2) Single parent ( )
   (3) Separated ( ) (4) Divorced ( )
5. Religion: (1) Christianity ( ) (2) Islam ( )
   (3) Traditional ( ) (4) Others (please specify ( ).....
6. School: (1) School of Science ( ) (2) School of Social Science ( )
   (3) School of Languages ( ) (4) School of Education ( )
   (5) School of Vocational and Technical Education ( )
   (6) School of Arts ( )
7. Department: _____
8. Level of Study: (1) 100L ( ) (2) 200L ( )
   (3) 300L ( )
9. When last did you have sex: (a) Within a week ago ( )
   (b) Within a month ago ( ) (c) 2-4 months ago ( )
   (d) 5 - 7 months and above ( )
   (e) I have not had sexual intercourse before ( )

SECTION B

KNOWLEDGE ABOUT SEXUAL RIGHTS QUESTIONNAIRE (KSRQ)

Please tick either True or False as it appears to you on each item.

Please read the following statement before responding to each item: A lady knows her sexual right if she…..		**True**	**False**
10	Refuses to be discriminated against because she is a woman/girl		
11	Resist unwanted touching by boy/man		
12	Decide freely on when to use contraceptive		
13	Resist being rape		
14	Freely enter into sexual relationship without being threatened/forced/coerced		
15	Decide freely when to get pregnant		
16	Decide freely on any type of sexual activity regardless of partners wish		
17	Demand for STIs/HIV/AIDS/Sickle cell anaemia status before sex or marriage		
18	Frowns at verbal sexual abuse against her		
19	Discourage being ask sexy questions from an unwanted person		
20	Resist being shown sexy objects against her wish		
21	Resist hugging/kissing from an unwanted person		
22	Demand mutual respects in all sexual relationship		
23	Demand consent before any action relating to her sexuality can be taken		

SECTION C

ATTITUDE TOWARDS SEXUAL RIGHTS QUESTIONNAIRE (ATSRQ)

Please tick the option on each item in line with your level of agreement.

		SA	A	D	SD
24	Girls that are social have many sex partners				
25	Girls that are social have many dressing to show sensitive parts of ones body show one is fashionable				
26	It is not proper to refuse sex when a man says he loves me				
27	It is good to kiss or be kissed by a boy/man who says he love me				
28	Refusing hugging by anybody is unfashionable				
29	It is disrespectful to demand for STIs/HIV/AIDS status and sickle cell anaemia status of would be sex/marriage partner				
30	Parents have right to circumcise their female children				
31	Men should decide on all matters relating to sexual activities				
32	Demanding for condom use before sexual intercourse shows one doubts the sincerity of the sex partners				

SECTION D

SEXUAL RIGHTS PROTECTIVE BEHAVIOUR QUESTIONNAIRE (BTSRQ)

Please tick either Yes or No as it appears to you on each item

		Yes	No
33	I have many sex partners		
34	I demand for use of condom before sex		
35	I demand for STIs/AIDS status of my sex partner		
36	I resist verbal sexual abuse		
37	I resist being discriminated against my gender		
38	I resist non-consensual sexual relations		
39	I refuse coercive behaviour from lecturers and male counterparts		
40	I demand mutual respect from my partner		
41	I pursue safe and satisfying sexual life		

Thank you.

APPENDIX II

INFORMED CONSENT FORM FOR PARTICIPATION IN RESEARCH

(Qualitative research by interview, focus group discussion, experiment and so on)

I..... being an adult over the age of 18 years hereby consent to participate as requested for the research project on.....

1. I have read and fully understand the information provided by the researcher(s)
2. I have been given details of procedures for the research and risks have been explained to my understanding and satisfaction.
3. I give consent and approval to audio/video recording of my information and participation.
4. I am fully aware that I should keep a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:

   -I may not directly benefit (materially or otherwise) from taking part in this research;

   -I am free to pull out from the project at any time and I am free to refuse to answer particular question(s);

   -While the information gathered in this research will be published as discussed with me, I will not be identified, and individual or personal information will remain confidential;

   -Whether I participate or not, or withdraw after participating, will have no impact on any treatment or service that is being offered to me;

   -Whether I participate or not, withdraw after participating, will have no effect on my progress in my course of study, or results gained; and

   -I could request that the recording/observation be terminated at any time, and that I may pull out at any time from the session or the research without any disadvantage whatsoever.
6. I agree/do not agree *to the tape/transcript* being made available to other researcher(s) who are not members of this research team, but who are assumed or

adjudges by the research team to be doing related research, on condition that my identity is not revealed. *delete as appropriate*

7. I have discussed taking part in this research with a family member, colleague or friend.

Participant's Signature…….

Date…….

I certify that I have explained the study to the volunteer and consider that she understands what it entails and freely consent to be a participant in the research. Researcher's Name……
……

Researcher's Signature..... Date.....

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorization of items 8 and 9, appropriately.

8. I, the volunteer participant whose signature appears below, have read a transcript of my information and consent to its use by the researcher as discussed.
   Participant's Signature.....Date.....

9. I, the participant whose signature appears below, have read the researchers report and agree to the publication of my information as reported.
   Participant's Signature.....Date.....